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Indirect Music Therapy Practice and Skill-sharing in Dementia Care

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Abstract

Public interests in the benefits of music for people with dementia has rapidly increased in the recent years. In addition to clinical work with clients, music therapists are often required to support and train staff, families and volunteers and skill-share some music therapeutic skills. Six music therapy researchers from six countries agreed it was timely to organize a roundtable and share their *indirect music therapy practice* and examples of skill-sharing in dementia care. This article was developed following the roundtable at the World Congress of Music Therapy in 2017 and further discussions between the authors. This process highlighted the diversity and complexity of *indirect music therapy practice* and skill-sharing but some common components emerged including: 1) the importance of making clinical decisions about when *direct music therapy* is necessary and when *indirect music therapy* is appropriate, 2) supporting the transition from *direct music therapy* to *indirect music therapy*, 3) the value of music therapy skill-sharing in training care home staff, 4) the need for considering potential risk and burden of *indirect music therapy practice*, and 5) expanding the role of music therapist and cultivating cross-professional dialogues to support organizational changes. In *indirect music therapy practice*, a therapist typically works with carers and supporters to strengthen their relationships with people with dementia and help them further develop their self-awareness and sense of competencies. However, the ultimate goal of *indirect music therapy practice* in dementia care remains the wellbeing of people living with dementia.

Key words

dementia, music therapy, training, indirect music therapy practice, skill-sharing

Dementia

Dementia is a syndrome that "affects memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgment" (World Health Organization, 2018). Dementia has significant cognitive, physical, psychological, social, economical and societal impacts on the person, families, friends and a wider community. With nearly 50 million people living with the disease, dementia is a global challenge (Alzheimer's Disease International, 2018) and a public health priority (WHO, 2012). Despite increasing public awareness of the disease, stigma attached to dementia is still not uncommon. Many people with dementia and families do not wish to acknowledge or discuss the signs and symptoms associated with dementia (Batsch & Mittelman, 2012), which often leads to delays in seeking medical help and diagnoses (Bunn et al., 2012). Currently there is no drug or other therapy to cure dementia. In order to maintain the sense of self, managing and living well with dementia is extremely important (Wolverson, Clarke, & Moniz-Cook, 2015). Timely psychosocial interventions are essential, not just as non-pharmacological treatments to manage dementia symptoms, but also to support the unique psychological and social needs of the person (McDermott et al., 2018; Moniz-Cook et al., 2008).

Note on the terms

Carers, staff and supporters

In dementia research and dementia policies, people who provide direct care (e.g. helping with activities of daily living) to people with dementia are usually divided into two groups: 1) those who are employed (paid) to provide direct care, for example nurses, care assistants, health and social care professionals, and 2) those who provide care because of their personal contacts and are not usually employed, for example family members, volunteers or close friends. The first group is commonly described as *carers, caregivers*, *formal caregivers* or *professional caregivers*. The second group is usually described as *families, family carers*, *caregivers* or *informal caregivers*. Another term *supporters* is beginning to be used widely in dementia psychosocial research. The choice of these terms seems to be largely influenced by the cultural norm, research context, societal views on

dementia, and researchers' and policy makers' personal and organizational views. The six authors of this article use different terms to describe the two groups. The terms chosen by the individual authors for their sections are unchanged in order to highlight this diversity. For the remaining sections of this article, we will use the terms: 'carers' or 'staff' for paid caregivers and 'supporters' for family members, friends or volunteers who provide largely voluntary care, for consistency.

Music activities and music therapy

In this article, we will use the term "music activities" to describe a broad range of music-based activities and interventions that are not music therapy. Some music activities may be informal (e.g. sing-along in a care home) and others may be more formalized (e.g. following a guideline on individualized music listening). Music therapists may also provide music activities in some cases. However, for the purpose of simplicity and clarifications, we will refer to all direct clinical work with clients conducted by qualified music therapists as music therapy in this article.

Background to this article

Public interest in the benefits of music for people with dementia has rapidly increased in the recent years. In particular, group singing and individualized music listening are frequently acknowledged as beneficial in many countries. Media coverage of music and dementia is high. In the UK, the Commission on Music and Dementia recently published an extensive report (International Longevity Centre-UK (ILC-UK), 2018); synthesizing outcomes from literature reviews, site visits, oral evidence sessions and written evidence submitted by people with dementia, clinicians, academics, practitioners and policy makers. The report (ILC-UK, 2018) highlights the diversity of music activities currently offered in the community, hospitals and residential settings. It also demonstrates increasing involvement of non-music therapists (e.g. classically trained musicians, keen volunteers) in using music with people with dementia. Increased public interests in the therapeutic use of music has great potential to enrich the lives of people with dementia and their carers; however, ways to ensure that music activities are appropriate and of a high quality are not clear. Many music activities rely

on the skills of the individual delivering the experience. Not all facilitators may have sufficient knowledge of dementia and how to use music in a safe and informed way, and many do not have access to regular supervision or mentoring. Without having a space to reflect on one's work, it is difficult to ensure a facilitator always pays sufficient attention to *how* to be with people with dementia beyond planning *what* kind of musical experiences they are aiming to offer.

