

**MUSIC THERAPY PRACTICES FOR INCOMPETENT TO STAND
TRIAL (IST) PATIENTS IN FORENSIC PSYCHIATRIC
HOSPITALS: CONTENT ANALYSIS**

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ABSTRACT

The statistical trends in forensic psychiatry populations have changed tremendously over the decades, yet music therapy practices with the Incompetent to Stand Trial (IST) population remain relatively unexplored. Limited research has been conducted on the role of music therapy in competency restoration for IST patients. This study aimed to examine current music therapy practices with IST patients by exploring music therapists' perspectives on patient needs and goals, the use of music in competency restoration, and the specific methods and techniques employed within forensic psychiatric hospitals in the United States. A qualitative approach was utilized through interviews with music therapists working with IST-committed patients. Data were gathered on various aspects of clinical music therapy practices, including treatment rationale, assessment, methods, technique, and therapeutic approaches. The qualitative data were transcribed, categorized, coded, and analyzed using deductive content analysis to identify patterns and themes. The findings revealed the most frequently used music experiences, music therapy techniques, and a broader range of patient-centered goals than previously documented in the literature. This study provides valuable insights into the evolving role of music therapy in forensic psychiatric settings and highlights its potential contributions to competency restoration for IST patients in the United States.

*Dedicated to my God and people in my life
who made me who I am*

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Someone once told me that a job is just a job and doesn't define who you are. However, being a music therapist was never just a job for me. It was a calling that became an integral part of my identity and gave profound meaning to my existence. For me, exploring the philosophical questions of what music therapy is and why it matters wasn't merely important, it was essential. I consistently reflected on, researched, and reconnected with the core foundations of my profession and purpose.

Working with IST patients deepened my passion for music therapy and inspired my return to academia. Studying at Temple University fulfilled my hunger for knowledge and led me on a journey of inspiration and growth. While the road had its challenges, and progress often felt slow, every step was worthwhile. This journey provided an opportunity to expand my understanding of my clinical field and to support one of the most underserved populations during some of the most difficult times of their lives.

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CHAPTER 1

INTRODUCTION

Forensic psychiatric services are a branch of mental health services that focus on the intersection of psychiatry and law. Forensic psychiatry aims to assist mentally ill individuals in trouble with the law to navigate three completely inimical systems: mental health, justice, and correctional (Arboleda-Florez, 2006). Patients in forensic psychiatric hospitals experience the same mental health concerns as those in the community, regarding symptoms of psychosis such as hallucinations, delusions, dysregulated mood, or dysregulated thought functions. The differences are that psychotic symptoms in forensic patients tend to be more acute and chronic compared to those in the community, and they always involve criminal behaviors. When mentally ill individuals are in trouble with the law, they are classified as forensic psychiatric patients.

Patients in forensic psychiatry generally fall into three legal commitment categories: Incompetent to Stand Trial (IST), Offenders with Mental Health Disorders (OMD), and Not Guilty by Reason of Insanity (NGI). Depending on the facility, patients with other commitments, such as Mentally Ill prisoners or Sexually Violent Predators (SVP), may also be housed and treated in forensic psychiatric hospitals.

Among these commitment categories, Incompetent to Stand Trial (IST) commitment is a relatively new area in forensic psychiatry. The IST population represents an interesting subgroup within forensic psychiatry due to its unique characteristics, which distinguish it from other forensic populations. Like other psychiatric patients in forensic facilities, IST patients have a mental illness and have committed a crime. However, unlike others, IST patients are expected to return to court

once they have completed treatment to gain competency. During IST treatment, their legal cases in court are put on hold, and a verdict has not been rendered for the alleged crimes.

The IST population has grown immensely across the United States over the past several decades. Despite this increase, music therapy studies focusing on this population remain extremely rare, and how music therapy supports the treatment of patients who are in a competency restoration process is not well understood. While patients' inability to participate in their legal proceedings is identified as a primary reason for incompetency (Colwell & Giancesini, 2011; Sammons, 2014; Warburton, 2015), the specific factors contributing to their incompetency or their inability to participate in legal processes are neither thoroughly explored nor adequately explained in the literature. To better understand IST patients and provide effective music therapy tailored to IST specific needs, it is essential to look at how the field of forensic psychiatry has developed over the decades and how the IST population became part of forensic psychiatry in the United States.

Background

Deinstitutionalization

One of the most recognized reasons for the increase in the forensic psychiatric population is the deinstitutionalization movement of the 1960s. The findings of many studies indicate that the number of service users in forensic psychiatric facilities began to rise during the deinstitutionalization movement of the late 1960's and early 1970's (Thaut, 1992; Silverman & Marcionetti, 2004; Arboleda-Florez, 2006; Warburton, 2015; Seppanen et al., 2018). While deinstitutionalization was a necessary and progressive

change, psychiatric hospitals in many communities released individuals faster than society could develop the adequate community resources and alternatives envisioned in the original policies (Arboleda-Florez, 2006). Patients were discharged without sufficient planning or assessment of the needs of those patients. Consequently, this lack of preparedness and support led to the unintended neglect of patients' needs, potentially contributing to their involvement in the criminal justice system. Although deinstitutionalization was not the sole cause of the growing forensic psychiatric population, several studies have shown a correlation between the decrease in psychiatric bed numbers and the increase in mentally ill prisoners (Thaut, 1992; Silverman & Marcionetti, 2004; Seppanen et al., 2018).

Deinstitutionalization also created several side effects and challenges for individuals with mental illness. One common issue was treatment non-compliance among patients with mental illness. Patients with mental illness are frequently known for medication noncompliance after their release. When patients discontinue medication or refuse treatment, the likelihood of committing a crime and being arrested increases. Studies indicate a highly significant correlation between failure to take prescribed medication and a history of violent acts in the community among patients with severe mental illness (Smith, 1989; Swanson et al., 1997; Warburton, 2015). Moreover, there are no effective sanctions for patients who refuse treatment after discharge, which contributes to the increase in the forensic psychiatric population. Without social support, treatment and medication, many patients decompensate, leading to further involvement in the criminal justice system (Beck, 1996; Warburton, 2015). Substance abuse is a significant reason why this population fails to remain on medication after discharge. Studies have

found that substance abuse rates are high among patients with mental illness, with roughly 50 percent of individuals with severe mental disorders are affected by some form of substance abuse or dependence (Substance Abuse and Mental Health Services Administration [SAMHSA], 2019). When patients withdraw from medication, the risk of misusing or abusing illegal substances and encountering legal troubles increases. The increase in the forensic psychiatric population raises concerns about multiple interconnected social issues. Numerous studies suggest that this trend reflects a broader withdrawal of adequate community care and treatment, alongside increases in homelessness, substance abuse, arrest, recidivism, and re-admission to the mental health care system (Peters & Hills, 1997; Swartz et al., 1998; Swanson et al., 2002; Arboleda-Florez, 2006; Warburton, 2015; NAMI, 2019; Andine & Bergman, 2019).

IST Population

If deinstitutionalization drove the increase in forensic psychiatric population, the increase in the IST population was influenced by judicial cases within the forensic psychiatric system that evolved over several decades. The Sixth Amendment of the U.S. Constitution guarantees the rights of criminal defendants to a fair trial without unnecessary delay and provides several trial-related rights pertaining to their defense. In 1960, the Supreme Court ruled that the U.S. Constitution requires all defendants to be competent to stand trial before a judge can issue a verdict (*Dusky v. the United States*, 1960). This ruling establishes that defendants with a mental illness must understand their legal situation, be able to defend their legal cases, and assist their attorney in a coherent and rational manner. When a patient is deemed IST, the court orders the individual to be sent to a forensic psychiatric hospital or a state affiliated facility for competency

restoration. These forensic psychiatric hospitals are commonly state hospitals that provide diagnostic services to the criminal justice system and psychiatric treatment for defendants with mental illness (Renner et al., 2017; Seppanen et al., 2018).

During the deinstitutionalization movement, patients with mental illness were released from hospitals based on their rights, while the *Dusky v. the United States* ruling effectively returned some of the patients right back to forensic facilities. The consistent and dramatic increase in the IST population in the U.S. has drawn the attention of policymakers and researchers. Although not all states have experienced the same growth in their forensic psychiatric populations, a study by Wik et al. (2017) reported a 76 percent increase in the number of forensic patients in state hospitals from 1999 to 2014, reflecting overall national trends. According to Wik et al. (2017), this increase is primarily attributed to the rise in the incompetent to stand trial (IST) population. Unlike OMD or NGI commitments, patients with IST in forensic psychiatry are committed to a hospital for an evaluation and treatment ordered by court but have not yet been sentenced for a crime. Treatment for this population focuses primarily on restoring competency. Because IST patients are expected to return to court after competency restoration, their treatment is described as more distinctive, direct, and time-sensitive than that of other forensic commitments, while they continue to share similar psychiatric and psychological issues.

Competency restoration treatment is provided by various clinical professionals within an interdisciplinary team. However, the specific goals and strategies for IST patients are not always straightforward, clearly directed, or effectively communicated.

Music therapists, as members of interdisciplinary teams, have utilized music therapy to assist competency restoration for IST patients in forensic psychiatric hospitals.

Why Music Therapy

Music therapists have served the population with mental health diagnoses, including forensic psychiatry for quite some time. Music therapy literature reports that music therapy could assist wide ranges of mental illness symptoms such as dysregulated mood, thoughts, behavior, and cognitive issues (Gallagher & Steele, 2002; Solanki et al., 2013; Tolman, 2013; Frederiksen et al., 2015; Hakvoort et al., 2015) that are common among individuals with IST commitment. Existing music therapy studies emphasize that music therapy may assist IST patients in learning court materials that is focused on cognitive functioning (Sammons, 2014; Mace, 2017; Linder, 2019). However, there is still much to learn about how music therapists utilize their professional training to help patients with IST.

The current music therapy literature on the IST population does not adequately address the organic needs of patients such as psychotic symptoms and/or cognitive, behavioral, emotional symptoms that may be a cause of criminal incidents, their arrest and referrals to IST. The fast-growing IST population and its unique condition in forensic psychiatry are sufficient reasons to invest in this study, especially as music therapy studies on IST patients are surprisingly lacking and very limited. Moreover, the needs of IST patients are not widely explored and the role of music therapy with this population is not thoroughly described in the existing literature.

Successful music therapy treatment for IST patients requires an effective and efficient treatment approach. Understanding how music therapy functions within the

realm of forensic psychiatry and how to approach the specific needs of IST patients in music therapy is important knowledge to obtain. This knowledge is particularly important given the current trend of a significant increase in the IST population among service users in forensic psychiatry.

Definitions

Music therapy in this study is defined as a clinical treatment approach that uses music to help IST patients achieve nonmusical goals and address their needs, as delivered by a trained music therapist. Music therapists typically provide treatment sessions in either group or individual settings. Group sessions can be structured or unstructured, depending on the therapist's discretion and needs of the participants.

In this study, a structured group refers to a session where methods, goals, and intervention steps are pre-planned and implemented by the therapist (Barlow, 2013). In contrast, an unstructured group is described as an open group session where therapists identify a theme for the group in the moment. Participants in unstructured groups are free to join, leave, or engage as they choose, allowing for flexibility.

The music therapy methods discussed in this study encompass four music experiences: receptive (listening), improvising, recreating (performing), and composing (Bruscia, 2014).

Defining Bruscia's Approaches and Their Use in This Study. Receptive approaches in music therapy involve the use of music listening, both passive and active listening, depending on how the experience is utilized in therapy. When listening method is goal directed and requires attention to musical elements or lyrics- such as discriminating musical features, guided relaxation, or song discussion-, it is considered

active listening in this study. In contrast, music listening based on patient song requests or as background music to support other activities like art, movement, mindfulness, or play is considered as a passive music listening approaches.

Improvisation experiences are described as methods of creating music extemporaneously through vocal or instrumental play in group or individual settings. In this study, drumming and percussion instrumental play were noted as the primary improvisation approaches used. No instances of vocal improvisation experiences were reported.

Recreative methods involve the performance of existing music in settings such as bands, ensembles, or choirs. Musical bands were reported as the primary recreative method mentioned in this study. Notably, similar to improvisation approaches, no choirs or ensembles were mentioned in this study.

Composition experiences are defined as the creation of musical products. Songwriting, implemented through methods such as fill-in-a blank templates, writing lyrics to existing songs, or creating entirely new songs with original lyrics and melodies, emerged as a popular form of composition. In this study, songwriting was the primary composition experience utilized in music therapy sessions.

As described above, music therapy has a wide range of methods and techniques which can address patients' needs. However, the current music therapy literature offers a very limited perspective on choosing which methods to implement based on the specific needs of the patients.

Problem Statement

There has been an increase in mental health challenges for individuals within the country and particularly with the forensic population. When individuals with mental illness are identified as incompetent to stand trial by the court system, they must first regain competency before moving forward with the court case. Individuals committed to a state hospital to regain mental competency receive therapy as an important element of treatment and for the future trajectory of the person's life. Music therapists have worked successfully with individuals in forensic institutions to assist in regaining competency. However, it is not known how music therapists in the United States working in forensic psychiatric settings describe their work with patients found incompetent to stand trial.

It was anticipated that the results of this study would offer valuable applications for music therapists who work with IST patients and who have an interest in working with the population. This research offered readers a new understanding of, and insight into music therapy practices when working with IST patients/individuals participating in competency restoration in forensic psychiatric hospitals in the United States. It was a hope that this study would contribute to the existing body of knowledge regarding forensic music therapy, assist in determining levels of training, education, and services in the field.

Researcher's Stance

I am currently working as a music therapist at a state psychiatric hospital, one of sites included in this study. I have been working with the IST patients for 15 years. As a long-time clinical therapist for IST patients, I noticed that treatment approaches and

methods were mostly influenced by the clinician's perspective and personal understanding of the IST population rather than a more codified or universal approach.

My experience and upbringing have deeply influenced me as a therapist. My clinical perspective is rooted in my conservative upbringing, understanding human development and behavior, and belief in the importance of wholeness and balance in life. Having diverse experiences from several state hospitals has helped me to develop a balanced treatment approach. I am committed to understanding the IST population, and I am aware that my perspective might influence this study in two ways: First, my experience of working with patients with developmental disabilities for nine years before I worked with IST patients shaped my perspective on seeing therapy as a means to improve a patient's quality of life. My music therapy practice then pursued a structured and goal-oriented treatment that was based on the perspective of human development and values. Secondly, my current work with IST patients in a state hospital encourages me to be creative and flexible while working in a restricted environment with strict policies. Working with the IST population also has provided me an opportunity to collaborate with various disciplines who have their own professional theories and treatment approaches related to IST treatment.

IST patients have various challenges that impact their competency process and treatment directions. Most of IST patients in this state hospital are homeless, have challenges with cognitive issues, have experienced many abuses and traumas, and have an addiction problem with substance use. I understand that not only patients' acute psychiatric symptoms, but also their psychological and social behaviors, and the cognitive challenges of IST patients are critical barriers to competency restoration. My

music therapy approaches are resource-oriented, towards psychoeducational and psychotherapy. Therefore, treatment groups with IST patients can range from a rigid approach exemplified by factual teaching of court material to a more in-depth approach to processing the inner challenges of patients with IST, such as developing insight and coping skills.

My professional experience as a music therapist has shaped my perspective of IST assessment and treatment approaches, and I am positioned as an insider in this research study. Being in an insider position, I know that my perspective can be influenced in understanding or interpreting participants' responses. Due to my familiarity with the population and being an insider in the research, I may overlook necessary information that should be articulated or explained in more detail. However, I believe that it is beneficial to be an insider for this study because of the complexity of the setting, patients and the practice of music therapy with IST patients. Having preconceived knowledge of the study participants and familiarity with the context can be an advantage if it does not affect the informant or the interpretation of the results (Bengtsson, 2016). As an insider, selecting study participants and formulating questions may be easier. Also, meaningful and insightful questions will be possible with having a position as an insider in the research study.

CHAPTER 2

LITERATURE REVIEW

Significant numbers of individuals with mental illness are in the forensic system, which indicates that many patients with mental illness become incarcerated. The Bureau of Justice Statistics (2006) reported that 56 percent of state prisoners and 64 percent of jail inmates nationwide were clinically diagnosed as having a mental disorder, received treatment by a mental health professional, or experienced symptoms of a mental disorder in the previous 12 months. Another study reported that approximately 20% of inmates in jails and 15% of inmates in state prisons are estimated to have serious mental illness, and this represents nearly 10 times the number of patients remaining in the psychiatric hospitals in the United States. (Torrey et al., 2014). The National Alliance on Mental Health (NAMI, 2019) also reported that the average rate of *serious* mental illness among individuals in jails, in prisons, on parole, or on probation is 17 percent, which is significantly higher than general populations (5%). In California, the proportion of incarcerated people in jails with an active mental health case rose by approximately 63 percent, rising from 19 percent in 2009 to 31 percent in 2019 (Franco, 2020). Sirotich's (2009) study found that between 28 and 52 percent of individuals with a severe mental illness have been arrested at least once in their lifetime.

