Factors that influence music therapy inclusion in adolescent residential treatment in Utah

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Abstract

Utah houses a significant number of adolescent treatment programs, but many do not offer music therapy services to their clients. Music therapy has been not only effective with adolescents (Gold, Voracek, & Wigram, 2004) but also important in their psychological development (Laiho, 2004). This thesis explores the question, "What are the factors that influence music therapy inclusion in adolescent residential treatment in Utah?" The researcher conducted interviews via phone or in person with seven clinical directors at adolescent residential treatment centers in Utah. Three of these programs were already implementing music therapy. The researcher then transcribed the interviews and coded the data into factors that stood out in each interview question, as well as overarching themes across multiple questions. Several of these factors include client need, evidenced-based practice, review through facility leadership, music therapist qualifications, the importance of music with adolescents, connecting with decision makers and insight into the current understanding of music therapy from the clinical directors. Three main themes were developed as well which included fitting in with the facility, cost effectiveness, and in-house music. Discussion of current research backing up these themes was addressed.

Acknowledgements

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I am passionate about my work with adolescents and hope this can provide some insight into furthering music therapy services for teens by gaining insight into the business and logistics side of implementing new programs.

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Introduction

Background

Music is a crucial aspect of adolescence and music therapists play an important role in realizing its power with adolescents in treatment. Adolescents engage in nine hours of media on average, including music and video, per day. Sixty-six percent of them use music more than any other media (Common Sense Media, 2015). Additionally, the music listened to in adolescence and early adult years stays with them throughout their lives, due to the way the brain is forming at that time (Giedd, 2002). Because of this, music plays an important role in development and identity. Many adolescents deal with serious struggles including depression, self-doubt, and substance abuse. It has been revealed that adolescents use music in healthy ways for coping but also in unhealthy ways (Saarikallio, Gold, & McFerran, 2015). Using music to decrease depression, anxiety, substance use, and behavioral concerns are just some of the areas targeted by music therapists when working with this population. Additionally, adolescents in treatment have found that music therapy is motivating (Doak, 2003) and numerous studies have demonstrated it to be effective (Gold, Voracek, & Wigram, 2004, McFerran, 2010, American Music Therapy Association, n.d.). Music therapy programs and services can be implemented for adolescents in numerous sites. Some of these sites include music therapists who are employed as well as contracted through a private practice.

Many music therapists work in a variety of settings but are increasingly working in private practice (Silverman & Hairston, 2005) as opposed to being an employee. According to the American Music Therapy Association's 2017 Workforce Analysis, 26% of music therapists work in private practice and own their own businesses. In private practice, music therapists are often required to take on business roles in order to market and create new programming and

contracts. However, business courses are not included in the curriculum for the undergraduate degree in music therapy, which could result in a lack of general business knowledge for music therapists. Because of this, effectively marketing and proposing music therapy services as well as collaborating with business consultants is crucial for development and sustainability in the field (Kern & Tague, 2017). Other barriers may include budget restraints, lack of time to coordinate, or little understanding about music therapy services (Kern & Tague, 2017). These obstacles and others result in the absence of music therapy services provided to adolescents.

Problem

Music therapy has made a significant difference in the treatment of my clients. When working with adolescents I have heard them say phrases such as, *music saved my life* and *music is my life*. The work of a music therapist is not only evidence based but very important to the adolescents we serve. Aletraris, Paino, Edmond, Roman, & Bride (2014) stated, "There is a lack of nationally representative data addressing the organizational settings of art and music therapy" (para 12). Because of this, it is difficult to find out where music therapy services for adolescents are offered.

Residential treatment centers (RTCs) are settings in which adolescents can benefit from music therapy services; Utah houses the most adolescent residential treatment programs in the nation (Woodbury Reports, Inc., 2012). However, it appears that only a small percentage of RTCs offer music therapy services. The Utah Department of Human Services currently lists 220 residential programs that are licensed in Utah (Utah Division of Human Services, 2018). These however include adult services as well as adolescent services. I chose to only review the directory of The National Association of Therapeutic Schools and Programs (NATSAP). While there are several associations and accreditations RTCs can register with, in Utah, The National

Association of Therapeutic Schools and Programs (NATSAP, 2018) seems to be one of the most widely accepted. NATSAP currently list 51 programs registered in Utah out of 187 programs listed nationwide. Of these programs, only eight are implementing music therapy services. These eight programs were identified through speaking with Utah music therapists and business owners and the Utah Association of Music Therapists collaborative file entitled, Utah Music Therapy Employers, through a private Facebook group (UAMT, 2018).

In 2017, 13% of members of the American Music Therapy Association (AMTA) reported working with teens and 16% reported working with young adults. Both of these populations will be addressed in this research study, as they reside in RTCs being interviewed. In a recent survey, 100% of Utah businesses that utilize music therapy services would recommend music therapy to other businesses (Utah Association of Music Therapists, 2016). These statistics brought up an significant question; if music therapy is beneficial and important to adolescents and every business in Utah that uses music therapy would recommend it to others, why are more RTCs not implementing a music therapy program?

Few studies have been carried out to look into this type of research question, for any clinical population. Hilliard (2004) identified that music therapy services are underutilized in hospice settings and proposed that it would be helpful to contact decision makers to find out reasons, according to them, for implementing or declining music therapy services. This was done through a survey sent via email and contained short answers and yes and no questions. I intended to conduct a similar study targeting the population of adolescents in RTCs in Utah. Additionally, I focused on a qualitative interview style to obtain richer information. Therefore, the purpose of this study was to explore deciding factors of music therapy inclusion in adolescent residential treatment centers in Utah.

Definitions

Music Therapy. The American Music Therapy Association defines music therapy as "the clinical and evidenced-based use of music intervention to accomplish individualized goals within a therapeutic relationship… to address physical, emotional, cognitive, and social needs of the individuals" (AMTA, 2018, para 1).

Residential Treatment. Residential treatment refers to a setting in which individuals reside overnight and for extended periods of time to work on treatment needs.

Adolescents. Adolescents include individuals ranging from ages 10-19 (World Health Organization, 2019).

Limitations

Time constraints are a limitation in this study, as there were only four weeks allotted to conduct the interviews. This study was beneficial for me with my work in private practice and adolescents and could also be helpful for other Utah music therapists. It may transfer to other therapists across the country in similar situations but may not be able to be generalized. Austin and Sutton (2015) share, "it is not the intention of qualitative research to allow the findings to be generalized, and therefore this is not, in itself, a limitation" (p.230).

Research Question

What are the factors that influence music therapy inclusion in adolescent residential treatment in Utah?

Review of Literature

Music Therapy

Music therapy involves using a set of specific music interventions to address emotional, cognitive, behavioral, physical, and social goal areas through the therapeutic relationship a music therapist gains with their client. These interventions could include songwriting, improvisation, receptive music listening, or active music making. The music is usually geared towards the client's preferred music, as that is most effective (Grocke & Wigram, 2007; Yinger & Gooding, 2014), and is focused on the goals and objectives obtained during a music therapy assessment. Documentation and data collection are done regularly to show session outcomes (American Music Therapy Association, 2018).