In some countries the increased popularity of music activities delivered by non-therapists and/or volunteers, who are less expensive than qualified music therapists, has in some cases negatively impacted music therapy positions. On the other hand, increased public interest in the use of music with people with dementia is also providing opportunities for music therapists to contribute to wider dementia care by collaborating with carers, supporters and community musicians beyond traditional music therapy practice. When collaborating with others it will be even more important to consider *when* and *why* music therapy is necessary and when other types of music activities or musical interactions are beneficial for people with dementia. As the number of people living with dementia grows it is likely that the roles of music therapists working with this population will have to expand in order to meet their unique clinical and societal needs.

The term *indirect music therapy practice* may not be part of the everyday-language of a practicing music therapist. However, if we apply the term *direct music therapy practice* to describe clinical work with music therapy clients, it may be possible to categorize any other non-direct clinical work that is necessary to optimize the benefits of music therapy: for example, during team meetings sharing how the client is doing in music therapy to increase staff awareness of the client's wellbeing, or contributing to staff training so that staff develop awareness how they can use music in daily care, as *indirect music therapy practice*. It is part of a typical clinician's everyday practice to share therapeutic skills and it is likely to come in various forms and sizes depending on clinical, cultural, political and financial contexts. As the popularity of music activities for people with dementia increases, so does the need for ensuring the safe and informed use of music. As a relatively new profession, it has been

necessary for music therapists to establish their specific, distinctive roles in a health care system. This sometimes led to a "protectionist" way of working. In dementia care, however, music therapists are often required to broaden their roles and skill-share with others due to the essential role and popularity of music in their daily care and activities. Skill-sharing is not new. Music therapists have been skill-sharing in various contexts; for example, through international outreach work (Music as Therapy International, http://www.musicastherapy.org) and through the production of a resource book for other health professionals working with older people (Clair, 2008). This highlights the importance of flexibility and consideration towards context-specific clinical needs when sharing music therapy skills with non-music therapists.

Focus of this article

The main purpose of this article is to illustrate the diversity of current *indirect music therapy practice* and skill-sharing in dementia care. It is not within the scope of this article to propose a new approach to music therapy practice or reach a consensus about terms and their definitions. Rather, we aim to highlight emerging key components of *indirect music therapy practice* and skill-sharing in an attempt to articulate how music therapists may be able to contribute to further development of dementia care.

The roundtable

Music therapy researchers from six countries specializing in dementia care agreed it would be timely to widely share current *indirect music therapy practice* and organized a roundtable discussion for the 15th World Congress of Music Therapy held in Tsukuba, Japan. Five experts, each a contributing author to this manuscript, gave individual presentations about their own work on *indirect music therapy practice* followed by a panel discussion (McDermott, Ridder, Baker, Wosch, Ray & Stige, 2017), which was audio-recorded and subsequently transcribed by the roundtable chair (OM) in preparation for this article.

As the first step, OM used the presentation transcript to summarize the presentation content, identify key comments, and develop a working outline for this article. The five

experts read the draft outline then independently developed content from their presentation segment highlighting the key aspects of their work. Contributions from the five experts were incorporated into the draft article. OM aimed to edit their contributions as little as possible since keeping the unique voice of individual authors was deemed important to develop an overall picture before identifying and achieving consensus on the emerging key elements of individual music therapy practice and skill-sharing in dementia care. Presentations by the five experts highlighted the diversity in the concept of, as well as types of *indirect music therapy practice* offered in their countries. The following summaries of their presentations were produced individually for this article by each expert.

Carer training (Ridder, Denmark)

The terms *indirect* and *direct music therapy practice* described by Bunt and Stige (Bunt & Stige, 2014) are increasingly used in the context of dementia care in Denmark and Norway. Direct music therapy is necessary in treatment contexts, for example to treat severe behavioural and psychological symptoms. However, once the music therapist has found a way to work with the person with dementia, it is necessary that the therapist share with carers how music may assist the person in daily care. This means that the music therapist is able to withdraw from the therapeutic relationship when formal therapy work is complete, ensuring that the relationship is replaced by those who are in the daily life of the person. Music therapists can contribute to an important change in the culture of care by adding their expertise to activities of daily living and care. This can be achieved by also offering indirect music therapy practice and knowledge-sharing with carers. Training carers is an important part of indirect music therapy practice and may happen in daily care where the music therapist acts as a role model, exemplifying how musical interactions are integrated in activities or communication. Further, training may happen more formally with the therapist in a teaching role. The first type of training implies situated learning and the latter, learning happens in a context separate from daily practice. Both types of training are needed.