The population of individuals who are incarcerated and admitted to forensic psychiatric hospitals has increased significantly over the decades, and the majority of them are those found to be IST (Wik et al., 2017; Franco, 2020; Warburton et al., 2020). When a patient with mental illness commits a crime and is arrested, it indicates several facts about the patient's psychiatric condition. First, it is highly possible that the patient

was not on medication and not receiving treatment at the time of arrest. The Bureau of Justice Statistics (2006) reported that comparing state-by-state rates of incarceration with access to mental healthcare, shows a strong positive correlation between rates of adults who are in the criminal justice system and those who lack access to mental healthcare. Swanson et. al. (1997) reported that patients with mental illness who have had no treatment contact in the past six months had significantly higher odds of violence in the long term. Other studies also supported that persons who were non-compliant with their medications had engaged in violent physical assault at a much higher rate (Smith, 1989; Schreiber et al., 2015; Franco, 2020). In Perkins' (2002) study, approximately 40 percent of patients stopped taking their anti-psychotic medications within one year while 75 percent stopped taking their medications within two years after release from a hospital. In 2019, NAMI reported that only 65.5 percent of the U.S. adults with serious mental illness received treatment and one third of patients with severe mental illness have not sought treatment. When a patient with severe mental illness is not on medication, it is highly likely that the patient could experience acute symptoms of mental illness and their active psychiatric symptoms could interfere with the criminal incident and their arrest which may result in the person picking up additional charges while being arrested.

Another fact could be that the patient might be under influence of controlled substances at the time of arrest. According to NAMI (2019), 18.4 percent of the U.S. adults with mental illness experienced substance misuse or abuse. National research suggests that as many as three out of every four criminal defendants in major cities tested positive for illegal substances at the time of arrest (National Institute of Justice, 1998). Patients with mental illness are more likely to develop a substance use disorder, and

individuals with mental illness and addictive disorders are likely *not* to comply voluntarily with conventional outpatient therapies (Swanson et al., 1997). As previously mentioned, the probability of violence is greater with patients of non-compliance with medication and substance abuse (Schreiber et al., 2015; Swanson et al., 2002) and unfortunately, this dual diagnosis is high among the IST population (Schreiber et al., 2015). Studies have shown that patients with a dual diagnosis, mental illness and substance use disorder, are more prone to develop different challenges such as homelessness, noncompliance with medications, and violent behaviors (Peters & Hills, 1997; Swanson et al., 2002; Swartz et al., 1998).

Policies and social issues have also had direct influence on the number of IST patients in forensic psychiatric hospitals. Over the years, the awareness of complex relationships among mental illness, substance uses, and homelessness has increased in the criminal justice system which contributed the increase in patients' arrests (Katz, 2016; Warburton et al., 2020). Individuals with mental illness are more likely to be repeatedly arrested over time and face a higher chance of failing competency evaluations when they encounter the legal system. One of the most evident cases is found in Los Angeles County in California which had a 350% increase from 2010 to 2015 in IST cases was referred by the court (Katz, 2016).

Competency Restoration

In *Dusky v the United States (1960)*, the Supreme Court ruled that the United States Constitution requires all defendants to be competent to stand a criminal trial. Each year, roughly 50,000-60,000 defendants are evaluated for competency to stand trial and approximately 20% of those are found incompetent (Mossman, 2007). IST restoration

service is the process by which defendants are prepared to move forward with their pending legal case(s) knowledgeably and reasonably, and without their due process rights being violated (Zapf & Roesch, 2011). Competency restoration is ordered by the court for patients to receive restoration services which help them understand the proceedings being brought against them and help them to become competent to assist in their own defense. Competency restoration service includes two main parts: understanding court material and being able to cooperate with the attorney. Understanding court material includes understanding the nature of charges, knowledge of possible pleas and consequences, understanding court procedures, and being able to cooperate with the attorney means having the capacity to assist the attorney, and capacity to maintain appropriate behavior (Department of State Hospital (DSH)-Patton, 2021; Pennsylvania Department of Human Services (PDHS), 2019). Therefore, competency restoration is a comprehensive program to protect patients with mental illness and it is the most common intervention used with individuals with mental illness involved in the criminal justice system (Golding, 1992). Among the IST population, some patients may report feigned symptoms to avoid the legal responsibility. A study revealed that 20 percent of individuals undergoing a forensic evaluation for competency to stand trial are feigning (Gottfried et al., 2017). Therefore, competency restoration services also include forensic evaluations for patients who feint their psychiatric symptoms (e.g., malingering, or exaggerating symptoms) and/or cognitive ability (e.g., understanding court material, court procedures, court personnel) to avoid their criminal responsibilities (Sammon, 2014; Gottfried et al., 2017).

Competency restoration treatment has a time limit in order to protect the rights of the patient. The length of time for a hospital to hold the IST patients vary depending on

their charges and state but generally lasts from ninety days to two years (Wik et al., 2017; WSDSH, 2019; Warburton et al., 2020). It is expected that a patient can regain competency within a reasonable amount of time and if a patient is not able to regain competency, the patient will be retained under a different status to continue treatments (Jackson v. Indiana, 1972; Wik et al., 2017; Linder, 2019).

The duration of stay for individuals found incompetent to stand trial (IST) in forensic hospitals is a significant concern nationwide. The length of time required for competency restoration in these facilities affects both the progression of IST patients' legal processes and the availability of treatment services for incarcerated individuals (Warburton et al., 2020). In other words, when the time of restoration is longer, it can directly impact the treatment availability for patients with severe mental illness in the correctional system who are waiting for their turn to transfer to the hospital (Linder, 2019). The court has the right to fine forensic psychiatric hospitals when the restoration process takes longer and, as a result, delays returning to court for a patient which affects a new admission of the IST patients from jail (Warburton et al., 2020). Therefore, effective and efficient restoration treatment strategies and programs are imperative for IST patients as well as for the forensic psychiatric hospital.

IST Patients

IST patients in forensic psychiatric hospitals have distinctive conditions and challenges unlike other patients in psychiatric hospitals. Studies describe IST patients in forensic psychiatric hospitals as individuals who suffer acute and chronic symptoms of mental illness from a long history of mental illnesses, severe personality disorders, and have greater likelihood of cognitive deficits or intellectual disabilities (Mossman et al.,

2007; Kapoor et al., 2018; Secarea et al., 2020). They are frequently diagnosed with comorbid substance use disorder, many are homeless, and have fewer years of education at the time of their alleged offenses (Schreiber et al., 2015; Warburton et al., 2020).

While schizophrenia and schizophrenia spectrum disorders are most common among IST patients, major depressive disorder, bipolar disorder, borderline personality disorder, and unspecified psychosis are also found (Hakvoort, 2002; NASMHPD, 2014; Linder, 2019).

The most common reason for failing competency with IST patients is being unable to assist the attorney in their defense (Colwell & Giancesini, 2011). IST patients are referred for competency evaluations and treatment due to their active psychotic symptoms, behavior issues, and cognitive challenges that are considered major barriers to their ability to assist the attorney and participate in their legal cases (Mossman et al., 2007; Kapoor et al., 2018; Secarea et al., 2020). When they are experiencing severe psychotic symptoms such as hallucinations, delusions, or paranoia, patients are most likely not able to work with their attorney. Anxiety and mood disorders are also common with this population. Patients may refuse interviews with evaluators or refuse to work with or assist the attorney. IST patients may experience extreme stress, agitation, or anger after being arrested that may prevent participation in their legal case. Also, many IST patients are challenged with low cognitive functioning, thus they may not understand what has been or is going on with their legal cases. Often these IST patients fail to assist their attorney in defending their charges and allegations.

Substance use disorders are common among the IST population. Many IST patients have comorbid issues such as substance abuse and addiction on top of their psychotic symptoms (Schreiber et al., 2015; Fazel et al., 2016). Substance abuse is not a

primary reason for patients to be deemed incompetent yet, patients with mental illness who also are under the influence of substance often find their way to state hospitals for competency restoration. Pickard and Fazel's (2013) study stated that 40 percent of the offenders with schizophrenia had concurrent substance abuse, higher than a comparison group of individuals with schizophrenia in the community, of whom 26 percent abused substances. It is not uncommon that many patients with mental illness use substances and do not wish to stop using drugs and alcohol because they enjoy the effects or are using substances to cope with the psychiatric symptoms they experience (Gallagher & Steele, 2002). One study suggests that patients with substance use disorders are more likely to develop mental illness and people with mental illness are more likely to develop a substance use disorder (Peters & Hills, 1997). IST patients who have unspecified psychosis with substance use disorder and being medication non-adherent are likely to be restored and more easily become competent than the others (Secarea et al., 2020; McDermott et al., 2020) when they are medicated. If, however, the patient has no insight into their mental illness, they are known for having an increased risk of becoming non-adherent with their prescribed medications, may go back to use illegal substances, and subsequently tend to decompensate (American Psychiatric Association, 2010).

Although each state describes and defines who IST patient is, the Pennsylvania Department of Human Services (2019) provides a clear description of IST patients in different conditions and stages. It describes incompetent to stand trial (IST) patients with five classifications: 1) the individual in the advanced/maintenance stage who has completed competency evaluation or is close to being competent, 2) the individual who is delusional/irrational and experiences distortions or misinterprets the reality, 3) low-

functioning individuals who are limited in learning and retaining information, 4) the psychotic/confused individual who is unable to understand or communicate, and 5) the individual who is disruptive with behavior issues. The categories of IST patients listed above are similar throughout the states and treatment is developed alongside their needs.

In summary, the IST population has unique challenges in psychiatric, psychological, social, and juridical settings. The IST population typically has an extensive history of psychiatric hospitalizations and often has many prior arrests. They frequently have acute psychotic symptoms, cognitive deficits and limited insight into their mental illness. IST patients are often at an increased risk of aggressive or violent behavior. They have the history of medication non-compliance and tend to resist treatment because of their acute psychiatric condition.

IST Treatment

Although the population of IST has increased significantly over several decades in the U.S., no standardized treatment protocol for competency restoration has been established. This is because of the differences in the court system in different jurisdictions across the U.S. make it difficult to standardize treatment protocol for IST patients despite the legal standard for competency being the same at the federal and state level (*Dusky v. United States*, 1960; Grossi et al., 2021). Competency restoration treatment, therefore, has been provided by clinicians in various disciplines who often develop their own resources or adapt existing treatment method, and often this involves a multidisciplinary treatment team approach to address a multitude of issues of IST patients (Sammons, 2014; Linder, 2019; Grossi et al., 2021). Competency restoration process is tailored in treatment groups on an individual basis depending on their shared needs,

individual needs, condition of physical and mental health, and stage of IST classification condition mentioned above. Treatment for IST has a multidimensional approach and depends on a clinician's perspective and understanding of the needs of IST patients, and therefore the approach to restoration of competency can be different based on the individual clinician.

Interventions and Approaches

Common treatment for IST patients in forensic psychiatric hospitals is based on three factors: medication for symptom management, psychoeducation for understanding court information, and psychotherapy for being able to assist their attorney (AHRQ, 2012; Warburton, 2015; Kapoor et al., 2018). Medication treatment is the first treatment approach when IST patients are admitted to the hospital. Medication plays an important role in competency treatment especially for acute IST patients. Medication commonly helps patients' acute psychotic symptoms such as hallucinations, disorientation, thought disorganization, mood, and anxiety (Grossi et al., 2021). To be able to implement other IST treatment methods, patients' symptoms must be decreased, have subsided, or be controlled. Psychological and psychoeducational treatments are offered for IST patients in the form of group and individual therapy provided by interdisciplinary teams, usually by clinical psychologists, clinical social workers, rehabilitation therapists and/or other mental health professionals. Patients' needs are approached at different levels depending on their psychological and functional abilities. Various approaches such as psychosocial, psychoeducation, or psychotherapy are used in treatment to target multifaceted IST patients' needs and goals. Literature finds that psychological therapies often include Dialectical Behavioral Therapy (DBT), Cognitive Behavior Therapy (CBT), or

Motivational Interviewing (MI), or Forensic Assertive Community Treatment (FACT) all of which were not specifically designed for restoration of competency use but have been applied in or adapted for treatment groups by different disciplines (Grossi et al., 2021).

Some hospitals may provide unique, intensive, and specialized treatment programs, such as Functional Rehabilitation and Educational Experience (FREE) for patients with cognitive challenges (Department of State Hospital-Patton [DSH-P], 2021). Because IST patients often come with complex challenges, both group and individual therapy utilize the best possible approaches to meet IST patients' needs and to address their specific barriers and risk factors that will hinder competency of IST patients in forensic hospitals. Treatment for dual disorders or co-occurring disorders, such as substance abuse or addiction with mental illness was also commonly available to IST patients (AHRQ, 2012; Fazel et al., 2016; WSDSH, 2019). Trauma-informed care (TIC) approach has been strongly encouraged in the treatment of IST patients (DSH-P, 2021). Although there aren't much of music therapy literature addressing specific models for IST treatment, Linder (2019) suggested applying music therapy techniques through the framework of Acceptance and Commitment Therapy (ACT). ACT is a contemporary behavior therapy model that focuses on the functions of language, cognition, and behavior change, which aims to assist patients in their competency restoration process.

The competency restoration treatment is a comprehensive approach and intervention. IST patients are not only educated on factual legal information related to their cases but also encouraged to learn to understand and manage their psychiatric symptoms as well as their dysregulated moods and behaviors. The goal of treatment can be explained as simply as learning court information and demonstrating the ability to be

able to consult with their attorney and aid in their defense when going back to court (Linder, 2019). However, understanding and learning about legal issues as well as assisting the attorney during the court trial are difficult tasks for IST patients unless their symptoms are managed, and their insights are developed.

Focuses on Treatment

Consequently, treatment for IST patients is offered according to their needs and their level of functioning. In the research literature, focuses for IST patients are reported as administering psychotropic medication and educating patients about the court process (Roesch & Zapf, 2016). Group and/or individual treatment for competency restoration generally encourages patients to learn about all facets of legal matters and mental illness which include reality orientation, the court process, charges they are facing, and issues related to mental illness in court such as their inability to assist their attorney with their defense due to psychotic symptoms (Fulford, 2002; Sammons, 2014; Kapoor et al., 2018).

Besides psychotic symptoms, cognitive deficits (minor to severe) are one of the primary challenges among the IST population. A study by Mace (2017) stated that only about 18 percent of IST patients with cognitive challenges regained competency through a competency restoration program. Although not every IST patient experiences cognitive challenges, patients with low cognitive functioning face extreme challenges in gaining competency and end up prolonging their stay in the hospital. Therefore, it is commonly found that the competency restoration program in forensic psychiatric hospitals tends to be heavily weighted on assisting patients with legal education.

Violent behavior is another challenge listed as a barrier for competency restoration (Broderick et al., 2020). Patients with violent behavior will often be segregated from other patients and group treatment and have limited movement with direct observation. Even though not all IST patients are violent, aggression and physical violence are common within the IST population and often delays the process of competency restoration.

Grossi et al. (2021) suggested that individualized and targeted interventions are important for competency restoration. Treatment interventions should be applied depending on patients' specific symptoms and needs that are based on reality and aim at building the patient's insight into their mental illness to develop coping skills. Developing insight is important because even after being successfully restored to competency, there still is a great risk of decompensation when a patient lacks insight into their mental illness. Without insight, patients who are not hospitalized may become non-adherent with their prescribed medication regimens before their cases are resolved (American Psychiatric Association [APA], 2010; Grossi et al., 2021). When patients develop some level of insight of their mental illness, they are often more compliant with their prescribed treatment and the overall competency restoration process. Although, developing insight into patients' mental illness is not a core requirement for competency restoration treatment, it is essential to promise better results in competency restoration with developing self-motivation and expecting less chances of decompensation.

Treatment for IST patients require effective and efficient procedures to meet the need of patients and the court. The challenges of IST patients are complex with their symptoms of mental illness, dual diagnosis, cognitive and behavioral issues on top of

legal issues in which they are involved. Therefore, competency restoration treatment needs to be approached with a more comprehensive perspective based on their symptoms, conditions, level of functioning, and recovery-based multifocal principles that include psychoeducation, rehabilitation, and recreating activities (Warburton, 2015) not only to assist competency issue but also to minimize the number of relapses and readmissions.