Bruscia (2014) is also well known in the field for defining music therapy further. He states:

> Music therapy is a reflexive process wherein the therapist helps the client to optimize the client's health, using various facets of music experience and the relationships formed through them as the impetus for change. As defined here, music therapy is the professional practice component of the discipline, which informs and is informed by theory and research (Chapter 4).

This definition can also be broken up into four methods of music therapy. These methods include: Improvisational, Re- creative, Compositional, and Receptive music therapy. These methods are music experiences for assessment, treatment, and/or evaluation (Chapter 13).

Music therapy has also been identified as an experiential therapy (Calabro, 2016). Oxford Treatment Center (2017) defines experiential therapy as, "based in the idea that sometimes people can gain a better understanding of themselves through experiencing and observing how

they respond – emotionally and behaviorally – while performing an engaging or purposeful activity" (para 1). Through this definition music therapy often fits the unique needs of clients by engaging in the experiential therapeutic intervention of music therapy. The National Center for Complementary and Alternative Medicine (CAM, 2013) identifies music therapy as a diverse treatment. CAM includes therapies such as art therapy, hypnotherapy, and acupuncture. While music therapy is identified as both an evidenced based practice and an alternative to traditional therapies, it is still a growing practice.

Music therapy is also a small field. There are currently about 6,800 credentialed music therapists nationwide, according to the Certification Board of Music Therapists. In Utah, there are about 45 state certified and practicing music therapists (Certification Board for Music Therapists, 2014.) Utah State University is the only university in Utah that offers the music therapy program to earn a Bachelor of Science degree in music therapy. The curriculum for music therapy students includes a variety of courses from *Anatomy* to *Psychology of Music*. As deemed an evidence-based practice by The American Music Therapy Association (AMTA, 2018), music therapists have seen benefits working with those with autism, dementia, substance abuse, developmental disabilities, and more. Because of this diverse range in populations, music therapists work in a variety of settings and can be hired as an employee or contractor in a private practice.

Music Therapy Private Practice

Private practice has many definitions but for the purpose of this study it is defined as being self-employed (Reuer, 2007). Music therapists who are self-employed have the responsibility of obtaining contracts to carry out their work. These contracts can be with various businesses or with just one client. They are often called contractors and have distinctions from

employees. In a recent survey, 72% of businesses in Utah who utilize music therapists identified them as contract workers (Utah Association of Music Therapists, 2016).

The number of music therapists in private practice is increasing, but few academic studies have addressed the topic of starting and maintaining a private practice (Silverman & Hairston, 2005). Reuer (2007) believes that if music therapists have the dream to be an entrepreneur that dream can come true with hard work. A music therapist's dream for private practice may be due to the many benefits that private practice has to offer, some of which were reported as an increased salary and a more flexible schedule (Silverman & Hairston, 2005). However, anecdotally, when I had talked to professionals in the field, most were concerned that there is not a lot of information out there to help them maintain a successful private practice. Furthermore, existing research on private practice in music therapy is scarce. Being knowledgeable in the areas of business and private practice is key in running successful programs. Connant and Young (1996) reiterated this dilemma that, "…even the best therapists can fail in their pursuits if they do not take into consideration the intricacies of operating the business aspects of a music therapy practice" (p. 56).

Music therapists need to develop tailored programs to propose to facilities inquiring about music therapy services. However, it is a rare occurrence for facilities to be the first to reach out about music therapy. In Utah, I have found that most music therapy contracts are self-generated by me, as the music therapist, reaching out through marketing efforts. Wilhelm's (2004) survey supports this anecdotal experience; he identified word of mouth, presentations, and business cards as the most frequent marketing strategies for music therapists. Additionally, as a private practice owner, I have found if a contract does get signed that it usually took one to two years and many follow-ups and interactions to come to fruition. This length of time can be

very long for some music therapists to wait for and could lead to burn out. Due to these struggles, I explored some of the barriers to connecting with decision makers at adolescent residential treatment centers in Utah. It was also interesting to find out their thoughts on music therapy with adolescents.

Music Therapy with Adolescents

Adolescence is often seen as a time of many changes. Physical, cognitive, emotional, social, and behavioral are just of few of the domains in this developmental period (APA, 2002). Mihály Csíkszentmihályi, a well-known psychologist, studied adolescence and stated, "Emotions refer to the internal states of consciousness. Negative emotions like sadness, fear, anxiety, or boredom produce 'psychic entropy' in the mind, that is, a state in which we cannot use attention effectively to deal with external tasks, because we need it to restore an inner subjective order" (p. 22, 1997). All adolescents experience psychic entropy, which can contribute to bad mood, lack of sleep, self-esteem, and passivity/loss of motivation. They can also experience psychic negentropy, which includes tasks that bring positive feelings for self and others, feelings of competence, intrinsic motivation, and effective concentration (Csikszentmihalyi, & Larson, 1984). While these may be the experiences of most if not all adolescents, those adolescents who go to treatment usually experience one or more of the following areas; depression, anxiety disorder, behavior problems, substance abuse issues, stress, school-related issues, legal problems, low self-esteem, trauma, and grief (Morin, 2017). These teens are dealing with a lot all at the same time.

Adolescents are at a pivotal time in their life and many parents choose to help their teens by enrolling them in a residential treatment center when significant mental health or developmental needs arise. Adolescents dealing with a variety of mental health needs and

developmental changes require an outlet to help develop coping skills (Arden & Linford, 2009). Many have already chosen music as that vehicle for help (Laiho, 2004). It is important to note however, that adolescents need to accept responsibility for their music use as well as music therapists. McFerran and Saarikallio continue:

> Music therapists should intentionally share responsibility for music choices when collaborating with vulnerable young people during challenging times. It is important to discriminate between different types of adolescent music engagement and to be aware that young people who 'depend' on music experience the least success. They may sometimes perpetuate or intensify the very problems they hoped that music (as external to them) would resolve" (p. 95).

Like traditional mental health therapies, music therapy has several approaches. Gold, Voracek, and Wigram (2004) shared, "Our results suggest that eclectic approaches to music therapy, where techniques from different models or theories are mixed, are particularly effective" (p.1059). They suggest the therapist be flexible with their treatment and attitude towards the process and keep individualized music therapy in mind. This client-geared, eclectic, and ever changing approach has a clinically relevant effect.

Music therapy has been shown to serve the needs of the adolescent population in treatment (Vourakis, 2005). Specifically, clients with behavioral or developmental disorders, or with multiple psychopathologies, may benefit from music therapy. (Thompson and McFerran, 2015). The significant benefits music therapy has for adolescents are outstanding (Laiho, 2004). Music therapy research has indicated that music therapy can promote positive emotional change; help with relapse; promote a decrease in anxiety, depression, anger, and stress. As an experiential therapy, music therapy may be especially helpful for adolescents with depression. Depression is

common as a co-existing factor in many diagnoses and research suggests that adolescents admitted with preexisting depression might benefit from experiential therapy treatment needs (Vourakis, 2005).