As part of a current research project, we collaborate with music therapists about skill-sharing (Ridder, Anderson-Ingstrup, Krøier, Ottesen & McDermott, 2018). The following is

an example from the data collection of carer training taking place as a structured course outside the nursing home. The training of so-called Music Ambassadors was led by an experienced music therapist, Marie Munk-Madsen, who had in-depth knowledge of didactics and learning theory. She was able to judge the most relevant teaching model for this group and was aware of her role as teacher to facilitate shared learning. The goal of the course was to give participants: 1) ideas to implement music activities and tools in activities of daily living, 2) theoretical knowledge of what works and how, 3) experiences of how music affects the human body, and 4) courage to use the voice and body dynamically (Munk-Madsen, 2017a).

Twenty caregivers from 11 nursing homes or day care centres attended the course funded by the municipality. The majority of the participants had one or two years' care staff training. They were not required to have musical skills in order to participate. The music therapist/course facilitator was interviewed after the third session and the researcher analysed the transcript of the interview (6949 words) with Nvivo. The facilitator's reflections half way through the course are summarised here. Frist, the participants were expected to have the competence to "put yourself into play" (Munk-Madsen, 2017b). The process was not passive; the carers were expected to both engage and be active. This required carers to have abilities to cope with time pressure and writing skills and to be able to express themselves. Second, the aim and structure of the training should be clearly negotiated with and communicated to funding administrators and participating carers. Third, the majority of the participants had limited previous training. The balance of combining theory and practice was important, not least when learning how to attune to the person with dementia in the process of applying music.

Supervision was not included in the training of Music Ambassadors. However, one of the participants asked the music therapist trainer for help in setting up a new initiative, which she then could continue independently but with supervision. Adding supervision to the music ambassador training became an import theme. Supervision increases the chance of finding the best learning models, for example apprenticeship learning (Nielsen & Pedersen, 2011),

situated learning (Lave & Wenger, 1991) and problem based learning (Savery, 2006). This links to the indirect use of music therapy approaches where it is important that the music therapist not only work as a teacher, but also as a supervisor and facilitator of interdisciplinary knowledge sharing.

Training family caregivers and social workers (Wosch, Germany)

There are three streams to our music therapy skill sharing at the University Of Applied Sciences Würzburg-Schweinfurt (FHWS) in Germany. First strand is counselling for family caregivers of people with dementia (PWD) living at home. Second strand is teaching music therapy techniques to social workers. Third strand is projects in social work using techniques of music therapy. There is a strong need for skill-sharing in all three strands.

Family caregivers provide most of the care for the majority of PWD (e.g. 62% in the UK, 75% in Germany) with some help from paid carers (ILC-UK, 2018; Deutsche Alzheimer Gesellschaft, 2018). There is no mandatory training for family caregivers to manage everyday challenges such as maintaining their relationships, communications and activities of daily living of PWD. Indirect music therapy practices aim to support carers to develop skills to manage these challenges and improve their quality of life. Counselling for family caregivers began in 2015 when Alzheimer Society Würzburg/Under-Franconia found the roundtable “Kultur und Demenz” (Arts and Dementia, Halma non-profit organisation, 2017). FHWS focuses on empowerment of family caregivers by enhancing musical experience in dementia care, especially to further develop communications with PWD, arousal regulation and activities of daily living. Two key areas emerged from the annual one-day intervention held in FHWS for family caregivers and PWD living at home. One area was to share experiences of being family caregivers. There was a strong need to express burden of care among family caregivers. The second area was to develop individualised use of music in informal care of family caregivers. The Melbourne-Würzburg-Dementia Song-project (MWD-Song) led by Tabea Thurn (FHWS) addresses this need (Wosch, Eickholt & Thurn, in press).

In addition, FHWS offers 270 hours of teaching to the final-year social work students undertaking the BA program. Students develop competencies of empathy by experiencing

clinical improvisation (Wigram, 2004), learn to self-reflect in Regulative Music Therapy (Wosch, 2013) and learn key components of leading groups in Active Group Music Therapy (Schwabe, 1997) and Therapeutic Songwriting (Baker, 2015). Elements of Active Group Music Therapy and Therapeutic Songwriting are integrated into music intervention sessions for social work students. This helps students to increase self-confidence with resource-orientation and to work in social competences and social behaviour with social-communicative orientation. The target groups of these interventions are the relatively disadvantaged clients (Stige, 2012); for example, those with learning disabilities, experiencing social exclusion, migration background, delinquency, or who are homeless. However, there are clear differences between the use of music for social workers' interventions and of music therapists' interventions. Some of the BA-undergraduates choose to proceed with a music therapy master program, which can be argued is a form of academic transition from skill sharing (social work BA program) to direct music therapy (music therapy MA program).

Certified Nursing Assistants training (Ray, USA)

More frequently, nursing homes are using nonpharmacological interventions to address symptoms commonly seen in people diagnosed with Alzheimer's disease or related dementias (Cabrera et al., 2015). Providing music to alter symptoms related to dementia (e.g. agitation) is typically delivered by a certified or licensed music therapy professional (Ray & Mittelman, 2015); however, in clinical settings music therapy sessions may be limited to once or twice a week and not during caregiver activities when residents' experience a higher frequency of disruptive behaviors. Training certified nursing assistants (CNAs), who interact with residents multiple times a day, may help improve care quality and extend the benefits of music therapy programming.