Challenges in Treatment

Providing treatment to IST patients is challenging because of the acute psychotic symptoms they have, as well as dysregulated emotions and maladaptive behaviors that have resulted in criminal charges. Patients with IST typically have a long history of hospitalization and criminal backgrounds; thus, they often have difficulty trusting others, particularly authority figures. Engaging in treatment for IST patients also seems challenging due to their poor attachment style and lack of responsiveness to therapy (Gallagher & Steele, 2002; Gold et al., 2014). Their motivation to treatment is extremely low, thus patients' attendance and participation in treatment groups is often a challenge to therapists (Hakvoort et al., 2012).

Safety is another issue when providing treatment with this population. Aggression and violence exist in both general and forensic psychiatric hospitals yet, the degree of those maladaptive or anti-social behaviors are significantly more severe and of higher frequency among IST patients in forensic psychiatric hospitals (Warburton, 2015). Therefore, forensic psychiatric hospitals have many restrictions on patient movements and resources due to safety issues, and this affects the options for therapists when conducting treatment courses for IST patients. General areas as well as treatment groups are controlled with locked doors and keyed entries, frequent searches, and high levels of

observation for security and safety (Compton Dickinson et al., 2013; Kapoor et al., 2018). Milieu management (e.g., contraband, and environmental controls, and mandating staff training in de-escalation and physical management techniques) is an important part of the daily routine and is conducted regularly. Pro re nata (PRN) medications, restraints, and seclusion are also often applied in emergencies with symptoms and behaviors in forensic psychiatric facilities (Wack, 1993; Coddling, 2002; Gallagher & Steele, 2002; Kapoor et al., 2018). These safety regulations must be applied the same way in all treatment settings because of patients' criminal history which often includes aggression and violence. The treatment conditions for IST patients in forensic psychiatric hospitals follows and adapts the strict safety guidelines and policies of the hospital for practicing music therapy. Incorporating security and safety into a therapeutic environment and building a therapeutic relationship can be challenging yet, the higher-security and safety setting in treatment methods and environment for this forensic population is extremely important for both patients' and therapists' safety as well as treatment.

Music Therapy for Competency Restoration

Music therapy services are available to assist patients with IST (Incompetent to Stand Trial) commitments in state hospitals. This study focused on music therapy practices with IST patients at state operated psychiatric hospitals mostly in California. Within this statewide system, music therapists are employed as Rehabilitation Therapists, a role that underscores their integration into the broader therapeutic and forensic framework. Understanding the expected role of music therapists in the state system is critical to comprehending music therapy practices in forensic psychiatric hospitals. While each hospital may have slight differences in mission and approach, there are overarching

similarities. As an example, the Rehabilitation Therapy mission at Metropolitan State Hospital is outlined as providing discipline specific evaluations, care, treatment, and services in a safe and responsible manner. It aims to maintain organizational excellence by delivering innovative treatment and forensic evaluations within an integrated behavioral health system. (DSH-Metro Rehabilitation Therapy Services Department Manual, 4/5/2023). Similarly, the mission of Patton State hospital (DSH-Patton) emphasizes fostering a culture of recovery-centered treatment that is holistic, diverse, and evidence-based. The goal is to help patients achieve better outcomes efficiently (DSH-Patton Rehabilitation Therapy Services Department Manual, Rev. 1/2020). More specifically, DSH-Patton describes music therapy services as the scientific application of music to facilitate changes in disabilities or behaviors. Music therapy is used to assess and treat various diagnoses and features specific to individuals in this setting. The stated goals include “habilitation of cognitive, physical, and psycho-social functions to promote the individual’s fullest potential” as well as “developing hope, a secure base and sense of self, supportive relationships, empowerment, social inclusion, coping skills, and meaning”. These objectives define the responsibilities of music therapists within the system. Additionally, the California Department of Human Resources [CalHR] highlights that music therapists utilize music media and activities to create a nonthreatening and self-motivating experience. This approach helps individuals connect with their immediate environment, themselves, and their community. It also provides an atmosphere conducive to behavioral change, self-expression, and both nonverbal and verbal communication (retrieved on 1/14/2025).

Target Areas in Music Therapy

Although the common needs of IST patients are *not* much different from the general psychiatric inpatient population, IST specific treatment focuses on addressing the most salient and immediate clinical needs that ultimately promote a patient's restoration to competency. This literature review shows that treatment for patients with IST targets four areas on the restoration of competency: symptoms of psychosis, cognitive functioning, mood/ behavior/ violence, and insight orientation. Those targeted areas were found in the music therapy literature and listed as the needs of patients with mental illness in forensic psychiatric facilities, but very few were addressed in treatment, specifically with IST patients.

Symptoms of Psychosis. Patients with IST in forensic psychiatry generally experience one or more acute psychiatric symptoms such as hallucinations, delusions, paranoia, disorganization, as well as secondary symptoms of anti-social, aggression/ agitation, isolation, or low motivation, etc. (NASMHPD, 2014). Primary symptoms such as hallucinations, delusions, paranoia, and disorganization are typically managed by medication, yet music therapy can be used in conjunction with standard care to aid coping for symptoms of mental illness. Numerous studies in the music therapy literature report the positive effects of music therapy on positive and negative symptoms associated with psychotic disorders such as auditory hallucinations, anxiety, and aggression (Ulrich et al., 2007; Gold et al., 2009; Hyun & Yang, 2009; Solanki et al., 2013; Mace, 2017; Linder, 2019). A meta-analysis conducted by Silverman (2003) also reported that music is an effective tool suppressing and combating the symptoms of psychosis.

Cognitive Functioning. Cognitive deficits or low cognitive functioning among the IST population is a common and challenging issue in competency restoration programs. One study found that those with intellectual disabilities and neurocognitive disorders were less likely restored, such that over 90% of patients with no or mild cognitive impairment were restored compared to 68% of patients with severe cognitive impairment (Porter Staats et al., 2021). IST patients who have a cognitive challenge commonly exhibit deficits in attention, language, memory, perceptual reasoning, executive functioning, and processing speed (Linder, 2019). Therefore, targeting cognitive functioning in a treatment for IST patients maybe a reasonable approach. The two existing music therapy studies are primarily focused on cognitive function to improve memory and learning court material (Sammon, 2014; Mace, 2017).

Cognitive function and music therapy were found in a large body of studies with a wide range of age groups and populations in the music therapy literature. Most of these studies were conducted on patients with dementia, brain injury, Alzheimer's disease and neurological or intellectual development disorders. Lyu et al. (2018) conducted a study with three groups of patients: a singing group, a lyric reading group, and a control group, to find the effectiveness of music therapy on cognition. The study reported that music therapy is effective in improving verbal fluency, memory, and language ability among patients with Alzheimer's disease. Thaut (2010) discussed music therapy and cognitive functions from the neurological point of view. In his study, he stated that music therapy provides an access for music to affect memory, attention, and executive function. Sammon (2014) implemented music therapy for IST patients to teach legal information. Sammon's (2014) method was intended to educate patients about legal information

through analyzing lyrics in a song. He used ‘fill-in-the-blank’ and ‘role play’ to teach court information more effectively. Mace (2017) conducted a single case study with an IST patient by implementing songwriting with legal content and recorded it in a studio. Mace (2017) stated that an individual music therapy with songwriting implemented with a music recording process can effectively assist patients in learning court material, even those who have cognitive challenges.

Aggression, Violence, and Mood. IST patients often suffer with anxiety, anger, or irritation due to mental illness. IST patients may also experience confusion and frustration when they are arrested and subsequently admitted to a forensic hospital for competency restoration. Their moods and behaviors are often unstable and unpredictable. Several music therapy studies have reported the effectiveness of music therapy targeting patients’ outward behaviors like aggression, impulsivity, or violence due to mental illness in prisons and forensic psychiatric institutions (Wack, 1993; Chen et al., 2014; Hakvoort, 2014; Kapoor et al., 2018; Hjernevik & Waage, 2019). Hakvoort et al. (2015) studied how music therapy with the CBT approach could teach patients to regulate and control their reactions to irritation or anger. The results of the study found that the CBT approach in music therapy improved anger management skills among patients in a forensic psychiatric hospital.

Being arrested, being admitted to a psychiatric hospital, and returning to court to face their legal charges can be extremely stressful. Many patients often report fear, frustration, and anxiety while waiting to go back to court. Learning coping skills to manage their mood and anxiety along with staying on medication is a crucial for IST patients in order to go through their legal process and defend themselves in court. That

(1989) investigated the effect of music therapy interventions on mood states among psychiatric prisoner patients. The result from a self-rating report on different mood changes showed that music therapy had a significant improvement on patients' relaxation state, affect, and thought processes. Numerous other music therapy studies also reported that music therapy can be an effective treatment method for the reduction of anxiety, agitation, stress, hostility, and combativeness that are common concerns among patients in forensic psychiatric hospitals (Thaut, 1987; Thaut, 1992; Loth, 1994; Hoskyns, 1995; Daveson & Edwards, 2001; Fulford, 2002; Reed, 2002; Gallagher & Steele, 2002; Gardstrom et al., 2013; Bensimon et al., 2013; Chen et al., 2016).

Insight Orientation. Competency restoration can be achieved more successfully when patients develop insight into their psychiatric and psychological conditions. When IST patients improve their insight, they become more compliant with treatment, have a shorter stay in a hospital, and lower their probability of decompensation. Developing insights into their mental illness is the most challenging goal for patients but it is also a crucial element in the restoration of competency. Linder (2019) stressed that music therapy can help IST patients by assisting in self-awareness, developing a sense of control over their actions, and motivating them to participate in competency restoration treatment.

Insight orientation also plays an important role for IST patients in substance abuse treatment. Even though substance abuse is not a critical issue for competency, patients are far more likely to decompensate when they do not have insight as patients with mental illness often choose substance use over medication or mix substances with prescribed medication. Several music therapy studies introduced music therapy to aid in

the recovery of substance abuse, and these studies reported positive results of music therapy implementation (Gallagher & Steele, 2002; Gardstrom et al., 2013).

Music Therapy Methods

Music therapy practices and methods with IST patients are found in the literature but are extremely limited. Both Sammon (2014) and Mace (2017) utilized music therapy methods such as lyric analysis and/or songwriting to teach legal information for IST patients. Linder's (2019) study took music therapy applications a little further suggesting a broader use of music therapy methods not limited to lyric analysis and songwriting but including recreational rhythm-based interventions with the ACT model when targeting emotional and behavioral changes in IST patients. The ACT model was explained in the study as a type of psychotherapy which follows a six-dimension framework of psychological flexibility: acceptance, cognitive diffusion (also known as de-literalization), present moment awareness, contextualized self, values, and committed acting.

Music therapy has numerous options regarding methods and techniques that could assist the needs of IST patients. However, studies of music therapy with IST are very few (Sammon, 2014; Mace, 2017; Linder, 2019) and these studies have used only limited methods, and no other methods were fully explored. Music therapy methods to support the different needs of IST patients will require further study.

The American Music Therapy Association (AMTA, 2006) introduced Bruscia's (2014)'s four basic methods that music therapists in correctional and forensic settings could use in music therapy practice: receptive, improvisation, recreative, and composition (Bruscia, 2014, as cited in AMTA, 2006).

Receptive. Receptive methods involve listening to live or recorded music and any form of responds to the experience (Bruscia, 2014). It is the use of music for rhythmic support or for motivation within activities like exercise, movement, relaxation, or discussion of popular songs. Music listening is a way to have musical experience through simple listening, guided listening, or music sharing. Music listening can be also used as background music with games, or as the inspiration for movement or art to promote a creative way to encourage participation. In the literature, music listening was often used for relaxation purposes for prisoners who experience anxiety and problems with affect regulation, such as anger (Thaut, 1992; Daveson & Edwards, 2001; Chen et al., 2014; Bensimon et al., 2015). Solanski et al. (2013) used music listening to stimulate cognitive functions and emotion. Their study found that listening to music stimulates neural activity in the brain and influences cognitive functions and emotional events evident in distinct neural substrates.

Gardstrom and Hiller (2010) promoted music listening experiences followed by song discussion and lyric analysis as music psychotherapy. They emphasized the importance of verbal reflection on musical expression, as it can bring subconscious processes and emotions into conscious levels, allowing individuals to explore feelings that might otherwise remain repressed. This approach and method can be particularly effective for patients undergoing competency restoration treatment, as it fosters self-awareness and interpersonal awareness, which may promote developing trust, social skills, and regaining social support. Sammon's (2014) study with IST patients also used receptive methods that included listening to songs and songs sharing. His study introduced a music therapy method called Competency Through Music (CTM), which

aimed to support cognitive learning by using songs that conveyed stories related to legal material. This method encouraged patients to learn and retain court-related information through song sharing. However, Sammon advocated for the use of songs objectively, as carriers of information, and discouraged patients from expressing personal feelings evoked by the song lyrics.

Improvisation. Improvisation requires patients to engage directly and actively in musical experiences by spontaneously creating music using their voice, instruments, or other sound sources. In music therapy literature, improvisation has been implemented in various forms, such as group drumming, musiking, and individual instrumental play. Watson (2002) highlighted the benefits of musiking through drumming, emphasizing its ability to foster social interaction, choice making, concentration, the ability to follow directions, awareness of others, the establishment of group identity, and the initiation of entrainment through improvisation. This method allows patients to experience their music being without verbally expressing themselves. Improvisation is a powerful tool for facilitating communication and self-expression while also supporting and improving mood and behaviors (Austin, 1996; Fulford, 2002). Furthermore, Improvisation can help address challenges commonly faced by IST patients, such as self-awareness, anger management, stress management and self-regulation (Hakvoort, 2002; Fulford, 2002).

Recreative. The recreative method involves active participation, offering musical experiences through singing, playing instruments, or engaging in structured music activities or games with precomposed music during sessions or groups (Bruscia, 2014). This recreative method is often described in music therapy as musiking, singing, performing, or playing an instrument (Bruscia, 2014; Hjernevik & Wagge, 2019).

Hjornevik and Wagge (2019) described musiking as an everyday musical activity, noting that its use in music therapy supports self-expression and exploration of patients' self-identity. Recreative method also help individuals develop skills that foster a sense of mastery and confidence, as they engage with others in structured musical settings such as bands, ensembles, or choirs.

Singing in a group or singing as an individual activity is a common recreative way of experiencing music. Singing can provide a very personal experience. Austin (1998) described the voice in singing as like a bridge that can connect the mind to body and heal splits between thinking and feeling. Singing is a way of expressing oneself vocally that could awaken one's awareness while hearing one's own voice. Singing was described as "a way to access one's deepest self and connect to our mind, body, and spirit" (Austin, 1998. p.316). It can reassure a connection of mind and body through the musical experience, of singing. Also, singing promotes expression, communication, attention, and connection in music therapy. Therefore, singing, or playing music together can be a great tool to benefit IST patients to improve self-awareness, awareness of others, and here and now experiences as well as developing self-esteem and confidence, all of these being important in the treatment of the IST population.

Composition. One of the most common composition methods used in forensic psychiatry is songwriting (Silverman, 2007). Songwriting is a creative process that requires different levels of complexity depending on the structure, from simply filling in the blank in pre-composed lyrics to writing the participant's own music. Songwriting was used in Mace's (2017) study with an IST patient as a way of learning court material and procedures. He stated that songwriting with court information can assist the IST patient in

learning and memorizing essential court competency material, thereby increasing their knowledge and understanding of the court process. Even though the focus of his study was on learning court material through songwriting, the patient was also had given a chance to discuss their musical experience in the process of writing and recording their song.

Studies on songwriting with IST patients exist in the literature, but the number of studies is extremely low. Furthermore, the goals of using songwriting in their music therapy are often limited to helping patients learn court related information. Given that IST patients face complex issues and challenges relevant to competency, songwriting in music therapy could be expanded to address a broader range of patient needs. Literature indicates that songwriting can be an effective method for patients to express their personal issues, feelings, and thoughts through creating a composition (AMTA, 2006; Baker & Wigram, 2005; Baker, 2015; Baker & MacDonald, 2017). Another study suggests that songwriting can serve as a powerful tool for patients to develop their musical and personal identity, express their emotions, and promote healing as relates to the theme of the song (Rolvjord, 2005). In this context, songwriting may provide patients with a more personal experience, evoking a deeper connection to their stories and feelings. IST patients come from unique backgrounds shaped by their culture and personal experiences with mental illness and incarceration. By engaging in songwriting, IST patients may develop deeper insight into their emotional and relational experiences. As Baker (2015) indicated, the songwriting process allows patients to externalize and cognitively process their internal feelings, emotions, and thoughts. When IST patients are

able to externalize and cognitively process their emotions, they may be more likely gain insight, enhance self-awareness, and engage in treatment more willingly and effectively.