Clients are more willing to participate in music therapy than other treatments (Aletraris, Paino, Edmond, Roman, & Bride, 2014). Among other factors, music therapy has been identified as a safe way to internalize a healthy self-image amidst patient images and roles adolescents take on during treatment (O Callaghan, Dun, Baron, & Barry, 2013). Adolescents' love and need of music (Laclair, 2016) is also apparent in many aspects of their lives. Many may find music therapy appealing because of their pre-existing daily use of music (Doak, 2003). Studies show that adolescents are motivated by music therapy (Thompson & McFerran, 2015) and recently a Utah RTC found this to be true when this author conducted a music therapy survey through her private practice in both 2015 by one music therapist and 2017 by another music therapist, with similar questions. In the first survey, 28 participants out of 30 answered yes they like music therapy and 44 participants out of 47 answered yes in the second survey. This survey was not published as it was conducted by my private practice to improve music therapy work done at the facility. The results suggest that music therapy is interesting and a viable treatment option for adolescents in residential treatment centers.

Residential Treatment Centers

Residential treatment includes individuals who receive overnight care and treatment and for an extended period of time. It may be difficult for parents to decide when to put their child into residential treatment and decipher between pathological behavior verses normal teenage behavior (Fell, 2019). Fell (2019) continues and quotes Berry (2017) by identifying 6 signs to look for. Some of these include harmful behavior to self and others, secondary trauma to

siblings, apathetic behavior, addiction and unwillingness to change. It is also important to find out what setting may be the best placement. He also includes a list of 10 questions to ask when researching adolescent treatment (p.424). Some clients may need to first start in a psychiatric hospital to be stabilized for a few days after a crisis while others may go directly to a drug rehab facility. Wilderness Programs are very common to start with for several weeks before an average stay of eight months to one year at an RTC. Fell (2019) also addresses some of the differences in these programs and describes three core services an RTC provides. This includes a residential component, an academic component, and a clinical component. It is often common to have a specialty in population and a specialty service, such as performing arts or sports.

The American Addiction Centers (n.d.) state, "residential treatment in particular is often more helpful because it requires that the person stay in treatment for the amount of time necessary to affect change" (para 1).

Oxford Treatment states:

> The greatest benefits from therapy arise when the program is designed to fit the individual's specific needs and when the individual commits to and completes therapy. Working with treatment program specialists to customize the program for the individual is the first step to find the research-based treatments – both traditional and less conventional – that will be most likely to help that person in the long run (FAQ para 4, 2017).

Services in adolescent RTCs typically include individual and group therapy through a primary therapist. In Utah there are qualified mental health providers including marriage and family therapists, licensed clinical mental health counselors and psychologists. Specialty groups

such as substance abuse, bereavement, autism specific needs, recreational therapy, and others involve additional experienced professionals with specialized training.

Aletraris, Paino, Edmond, Roman, and Bride (2014) studied the use of art and music therapy in treatment centers. Data collection was determined from face-to-face interviews with clinical directors or other administrators. Out of 307 treatment programs the researchers received a 68% return in responses. The programs have an emphasis on adolescents and young adults with substance abuse. The results included 36.8% of programs using art therapy, 14.7% of programs using music therapy, and 11.7% using both. It may be important to note that these statistics could be generalized to all RTCs, not just addiction specific, as most RTCs include addiction services.

Residential Treatment Centers in Utah

The first residential treatment program in Utah was created in 1989 when a parent needed a place for their teenager to attend that was still focusing on treatment needs but less of a hospital/medical setting. This unique program style was created to include school, activities, and a home-type setting all centered around therapy for teens (L. Steffens, personal communication, April 27, 2018).

Families receiving services in Utah for their adolescents often bring up the question, *Utah seems to be the largest hub for parent choice schools and programs, why is this the case?* In 2008, 45 Utah programs were listed and described in Woodbury Reports' Parent Empowerment Handbook, which is significantly more than any other state.

In the report published by Woodbury Reports (2012), Stednitz states:

> The culture of Utah is also unique and lends itself to the development of programs that are intended to help others. Utah citizens as a whole place value upon the family and community, perhaps more than any state in the Union. This sets the

> stage for supporting parents in getting help for their children and developing laws and regulations that effectively manage the huge number of programs in Utah (para 4.).

In the same document, Tibbetts continued, “I would also add that Utah's state laws are conducive to residential treatment and are some of the most well-thought-out, collaboratively-written laws concerning teen treatment in the nation” (para 6). The Utah culture and law regulations speak to the success that these programs have had.

In addition to the culture of Utah in helping others, Utah was known as the 7th healthiest state in 2010. Furthermore, Utah is known to have some of the happiest people in the nation (Utah Governor’s Office of Economic Development, n.d.). Due these factors, out of state parents may see benefits of sending their teens to a state that has these values and outcomes. According to programs registered as a member of NATSAP, Utah holds 27.3% of the nations programs and many of the students attending these RTCs are from out of the state. Utah holds the most RTCs registered through NATSAP across the nation and the majority does not have music therapy programs. Utah businesses that do offer music therapy services identified client/patient satisfaction, service quality, and community reputation as the top three ways music therapy positively impact their business (Utah Association of Music Therapists, 2016). Programming aids in the success of the RTC and admissions and programming is run through both an administrative and clinical team to make those programming decisions.

Decision Makers

A variety of clinical and administrative decision-makers in RTCs influence whether music therapy is included in treatment. Clinical teams comprise primary and secondary therapists for the client, clinical directors, psychologists, parents of the clients, and other professionals to

make clinical decisions for the benefit of the client. Clinical Directors are often the main point of contact for residential treatment centers to inquire about new clinical programming. In addition to their many duties, they also approve and oversee the therapeutic services implemented in the facility. As with any healthcare organization, it is important for music therapy business owners to know what the decision makers are aware of regarding music therapy to move towards more services being carried out (Hilliard, 2004). It is also important to be able to influence decision-makers by adding value to their organization (Cope, 2012). Unfortunately, even if decision makers understand the value of music therapy services, they may weigh cost heavily in their decisions. Cost is increasingly becoming a determining factor in closing a sale (Adamson, Dixon, Spenner, & Toman, 2015a).

The position of a salesman usually falls on contractors as they are working towards more contracts and sales. Adamson, Dixon, Spenner, and Toman (2015b) discuss the situation that many salesmen find themselves in, which is dealing with the "5.4" (pgs. 3-34). The number 5.4 refers to the number of decision-makers that need to sign off on a sale before it becomes final in today's business world. Sales are getting harder and harder to get buy in from just one person to be in production. This poses a great problem as with more people involved in the decision making role, the buying process can become more diverse, dysfunctional, and chaotic. Clinical directors may be the first contact for these RTCs but in most cases, they are not the last. They usually need to get approval from many others in the organization such as the executive director, the chief financial operator, and more.

After looking at the successful nature of music therapy with adolescents, the drive and use teens have with music, and the amount of RTCs in Utah, I sought out to learn what factors influence music therapy inclusion in adolescent residential treatment in Utah. This research

question is of great importance to not only be able to connect with decision makers, but better be able to provide future music therapy services to increase the benefits for and health of adolescents.