Three board-certified music therapists who had provided at least two weeks of music therapy for 132 residents, designed interventions for use by CNAs (Ray & Mittelman, 2015). Techniques were developed based on work by Sung and colleagues (2006), observed responses of residents during music therapy experiences, and grounded in Gerdner's mid-

range theory of individual music (1997), which suggests that agitation may be reduced or eliminated by providing music before situations that are known to cause agitation. During an intense 3-day training, CNAs were provided with instruction on the following three key topics: 1) overview of dementia, depression and agitation; 2) use of an iPod during caregiving; and 3) key elements of a successful music program (see Table 1 for detailed training schedule). The purpose of the dementia overview was to provide CNAs with a fundamental understanding of dementia and some common troublesome behavior occurrences that have been successfully addressed through music. The introduction of the iPod, their accompanying playlists, and keys to a successful music program served to guide the effective use of music by nursing assistants, like singing and listening to background music during difficult caregiving activities such as bath/shower.

Unlike typical nursing interventions, the training emphasized the use of indirect music therapy practice and skill sharing to help address agitation symptoms using techniques such as music with movement and the use of individualized music listening during caregiving activities. CNAs were asked to play personalized, recorded music on iPods with small speakers in the background during caregiving activities, sing-a-long to recorded music familiar to the resident, or lead gentle movement exercises along with recorded music. No headphones were used for listening. Music therapists created separate playlists for each music activity including, “music for bath/shower,” “music for movement,” or “music for sing-a-long.”

On the first day, the therapists defined music therapy and presented the foundations of music. This included differentiating between songs that have stimulative vs sedative characteristics based on musical elements like tempo and pitch. The CNAs were provided with expectations for use of music during their daily routines, such as playing background music during a bath/shower or while getting dressed. The music therapists also provided strategies for how to use singing a familiar song to reduce restlessness or to distract the resident who resists necessary care such as changing dressings for a wound. Music

therapists encouraged CNAs to use music with movement to motivate residents who may have difficulty leaving their room or who present with a depressed mood.

On Day 2, CNAs were coached that the iPods were preloaded with playlists that they could test and play. Next, the CNAs observed either a video or in-person music session. A demonstration and steps were presented for the protocols: music with movement, sing-a-long, tonal protocol, music-assisted bath / shower and music-assisted wound care. Participants were given time to reflect on learning for the day and asked questions. A game of jeopardy designed with components of the training including: dementia, depression and agitation, music therapy vs. music activities, successful music programs.

The third day, a review of all protocols occurred along with introduction of the music-assisted range of motion protocol. Music therapists presented methods to create a playlist from existing music on iPods to personalize music for residents based on preference. A final game of jeopardy took place to review all material presented during the first 2.5 days of training. Care instruction cards, outlining a brief description of each protocol, were provided. Afterwards, mock music-based interventions were led by CNAs who were asked to choose one protocol to demonstrate its use. Other group members volunteered to be "residents" while the CNAs demonstrated their knowledge of the protocols and iPods and speakers. Following the three-day classroom training, the music therapists guided CNAs' facilitation of two to four, individual or small group music-based protocols.

Evaluation of the music therapist designed interventions (Ray, Dassa, Maier, Davis, & Ogunlade, 2016) suggested that education and training materials on the use of music during activities such as bathing or wound care, or even adding singing, helped to decrease agitation in nursing home residents with moderate dementia. For those interested in duplicating this approach, the following steps are recommended: 1). During music therapy, music therapists identify musical preferences and music activities for decreasing agitation; 2). Music therapists provide training for CNAs to incorporate simple music activities like listening, singing, or music with movement for use during activities of daily living; 3). Music

therapists provide ongoing support for CNAs and residents adapting activities and providing updates of music as needed.

Therapeutic songwriting for family carers (Baker, Australia)

Family carers of people with dementia play an important societal and economic service to the community (Baker, 2017). However, caring for people with dementia can have a huge impact on family carers' emotional, physical and social wellbeing. There was a need to develop an intervention specific to family carers so that they can continue to take care of their family members with dementia.

Therapeutic songwriting is theoretically grounded (Baker, 2015) and is a widely applicable therapeutic method of practice (Baker, Wigram, Stott, & McFerran, 2008; 2009). The advantages of using songwriting with carers of people with dementia include: allowing them to tell their story, recording therapeutic progress, pairing the emotive content of music and lyrics, allowing a person to process and re-process issues and feelings, having a cathartic experience, communicating strong and difficult messages, increasing awareness, and encouraging peer support (Baker & Yeates, 2017).