Summary

The increase in the IST population can be understood by looking at various social, political, and systemic factors, that include ineffective treatment methods, lack of outpatient treatment and funding, patient's medication noncompliance, and complicated psychosocial stressors (National Mental Health Advisory Council, 1993; Perkins, 2002; Cloyes et al., 2010). Therefore, effective treatment and efficient therapy programs can play an important role in reducing the numbers of IST individuals in forensic psychiatric hospitals and in the court/ judicial system.

Evidence-based music therapy studies have shown that music therapy can be effective in addressing patients' psychiatric symptoms, psychological issues, and other behavior challenges. Music therapy has also been widely applied for patients with cognitive challenges, memory issues, and learning disabilities. However, music therapy as a tool to assist patients in the process of competency is a relatively new area for music therapists. Literature on music therapy indicates that music therapy may assist the needs of IST patients in the restoration process of competency yet, the studies found on music therapy with IST patients are few and the topics are limited to factual learning of legal information. Also, existing music therapy studies with IST patients do not address specifics of how music therapy approaches the competency restoration issue or how it is implemented accordingly with the different needs of the IST population in forensic psychiatric hospitals in the U.S.

The primary goal for IST patients is the restoration of competency by managing symptoms, improving cognitive functioning so that patients can understand and participate the court process, and regulating mood and behavior to help them to assist their attorney. Grossi et al. (2021) stated that being equipped with insight into their mental illness and having good coping skills is important for IST patients so that decompensation during their legal process can be minimized. Therefore, treatment for patients in competency restoration should involve psychiatric stabilization, didactic teaching of psychoeducation, and dynamic treatment groups that offer psychotherapy approaches.

Purpose Statement and Research Questions

The purpose of this study was to gain an understanding of music therapy practices for IST patients in forensic psychiatric hospitals in the United States. Music therapists' perspective of IST patients' needs, goals, and rationales on choosing a specific treatment method in music therapy practices were explored. From this study, the common needs of IST patients in the music therapy, and what methods music therapists considered helpful in meeting the needs of IST patients were identified.

The study was structured to examine the ways in which music therapy is practiced with IST patients in forensic psychiatric hospitals. The research questions were:

1. In what ways are music methods and experiences used to work with IST patients in forensic psychiatric hospitals?
2. In what ways do music therapists determine treatment domains and goals in music therapy for IST patients?
3. In what ways do music therapists assess, treat, and evaluate IST patients?

CHAPTER 3

METHOD

IRB Approval

Temple University's IRB (Institutional Review Board) approved the research study on February 2023. After approval was secured, recruitment of participants had begun, and interviews were set up. The informed consent forms and IRB permission are attached in the appendices.

Design

A qualitative research method was applied in this study to seek direct and first-hand information that reflected music therapists' subjective and professional experiences and perspectives on music therapy practices for patients with IST commitment. Because there was limited information in the current literature regarding specific knowledge about music therapy practices with the IST population, qualitative research was the best means by which to explore questions about music therapy and competency restoration (Ghetti & Keith, 1995; Elo & Kyngäs, 2008). An interview format was used to generate data from music therapists who work with IST patients in forensic psychiatric hospitals in the U.S.

Deductive Qualitative Content Analysis

Qualitative content analysis is a research method for analyzing large amounts of verbal or text data collected through interviews, media, or publication (Hsieh & Shannon, 2005; Schreier, 2013). Content analysis was chosen for this study for three reasons. First, because there was little known about music therapy treatment for IST patients and content analysis was suitable for the simple reporting of common phenomena identified in data about which not much is known (Green & Thorogood, 2004). Secondly, the aim

of the study was to understand where there was consensus about approaches among music therapists in their work with IST patients and to identify treatment approaches that were not commonly used by music therapists working with this population. Content analysis allowed the researcher to analyze the data qualitatively while also noting the frequency with which specific methods, goals, and treatment processes were implemented (Gbrich, 2007). Finally, content analysis is based on an empirical perspective that assumes the data to be accurate and truthful accounts of reality as presented by the participants' experiences (Sandelowski, 2010), which was appropriate for the kind of information that was gathered and analyzed in this research.

In this study, I used a deductive approach to content analysis. The categorization matrix (Table 1) and coding to the categorization (Table 2) was developed based on AMTA (2006) guidelines and Bruscia's (2014) music therapy methods. A deductive content analysis was useful because the predetermined categories of this inquiry were derived from the research questions and were based on existing knowledge of methods, goals, and treatment processes that were used in music therapy practice generally, and more specifically in forensic treatment as described in the literature (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005).

Table 1. Initial Categorization Matrix

	Music Experiences	Method	Goals	Assessment and Evaluation
Music therapy practice for patients with IST				

Table 2. Initial Coding to Categorization Matrix

	Music Experiences	Method	Goals	Assessment and Evaluation
Music therapy practice for patients with IST	Listening	Receptive	Regaining competency	
	Singing	Recreative		
	Playing	Improvisation		
	Talking	Composition		
	Writing			

Burns & Grove (2005) stated that a deductive approach can be used when the general aim of data analysis is to compare categories and develop them from general to specific. Due to the complexity of responses within each category, subcategories were identified within each category for subsequent analysis. Since I compared methods, goals, and treatment approaches that were described within each of the interviews, a deductive approach was most applicable as it allowed me to compare the range of responses within the predetermined categories (Hsieh & Shannon, 2005) and to further develop the conceptual frames upon which this research was based (Burns & Grove, 2005).

In summary, the purpose of content analysis was to understand phenomena and to draw realistic conclusions from the collected data (Ghetti & Keith, 2016; Bengtsson, 2016). In this deductive content analysis method, the interview data was analyzed through a systematic process of categorization, structuring, and organizing, and where necessary, noting the frequency of specific words analyzed in the data.

The procedures of this study are described on the flow chart provided below.

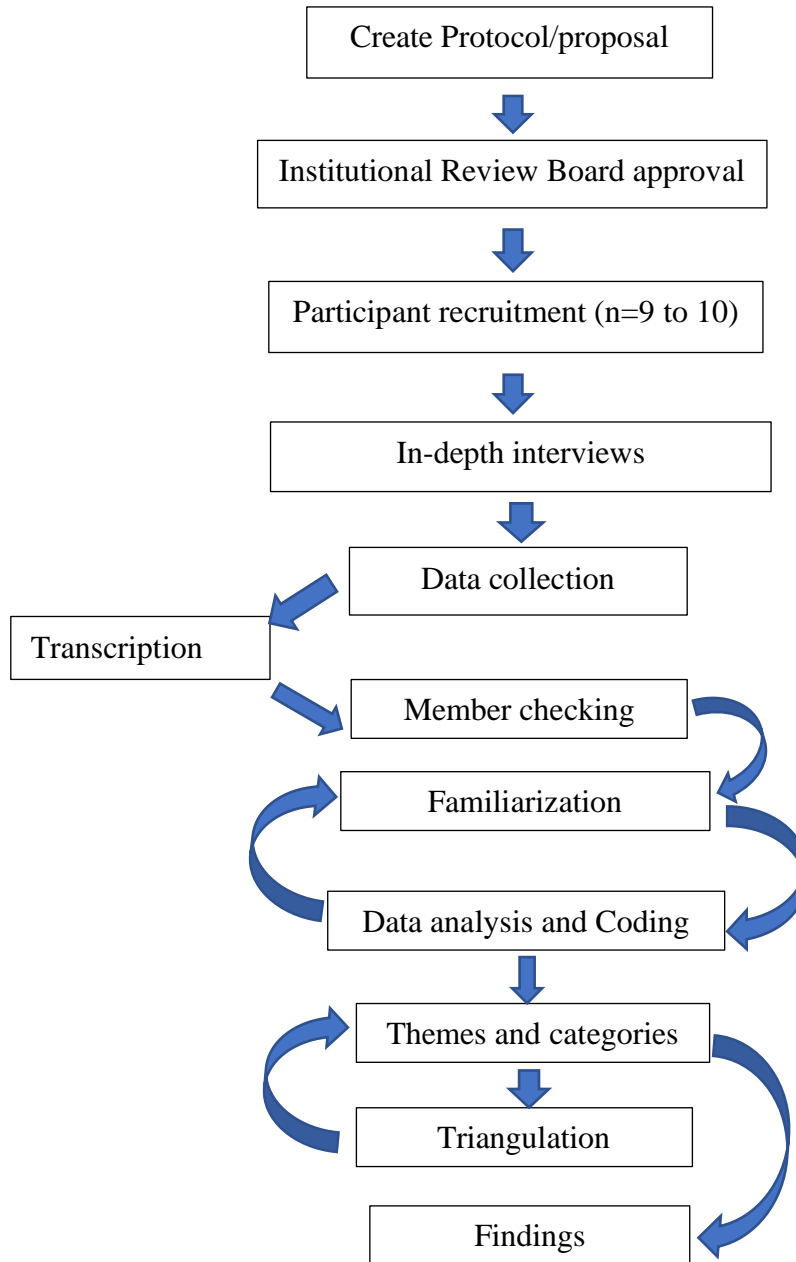


Figure 1. Study Flowchart

Participants

The study was designed to include participants from different states in the U.S. to increase the possibility of generalization and to place me in a researcher position as an outsider with those participants from different states. This study began with a reflective

understanding of both my role as a researcher and the context of the study, which played a significant role in shaping my plans to ensure the credibility of the research. However, due to unforeseen circumstance including the Covid 19 pandemic, the majority of participants were from California, with only one participant from outside the state was able to participate. As a result, the study included a total of nine participants, consisting of eight from California and one from Texas.

Music therapists included in the study met the following inclusion criteria: 1) an accredited (MT-BC) music therapist, 2) music therapists who work with adult IST inpatients in a forensic psychiatric hospital in the U. S., and 3) music therapists who practice individual and/or group music therapy with IST patients. Exclusion criteria for participation were: 1) therapists who used music experiences but who have no board certification, 2) music therapists who do not work with IST population within a forensic psychiatric hospital, 3) music therapists who only provide leisure activities but no music therapy for patients.

Recruitment

Purposive sampling was used to target a specific group of music therapists who practice music therapy with IST patients in forensic psychiatric hospitals in the U.S. Even though there are music therapists working with the IST population in forensic psychiatric facilities, many music therapists in forensic psychiatric hospitals fall under the rehabilitation therapy umbrella and often provide leisure activities or psychoeducational groups rather than music therapy. Since it was impossible to distinguish which music therapists provide music therapy treatment for IST patients through the general music therapy listserv, recruitment was initially attempted by directly contacting music

therapists in various states and within the California Department of State Hospitals via work email. The process began with an email outreach to music therapists in the California Department of State Hospitals and other states to identify those actively conducting music therapy with IST patients. The email included questions about their music therapy practices with the IST population and their willingness to participate if they qualified for inclusion in this study. The study initially aimed to recruit between nine to twelve participants. Six music therapists from California initially responded and agreed to participate. During this recruitment process, music therapists from Western, Mid-Atlantic, Southwestern, Great Lakes, and Southeastern were also contacted via email. However, the overall response rate remained low, with only five individuals responding. Among them, three were from Southeastern and Mid-Atlantic regions, and either did not meet the inclusion criteria or declined participation. The remaining two respondents, one from Mid-Atlantic region and one from Southwestern region, initially agreed to participate. However, the participant from Mid-Atlantic region later withdrew for personal reasons before the interview. As a result, only one participant from the Southwestern region completed an interview for the study.

After the interviews began, snowball sampling was implemented to identify additional suitable participants, as accessing individuals with the target characteristics proved challenging (Naderifar et al., 2017). Through this method, existing participants were asked to share the researcher's contact information with potential candidates, allowing interested individuals to reach out if they wished to participate in the study. As a result of snowball sampling, two additional music therapists from California joined the study. In total, nine music therapists participated and completed the interviews.

Protection of Human Subjects

In accordance with federal regulations and guidelines of Temple University's Institutional Review Board, consent forms were provided to participants in advance of each interview and consent was obtained before beginning. Participants were not compensated for their time and participation in the study. In order to protect participants, pseudonyms were used in place of their actual names. Data was stored securely on an encrypted and password-protected hard drive. Only the researchers had access to interviews, transcriptions, and datasets used for analysis.

Interview Process

When a subject agreed to participate in the study, information sheets and consent forms were sent out through email correspondence, and a 45–60-minute interview was scheduled. Participants were given an option for preferred interview formats: in-person, zoom, skype or other web-based meeting sites. Demographic data such as gender, age, highest educational level obtained, region of graduating institution(s), additional credential/ licensures/ certifications, and training, AMTA regions, years of professional practice as a music therapist, types of population served in the past, types of treatment setting was obtained during and after the interview.

Nine music therapists who work with IST patients participated in and completed an in-person or a web-based interview that lasted about one hour. The interviews were semi-structured, and all the interviews were audio or video recorded. Transcriptions of the interviews were kept in a password-secured locked computer and intended to be stored for a maximum of five years. The identity of each music therapist participant was

protected by using pseudonyms in the data and the corresponding names of the participants was kept in a separate password-protected file known only to the researcher.

Data Collection

The primary source of data was the recorded interviews. Data were collected for this research through semi-structured interviews with open-ended categorical questions followed by targeted questions related to the pre-determined categories. Interview questions are included in Appendix F.

The research focus and initial research questions for this study were formulated to understand music therapy practices with the IST patients in forensic psychiatric hospitals. The target needs of IST patients, assessment, music therapy approaches and methods as well as evaluation to assist the IST process were explored. Additional detailed research questions were formulated as needed during the interviews. Each audio or video recorded interview was transcribed into text and sent to participants for member-checking, allowing them to review and verify the accuracy of their responses. This process enhanced the credibility and trustworthiness of the study by ensuring that the findings accurately reflected participants' experiences and perspectives.

Data Analysis

Data analysis began with reading the finalized interview transcripts multiple times. The next steps included the iterative processes of transferring data into an Excel master sheet, coding and arranging the data, creating tables or groupings to facilitate a deeper understanding of the collected data, and finally documenting the findings in the Results chapter.

In the process of data analysis, three approaches were adopted to understand and represent the data as accurately and fully as possible:

1. A deductive approach was taken for most of the analysis, in that pre-determined and specific questions guided the coding of the data. At the same time, important though divergent ideas and content were noted, adopting a more inductive approach when needed to fully represent the views and approaches of the music therapists.
2. The analysis and presentation of findings began with a semantic approach focusing specifically and exclusively on what the participants said. Subsequently, a more latent approach was incorporated, identifying ideas, assumptions or concepts that may have informed the words spoken by the participants.
3. The frequency of each of the key words was counted and presented for an enhanced understanding of data.

This deductive content analysis was based on the steps proposed by Elo and Kyngäs (2008). In the first step of analysis, all the interviews were transcribed and returned to the participants for member-checking; upon their return and the inclusion of any adjustments, the researcher continued to become familiar with the data through repeated listening to the interviews, along with reading and reviewing the transcripts. In this phase the aim was to become immersed in all the data to acquire a sense of the whole (Bengtsson, 2016; Elo & Kyngäs, 2008; Hsieh & Shannon, 2009).

To begin transcript analysis, each interview transcript was analyzed individually, where I transferred significant data into master excel sheet, and then categories were compared across each interview. For this study, there were three levels of categories. The

main category is the larger context of the question which was further divided into *generic categories*, and *sub-categories*. (Elo & Kyngäs, 2008). For example, each research question in this study formed the basis of each main category. This included the following categories: music experiences used; music therapy methods used; IST targeted needs, and goals of IST treatment. Generic categories were then formed based on findings from the main categories, for example, listening, instrumental playing, singing, writing/composition for music experiences and cognitive functions, social skills, coping skills, etc. for music therapy goals. Sub-categories identified specific target goal area such as attention/focus, memory, mood, behaviors, and thought related issues, etc. within generic categories. Operational definitions of the categories were formulated during each step of category development to help clarify the meaning of each category.

The next step involved developing a categorization matrix and systematically coding the data based on the newly established categories (Elo & Kyngäs, 2008). For example, in this study, responses to the question regarding music therapy methods used with IST patients were categorized into receptive, re-creative, improvisation, and composition. These methods were incorporated into the matrix as generic categories. Following this step, the data were further refined into specific techniques used within each method and grouped according to shared musical elements, ensuring a structured and coherent analysis.