Methods

Design

The design of this study was qualitative. Qualitative studies have different purposes and processes than quantitative studies and utilize data in the form of interviews, audiovisual information, texts and images. They also involve a unique way of sorting through the data analysis to draw conclusions (Creswell, 2014). The questions of interest were researched through an interview and then analyzed to produce a narrative report. An interview was chosen partly for the sample size and also for the more personal nature of meeting together to understand responses better. I aimed to create a person-centered approach to the interview style by giving the interviewee respect and self-reflexivity.

Participants

Seven decision makers from several RTCs in Utah, including those that do and do not have a music therapy program, were interviewed. The RTCs were found through the NATSAP website's location finder. I began recruiting by contacting facilities that may be in close proximity to reach in person, and then addressing those farther away. Inclusionary criteria comprised anyone from this list of facilities who responded to the survey and fills the role of clinical director or decision maker for new programming, and who could meet within the four-week time frame of the study. These decision makers may have identified as executive directors, chief financial operators, or others involved in an administrative role at the facility. Exclusionary criteria included those that were unable to meet within the time frame of the study. I did not discriminate based on gender, race, ethnicity, or other factors when contacting candidates for interviewing. I was aware of busy schedules, so interviewees were first offered to set up a face-to-face interview in person and then by phone interview if they were unable to meet in person.

By reaching out to 20 RTCs, I ended up interviewing seven clinical directors. I asked mostly open-ended questions with the aim of facilitating an open and honest conversation in the process and eliciting personal perspectives, opinions, and experiences from the interviewee. Eighteen clinical directors were contacted by email and in person to participate in this study. Additionally two other facilities were contacted requesting clinical director contact info but this was not returned. Of the 18 contacted, two were in person and 16 were sent an email regarding the request for an interview. One clinical director responded no to the request, seven did not respond at all, three responded but did not follow through with setting up a time or had a no show for a set interview time, and seven completed the interview. I then sent 10 follow up emails, which resulted in three of the seven successful interviews, one gave no consent, another had a no show to a scheduled interview, and five gave no responses. The other four successful interviews responded within three days. Due to the successful return rate of seven interviews, I did not follow up more than once nor did I go about by any other means of contacting, including phone call or in person requests.

Figure 1.

Procedure

In person and over the phone interviews with decision makers at various RTCs found through the NATSAP directory were conducted. Once a decision maker agreed to an interview, I sent over a consent form to be reviewed before the interview was conducted. I then engaged in the interview by asking the list of questions found in Appendix A. The general ideas of the questions were three fold; one section included questions regarding implementing new services, another part discussed music and music therapy knowledge, and the last section discussed contract services in music therapy.

During the interview process I did not give any responses to the answers that were given, however. Clarification on music therapy was not provided during the interview, which is why a follow up meeting or presentation was offered to participants who may benefit from further understanding.

Data Collection

Interviews were an average of five to ten minutes in length. In person interviews were recorded via an audio recording device. In phone interviews were recorded through a phone app. All interview recordings were then transcribed in their entirety. Next I used Braun and Clarke's (2006) six phases to conduct a thematic analysis.

Data Analysis

The phases in Braun and Clarke's (2006) thematic analysis include: "familiarising yourself with your data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report" (pgs. 16-23). Once the information was recorded I then coded, by hand, and put the information into factors and then themes of congruent and similar

responses between interviews. All recurring topics were considered and the factors and themes were then put into a qualitative narrative as suggested by Creswell (2013).

Familiarizing yourself with your data. I first fully immersed myself in the data collection. This included listening to the recordings several times to transcribe them and then re-reading the transcriptions.

Generating initial codes. After understanding the transcriptions I was able to identify some preliminary codes. Austin and Sutton (2015) further explain:

> Coding refers to the identification of topics, issues, similarities, and differences that are revealed through the participants' narratives and interpreted by the researcher. This process enables the researcher to begin to understand the world from each participant's perspective. Coding can be done by hand on a hard copy of the transcript, by making notes in the margin or by highlighting and naming sections of text (p.228).

The codes found were more numerous and specific than themes and identified as factors. These factors are explained in each question asked.

Searching for themes. Next I began to look for overarching themes. This was also broken up into smaller categories such as subthemes and their relationship between codes. Braun and Clarke (2006) define a theme as, "a theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set" (p.10). Austin and Sutton (2015) further explain, "Theming refers to the drawing together of codes from one or more transcripts to present the findings of qualitative research in a coherent and meaningful way" (p.229).

Reviewing themes. I was able to sort through the themes and pick ones that stood out by counting the frequency that factor occurred. The top three themes were identified due to the recurring responses of that topic across multiple questions.

Defining and naming themes. This involved defining themes and renaming them into clear themes that were well understood.

Producing the report. This step involved an analysis that can be presented in an understandable way. I chose to involve both tables and a narrative description of the results.

Data analysis in general was time consuming and a rigorous task, as the interviews were not fully structured, but contained a list of questions as well as time for the interviewee to add additional thoughts. Additionally, in an interview style, "not all people are equally articulate and perceptive" (Creswell, p. 191, 2014), resulting in possible skewed outcomes. I did not do member checking with the information given, due to the time frame of the research, but did follow up with the interviewees by sending them the completion of the thesis.

Ethical considerations

Ethical compliance was a priority of mine so I proceeded in this research by certain precautions. First, I received approval from the Institutional Review Board (IRB) to proceed with the research outlined. Second, I maintained complete confidentiality of all names in the interviewing of subjects. There was no need to have specific organizations or employees named for this research. All interview recordings were stored in a secured location with password protection while data collection was being analyzed. Last, for additional precautions the information contained was held in a password-protected file for both the audio recording and the write up of interview content for up to five years until it is required by the American Psychological Association (2010) to be destroyed.

The American Music Therapy Code of Ethics (AMTA, 2018) was also adhered to by striving to act in a professional, honest, and thoughtful manner throughout the process. The research achieved is aimed towards bettering the field of music therapy and shedding light onto issues that may have possible solutions, as well as providing more music therapy services to adolescents in residential treatment settings.

Results

The purpose of this study was to explore deciding factors of music therapy inclusion in adolescent residential treatment centers in Utah. The results help to answer the primary research question: what are the factors that influence music therapy inclusion in adolescent residential treatment in Utah?

Questions

Data collection and analysis provided insight into the research questions at hand.

Figure 2.

Below is a table to showcase research highlights as well as the interview questions and factors that emerged in responses from the participants. Additionally, overarching themes were also addressed. Under each question are multiple factors identified, the number of interview participants who responded with that factor, and a relevant quote backing up that factor.

Table 1.1

Question 1: What factors influence decisions when adding new therapeutic programs to your facility?