Problem focused/behavioural approaches to coping and emotion-focused/cognitive approaches to coping (Del-Pino-Casadao et al., 2011; Lazsarus & Folkmans, 1984) are effective frameworks for caregivers of people with dementia (Baker 2017). By incorporating those coping frameworks into a group therapeutic songwriting experience, Baker developed a protocol for 12 weekly songwriting sessions that enabled small groups of family caregivers to create three group songs, with the process facilitated by qualified music therapists (Baker, 2017).

The first song draws on the theoretical model of insight-oriented songwriting where the family carers explore their experiences of being a carer. When experiences are positive, they are celebrated and transformed into song lyrics. When experiences are negative, time is taken to explore and express these, and at times reappraise these feelings, reframe thinking, and again transformed into meaningful song lyrics (sessions 1-4). Essentially the

songwriting process enables the carers to have greater insight into the positives and challenges associated with their carer role and to reflect on how they feel about it.

Song 2 draws on narrative songwriting concepts to identify, explore, express and reconcile conflicts in carer identity (sessions 5-8). Questions such as “who am I, who was I, and what have I lost and how do I feel about it?” are explored and the synthesis of the group’s experience transformed into song lyrics. Both song 1 and song 2 draw on emotion focused/cognitive approaches to coping. The final song moves to focus on problem focused / behavioural approaches to coping by utilizing a psychoeducational songwriting approach. Here, the carers are engaged in exploring feasible methods of looking after themselves, how to ask for help, to better comprehend what to expect in the future expectations as their loved one’s wellbeing declines (sessions 9-12). It aims to increase personal and social resourcefulness and prepare them for long-term carer role.

Family carers who participated in pilot studies confirmed they valued shared experience as a group and joint process in their own space without worrying about their family members with dementia. It differed to other carer support programs in that this experience enabled them to explore the whole carer journey. It enabled them to gain clarity about the carer journey and it helped them foster inner strength and personal growth (Baker, Stretton-Smith, Clark, Tamplin, & Lee, submitted). Therapeutic songwriting is ‘direct music therapy’ for carers but people with dementia also benefit indirectly through increased carer wellbeing, thus this work is included as a form of indirect music therapy for people with dementia.

The ecology of polyphonic partnerships (Stige, Norway)

Although traditionally music therapists have worked mainly with groups and individuals, increasingly they also work in systemic or ecological ways. One rationale for indirect music therapy service is based in an ecological perspective on music therapy. Initially, ecological analyses were developed within biology, for descriptions of relationships between organisms and environments. Since the 1970s, use of the term ‘ecology’ has been extended to fields such as psychology, education, and – eventually – music therapy.

Ecological perspectives imply that goals and practices focus upon the fostering of health-promoting relationships between people, activities and systems. This naturally leads practitioners to indirect practices, where they enable and support various agents in their attempts of employing music as a health resource within a system. We could talk of "consultation-collaboration music therapy" concerned with the overall functioning of a care system supporting a person (Stige, 2002, pp. 135-155).

Ecological practices are usually also economical practices, and as such they are linked to social justice: The financial side of therapeutic practice involves values-based choices. If music therapists work with people individually or in groups only, fair access in society to music as a health resource is hindered (Stige & Aarø, 2012). Consequently, ecological and economical perspectives go together and suggest that the transactions of a broader range of participants need to be taken into consideration. In addition to services to individuals and groups, music therapists have started to work more indirectly, for instance collaborating cross-professionally and with family and friends, supporting people to use music as a resource in their everyday lives (Bunt & Stige, 2014).

In Norway, an ecological and economical logic similar to the one described above informs the national guidelines for dementia since 2017. The guidelines suggest that music therapists should work individually with the patients with most severe needs and that they in addition should prioritize to supervise and support other carers in their attempts of integrating music activities into the practice of person-centered care (Helsedirektoratet, 2017).

To implement indirect practice is not easy, however. It requires that music therapists are willing to and capable of working with "polyphonic partnerships" that enable cross-professional dialogues and organizational change. In order to create the necessary conditions for this, the profession needs to work with service development in ecological ways too, so that professionalization and collaboration can develop as interacting processes (Stige & Aarø, 2012).

In the Bergen area in Western Norway, POLYFON knowledge cluster for music therapy is one attempt to create a conscious push for policy change in this direction. The idea of a "knowledge cluster" is in itself both ecological and economical; it suggests university-community relationships that can develop the identity of the music therapy profession to embrace direct as well as indirect practices within the health care services. Skill sharing and collaborative practices not only require development of the competencies of the music therapists, then, but development of their situated "license" to work with organizational change, including collaborative work with service users, staff, community members and leaders (Stige, 2017, 2018).

If summing up these reflections, I argue that indirect music therapy involves consultation and collaboration with lay or professional members of a community of practice, aimed at mutual distribution of knowledge and skills in ways that stimulate health-promoting changes in the systems involved (Stige, 2002).

Emerging key components of *indirect music therapy practice* and skill-sharing

It is not the purpose of this article to determine what should be or should not be regarded as *indirect music therapy practice*. Instead this section aims to identify some of the emerging essential components of *indirect music therapy practice* and skill-sharing in dementia care.