After a categorization matrix had been developed and data from each interview had been analyzed and placed into main, generic, and sub-categories, each main category was reviewed across all interviews to identify goodness of fit of patterns and themes related to content. Next, categories were checked for variability and consistency within

the identified categories (Elo & Kyngäs, 2008). This step necessitated re-labelling of some sub-categories after the content was compared for commonalities and variations. Data that did not fit the matrix was analyzed for goodness of fit in other main categories or new sub-categories. An additional step involved investigator triangulation, where two research advisors from my dissertation committee members - the primary researcher and one other- independently reviewed all iterations of the main, generic, and sub-categories after the researcher had identified these categories from the raw data. Thus, after coding and categorization, all data were triangulated through an independent review by two research advisors to ensure credibility and trustworthiness. These advisors examined the coding and categorization process to confirm agreement with the researcher. Where there were some questions about which techniques belonged in which method, the researcher and two advisors addressed this by referring to the Bruscia (2014) extended definitions of methods to reach agreement. For consistency, this study based the content analysis on categories from Bruscia's (2014) definitions for methods and techniques, as well as goals derived directly from participants' statements. Because these definitions were clear to participants, researcher and advisors, there were no disagreements regarding the categories and coding. The research advisors independently reviewed again and cross-validated the categorization and themes at the stage of reporting the results, ensuring consistency and reliability in the analysis.

Participants' specific descriptions such as demographic information or any significant training information aided in understanding the results. Therefore, demographic information was coded for categories such as the age, years of education, years of experience, special trainings, regions, states, etc. and included in the results.

Steps in data analysis were explained in figure 2.

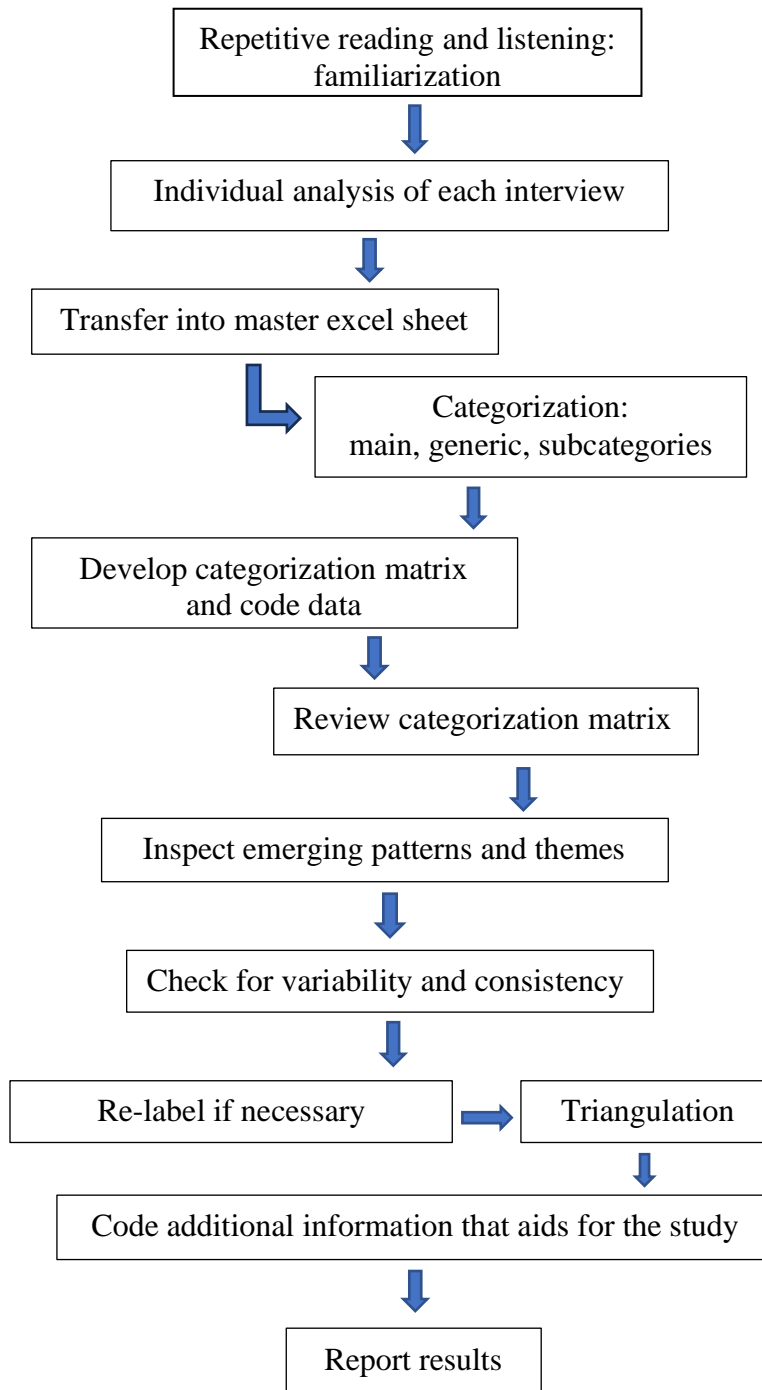


Figure 2. Steps in Data Analysis

Trustworthiness

This study used member checking and triangulation to enhance the credibility and trustworthiness of the findings. For member checking, transcribed interviews were sent to participants for review to verify the accuracy of their responses. This process ensured that the findings accurately reflected participants' experiences and perspectives. Additionally, all data were triangulated through an independent review by two research advisors from the committee to ensure credibility and trustworthiness. This triangulation process not only confirmed the validity and accuracy of the analysis but also helped deepen the understanding of the phenomena (Bengtsson, 2016).

CHAPTER 4

RESULTS

This study explored the ways in which music therapy was practiced in forensic psychiatric hospitals to gain an understanding of therapists' treatment methods, choices, preferences, and goals for sessions when working with patients who had been found incompetent to stand trial (IST). Upon approval from Temple University's IRB (Institutional Review Board) participants were recruited, consent forms were sent, and interviews were set up.

Participants

The total of ten participants were recruited and nine completed the study. The nine music therapists who participated in the study met inclusion criteria and the number nine met the minimum required numbers for this study (Hennink & Kaiser, 2021).

Table 3. Respondents Included in the Study

REGION OF WORK/ STATE	N
CALIFORNIA	8
TEXAS	1

Eight of the nine music therapists interviewed were employed at one of the five Department of State Hospitals located throughout the state of California (Table 3). Their job title was Rehabilitation Therapist as music therapists share the same umbrella term with therapists who practice art therapy, dance therapy, or recreation therapy and the therapists are expected to tailor treatments to their specific areas of expertise. Each music therapist makes choices and adapts their practice to provide patient treatment according to their own understanding of the context, while adhering to the guidelines and

requirements of a Rehabilitation Therapist. This is an important distinction in understanding the music therapists' perspectives since their jobs are not structured or understood to be music therapy, specifically. On the other hand, one participant from Southwestern region stated that their job title is a *registered therapist*, and they only provide music therapy.

Of the nine music therapists who participated in the study, 6 identified as female and 3 as male. The average length of work with IST population in the study was 4 years and 4 months working between 6 months to 8 years. Their average length of total work experiences as a music therapist was 10.4 years with the range of 6 month to 29 years. Their length of education reported 5 with an undergraduate degree and 4 with a master's degree. Their region of graduating institution was varied. Four studied in the Western region, two studied in the Mid-Atlantic region, one studied in the Great Lakes, one in the Mid-Western, and one in the Southwestern region. Three music therapists had a NMT background, and one music therapist had a Sound Healing certificate. Seven out of nine music therapists stated they incorporated mindfulness in their treatment focus. Among the seven, two music therapists had some type of training in Dialectical Behavior Therapy (DBT) or DBT informed music therapy. (Table 4)

Table 4. Demographic Data

	Highest Ed.	School Region	Major Instrument	State	Total yr. of MT	Yr. of IST Exp	Theory	Focus/ Training
P1	BS	Mid-Atlantic	Saxophone	CA	20	2	ISO principal Holistic Reality-orientation	NMT Musician
P2	BA	Western	Piano	CA	2	1.9	ISO principal Humanistic	None specified
P3	BA	Western	Flute	CA	14	6	Holistic	Creative therapy Mindfulness

Table 4. (Continued)

	Highest Ed.	School Region	Major Instrument	State	Total yr. of MT	Yr. of IST Exp	Theory	Focus/ Training
P4	MA	Western	Piano/ percussion	CA	5.6	5	ISO principal Humanistic Behavioral Rehabilitation	Sound Healing Multi-cultural Integral TIC Mindfulness
P5	MM	Mid-Atlantic	Voice	CA	8	6	ISO principal Creative music therapy	Creative therapy Mindfulness
P6	MA	Western	Voice	CA	6	2.5	Rehabilitation Reality-orientation	TIC Mindfulness Substance Abuse
P7	BA	Great Lake	Voice	CA	29	8	Rehabilitation Quality of life	DD DBT informed
P8	MA	Mid-western	Piano	CA	7	8	None specified	NMT DBT
P9	BA	South-western	Voice	TX	2	.6	Holistic Reality-orientation	NMT DBT informed Mindfulness

Findings

The findings are presented as responses to the research questions guiding this study. Research Question 1: *In what ways are music methods and experiences used to work with IST patients in forensic psychiatric hospitals?* This question was developed based on the common experiences used in music therapy: listening, playing, discussing, writing, and singing. Also, approaches in music therapy were incorporated from the recommendation of The American Music Therapy Association (2006) which stated that music therapists in correctional and forensic settings could use Bruscia (2014)'s four basic approaches in music therapy practices: receptive, improvisation, recreative, and composition. These four approaches were found in musical experiences and music therapy for IST patients in forensic psychiatric hospitals.

Music Experiences and Methods

Each participant in this study incorporated the following music experiences into music therapy when working with IST patients: listening, playing, discussing, writing, and singing. Taken as a whole, participants mentioned some experiences more frequently than others throughout the interviews. The frequency of use for each music experience is presented in Table 5.

Table 5. Music Experiences

Music Experiences	Listening	Playing	Discussion	Writing	Singing
Frequency	49	35	34	32	28

Among the various music experiences discussed, listening was the most frequently mentioned, cited 49 times across the nine participants during the interviews. Playing, discussion, and writing were mentioned more frequently than singing, which was the least discussed music experience, mentioned 28 times in relation to IST patients. While discussion was commonly used in lyric analysis and song discussions during music therapy, participants also noted that any group involving music experiences could lead to a discussion at some point.

Participants in this study employed these music experiences within the framework of the suggested method forms: receptive, improvisation, recreative, and composition. Table 6 shows the prevalence of each method and specific techniques used within them.

Table 6. IST Music Therapy Methods

	Receptive				Improvisation		Recreative		Composition
	Passive		Active		Instrumental		Precomposed		Writing
	Listening		Listening		Playing		Music		
	PR	MA	MGA	LA	IMP	DM	Singing	MM	Songwriting
P1	X	X	X	X	X	X			X
P2	X	X		X	X	X	X		X
P3	X	X	X	X	X	X	X		X
P4	X	X	X	X	X	X	X		X
P5	X	X	X	X	X	X	X		X
P6	X		X	X		X	X	X	X
P7	X			X		X	X		X
P8			X	X	X				X
P9	X			X	X	X	X	X	X

Note. P = Participant; X = Positive response; PR = Patient’s request; MA = Music Assisted; MGA = Music guided activity; LA = Lyric analysis; IMP = Improvisation; DM = Drumming; MM = Music making

As indicated in Table 6, the receptive methods were represented in both passive and active listening. These included music listening based on patient’s song requests, background music, music-guided activities, and lyric analysis. All nine participants utilized receptive listening methods in their music therapy sessions. Improvisation was employed by all nine participants, either through various musical instrumental improvisation or drumming. Seven participants incorporated singing and two used music making as recreative methods. Additionally, eight participants used composition by engaging IST patients in songwriting through lyric substitution or fill-in-the- blank.

Among all the methods listed above, lyric analysis and songwriting were used by all nine participants in their music therapy sessions. Patients’ preferences for song listening (8) and drumming (8) were identified as the second most utilized method, based on the number of participants. For the recreative methods, singing (7) was used more frequently than music making (2) by participants in this study.

The music therapy methods used in this study were explained by the participants. Lyric analysis, which involves the music listening method, was mentioned by all participants. One participant, who considered lyric analysis an excellent method, stated that she used songs to connect with emotions; for example, she might ask patients to identify something in the song that they could relate to their experiences as being committed to IST (Participant #3). Another participant stated she used lyric analysis to help patients learn legal material and practice logical thinking, which could assist them in court appearances (Participant #5).

Another common music listening method was music listening to patient-preferred songs. Any patient eligible to attend groups could opt in at the beginning of the session on a given day. This process was structured by asking patients to write down or communicate their song requests; the music therapist then played a recording of as many requests as possible within the duration of the session. Patient-preferred music listening was a popular music method chosen by participants, who reported using it to ease unit tension caused by a patient's acting out or engaging in violence, to address boredom, to increase motivation, and/or to develop rapport- all of which are common challenges in IST units. Therefore, listening to patient-preferred music was generally implemented in a less structured and informal manner, such as in open groups, and was frequently provided without being scheduled. Although music groups based on patient-preferred songs were common in IST population and were seen as a needed intervention on IST units, listening to patient-preferred songs was not always seen as music therapy among participants. One participant stated that they believed listening to patient-preferred songs was not music

therapy because music therapy should provide patients with music experiences through music making and improvisation in order to empower them musically (Participant #5).

Participants reported another music listening experience involving an active music listening method in music therapy sessions. This method focused specifically on musical elements such as rhythm, melody, pitch, timbre, dynamic, and lyrics. This method was practiced by asking patients to listen with a specific focus, such as identifying a particular musical element or words in the lyrics and reflecting on how they evoke emotions. One participant explained that they used this method of music listening to “*explore the whole person by utilizing harmonic, melodic, and rhythmic archetypes that will cognitively, emotionally, and physically move patients to their music listening responses*” (Participant #1). The participant further stated that they believed musical archetypes can inspire patients to discover deeper emotions, improve listening skills, and foster greater openness to others during this experience. Another participant noted that active music listening increased awareness (Participant # 5).

Additionally, music listening was used receptively to support other creative activities such as visual art (e.g., drawing, coloring) or writing poetry. This therapeutic use of music listening also extended to music therapists playing selected music videos or recorded music while patients engaged in practices like yoga or meditation.

Playing instruments was the second most commonly used music method after listening. Nine music therapists mentioned playing instruments 35 times, and for two of them, it was the most frequently referenced method. When music therapists discussed patients playing instruments, they nearly always referred to playing hand drums and drums with other instruments in the improvisation method. No instances of vocal

improvisation in music therapy sessions for IST were reported. The improvisation method was most often used with drumming, and music therapists in this study highlighted spontaneous and free engagement as key elements in improvisation. One participant stated during an interview, *“I do (it) with one or two patients...just play instruments and improvise on the spot. Improvise a beat with them, and they can sing and improvise on the spot”* (Participant #2). Another participant noted, *“I give them this foundation...it just comes out...because it’s freedom and it’s engaging; it can go in so many different directions”* (Participant #5). Although drumming was a common method used for instrumental play, some participants differentiated drumming in music therapy from drum circle. One participant emphasized that it is *“rhythmic drumming”*, not *“drum circle”*, and stated that it targets various goal areas, including social interaction, self-esteem, creating a modicum of camaraderie, and improving reality orientation and cognitive focus (Participant #1).

While views on drumming varied, participants used drumming with IST patients to achieve specific goals beyond community group-playing experiences. One participant explained that drumming helps patients with schizophrenia by grounding them and distracting them from auditory hallucinations (Participant #2). Another participant used drumming to reinforce learning the roles of courtroom personnel, conducting a drum circle to teach the concept by incorporating musical rhythms into court-related terms and roles (Participant #3). Another participant reported using drumming with a *“whole person perspective”* that focuses on emotional, psychological, spiritual, and physical well-being. This participant also highlighted using drumming to relieve stress associated with being in an IST situation. (Participant #1). For another participant, making music with drums

and other melodic instruments provided patients with opportunities to practice listening skills, experience “*togetherness*”, and embark on a shared musical journey (Participant #4).

The recreative method for music making was described by two participants as music making in a band (2) and making a music video (1) (Participant #6 and Participant # 9). Their musical band consisted of various rhythmic instruments and singers. However, no forms of choir or ensemble were mentioned in this study.

Singing was the most frequently used recreative method among participants in this study. It was implemented by seven participants, with experiences ranging from patients singing in a music band consisting of peers, to singing along to recorded backing tracks in a karaoke group. Singing, including karaoke, was mentioned by participants 32 times, and two participants identified singing as their most frequently used method. One participant explained, “*You can engage in the group by just following the lyrics...everyone has the lyrics book, or you might sing along with me. They take turns picking a song from the book*” (Participant #6). Another participant noted, “*Karaoke group has really been a great expressive opportunity and outlet*” (Participant #7).