Factors	# of Participants	Relevant Quote Example
Needs of students	6	"The first factor of course is need and looking at our population and what kinds of therapeutic issues need to be addressed."
Best practice/Evidenced-based	5	"Um I think the primary factors would be probably clinical effectiveness in terms of using best practices."
Trend/Marketing	2	"I'll be honest with you when we add like a different kind of therapeutic modality

		sometimes it's going to be because it's a trend that consumers are requesting."
Scheduling	2	"Second consideration is looking at what our current matrix of interventions and modalities is and where is can fit into that because we want to make sure we have a streamline model that doesn't get too unruly. Keep it efficient."
Financial	2	"Um well the biggest would be financial so whether or not we can afford adding new programming."
Goals for facility	1	"Second one would be remaining focused on the core of what we want to accomplish and not adding too many extra things that you know make things more complicated So just how things work into the current model and structure. "

Needs of clients was a primary factor influencing the decision to add new therapeutic programs, according to six out of the seven participants. This was followed closely by the practice of choosing "evidence based practices", which was chosen by five participants as the primary factor. Scheduling, financial reasons, and a trend/marketing were also identified by at least two participants each as important factors.

Table 1.2

Question 2: What is the process of implementing services?

Factors	**# of Participants**	**Relevant Quote Example**
Review on leadership levels	5	"Treatment delivery council which is a small group of clinical and residential and a few other people in leadership to kind of go through the development process and figure out how it's going to work in proposal and vet it and then when ready present to leadership team as a whole."
Development/Roll out	3	"Roll out then includes time frame, info given in the right order to

		clients, families and to the staff and therapists and everyone involved so those who need to know first know to avoid confusion. And give enough time to launch effectively so everyone is ready."
In-house options	2	"First of all, is it something we already have the training and resources within house to accomplish? Then we work with those individuals or therapists and whatever the treatment is to provide that into their job descriptions. Look for how to contract that out of house, if not in house."
Qualified music therapist	2	"Probably qualifications of someone to do it."
Cost effective	2	"Of course we would have to see how cost effective [it is]."
Fits in	2	"[See] how it fits in with our other aspects of our treatment modalities that we already use."
Research	1	"Looking at is it research or evidenced based with the population that we're looking and then we'll look at anything with best practice."
Curriculum	1	"Look for whether it's curriculum or someway that it would be methodically introduced and implemented into the program for those individuals that would need that."
Training	1	"So once we've identified that new therapeutic service into play then look at how we'd train our therapists. And as they're working on new modalities or services like that we have ways that we are using group consultation as well as 1:1 as me as a clinical director just make sure they're using those skills effectively."

Five participants shared that any new service would need to be reviewed by leadership first before implementation. Development and roll out was also identified by three participants as the next steps for implementing services. Looking at in-house options first, a qualified music therapist, cost effective services, and whether it fits in with the facility were all identified by at least two participants.

Table 1.3

Question 3: If two similar programs have similar benefits, how do you decide?

Factors	# of Participants	Relevant Quote Example
Training/Therapeutic qualifications	4	"Probably qualifications of someone to do it."
Student needs	3	"First factor would be which one would meet the most needs for the most clients."
Fits in with facility	3	"How does it complement our therapeutic and milieu interventions?"
Scheduling	2	"Does it fit in with the overall philosophy or scheduling of school?"
Cost effectiveness	2	"Ah probably cost effectiveness."
Parent input	2	"Based on what um the biggest reason why our parent or our referral sources are choosing to place with us. For example we always ask on the exit interviews what's been the most impactful."
Student interest	2	"I think we would probably default back to some polling or talk to the students and see where their interests lie."

The top response given by four participants was based on the training or therapeutic qualifications of the music therapist. Client needs and fitting in with the facility was also a common factor repeated by multiple participants. Scheduling, cost effectiveness, parent input, and student interest were identified as well.

Table 1.4

Question 4: What importance does music have with adolescents?

Factors	# of Participants	Relevant Quote Example
Music is everything	5	"I think it's critically important."
Emotional connecting	4	"It's one of the ways that they connect with each other and relate to emotions and even start to identify with their own in relating with themselves."
Therapeutic/Coping skill	3	"They spend a lot of time listening to music so I think it's a big part of their lives and has an impact. If you can use it to have a therapeutic benefit or component then it's very valuable that way."
Best way to connect with teens	2	"In working with adolescents a key part of the relationship is kind of knowing where they are with music."
Identity	2	"It's actually one of the ways that they connect and communicate and share ideas and define themselves. I think music is a very important aspect of adolescent functioning and development and identity development frankly."
Connect with peers	2	"It's one of the ways that they connect with each other and relate to emotions and even start to identify with their own in relating with themselves."
Thought process	2	"I think it can be a window into thought process at times."
Music is a privilege	1	"Music is seen in some ways as a privilege something that is highly sought after."

Five participants responded to this question immediately with statements such as, "music is enormous, tremendous, or huge! It is everything." Four identified that music is used for emotional connecting. Three identified that it is a therapeutic coping skill and two identified that

it is used for identity, connecting with peers, and for thought processing. One responded that music is a privilege for adolescents in treatment.

Table 1.5

Question 5: Prior to me contacting you about music therapy, what was your knowledge about music therapy?

Factors	# of Participants	Relevant Quote Example
Limited knowledge	4	"Um… I knew it existed haha I knew that there was you know this idea but I actually didn't know that were certified music therapists prior to that contact. Um I did know that you could use music in therapy as a helpful thing but it was actually pretty limited."
Some version of "music therapy" with in-house music use	4	"We have a therapist here that currently runs a what he calls it art and music therapy group. Um now he's not specifically trained as a music therapist but um utilizes ah music interventions in what he does in the group. So we know a little bit about it. We haven't incorporated a lot of it into our program nor have we had real formal training or interventions with music therapy. So I would say minimal, probably minimal knowledge."
Pretty well-versed	3	"I did a lot of research in understanding how to use it with this population."
No knowledge about certification/goals and objectives	3	"Pretty. I'm pretty well versed in it. I guess I don't know all the particularities about the approach but we have a number of different aspects of music that we use already in our program although we don't have like a specified music therapy intervention approach if you will. So we are pretty well versed in it in terms of the benefits. I would say I don't know the

		particularities about the processes or how you determine the objectives and outcomes.”

Four shared about how they know some about music therapy because they have some kind of in-house music groups facilitated by therapists, who are not music therapists. However, as they kept talking they identified with other responses as well. Four came to the conclusion as having limited knowledge of music therapy. Three identified as feeling “pretty well versed” on music therapy. And three identified as having no knowledge of music therapy, specifically as not knowing much about the actual practice of music therapy in certifications or goal and objectives.

Table 1.6

Question 6: Have you ever sought music therapy services for the youth at your facility? Please tell me about that experience.

Factors	**# of Participants**	**Relevant Quote Example**
No	**3**	“Not specifically. Like I said we have some- a lot of different ways that we incorporate music into their therapy already.”
Kept going once contacted	3	“Our normal process to review things but ultimately we dove right in and we’ve stuck with it ever since. We look for ways and have found and considered ways to expand it throughout our different services. And I will still continue to do.”
In house music, not necessarily music therapy	3	“Not from an outside provider just you know one of our therapists internally does some of it although like I said, not really trained specifically in that.”
Yes	1	“Yes. In two different facilities that I’ve been in.”

Three responded, “no” to seeking out services, three responded with “keeping music therapy going once they had been contacted”, and three mentioned they “have music groups in-house from other therapists who are not music therapists to compensate for not implementing music therapy”. Only one participant said they were the instigator for reaching out for music therapy services.