Deciding when direct or indirect music therapy practice is necessary or appropriate

The experts emphasized the importance of a therapist's clinical judgment on deciding when to offer music therapy (*direct practice*) and when to support staff and families' use of music with people with dementia (*indirect practice*). Meeting the needs of a person with dementia who is showing severe behavioral and psychological symptoms was considered to be a music therapist's responsibility (*direct music therapy practice*) (Ridder, Stige), but the need to support staff working with people with behavioral and psychological disturbances (*indirect music therapy practice*) was also highlighted (Ray). Ridder recommended supporting a person with dementia to develop and maintain a therapeutic relationship with a carer when formal music therapy work comes to an end so that the carer can "take over" the

interactive role when music is shared. It was suggested that teaching carers and families how to use personalized music attuned to the individual is one way of maintaining a person's wellbeing following direct music therapy.

Moving from direct music therapy practice to indirect music therapy practice

Direct and indirect music therapy practice can merge in some situations. When families of people with dementia attend music therapy (e.g. Baker therapeutic songwriting group) it can be argued it is direct music therapy for families because the initial focus of the sessions is on meeting their needs. However, when the focus of therapy shifts more towards their reciprocal relationships with family members with dementia and addressing the needs of people with dementia, it moves closer to indirect music therapy practice. Similarly, family counseling (Wosch) may initially need to address families' psychological needs (e.g. sharing carer burden) but it may move towards indirect music therapy for people with dementia when families start sharing their thoughts on how to support their family members with dementia.

Carer training and staff support

Carer training that incorporates music therapeutic skills aimed at improving care for people with dementia was developed in the USA (Ray) and in Denmark (Ridder). Protocol- or manual-based music therapeutic interventions are still rare, but rigorously developed and evaluated structured training would allow wider implementation of music therapy skill-sharing in the future. Ridder highlighted the importance of considering a 'learning model' best suited to carers. Music therapy skill-sharing often focuses on 'how' to work with the person, it is not only about 'what' music activities. When the emphasis is on relational aspects, it is even more important to pay attention to how carers truly understand the content of training. The challenge of maintaining 'good practice' beyond the initial training period is well acknowledged in other dementia psychosocial intervention research (e.g. Brooker et al., 2016; Fossey et al., 2014). As such, future staff training on music therapy skill-sharing will need to consider how to encourage long-term implementation.

Wider vs. client-specific music therapy skill-sharing

In addition to crucial micro-level work (e.g. working closely with a carer to meet specific needs of a care home resident with advanced dementia), music therapists have been skill-sharing at the meso-level. In the UK, the CHORD (CHOrus Research in Dementia) singing manual for non-therapists was developed as a music therapy skill-sharing study (McDermott 2018). It aims to highlight key therapeutic components of singing groups for people with dementia, as well as offer practical advice on running a group. Through their BA program, Wosch and colleagues skill-share some key music therapy components such as empathy and self-reflection with final-year social work students. Skill-sharing at the meso-level may focus less on 'here and now' needs of a specific individual that are often the focus of direct music therapy, and more on working with a specific population in general.

Expanding the role of a music therapist

Informal skill-sharing and *indirect music therapy practice* may be an integrated part of a music therapist's daily clinical work. However, the need for more formal recognition of the expanding role of music therapist working with people with dementia was highlighted. In particular, a wider supervisory role to support therapeutic work of staff was considered important in the future dementia care. In Ridder's study, carers requested continuing support from a qualified music therapist. Skill-sharing is an ongoing process. In order to ensure sustainability of therapeutic work between people with dementia and their carers, music therapists may be required to spend more time supervising or mentoring other health care workers. They may even request further specialization to be prepared to take on this expanding role.

Potential risk and burden

The experts also highlighted the importance of considering potential risk and burden arising from promoting indirect music therapy practice and skill-sharing.

Potential Risks. Music interventions may not always prove beneficial if the music is not used appropriately or sensitively. Repeatedly playing someone's "favorite music" without checking the person's mood first, for example, is unlikely to be therapeutic. If someone is highly aroused or agitated, trying to engage the person safely and appropriately using music

requires longer training and more in-depth understanding of the process, which may not be easy to address in generic group staff training. Although wider implementation of music in daily care should be encouraged, the experts agreed that there is a need to increase awareness about the potential for harm when using music, as well as discussing the benefits of music interventions for people with dementia. The experts also questioned whether encouragement of wider skill-sharing and training non-therapists in music interventions would potentially reduce job opportunities for qualified music therapists.

Potential burden. It was pointed out that many music therapy clinicians already work to their limit delivering direct music therapy services, with little room for *indirect music therapy practice*. Some may argue promoting indirect music therapy services in addition to their regular clinical work (i.e., *direct music therapy practice*) is not realistic. Furthermore, the fine balance of engaging care home staff who are often under time pressure to deliver day-to-day care was acknowledged. Cultivating a learning environment in care homes is often a challenge, which may require even greater efforts from music therapists.