Writing music or song lyrics was mentioned 32 times by all nine participants. Participants in this study reported using writing experiences in music therapy through lyric writing or songwriting. When asked about the use of the composition method in music therapy, all nine participants mentioned songwriting 23 times, which was less frequent than other methods. Songwriting was often implemented by using a familiar song with a fill-in-a blank template, allowing patients to personalize pre-existing song lyrics. One participant explained, “*It’s like some fill-in-the blank and write... and giving*

the patients opportunities to get in front of the group and share” (Participant #6). In other cases, patients engaged in writing all the lyrics for a song to express emotions or thoughts related to their IST situation. Another participant shared, “You can write lyrics. Lyric writing ...hum...the tune starts a melody, have your song. I’d like to do the Blues a lot...Blues songwriting. Songwriting is to really negotiate and collaborate. It does incorporate the skills of negotiating lyrics and choices” (Participant #5). One participant used the writing method to compose songs, poetry, and spoken word, which were later developed into hip hop or other freestyle art forms (Participant #4). They believed this method could help improve patients’ communication, concentration, and insight.

In summary, participants in forensic psychiatric hospitals employed various music experiences in their work with IST patients, including singing, playing and improvising, writing, listening, and engaging in discussion. While the receptive method was the most commonly used method among all participants, music listening was found to be integral across various music therapy methods and techniques, as listening was required in all music production. This study found that most participants used drumming, improvisation, music listening, singing, lyric analysis, songwriting, music in meditation or relaxation, and music making as music therapy methods for IST patients. Among the listed music therapy methods, lyric analysis and songwriting were utilized by all the participants, while the implementation of drumming within the improvisation method was mentioned most frequently (see Table 7).

Table 7. IST Music Therapy Methods Ranked

Method	Frequency of Words	Number of Responses (N=9)
Drumming	40	8
Improvisation	33	7
Sing-along/singing/karaoke	32	7
Music listening (pt. preferred)	29	8
Lyric analysis	26	9
Songwriting	23	9
Music in meditation/ relaxation	22	6
Music making	13	6
Listening (background)	8	4
Active listening	6	4
Tone chime/ tone bar	5	4
Music video	4	2
Listening & drawing music	3	1
Role play/play	2	1

Goals in Music Therapy

Research Question 2: *In what ways do music therapists determine treatment domains and goals in music therapy for IST patients?* Music therapists determine treatment domains and goals for IST patients based on several factors, including their conceptualization of the overall purpose of patient treatment, the requirements for patients to be evaluated as competent to stand trial, and their understanding of the skills needed to meet competency requirements. The findings in this study reflected the

participants' perspectives on treatment directions and approaches when working with IST populations (Table 8).

Table 8. IST Music Therapy Overall Goals and Targets

Goals	Frequency of Word	Number of Responses (N=9)
Interpersonal skills	80	9
Social skills	53	9
Cognitive functioning	51	9
Focus/ alertness (Psychiatric reason)	51	8
Emotion	47	9
Learn legal information	47	9
Relaxation/calmness	29	7
Coping skills	28	9
Motivation/ increase participation	28	7
Maladaptive behaviors	28	7
Psychosis/ symptom management	27	8
Self-expression	23	6
Reality orientation	17	6
Empowerment/ self-esteem/confidence	16	8
Self-awareness	15	6
Building trust	15	5
Stress/ Anxiety	13	7
Leisure Skills	12	2
Expand limitation/ choices	11	6
Insight	9	4
Life skills/ ADL skills	8	3

Table 8. (Continued)

Goals	Frequency of Word	Number of Responses (N=9)
Trauma	6	3
Quality of life	6	2
Spirituality	4	3
Well-being	4	2

A text frequency analysis revealed the goals most and least frequently mentioned by participants, highlighting the relative importance of these goals in their practice with IST patients. During coding and categorization, the specific words used by the participants were preserved as much as possible to create category labels, ensuring fidelity to the data.

Goals for treatment in music therapy were mentioned 628 times by the study participants and, during data analysis, were categorized into 25 distinct categories (Table 8). Among the goals, interpersonal skills were by far the most frequently mentioned. All nine participants referenced interpersonal skills a total of 80 times (7.85% of all responses). The top six categories for treatment goals mentioned by the participants were: social skills which were mentioned 53 times, cognitive functioning, 51 times, focus and alertness, 51 times, emotion, 47 times, and legal education, 47 times. These top six categories collectively accounted for 329 mentions, representing more than 50 % of all responses.

The next most common goals were *relaxation* and *calmness*, stated 29 times by seven participants, and *coping skills*, which had a total of 28 mentioned and was referenced by all nine participants. *Increasing motivation or participation* and *decreasing*

maladaptive behaviors were each mentioned 28 times by seven music therapists. *Symptom management* was cited 27 times by eight participants. *Increasing self-expression* was mentioned 23 times, while *reality orientation* was referenced 17 times by six participants. Eight participants identified *empowerment*, *self-esteem*, or *confidence* as goals in music therapy for IST patients, with a combined total of 16 mentions. *Self-awareness* and *building trust* were considered important goals, with each being mentioned 15 times by six and five participants, respectively. *Stress and anxiety management* was cited 15 times by seven participants, while two participants indicated that *leisure skills* were important, mentioning them 12 times. Additionally, expanding *one's limitations* and *making choices* were reported as goals 11 times by six participants. Some participants also reported that *life skills* or *activities of daily living (ADL) skills*, *trauma*, *spirituality*, *quality of life*, and *well-being* were appropriate goal areas for music therapy with this population.

Participants determined goals and treatment based on IST patients' needs. Data from this study showed that music therapists working with IST patients conceptualized the purpose of patient treatment in two distinctive ways. The first was addressing *legal education* as part of competency restoration, ensuring that patients understood basic courtroom procedures, personnel, and expectations (Prong I). The second was focusing on a *comprehensive psychosocial perspective*, addressing perceived deficiencies or impairments in overall mental and physical functioning (Prong II). Both approaches were evident in all study participants. During interviews, participants indicated that at certain times in their practice, one of these approaches (legal education or comprehensive psychosocial perspective) may take precedence, while at other times, the two were more

equally integrated. Participants selected goals and objectives for specific sessions with IST patients based on varied conceptualizations and approaches. One commonality among all music therapists was that the goals aligned with working toward IST patient competency as defined by the *Dusky standard* (see Chapter 2) and the two prong requirements outlined by the California Department of State Hospitals (DSH). Grouping the findings according to each prong of the California DSH requirements provided a clear understanding of the music therapists' work with this population.

Prong I: Understanding Legal Issues. Prong I is closely associated with psychiatric stabilization and cognitive functioning, which are critical for the patient's ability to learn and retain information to return to court. Participants in the study emphasized teaching and assisting patients in learning and understanding court material as a key aspect of addressing Prong I. In addition to these efforts, participants reported using music therapy to alleviate patients' psychiatric symptoms and create an environment conducive to learning. Techniques such as using music as distraction or relaxation tool were employed to help patients focus, organize their thoughts, and improve their capacity to absorb and retain court-related information.

Cognitive challenges are prevalent among IST patients and can stem from acute psychotic symptoms due to mental illness, substance use, or organic cognitive deficits. These impairments hinder the ability to learn and comprehend legal material. All participants in the study identified improving cognitive functioning as a primary goal for this population. The specific cognitive goals addressed in music therapy included improving attention, information retention, communication skills, reality orientation

(involving rational thought processes and awareness), and the ability to follow instructions or conversations, and conceptualization (see Table 9).

Among these goals, improving focus, attention, and alertness was the most frequently mentioned, with eight out of nine participants highlighting its importance. This goal was referenced 51 times in total, making it the most prominent cognitive focus in the study. Understanding and learning court material was mentioned 47 times, while improving communication was cited 28 times. Reality orientation was identified as a goal by six participants, appearing 17 times across the data. These findings indicate that addressing cognitive goals through music therapy is closely tied to fulfilling the competency criteria of Prong I.

Table 9. MT Goals for Cognitive Function

Cognitive Functioning	Word Counts	Number of Responses (N=9)
Focus / attention	51	8
Understanding/ learning court material	47	9
Communication	28	9
Reality orientation	17	6
Retention	3	2
Following along	3	2
Conceptualization	1	1

Note. Goals are based on participants' responses regarding understanding legal issues.

Participants demonstrated an awareness of the importance of addressing cognitive goals as a means of enabling patients to learn court material, thereby fostering competency. While all nine participants agreed on the significance of helping patients understand court processes, eight explicitly stated that their work involved teaching legal

information. Only one participant did not include this focus in their group treatment. Two participants noted that they used music therapy interventions to teach court information - such as the roles of court personnel, legal processes, or legal terminology- but did not perceive these activities as part of music therapy.

Cognitive alertness and present-moment orientation (“here and now”) were consistently highlighted by participants as essential practices for IST patients. The retention of learned material and the ability to follow along in a group setting were mentioned twice by two participants, while conceptualization was mentioned once (see Table 9). Structured goals and interventions aimed at helping patients learn court material were identified, but participants varied in how they perceived and implemented these approaches in music therapy. This inconsistency suggests a need for clearer guidelines and standardized methods in addressing cognitive goals for IST patients within music therapy practices.

Prong II: Assisting Counsel in a Rational Manner. The second criterion for determining a patient’s competency to stand trial, as outlined in Prong II, pertains to the patient’s ability to assist their attorney in a rational manner throughout the legal process. This competency requires patients to effectively manage internal and social challenges that may interfere with their participation in legal proceedings.

Participants in the study highlighted the importance of addressing psychiatric symptoms such as hallucinations, thought disorganization, delusions, and mood dysregulation, as well as secondary symptoms like antisocial behaviors. These symptoms were identified as key barriers to patients’ ability to engage with their attorney rationally.

The data further emphasized the role of mood and behavioral regulation in supporting this aspect of competency restoration.

To achieve these goals, participants noted that treatment compliance was critical. Patients needed to demonstrate sufficient psychiatric stabilization, allowing for the development of the interpersonal and coping skills required to meet Prong II criteria. Accordingly, this section of competency treatment was divided into two primary skill domains: Interpersonal and social skills and coping skills.

1. **Interpersonal and Social Skills:** Participants reported that assisting patients in developing effective communication, motivation, building trust, and appropriate social skills was fundamental. These skills enable patients to interact appropriately with their attorneys and engage constructively in the legal process.
2. **Coping Skills:** Emphasis was placed on equipping patients with strategies to manage internal stressors, regulate their emotions, and respond adaptively to challenging situations. This focus on coping mechanisms was essential for ensuring that patients could maintain rational thought and behavior during restoring competency processes in the hospital as well as in court for interactions with their legal counsel.

Table 10. MT Goals for Interpersonal and Social Skills

Goals	Word Counts	Number of Respondents (N=9)
Communication	28	9
Motivation	28	7
Building trust	15	5
Appropriate behavior/Interaction	15	4

Table 10. (Continued)

Goals	Word Counts	Number of Respondents (N=9)
Openness/Flexibility	13	5
Following direction/ Social cues/ Eye contact/ Listening	11	5
Turn taking/Sharing	10	5
Negotiate/Collaborate/Togetherness	7	2
Self-control/ Patience/ Tolerance/ Boundary	3	2
Public speaking	1	1

Note. Goals are based on participants' responses regarding working with attorneys.

As shown in Table 10, interpersonal and social skills were popular goals for IST patients considered important for developing or improving their ability to work with attorneys. Of all the interpersonal and social skills listed in Table 10, communication skills were regarded as the most important area for this population. Communication was mentioned 28 times, with all nine participants in agreement. Motivation was another significant challenge for IST patients, recognized by seven participants, mentioned 28 times, and incorporated into music therapy treatment sessions. In this context, motivation referred to a patient's willingness to remain engaged in treatment and to return to treatment sessions quickly after a lapse.

Five participants agreed that building trust, as well as openness and flexibility, were two crucial goals to assist IST patients in working with an attorney upon their return to court. These goals were mentioned 15 and 13 times, respectively. Appropriate behavior and interaction were noted 15 times by four participants. Another area of focus within interpersonal and social skills included following directions, understanding social

cues, maintaining appropriate eye contact, and exhibiting good listening skills. These were mentioned 11 times by five participants. Turn taking and sharing were also identified as critical social skills required in court and when working with an attorney. Collaboration, cooperation, and togetherness were also highlighted by a few participants, along with self-control, patience, and maintaining boundaries. One participant noted that being able to speak in public or in front of others could help patients prepare for returning to court.

Coping skills was another critical component that IST patients needed to effectively engage in with their attorneys to navigate the legal process. Developing these skills involves addressing goals such as emotion regulation, stress and anxiety management, relaxation, self-awareness, self-esteem, and insight. These areas are foundational for enabling patients to maintain emotional stability and interact appropriately in forensic settings.

The data in Table 11 highlight that emotion regulation was the most frequently addressed coping skill, mentioned 47 times by all nine participants. Participants commonly used terms such as “emotion regulation”, “understanding emotions”, and “managing or processing emotions” when describing their work with patients on mood and emotional stability. Managing anxiety, stress, and agitation was another prominent theme, with relaxation and calming practices cited 32 times across all participants.

Additional targeted coping goals included impulse control, stress tolerance, and maintaining appropriate behavior, collectively mentioned 28 times by seven participants. Symptom management was reported 27 times by eight participants, while self-awareness and insight were mentioned 24 times by seven participants. Similarly, self-expression

was identified as a goal 23 times by six participants. Reality orientation, though primarily linked to Prong I, was also recognized as a coping skill goal by six participants and was referenced 17 times overall.

Empowerment, encompassing self-esteem and confidence building, emerged as another key coping skill, mentioned 16 times by eight participants. Expanding patients’ perceptions of their own limitations or choices was cited by six participants as a way to foster empowerment, with this goal was mentioned 11 times overall. Trauma and spirituality, though less frequently addressed, were included as coping goals, with trauma mentioned six times and spirituality four times, both by three participants.

While self-awareness and insight were emphasized as part of treatment goals under Prong I to support reality orientation, they were also integral to coping skills, serving as a foundation for empowerment. The findings suggest that strengthening these coping skills can help IST patients achieve the emotional and psychological stability required to effectively assist their legal counsel and progress toward competency restoration.

Table 11. MT Goals for Coping Skills

Goals	Word Counts	Number of Respondents (N=9)
Emotion regulation	47	9
Anxiety/ Stress (relaxation/calm)	32	9
Impulse control/Stress tolerance/ Non-violence (Maladaptive behavior)	28	7
Symptom management	27	8
Self-awareness/Insight	24	7
Self-expression	23	6

Table 11. (Continued)

Goals	Word Counts	Number of Respondents (N=9)
Reality orientation	17	6
Empowerment/ Self-esteem/ Confidence	16	8
Expand limitation/Choices	11	6
Trauma	6	3
Spirituality	4	3

Summary of Findings on Treatment Domains and Goals

This study revealed that music therapists structured treatment domains and goals for IST patients primarily around the two competency Prongs, organizing their interventions into four key areas: symptom management (including emotion and mood regulation), cognitive functioning, behavior, and insight (see Table 12). Participants reported using music therapy techniques for symptom management in diverse ways, such as employing distraction techniques to alleviate or mitigate symptoms like hallucinations or psychotic disturbances. Mood instability, particularly anxiety and stress, emerged as the most frequently addressed issues among IST patients in this domain. Cognitive functioning was another primary focus, particularly in relation to understanding and retention of legal concepts. Goals frequently included improving patients’ focus, enhancing memory, and fostering their ability to follow directions. Helping IST patients comprehend court proceedings, including understanding charges, identifying court personnel and their roles, exploring plea options, and learning basic court procedures was emphasized by all participants. Learning and understanding legal information was

identified as primary goals by all participants. However, responses varied regarding the methods used to teach this information and whether such activities constituted music therapy. While seven out of nine participants reported focusing on teaching court related material, only two explicitly stated that they used music as a tool for this purpose, though they did not classify these activities as music therapy. Behavior modification was also emphasized as essential components of competency restoration for the IST patients. Many of these patients exhibited socially inappropriate behaviors, including aggression, impulsivity, anger, and argumentativeness. Participants addressed these issues by setting treatment goals tailored to their patients' specific needs. Music therapists' clinical assessments and interpretations were critical in identifying these needs and in selecting appropriate therapeutic goals and interventions.