Table 1.7

Question 7: What benefits do you think music therapy could provide to your facility and clients?

Factors	**# of Participants**	**Relevant Quote Example**
Students enjoy it	**3**	“They look forward to it!”
Alternative approach to talk therapy	3	“It provides an experiential process in which most teens buy into that certain talk therapy couldn’t.”
Calming tool	2	“It can help with specifically coping skills, use it as a self soothing skill which I see is a little different than a coping skill.”
Emotional response	2	“You know being able to understand their internal process emotionally with music or lyrics.”
Value	2	“Has value for sure.”
Diagnosis, treatment, assessment	2	“It is also a medium to do an assessment and intervention.”
Connection	1	“Being able to put their narrative of what they’ve been through in their lives into something that they could share with someone.”
Research	1	“Most recently what I have been working on with our MT is for research and data. So we can research, track that data, spread the word, and publish it.”
Marketing	1	“Even for marketing and the scope for the services provided.”
Rapport	1	“Help establish rapport and overall feeling about other treatment probably too.”

Expression	1	"It creates a space where they can find emotional expression."
Insight to primary therapist	1	"Give some good information back to their primary therapist for their treatment plan."

The highest response was that students enjoy music therapy and it is an alternative approach to talk therapy. The next benefits include that music therapy could be a calming tool, used for emotional response, holds high value, and used for diagnosis, treatment, or assessment. And last, a benefit identified was to provide connection, expression, rapport, insight back to the primary therapist, and for research and even marketing according to the clinical directors.

Table 1.8

Question 8: If you have been contacted about music therapy services, how did you respond?

Factors	**# of Participants**	**Relevant Quote Example**
Reviewed it and then reached out eventually then implemented it	**3**	"Delayed it for several months and then contacted you."
Reviewed it with leadership but did not implement	1	"When we've been contacted we've listened to and talked about it. Put it in front of the leadership team to see if its something we want to do or not."
Unaware they were contacted, but had been	1	"I have never been contacted."
Have not been contacted	1	"Haven't been contacted in the past that I am aware of."
Sought it out	1	"We sought out [our music therapist]. We got her recommended to us from someone else that was familiar with her. So we sought it out."

Three mentioned they reviewed music therapy services and responded eventually and then implemented it. One reviewed it with leadership but did not implement it. One shared they have never been contacted; however the author has record of reaching out to them several times in the past. One shared they have not been contacted and another mentioned they sought out music therapy services themself.

Table 1.9

Question 9: If a music therapist was interested in providing contract services in your facility, how should they connect with you?

Factors	# of Participants	Relevant Quote Example
Call/Email to meet with clinical or executive director	**6**	"The easiest way is to either look at the website and contact a clinical or executive director, or you could just call and ask and leave a message."
Proposal	2	"I think that what we would do is have someone come in and talk to us about it. Have someone come in and reach out with some of the benefits of music therapy that can be applied to the setting we work in. We've asked for proposals."
How to fit needs	2	"Please put together what your thoughts are. How you can come in and meet the needs of the population."
Demonstrate cost effectiveness	2	"Demonstrating the cost effectiveness of that piece."
Know how to work in with facility	2	"Have a vision of what we do and how music therapy could fit into our model."

Phone and email were identified by six participants as the easiest way to try and reach them. Including a proposal that demonstrates effectiveness, how to meet the needs of the students, and how to work in smoothly with the facility were the other main factors for having best results when reaching out.

Table 1.10

Question 10: Would you like a follow up meeting, in-Service, or presentation?

Factors	**# of Participants**	**Relevant Quote Example**
Already have music therapy	**3**	*This question was not asked to those facilities that already work with a music therapist.
Yeah, probably	3	"Um possibly. It could be interesting to kind of see what's out there and what is current. We wouldn't be opposed to it. I mean we're always open to trying new things and learning and improving ourselves."
Yes	1	"Yes. I am hoping as we have kind of a new leadership team that we can have some more openings on both of our campuses. Always try to figure out how do we offer enough groups for that population."

Follow Up. Three facilities already have music therapy, three facilities stated they would probably be interested and one stated a for sure yes in being interesting in having a music therapy presentation to learn more.

Themes that emerged

After identifying several factors under each interview question, I was able to look across multiple questions and identify some overarching themes due to similar factors in several questions. The following themes emerged: Fits in with the facility, cost effectiveness, and in-house music. Student needs and therapist qualifications was also a popular theme but will not be addressed in depth for this Thesis. Instead I chose to focus on three themes to remain succinct. Below I have described the three themes in more detail. For more information see table 1.2 in Appendix C for supporting data condensed from Table 1.1.

Fits in with facility. This theme was present in five questions as an important factor for including a new program. Facilities want their goals to be realized with any service they provide as well as to have continuity in their therapeutic approaches. They want to be able to see how a new service could complement what they already have in place in their programming. Sharing a similar vision and not creating additional struggles with scheduling or too many services was identified. Being able to address the needs of the facility or solve a problem was identified as a great way to align with the facility.

Cost effectiveness. Finances were prevalent in four of the question responses. Logistics of how affordable the service is as well as how a facility's budget can take on new services was a big factor for many facilities. Being able to show how a new program can benefit the facility financially was presented as a top area of interest for decision makers.

In-house music. Responses to three questions included the use of in-house music services to fill the need of music therapy for their clients. This was often explained as a therapist leading a music group, with little clarification of the difference between music therapy or music in treatment. Some shared that their facility can first see if they can fill a need with the staff or resources they already have.

Researcher Bias

Austin and Sutton (2015) stated it well when they said:

> When being reflexive, researchers should not try to simply ignore or avoid their own biases (as this would likely be impossible); instead, reflexivity requires researchers to reflect upon and clearly articulate their position and subjectivities (world view, perspectives, biases), so that readers can better understand the filters through which

> questions were asked, data were gathered and analyzed, and findings were reported (p.226).

I recognized a bias in thinking most facilities would benefit from music therapy. This bias comes from the experience gained in working in a residential treatment center with adolescents. I have seen significant positive outcomes from utilizing music therapy with this population and would love others to experience it.

Conclusions

A qualitative research design was chosen to highlight the responses from seven clinical directors regarding the factors that influence music therapy inclusion at adolescent residential treatment centers in Utah. Data collection was obtained through semi-structured, one-on-one interviews by phone or in person. Responses were then transcribed and coded into factors as well as recurring themes for data analyses. Three major themes emerged including: fitting in with the facility, cost effectiveness, and in-house music services.

Discussion

It was apparent that most facilities saw the value of music within the adolescent time period, especially those in treatment. Some were unclear on the benefits of music therapy, however. More than half of the facilities interviewed currently have or have had music therapy at their facility and those who do not, try to off-set this by having in-house music groups facilitated by mental health therapists or a music class taught by a music teacher.