Cultivating cross-professional dialogues and promoting organizational change

Stige acknowledged the challenge of developing and implementing sustainable *indirect music therapy practice*. The importance of fostering "health-promoting relationships between people, activities and systems" was highlighted. Music therapists may be capable of sharing their skills to support people to use music as a resource in their daily lives (Stige), but effective skill-sharing also requires meta-level organizational collaborations and policy changes. Stige promoted the value of mutual distribution of knowledge and skills for sustainable *indirect music therapy practice,* and argued that we need to take into consideration both the ecological and financial aspects of such processes. Music therapists may take on a wider role "as a health resource within a system" to support the overall functioning of the care system, which supports clients and families (Stige). Cultivating cross-professional collaboration will be strongly influenced by each country's cultural values, attitudes towards social inclusion and social justice, local and national economic climate, and day-to-day organizational contexts.

Contribution of indirect music therapy practice in wider dementia care research

Staff training and ways to support families of people with dementia are widely investigated in dementia psychosocial research (Brooker et al., 2016; Kurtz et al., 2016; Mittelman, Haley, Clay, & Roth, 2006). In the USA, Clair and colleagues have worked extensively with families of people with dementia (1997, 2002). The book *Therapeutic Uses of Music with Older Adults* (Clair and Memmott, 2008) has been a valuable resource for health care professionals. However, a dementia-specific music therapy skill-sharing manual or guidelines are still not widely available, particularly in Europe. Systematized music therapy skill-sharing, for example development and in-depth evaluation of a music activity handbook for carers and supporters, would allow a greater number of dementia care workers to benefit from music therapists' knowledge. Qualitative studies have consistently highlighted that people with dementia often remember "how" carers approach them and interact with them, even when they cannot recall "what" carers did with them (Brooker, 2003; Brooker & Latham, 2015). This resonates with the essence of music therapy: "it's not what you do but the way that you do it" (Aldridge, 2000). Teaching carers and supporters "the way that you do it" (how to be with a person) is much more complex than teaching "what you do". Challenges of implementing and sustaining a person-centred approach ("the way you do it") in dementia care is widely acknowledged (e.g. Brooker et al., 2016; Brooker & Latham, 2015). Nevertheless, if integration of "what you do" (using specific musical skills) and "the way you do it" (how to be with the person in the moment) is a specific skill music therapists have, it is the responsibility of the music therapy profession to skill share with the wider dementia community in order to support the wellbeing of people with dementia.

Concluding remarks

This article consistently highlights the diversity and complexity of *indirect music therapy practice*. At the same time, it can be argued that *indirect music therapy practice* and skill-sharing is not a specialized intervention or approach but something a music therapist naturally "does" out of clinical necessity. It is not the purpose of this article to propose what should be and what should not be classified as *indirect music therapy practice*. However,

based on the insights generated from our roundtable and further discussions, we would like to offer a simplified diagram that demonstrates relationships between *indirect music therapy practice*, *direct music therapy practice* and skill-sharing (Figure 1).

In *direct music therapy practice*, a therapist focuses on a client's specific needs and supports the client to develop their relationships with the external world and people around them. For *indirect music therapy practice* in dementia care, a therapist typically works with staff and supporters so that they can develop meaningful relationships with a person with dementia and help the person to connect with their external world. The ultimate focus of *indirect music therapy practice* is the wellbeing of the person with dementia, although the therapist is unlikely to work directly with the person. Skill-sharing is multi-dimensional and it includes: promoting informed and safe use of music, enabling carers and supporters to further develop self-awareness and sense of competencies so that they can be attuned to the needs of people with dementia, promoting cross-professional dialogues and contributing to organizational change.