This study demonstrates that music therapists developed and implemented treatment strategies for IST patients by addressing four primary areas: symptom management, cognitive challenges, behavioral and emotional regulation, and insight. These efforts closely aligned with the legal and critical requirements of the two competency prongs. Therapists utilized their professional judgement to tailor interventions to the unique challenges of the IST population. As the findings indicated, IST goals were identified and described in various ways within music therapy practices, reflecting individual music therapists' interpretations of patients' needs in the competency restoration process. When related categories were grouped together, music therapy practices predominantly targeted symptom management, cognitive functioning, emotional and behavioral issues, and insight (Table 12). Among these areas, mood instability and anxiety emerged as the most commonly targeted issues in treatment for

patients under Penal Code 1370 (incompetent to stand trial commitment), as noted by all nine participants. Symptom, mood, and behavior management were frequently addressed in music therapy through interventions aimed at improving coping and social skills. Cognitive functioning was another major focus of music therapy, regardless of whether deficits were attributed to biological, developmental, psychological, or psycho-social factors. Therapists aimed to improve patients' ability to follow directions, maintain focus, engage in critical thinking, retain information, and understand legal issues. These areas were consistently targeted by all participating music therapists. Behavior modification and emotional regulation were also identified as essential components of competency restoration. Patients often exhibited inappropriate behaviors, such as argumentativeness, impatience, aggression, impulsivity, or anger, which could hinder their ability to work effectively with an attorney. The data indicated that all participants in the study worked to address these behaviors to some extent. Although all goals and objectives for IST patients were considered important, fostering patients' insight into their mental health, and promoting reality orientation were viewed as crucial for achieving competency. These efforts included helping patients develop trust in their treatment teams and attorneys, which is a key component of competency restoration.

Table 12. IST Targeted Needs and Goals in Music Therapy

	Symptoms management			Cognitive functioning			Behavior		Insight	
	Hallucination	Anxiety	Low Motivation	Mood Instability	Understanding and Learning Legal Issues/Focus/Attention/Retention/Follow Along	Impulsivity	Aggression / Anger/ Agitation	Antisocial/ Inappropriate Behavior	Mental illness (Awareness)/Reality Orientation/Trust	
P1	X	X	X	X	X	X	X	X	X	
P2	X	X	X	X	X	X	X	X	X	
P3	X	X	X	X	X					
P4	X	X	X	X	X	X		X	X	
P5	X	X	X	X	X		X	X	X	
P6	X	X	X	X	X				X	
P7	X	X		X	X	X	X		X	
P8	X	X		X	X	X	X	X	X	
P9	X	X	X	X	X	X	X	X	X	

Note. P = Participant; X = Positive response

Table 12.1. IST Targeted Needs and Goals in Music Therapy: Frequency of Words

	SYMPTOMS AND MOOD (144)				COGNITIVE FUNCTIONING (98)			BEHAVIOR (28)		INSIGHT (35)
	Hallucination	Anxiety	Low motivation	Mood Instability	Understanding and Learning Legal Issues/ Focus/ Attention/ Retention/ Following Along	Impulsivity/Aggression/Anger / Agitation/ Antisocial/ Inappropriate Behavior	Mental illness/Reality Orientation/Trust			
P1	2	4	3	8	6	4	9			
P2	1	1	2	1	10	4	1			
P3	1	4	1	4	11	0	0			
P4	6	4	2	6	9	4	10			
P5	5	11	8	3	6	4	2			
P6	3	2	7	12	26	0	7			
P7	6	2	0	1	9	1	1			
P8	3	9	0	7	18	7	1			
P9	0	5	5	5	3	4	4			
TOT	27	42	28	47	98	28	35			
AL #										

Assessment, Treatment, and Evaluation

Research Question 3: *In what ways do music therapists assess, treat, and evaluate IST patients?*

Assessment Practices. The assessment process in California is standardized and conducted through in-person interviews. Unlike the music therapists in California, the one participant from Texas reported conducting a music therapy specific assessment when a referral was made, which was not specific to Penal Code 1370 (Incompetent to stand trial). The assessment was conducted through interview, observation, interaction, and treatment interventions in both states. All participants reported that assessment was an ongoing process until patients returned to court.

Assessment is an important process for IST treatment. Assessments were conducted initially and annually. When a patient is admitted, the interdisciplinary treatment team assesses the patient within seven to fourteen days. Music therapists in California state hospitals are required to complete an initial standardized rehabilitation assessment. The assessment of patients' psychological and physical conditions is an ongoing process after admission, applied both within and outside of treatment groups. In this study, assessment appeared to be a central aspect of the music therapists' practice. Study participants discussed their assessment procedures with IST patients in various of ways. They referred to initial or diagnostic assessments, assessments conducted during treatment sessions to inform their next steps (formative assessments), and their personal thoughts and beliefs about assessment practices.

The study participants were mostly from the California and worked at hospitals within the state hospital system. While they followed the same protocols for assessments,

there were individual differences in how they approached and conceptualized the assessment process.

When asked about patient assessment, most participants referred immediately to the standardized, comprehensive formal patient assessment they completed within 14 days of patient admission. This assessment involved completing an online form that included open-ended questions about potential barriers to patient competency, as well as checkbox sections for patient interests and specific treatment focus areas. The diagnostic assessment required aggregating information from multiple sources, including verbal input from the patient during an in-person interview, patient observation, and a review of the patient's chart.

One participant described the assessment as an opportunity to discuss the patient's background, stating, "*(It's a time to talk) about their history, about what their goals are, what their strengths are, what their interests are, trying to capture all of those things so that we can play to those strengths*" (Participant #7). Another participant echoed this sentiment, explaining, "*I would always ask what they like to do. Do they like art, do they like sports, do they like music? What type of music, what type of instruments, have they played instruments before?*" (Participant #2). In addition to patient interests, the initial assessment addressed basic cognitive, social and emotional functioning. This included observing and assessing factors such as whether the patient's affect was congruent with their mood, frustration tolerance, evidence of underlying anger, history of violence, ability to remain on task, coping skills, paranoia, presence of auditory or visual hallucinations, listening skills, and ability to communicate thoughts and feelings (Participant #2; Participant #6; Participant #8). Another participant stated his focus is on

the barriers for competency restoration - symptoms, such as the line of thinking, flexibility, rigidity, cognitive function and orient himself to the criteria of discharge (Participant #4).

Beyond the initial standardized patient assessment, participants also discussed their ongoing formative assessment practices with patients. These regular assessments, which focused on abilities, functioning, and skills, were conducted during treatment group sessions or other interactions with patients. One participant described the observations he used to determine the level of functioning a patient might demonstrate in groups: *“I look at focus. I look at engagement. I listen to the responses to the concepts they must know. If what I’m doing is remotely successful, if what I’m trying to convey is taking hold, or I look to evaluate if there is any place for these concepts to take hold”* (Participant #1). This participant emphasized assessing focus and attention as a way to gauge patients’ conditions, including but not limited to their responses to internal stimuli, cognitive functioning, mood, and reality orientation-whether patients were aware of their surroundings and mentally present during group sessions. At a deeper level, the participant highlighted the importance of assessing flexibility, openness, and emotional aspects by observing, *“where the patient is willing to go, are they brave enough to go out there by themselves and solo, or are they too shy, or how much tolerance for the group does each individual have”* (Participant #1).

In addition to assessing abilities and conditions during treatment groups, several participants mentioned using drumming groups as a tool for assessing patients’ communication style. For example, participant #1 described observing a patient’s ability to play back and forth during drumming sessions to assess how they tolerate interactions

or respond to stressors. Similarly, Participant #2 noted that during drumming, they observed patients' awareness of group dynamics-whether they played louder, quieter, faster, or slower than others. Participants often used this type of assessment during group warmups to observe *“who's here, who's not here, as far as mentally, emotionally, and creatively”* (Participants #1, #2, #9). Another participant shared that she prioritized building rapport and establishing a connection with the patient before conducting a more formal assessment. She explained that she then assesses, *“How severe their psychiatric symptoms are, and then how their relationship with people is... what they're lacking and what they need to improve in terms of social, cognitive, communication, and court knowledge.”* (Participant #8).

A music therapist working with IST patients must always be mindful of safety, and assessment can play an important role in maintaining it. One participant emphasized the importance of assessing patients in group settings, particularly to monitor risks and ensure group safety. She explained that observing for social cues and changes in patient behavior during treatment sessions was a key component of her practice, *“assessing for social cues and for the safety of the group...I don't want things to escalate further”* (Participant #5). The comprehensive and prolonged assessment processes not only informed music therapists of treatment options and group direction but also provided baseline data on patients.

In contrast to the participants from California, the participant from Texas shared that music therapists at his hospital do not conduct an initial IST assessment for patients. Instead, assessments are completed only after receiving a referral for individual services, and these assessments are specific to music therapy. The participant described approaches

to assessment as asking patients, *“What do you want to work on? What do you want to achieve musically and...what nonmusical thing you hoping to achieve while you’re here?”* (Participant #9). For this participant, assessment involved *“gathering information about musical preferences”* and *“to learn about patient’s past”*. The participant sometimes used song lyrics to assess patient’s thoughts and histories. Additionally, experiential methods were employed such as playing instruments, improvisation, or other techniques to assess patients’ willingness to try new experiences, levels of anxiety, cooperation, and preferences (Participant #9).

Treatment: Holistic and Adaptive Approaches. Participants described both the role of music therapy and the focused objectives of treatment for IST patients. While IST treatment is traditionally described as addressing goals under Prong I (legal competency) and Prong II (psychological restoration), participants approached treatment with a holistic perspective, emphasizing support for the patient as a whole person. This perspective involves fostering reality orientation, encouraging mindfulness, promoting self-awareness and self-control, and facilitating self-expression and empowerment. One participant highlighted the importance of reality orientation and grounding patients in the present moment: *“We’re affecting their reality orientation because so many of them have so much internal stimuli and are internally occupied. So, we facilitate a way with music to bring them out of that, without forcing it.”* (Participant #1), and further elaborated, explaining the role of music therapy in grounding patients: *“It’s a reality orientation in the music activity or music we’re playing. A person has to be there, right there.”* Another participant described treatment as a creative outlet for addressing inner struggles: *“I’m responsible for providing them opportunities for creative expression, opportunities for*

stress relief, or relaxation, or tools that will prepare them for mindfulness, and just in general like awareness.” This participant also emphasized how music therapy helps build strength and confidence: *“Music therapy...it gives them this container, this sense of releasing the stress of being on the unit... releasing the stress leading up to their court date, or like maybe feeling guilt or shame about their crimes, um and processing those feelings in improvisational music therapy... and building their strength and confidence again.”* For this participant, music therapy served as a treatment for symptom management through creative activities: *“I see my role... as simply symptom management which of course is the goal of getting out. So, I’m there like ‘OK great. doctor took care of that, psychologist working on that. OK, cool I get to be creative with them I get to reduce their stress it is more symptom management focused.”* (Participant #5).

Participants emphasized that music therapy can support a patients’ moods without imposing emotional changes. They noted the importance of understanding both the patient and the music itself: *“You match their mood and slowly bring them back to a clam reality baseline. The same can be true for people that are very lethargic or depressed, so music is the therapy. We just have to know how to use which music for different situations.”* (Participant #1). This participant also described the adaptive nature of music therapy treatment for IST patients, emphasizing the immediacy and flexibility required in practice: *“We are fluid in how we treat, how we use music as therapy on our unit. With IST patients, there’s a little bit more of an urgency to our music therapy interventions, I think. The sessions have a ‘right here, right now’ kind of feel... you have the target goal*

here and now, you're going to have to figure out the trajectory of attaining goals quickly." (Participant #1).

Another participant emphasized the role of music therapy in building rapport and establishing connections with the patient. *"... like trust issues. Unless they open up... they just could answer 'no', 'I'm OK', or 'no, no, no. I don't wanna answer'..."*

(Participant #8). Several participants highlighted how music therapy helps patients practice nonverbal communication. *"Even patients that maybe [are] less verbal, they're less oriented to reality, they can be in that moment and connect musically so, yeah."*

(Participant #6). Participant #5 stated that patients can learn how to communicate through instrumental playing, explaining, *"Are they play that drum a little too hard...[are they noticing] social cues...?"*.

Another participant shared the importance of active engagement and presence in treatment. *"I'll kind of lead the group singing it, usually a variety of popular songs. And I encouraged them [to sing with me] ...[that would be] like focused attention."* (Participant #6). She also described using musical instruments to create music together with patients, *"Sing along with me...or I might offer them like a drum to play a beat with me. So, we're actively making music together and [could be] working on attention in the moment ... being aware of each other, their peers, and the therapist."* (Participant #6).

Treatment was often tailored to the conditions and factors present on the unit each day. One participant described adapting treatment plans based on unit activity levels, such as when patients were acting out or when fewer staff members were available. *"I have to come up with treatment plans that would be appropriate for everyone not just for like one person but like what would benefit everyone...even staff"* (Participant #2). The

participant emphasized the goals of treatment on such days, *“to increase interaction, increase participation, turn taking, working on impulse control... so there's a lot of factors that need to be considered when creating this type of treatment style, this type of treatment plan.”* (Participant #2).

For another participant, the treatment focus was holistic, and they emphasized the therapeutic skill required to deliver effective interventions. *“At Napa, we are very holistic.”* The participant provided an example of *“being skillful”* and explained. *“This idea of skillful means... if you want to tell a joke, you're gonna tell this joke in a different way depending on who you are, right? It could be the same joke but depends on who's doing it. The same thing is with music therapy.”* This participant viewed music therapy as a process that *“builds rapport, you make it memorable. And it has this ability to do deeper stuff.”* and described the broader benefits of music therapy: *“music therapy helps with stabilization, building rapport, and increase motivation. In some cases, it improves insight, develops insight, uh... so all of those are music therapy tools to orient patients to understanding themselves better.”* (Participant #4).

Evaluating Progress in Music Therapy. Formal evaluations are conducted weekly, monthly, and annually, while on-going evaluations occur throughout patients' stay in the hospital. Participants reported conducting weekly evaluations for the first eight weeks of treatment by completing progress notes, followed by monthly progress notes for IST patients. Depending on the individual, some patients remain in the hospital for up to two years. For those staying their maximum term in the hospital as IST patients, an annual assessment is completed as part of their annual progress report.

Participants in the study indicated that they evaluate patients' progress based on their readiness to return to court. Key evaluation factors include patients' cognitive understanding on their legal cases, their ability to discuss their charges, their mood and behavior, and their level of participation in treatment. Patients are considered ready to return to court when they can state their charges, identify plea options and reasonably make choices of plea, understand courtroom rules and the roles of courtroom personnel, and demonstrate flexibility and rational cooperation with their attorney. Participant # 1 highlighted the importance of evaluating reality orientation, the ability to understand and retain information, focus, and level of engagement. Similarly, Participant #2 noted that she evaluates how much a patient cooperates with treatment and complies with medication, how much they can learn and retain court material, impulse and self-control, and their degree of interaction and participation in treatment groups. As the participants emphasized, evaluation focus on awareness, understanding and retaining court material, behavioral component including self-control, and the ability to participate and interact willingly and appropriately based on the criteria of competency. The evaluation of treatment progress is based on observation, interaction, and interventions, and these practices were consistent across both states examined in the study.

Conclusion

This study found that participants demonstrated consistency in their approaches to assessing, treating, and evaluating patients, addressing the overall need for patients to gain competency with a focus on whole-person treatment. Music therapy practices in forensic psychiatric hospitals, as observed in this study, actively incorporated a variety of musical experiences, including listening, playing, singing, discussion, and writing. The

music therapy methods utilized in this study included receptive, improvisation, recreative, and composition methods. The most commonly used musical experience was listening to patient's preferred songs. However, the most frequently employed music therapy methods were improvisation, singing, lyric analysis, and songwriting. The study also found that treatment domains and goals in music therapy for IST patients were strongly aligned with competency criteria and tailored to meet patients' specific needs, as assessed and clinically interpreted by IST music therapists. The most commonly targeted goals included improving interpersonal skills, social skills, cognitive functioning, focus, emotional regulation, and understanding court related information. The results of this study based on this sample demonstrated that music therapy practices with IST patients deliver patient-centered goals and holistic care while remaining strongly aligned with IST-related objectives.

CHAPTER 5

DISCUSSION AND RECOMMENDATIONS

In light of the limited research and literature in this area, this study provides valuable insights into current music therapy practices for IST, highlighting potential practical goals and methods with music therapy specifically designed to meet the needs of IST patients in U.S. forensic psychiatric hospitals. This chapter includes a discussion of the study's findings, contextualizes them within the broader forensic and therapeutic frameworks, and proposes directions for future research to advance this critical area of practice.

The findings from this research provides detailed analysis of practice, which may be considered for implementation. While participants discussed various goals and music therapy methods for the IST population during interviews, it appears that their focus of IST often centered on legal education. Nearly all participants stated that being competent involves knowing court material. For example, understanding and retaining legal information were commonly mentioned as goals. However, more specific goals, such as improving focus and attention to support competency, were recognized by only a few participants. Additionally, while goals related to mood or emotions were not immediately identified as IST-specific objectives, many participants acknowledging their significance within music therapy sessions. Trust issues among patients, cited by several participants (e.g., Participants #3, #4, #6, #8, & #9), represent a critical area linked to competency that requires therapists to address by fostering openness and flexibility in patients. However, only a few participants (Participants #4, #8, & #9) explicitly recognized and connected these aspects to IST goals. While data were collected about methods,

approaches, and goals of music therapists working with IST patients, meaningful analysis led to discernment of how the music therapists understood core contextual elements. Notably, music therapists' interpretations of two fundamental questions- "What does it mean to be competent to stand trial?" and "What is music therapy?"- significantly influenced their approaches and practices when working with IST patients.