The clinical directors were both passionate about the programming they provide to their clients and serious about including new services. They showed openness to learning more about music therapy and it was clear that it was not a well-known field for them regarding education, evidenced-based practice, qualifications, and benefits. Most were open to being contacted about services and educated on the specifics of music therapy in the interview. Unfortunately, when I followed up on a music therapy presentation at a later date (three months later), all participants denied accepting a presentation, even though in the interview they stated they would like a presentation.

Due to the lack of response regarding research participants, by contacting 20 facilities and conducting seven interviews, it may also be concluded that it takes several attempts to reach

clinical directors to start discussion about implementing new programs. Persistence and follow up is needed to not only implement music therapy services, but get the initial contact through phone or email. It is important to note that only one out of seven clinical directors sought out music therapy services. Three however were able to respond to a music therapist who reached out and keep programming up. It should be pointed out that the number of facilities who have music therapy services and participated in the interview may be due to the fact that I had connections with these clinical directors to schedule an interview.

The responses here have a rich set of data that provide a well-rounded idea of music therapy benefits from clinical director perspectives. It appears that while music therapy as a profession and the specifics of it are unclear to most clinical directors, the *idea* of music therapy and its benefits are positive and valuable. It was gratifying that a similar factor emerged about clinical directors noticing that music therapy is enjoyed by adolescents and is a preferred method of therapy through its experiential and expressive methods.

Overarching Themes

Fits in with facility. New programming that aligns well with facility mission statements, goals, and logistics is most enticing to clinical directors. Keeping congruency in treatment interventions and outcomes helps decision makers justify a new service. By creating a program proposal that solves a problem or fills a need, a music therapist may go far in the initial presentation of music therapy services to the facility and hopefully result in implementation of services.

Cost effectiveness. This theme is one that was definitely hypothesized from the beginning, not only by myself, but also from other colleagues and committee members when this thesis idea was presented. Understandably if there are no funds available, then the service cannot

be realized. However, demonstrating cost effectiveness of music therapy services could be a positive influencer for decision makers. Ways to produce cost effectiveness were not addressed in the interviews but music therapists could tailor their program proposals to address this barrier. The research themes of parent interest, student need and interest, and music being a huge part of their lives could be used to speak to this barrier as well. As a private practice owner, I have encountered this dilemma in several facilities but have been able to offset this at times by simply waiting until the facility's next annual budget review, submitting for a grant, or showcasing the cost-effectiveness of music therapy for their facility. Some research delves into this barrier by addressing group work versus individual work. Yinger and Gooding (2014) share, "The strengths of music therapy as a treatment of children and adolescents with mental health concerns include the fact that music therapy is known to benefit clients with a wide variety of diagnoses and can be effectively administered in group format, making it a safe, cost-efficient treatment (p.548).

In-house music. Being able to distinguish the differences in music verses music therapy is crucial in bringing on new music therapy services. If the decision maker believes they can get the same results from a music teacher or a music club, then they may not know the wide range of needs in treatment music therapy can fill, and only music therapy can fill. They may also not realize the power of music therapy and importance of practicing within one's scope. It is evident that music therapy education provided to those decision makers should be addressed to show importance of its unique benefits and properties that benefit adolescents in treatment. Adolescents are at a crucial time in their lives and using music therapy to help while they are in treatment is a remarkable tool.

Yinger and Gooding (2014) state:

> The fact that active musical participation engages more areas of the brain than passive music listening may explain in part why numerous studies have shown music therapy to be more effective than music medicine at augmenting treatment of neuropsychiatric disorders. It seems that active musical participation or engagement with the therapist are integral in the success of music therapy, in addition to the music itself. The effectiveness of music therapy is in part caused by the effects of music on the brain, and in part by the interaction between the client and the music therapist (p.536).

This brings up the crucial aspect of the therapist, client and music's relationship. It is merely not enough to have one without the other.

Yinger and Gooding (2014) continue, "Research indicates that the most effective clinical treatments using music tend to be those implemented by music therapists, compared with approaches using music medicine treatments" (p. 545). In addition, "it requires a trained professional (music therapist) to effectively administer treatment; without effective administration, the use of music in mental health treatment may serve to worsen patients' conditions" (p. 548). Music is powerful so it needs to be used appropriately when working with adolescents in treatment who deal with mental health needs daily.

In addition to mental health, other researchers have explored many other populations and the differences in music therapy verses music medicine. For example, when working with psychological issues and pain management, a study reported that 78% of cancer patients showed a preference for music therapy versus music medicine (Bradt, et. all, 2014). Furthermore, music therapy and music in special education has many other resources and studies available on this

topic. More specifically, the International Society for Music Education (ISME, 2016) commission speaks about music educators working with students with autism (which is a common diagnosis among adolescents in RTCs). They state, “This lack of training can lead to poor attitudes towards accepting students with autism or less than adequate music education if the appropriate educational environment is not developed (p.108).

Adolescents need to develop a conscious and intentional relationship with music so it is not used to further their distress from their diagnosis. Music therapists can identify areas of risk with music relationships and adolescents and help them adopt a more healthy relationship (McFerran & Saarikallio, 2014). Other professionals who have not been trained in music therapy may not be able to identify this very important element of healthy music use. These overarching themes of fits in with the facility, cost effectiveness, and in-house music are evident of some of the priorities for treatment centers.

Recommendations

There are many ways a music therapist can gain benefits from this research study and apply direction from the clinical directors in hoping to start new music therapy programs. Perhaps it would be beneficial to solicit presentations to describe the benefits and particularities of music therapy. It also appears that persistence is an important factor when clinical directors cannot be reached via phone or email initially.

It was also identified that music therapy and its benefits are not understood for most facilities. It may be advantageous to set up in services and presentations to facilities to highlight the education for a board-certified music therapist and differences music therapy can provide verses, music, at their facility. Application of these research studies may be relevant to other areas of work in various clinical settings. Future research is also recommended.

Future Research

Further research may be beneficial to find out more about how to increase the presence of music therapy within not only residential facilities for adolescents, but in general for facilities both in Utah and other areas. Additional research may be appropriate in the areas of music therapy and adolescents. The idea of music as a privilege for adolescents in treatments should also be explored, as this was brought up as an interviewee response. It may be important to research the knowledge of music therapy with clinical directors as many are subbing in music classes for this need. Lastly, further research on music therapy in private practice is needed to better understand the business side of contractual music therapy services. Would you recommend a structured, quantitative survey for a larger sample size, across the country, perhaps? Using the themes that emerged from this study? Or is additional qualitative data needed first?

Summary

Music therapy is a beneficial therapy avenue for adolescents in treatment that many facilities are not taking advantage of. Clinical directors are the primary point of contact for new programming and would like to know how new services can fit in with their facility and demonstrate cost effectiveness. As demonstrated in the themes emerging from the interviews in this study, many RTC decision makers already understand the importance of music and implement music programs but do not know the value music therapy has. Realizing the clinical outcomes, goals and objectives within music therapy, and qualifications and certifications of a music therapist, was not something clinical directors were well versed in. Additional education and knowledge about music therapy services is needed to change the small number of RTCs utilizing music therapy services in Utah.