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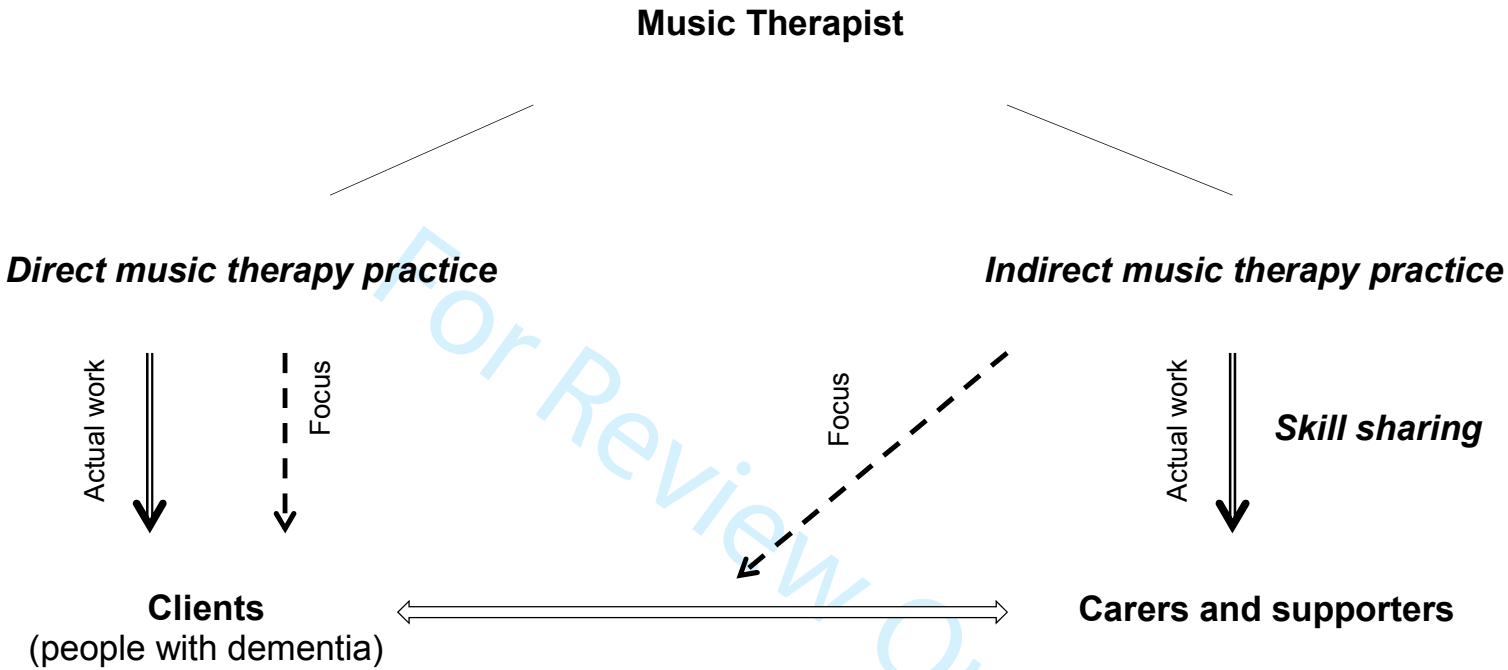
Table 1. Training Schedule for CNAs Caring for Nursing Home Residents with Moderate to Sever Dementia

Day 1	**Day 2**	**Day 3**
8 A.M. – 8:45 A.M. • Overview of 3-Day Schedule • Introduction to Music Grant • Ice Breaker – Name that Tune	8 A.M. – 9:00 A.M. • MP3 Introduction	8 A.M. – 9:30 A.M. • Overview or assessment tools • Music-assisted range of motion • Music intervention questionnaire
9:15 A.M. – 11:00 A.M. • Introduction to music therapy • Foundations of music • Music improvisation • Keys to a successful music program	9:00 – 9:30 P.M. • Movement Protocol/Video Demonstration 9:30 A.M. – 10:00 A.M. • Singing Protocol 10:00 A.M. – 11:00 A.M. • Observe & Assist Music Therapy Group (movement & singing protocol)	9:30 A.M. – 10:30 A.M. • MP3 Review 10:30 A.M. • Jeopardy (Content Review)
11 A.M. Lunch	11:00 A.M. Lunch	11:00 A.M. Lunch
12 NOON – 1:45 P.M. • Classroom Training: Dementia and Depression • Tonal Protocol 2:00 P.M. – 3:00 P.M. • Observe music therapist and patients (tonal protocol) 3:00 P.M. – 4:00 P.M. • Group Reflection	12 NOON – 12:30 P.M. • Reflections on Singing and Movement Group Observations 12:30 P.M. – 1:00 P.M. • Behaviors 1:30 P.M. – 2:00 P.M. • Music-assisted bathing protocol • Music-assisted wound care protocol 2:00 P.M. – 3:00 P.M. • MP3 Playlists 3:00 P.M. – 4:00 P.M. • Jeopardy (Content Review) • Reflections/Questions	12:00 P.M. – 3:00 P.M. • CNA's conduct mock groups (CNA choose one protocol for mock group) 3:00 P.M. • Schedule video taping • Course evaluation 3:30 P.M. • Stress Management for healthcare professionals

Figure 1. Direct music therapy practice, indirect music therapy practice, and skills sharing



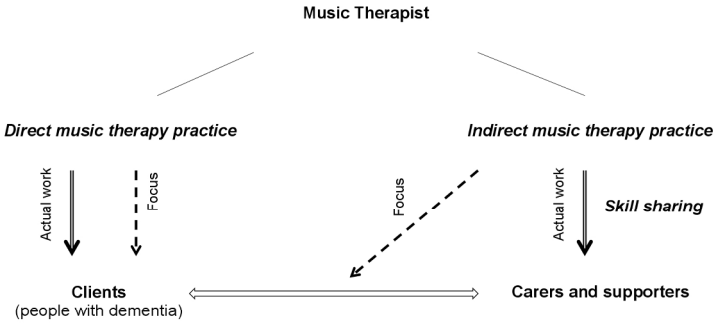


Figure 1. Direct music therapy practice, indirect music therapy practice and skill-sharing

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