Music therapists working in private practice could present a program proposal to facilities to propose music therapy services as well as present on the specifics of music therapy. This program proposal should address how music therapy can fit needs of the facility, address any problems music therapy can help with, demonstrate cost effectiveness, highlight parent and student interest and showcase like-minded approaches of the facility.

Persistence and following up were important elements in this research process in both initially contacting decision makers and following through with the interview and subsequent requests for additional information regarding music therapy. Additionally, I was able to glean insight into the workings of new programming, the needs of facilities working with adolescents, as well as information regarding the best ways of reaching decision makers.

I hope this thesis can be a resource to other music therapy contractors as well as adolescent program directors. The future is bright for music therapists interested in expanding services and connecting with important decision makers.

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APPENDICES

Appendix A

Interview Questionnaire

1. What factors influence decisions when adding new therapeutic programs to your facility?

2. What is the process of implementing services?

3. If two similar programs have similar benefits, how do you decide?

4. What importance does music have with adolescents?

5. Prior to me contacting you about music therapy, what was your knowledge about music therapy?

6. Have you ever sought music therapy services for the youth at your facility? Please tell me about that experience.

7. What benefits do you think music therapy could provide to your facility and clients?

8. If you have been contacted about MT services, how did you respond?

9. If a music therapist was interested in providing contract services in your facility, how should they connect with you?

10. Would you like a follow up meeting, in-Service, or presentation?

Appendix B

Saint Mary of-the-Woods College Consent to Participate in Research

Title of Study: Factors that influence music therapy inclusion in adolescent residential treatment in Utah.
Student Researcher: Mary Whyte

You are being asked to participate in a research study conducted by Mary Whyte, graduate student at Saint Mary of-the-Woods College (and Tracy Richardson, Ph.D., MT-BC, faculty sponsor). This research is being conducted as part of a thesis and your participation in this study is entirely voluntary. Please read the information below and ask any questions you may have before consenting to participate. You are being asked to participate because you are a clinical director at a residential treatment facility for adolescents or are over programming.

PURPOSE OF STUDY
The purpose of this study is to explore deciding factors of music therapy inclusion in adolescent residential treatment centers in Utah. An interview process will take place with clinical directors and other decision makers at adolescent residential treatment centers to gain information regarding the question at hand. Once the interview has taken place, data collection will be analyzed and coded into themes and categories to produce a qualitative report. The researcher is a graduate student and will use this information for the purpose of a thesis study. If it is used to continue onto publication, participants will be notified.

PROCEDURES
This procedure involves minimum risk for the participants and confidentiality will be maintained in the report. Names of interviewee and facilities will not be shared. Only the researcher will have access to that information for up to five years after the publication of results. Participants will be asked to engage in an interview in person or over phone in the Spring of 2018 to respond to specific questions and provide other feedback that may be relevant to the research question. Interviews may be audio taped but used only for the researcher to review interview responses. Audio recordings will also be kept confidential and deleted up to five years after publication. The interviewees will be given the opportunity to request a copy of the final study. An option for follow up questions or debriefing interview will be given, according to the interviewees desire and availability.

POTENTIAL RISKS OR DISCOMFORTS
This study involves no more than minimal risk. There is a risk that participants could be identified by readers of the thesis or any subsequent publication, even when names of interviewees or their places of employment are not used.

POTENTIAL BENEFITS
There are no anticipated benefits for the participants in this study.

CONFIDENTIALITY
Confidentiality will be protected by not including names of interviewees or names of residential treatment centers, rather using codes to separate responses from interviews. All data collection will be destroyed after 5 years of being secured in a locked location.

PARTICIPATION AND WITHDRAWAL
All participation is voluntary and unpaid. Participants have the right to withdraw from engaging in this study. The researcher is grateful for the participant's willingness to engage in this study. Data may be used for thesis, publication, or education presentation.

Thank you for your time amidst your busy schedules. If you have any questions please contact the researcher, researcher's supervisor, or the chair of the Human Subjects Institutional Review Board.

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This study was approved by the Saint Mary-of-the-Woods College Human Subjects Institutional Review Board on _____.

I , _____, give my permission to participate in the research study for Saint Mary of-the-Woods College.

☐ Consent ☐ Do Not Consent

_____ _____

Participant's Signature Date

Saint Mary of-the-Woods College Consent to Audio Recording

Title of Study: Factors that influence music therapy inclusion in adolescent residential treatment in Utah.
Student Researcher: Mary Whyte

You are being asked to participate in a research study conducted by Mary Whyte, graduate student at Saint Mary of-the-Woods College (and Tracy Richardson, Ph.D., MT-BC, faculty sponsor). This research is being conducted as part of a thesis and your participation in this study is entirely voluntary. Please read the information below and ask any questions you may have before consenting to participate. You are being asked to participate because you are a clinical director at a residential treatment facility for adolescents or are over programming.

PROCEDURES
This procedure involves minimum risk for the participants and confidentiality will be maintained in the report. Names of interviewee and facilities will not be shared. Only the researcher will have access to that information for up to five years after the publication of results. Participants will be asked to engage in an interview in person or over phone to respond to specific questions and provide other feedback that may be relevant to the research question. Interviews may be audio taped but used only for the researcher to review interview responses. Audio recordings will also be kept confidential and deleted up to five years after publication.

I , _____, give my permission to be audio recorded for the research study for Saint Mary of-the-Woods College.

☐ Consent ☐ Do Not Consent

_____ _____
Participant's Signature Date

Appendix C

Table 1.2

Factors	# of Participants	Relevant Quote
Fits In With Facility		
Fits in with facility	3	"How does it complement our therapeutic and milieu interventions?"
Know how to work in with facility	2	"Have a vision of what we do and how music therapy could fit into our model."
Fits in	2	"[See] how it fits in with our other aspects of our treatment modalities that we already use."
How to fit needs	2	"Please put together what your thoughts are. How you can come in and meet the needs of the population."
Scheduling	2	"Does it fit in with the overall philosophy or scheduling of school?"
Goals for facility	1	"Second one would be remaining focused on the core of what we want to accomplish and not adding too many extra things that you know make things more complicated So just how things work into the current model and structure. "
Cost Effectiveness		
Financial	2	"Um well the biggest would be financial so whether or not we can afford adding new programming."
Cost effective	2	"Of course we would have to see how cost effective [it is]."
Cost effectiveness	2	"Ah probably cost effectiveness."
Demonstrate cost effectiveness	2	"Demonstrating the cost effectiveness of that piece."
In-house Music		
Some version of "music therapy" with in-house music use	4	"We have a therapist here that currently runs a what he calls it art and music therapy group. Um now he's not specifically trained as a music therapist but um utilizes ah music interventions in what he does in the group. So we know a little bit about it. We haven't incorporated a lot of it into our program nor have we had real formal training or interventions with music therapy. So I would say minimal, probably minimal knowledge."

In house music, not necessarily music therapy	3	"Not from an outside provider just you know one of our therapists internally does some of it although like I said, not really trained specifically in that."
In-house options	2	"First of all, is it something we already have the training and resources within house to accomplish? Then we work with those individuals or therapists and whatever the treatment is to provide that into their job descriptions. Look for how to contract that out of house, if not in house."