Understanding Incompetent to Stand Trial

The interpretation of IST emerged as a crucial factor in addressing the research questions posed in this study and in guiding music therapists' selection of therapeutic goals and treatment methods for IST patients. This study found that music therapists frequently aligned their practices with surface-level legal definitions of competency, focusing primarily on helping patients understand court-related material. These choices by music therapists may reflect the primary goal of the hospitals, which is to support patients quickly meeting the discharge criteria for competency, rather than holistic rehabilitation. However, when music therapists become constrained by a literal interpretation of competency, they may inadvertently narrow their role to teaching court-specific content, thereby limiting the scope of treatment. As highlighted in the interviews, this literal interpretation of IST competency significantly shaped many music therapists' approaches, emphasizing legal comprehension while often neglecting the psychological, behavioral, and emotional needs of IST patients. This narrow focus seems to stem from the lack of resources and specialized training for music therapists working with IST population. Similarly, other studies on music therapy with IST populations have predominantly focused on the competency process and the therapists' efforts to teach required court material. The existing literature does not adequately explore or address the

broader needs that music therapy could address, leaving a critical gap in understanding and practice.

The findings of this study underscore these gaps in the existing literature while offering an alternative and in-depth perspective. Beyond addressing only Prong 1, which focuses on understanding legal proceedings, this research presents a broader lens for re-evaluating current music therapy goals practiced with IST patients. The study emphasizes the necessity of addressing IST patients' psychological, behavioral, and emotional challenges as integral components of competency restoration, moving beyond the known focus on legal comprehension. For instance, McDermotta et al. (2017) utilized various assessment tools to target specific areas relevant to IST commitments, providing a framework for understanding IST goals. The tools they introduced included the M-FAST (Miller Forensic Assessment of Symptoms Test) for feigning symptoms, the BPRS (Brief Psychiatric Rating Scale) for psychotic and mood symptoms, the GCCT (Georgia Court Competence Test) for court knowledge, the APS (Atypical Presentation Scale) for atypical presentations, and the COVR (Classification of Violence Risk) for evaluating violence risk. Additional research and scholarly literature have identified IST patients as suitable for competency evaluations and treatment when active psychotic symptoms, behavior issues, and cognitive challenges significantly impede their ability to assist their attorneys and participate in their legal cases (Mossman et al., 2007; Kapoor et al., 2018; Secarea et al., 2020). These studies also address similar critical areas for IST patients such as symptom management, cognitive functioning, violent behaviors, that were identified in this music therapy research and aligning closely with broader competency restoration goals. Developing insight has also been recognized as an essential component

of patients' treatment and their ability to participate in court proceedings (Linder, 2019). According to these literature findings, common goals and treatment approaches for IST patients should focus on addressing comprehensive issues found in this study such as psychiatric symptoms, behavior, mood, cognitive functioning, and insight.

The results of this study suggested that the participants of this study believe competency to stand trial involves more than just a basic understanding of court material. They noted that it requires a patient to be mentally and emotionally coherent, capable of understanding their legal situation, and able to participate appropriately in legal proceedings. The participants' holistic understanding informed the development of broader and more appropriate therapeutic goals. This finding is critical and fundamental, as it expands the understanding and perspective on music therapy treatment for IST patients. By incorporating these multidimensional aspects, music therapists can expand the focus of music therapy beyond teaching court material to address the holistic needs of IST patients, ultimately fostering a more comprehensive and effective approach to competency restoration. This suggests that music therapy has the potential to go beyond teaching legal material and address the comprehensive needs of IST patients, ultimately fostering a more well-rounded approach to competency restoration.

Understanding Music Therapy in the Context of IST Treatment

The question, "what is music therapy?" emerged as a pivotal theme in understanding how music therapists apply their practice for IST populations. The findings of this study indicate that while many participants reported using music in their groups, not all interventions involving music were consistently categorized as music therapy. For instance, patient-preferred music listening was a common activity offered to IST patients,

often involving taking song requests and playing pre-recorded music. Some participants viewed this as a recreational activity rather than music therapy, whereas others believed it held therapeutic value. Some participants used familiar music tunes to teach court material. While some therapists stated this approach a form of music therapy, others stated otherwise. Similarly, Karaoke was another intervention cited by participants. While some music therapists identified its therapeutic benefits and goals, others classified it as a leisure activity due to its lack of explicitly therapeutic objectives. This contrast in perceptions among participants highlights the diverse perspectives on the definition of music therapy and underscores the need for clearer guidelines on its application within music therapy with the population.

Many participants emphasized that music therapy should involve experiential musical engagement, allowing patients to actively participate in music making (Participants #1, #4, #5, & #9). However, the extent nature and scope of musical experiences required for an intervention to be classified as music therapy remained unclear. This ambiguity also frequently blurred the lines between music therapy and music-assisted group activities, such as yoga, relaxation, or movement groups incorporating music. The variation in perspectives observed in this study suggests several possible explanations. One potential factor could be differing interpretations of what constitutes *therapy*. For some, music therapy may be seen primarily as a process of active musical engagement aimed at specific therapeutic goals, such as emotional regulation or cognitive functioning. For others, music's role may be more aligned with providing a supportive or familiar context for achieving treatment goals, even if the musical engagement is limited or more passive in nature.

Another contributing factor could be the therapeutic philosophy or approach of individual therapists. For example, therapists who prioritize an experiential, music listening approach may view passive musical activities (like listening patients' requested songs) as insufficiently engaging for patients. In contrast, those with a more flexible or integrative view of music therapy might consider these interventions valid as long as they support the patient's recovery or legal competency.

These differing viewpoints among participants highlight the need for clear definitions and standardized practices within the field of music therapy for IST patients. The lack of consensus on what qualifies as music therapy, as well as the overlap between music therapy and music activities suggests the necessity for further discussion and development of specific guidelines. Establishing these guidelines will help ensure a more consistent application of music therapy, allowing therapists to better navigate how to use music in ways that effectively support both clinical and competency restoration goals for IST patients.

Addressing IST Patients' Needs Through Music Therapy

Competency restoration for IST patients involves addressing a range of interconnected goals that align with legal competency criteria. The ultimate objective for IST patients is to restore competency, which encompasses two primary pillars: (1) understanding court procedures and (2) being able to assist their attorney rationally. Within this framework, the findings of this study emphasized the importance of translating these overarching goals into music therapy interventions tailored to the specific needs of IST patients.

Participants in this study identified four key areas of focus in their practice: symptom management, cognitive functioning, behavioral management, and insight development. Their perspectives offer a deeper understanding of how music therapy aligns with the specific needs of IST patients and how it can be strategically applied to support competency restoration.

Symptom management. While symptom management was not explicitly identified as a goal of IST patients, participants frequently emphasized the role of music therapy in reducing anxiety, agitation, mood instability, and hallucinations- factors that can hinder the competency restoration process. Many reported using receptive music therapy, such as music listening or relaxation with music to help patients self-regulate emotions and decrease distressing symptoms. Active music making, including drumming and improvisation, was also noted as a method to provide sensory grounding for patients experiencing dissociation or auditory hallucinations. These findings align with existing music therapy literature, which suggests that structured music interventions can reduce stress responses (Bradt & Dileo, 2014) and support emotional regulation in psychiatric populations (Gold et al., 2013).

Cognitive functioning. Cognitive deficits, including memory impairments, poor attention span, and difficulty processing information, were significant challenges noted in IST patients. To address these issues, participants utilized various techniques such as music listening, lyric analysis, drumming, songwriting, and singing to improve focus, attention, and retention of information relevant to legal competency.

Participants described interventions in which IST patients engaged in focused music listening, attending to musical details, or call-and-response drumming to reinforce

concentration and short-term memory recall. Additionally, songwriting exercises were implemented to support sequencing and organization of thoughts. These findings align with previous research demonstrating music's effectiveness in enhancing executive functioning and working memory in clinical populations (Thaut, 2010; Baker, 2015).

These approaches reflect the cognitive rehabilitation framework in music therapy, wherein rhythm and melody provide predictable, structured auditory cues that facilitate neuroplasticity and cognitive skill-building (Thaut et al., 2009). By leveraging these elements, music therapy offers a structured yet engaging means of improving cognitive functioning, ultimately supporting IST patients in their competency restoration process.

Behavioral management. IST patients often exhibit impulsivity, aggression, inappropriate social behaviors, and low motivation, requiring structured interventions to address these behavioral concerns. Therapists reported using group music-making, such as drumming and instrumental playing, to promote self-regulation, improve communication, enhance understanding of social cues, encourage cooperation, and reinforce adherence to social norms. Some participants described music activities such as taking turns playing requested songs, creating music videos, or actively participating in group music making. This approach aimed to reinforce impulse control, encourage social engagement, and support structured self-expression. Additionally, one participant noted that group songwriting provided patients with opportunities for self-expression while reinforcing decision-making skills and promoting autonomy. Research supports these findings, as studies indicate that active engagement in music-based social interactions can strengthen self-regulation, emotional processing, and cooperative behavior (Gooding, 2011).

Insight development. Developing self-awareness, emotional insight, and a sense of reality orientation was a major challenge with IST patients. Participants reported that lyric analysis, songwriting, lyric writing, and improvisation were particularly effective in encouraging patients to explore personal experiences, emotions, and their understanding of their legal situation. For example, one participant described a song discussion or lyric analysis session where patients listen to selected songs that resonated with their emotions, then engaged in reflective discussions about how the lyrics related to their life experiences and current challenges. Another therapist used songwriting with spoken words, lyric substitution, or fill-in-the blank, encouraging patients to create lyrics that expressed their personal struggles and aspirations, leading to deeper self-awareness and insight development. This aligns with existing research in forensic music therapy, which indicates that music-based self-expression can foster emotional insight and facilitate engagement in rehabilitative processes (Compton-Dickinson, 2012). Additionally, studies suggest that narrative songwriting can help individuals reframe their experiences and develop healthier perspectives on their behaviors and challenges (Baker, 2015).

The findings from this study demonstrate that music therapists working with IST patients tailor their interventions to address psychiatric symptoms, cognitive challenges, behavioral modulation, and insight development, reinforcing current literature in forensic and psychiatric music therapy.

Music Therapy Methods for IST Patients

This study highlights the diverse applications of music therapy methods used with IST patients. While participants did not always identify specific methods uniquely

tailored for this population, several methods emerged as particularly prevalent, including drumming, improvisation, lyric analysis, songwriting, and music listening. Silverman (2007) noted that songwriting is frequently employed with forensic populations, a finding that aligns with its application in IST settings. Unlike prior studies emphasizing learning court material through lyric analysis and songwriting (e.g., Sammon, 2014; Mace, 2017), this study revealed broader applications of these methods.

Drumming, for instance, was not only a means of nonverbal emotional expression but also served as a structured intervention to promote sensory integration, impulse control, anger management, and group cohesion. The repetitive and rhythmic nature of drumming helped regulate arousal levels, offering patients an immediate, accessible way to release tension and develop self-regulation skills in a controlled environment.

Similarly, songwriting and lyric analysis allowed patients to process and organize thoughts related to their emotions, relationships, and personal goals. By engaging in lyric substitution or guided songwriting exercises, patients were encouraged to articulate their thoughts in a coherent manner, reinforcing cognitive processing skills essential for legal competency. These methods also promote insight, encouraging individuals to reflect on past experiences, recognize causes and consequences, and explore alternative coping strategies.

Music listening was employed to de-escalate crises and manage acute symptoms and behavioral episodes, leveraging the well-documented effects of preferred music on emotional self-regulation. By selecting or creating evidence-based playlists tailored to the individual's needs, therapists guided patients toward music that could modulate mood states, decrease agitation, and promote relaxation. This method was particularly valuable

for patients struggling with anxiety, aggression, or impulsivity, as it provided an accessible coping tool that could be employed beyond therapy sessions.

Improvisation, on the other hand, offered an unstructured yet therapeutically directed space for creative expression and emotional exploration. Spontaneous musical interactions allowed patients to engage in real-time decision-making, practice self-expression without the pressure of verbal articulation, and explore emotional themes that might be difficult to access through conventional dialogue. This approach also fostered interpersonal engagement, as patients learned to listen, follow, respond, and collaborate musically, reinforcing social skills that are critical for reintegration into the legal system and broader society.

The integration of these common music therapy methods into IST treatment reflects an intentional approach grounded in both clinical reasoning and evidence-based practice. Ultimately, these techniques extended beyond general therapeutic benefits, aligning with IST-specific goals such as symptom management, cognitive functioning, behavioral regulation, and insight development. By incorporating these familiar music therapy methods within a forensic rehabilitation framework, therapists aimed to support IST patients in restoring competency while also addressing the broader psychosocial challenges that contribute to their legal and mental health struggles.

This shift in focus reflects a more holistic approach to treatment, emphasizing the importance of addressing underlying factors that contribute to competency restoration. These findings align with Linder's (2019) emphasis on addressing reality-based challenges through music therapy, underscoring the versatility of these methods in fostering competency.

Beyond Legal Education: A Holistic Approach

This study revealed that IST-specific goals in music therapy are broader and more complex than those for non-IST populations. While music therapists consistently addressed psychiatric symptoms using similar methods, their goals for IST patients were tailored to competency restoration, demonstrating a nuanced approach to care. For example, while legal education was often a primary goal, music therapy methods also targeted emotional regulation, stress management, and interpersonal skill development—areas critical to overall progress and competency restoration.

The findings of this study suggest that music therapy for IST patients should extend beyond teaching court material to encompass clinically driven objectives that facilitate psychological stability, emotional insight, and meaningful participation in the legal process. This dual-purpose approach underscores the versatility of music therapy in addressing both the immediate and long-term needs of IST patients, ensuring that treatment not only meets competency goals but fosters overall well-being.

Flexibility and Adaptability in IST Music Therapy

Although the study found variability in how music therapists conceptualized and applied IST-specific goals, the flexibility and adaptability of music therapy methods were consistently emphasized. Therapists often tailored interventions to the immediate needs of their patients, using professional judgement to ensure safety and therapeutic efficacy. For example, the acute nature of IST units often presented challenges such as interruptions due to medical or psychological appointments, medication changes, and behavioral crises. In these situations, therapists relied on clinical intuition to modify or adapt their methods. This adaptability further highlights the need for developing clear

guidelines to ensure consistency and effectiveness in music therapy for IST patients. By establishing structured frameworks, music therapy can grow as an integral component of IST treatment while maintaining flexibility to address dynamic patient needs.

Integration with Broader Treatment Modalities

Additionally, the study highlighted how music therapy was often integrated with other treatment theories and modalities, such as mindfulness practices, DBT informed approaches, and creative art therapies. This integration underscored the versatility of music therapy in addressing the unique and multifaceted needs of IST patients. By incorporating a variety of therapeutic frameworks, music therapy can support a comprehensive treatment plan that aligns with the overarching goals of competency restoration.

These findings suggest the need to recognize and expand the role of music therapy for IST patients, ensuring it is not limited to narrowly defined competency goals. By leveraging the creative and flexible nature of music therapy, therapists can address the multifaceted needs of this population, ultimately contributing to their overall well-being and successful reintegration into the legal system.

Challenges and Opportunities in IST Treatment

A notable finding was the acknowledgement of cognitive functioning as a critical component in IST treatment. Literature indicates that patients with severe cognitive challenges face significant obstacles in gaining competency, with only an 18% chance of restoration in such cases (Mace, 2017; Porter Staats et al., 2021). Despite this, music therapists frequently emphasized legal education as a primary treatment goal, suggesting a need for broader, more flexible approaches to addressing cognitive challenges. The

development of standardized guidelines or manuals for music therapists working with IST patients could help bridge this gap, providing clear frameworks for integrating cognitive goals into therapy.

This study also highlighted the complexity of IST patients' psychosocial backgrounds, which often included issues such as homelessness, poverty, addiction, trauma, and violence. These factors significantly impact competency restoration by influencing patients' coping skills and emotional resilience. Music therapy goals such as emotional regulation, stress and anxiety management, relaxation, self-awareness, self-esteem, and insight were commonly included to address these challenges and enhance coping skills. By targeting these psychosocial factors, music therapy can play a pivotal role in addressing the broader needs of IST patients, ultimately facilitating their progress towards competency restoration.

Implications For Practice

The findings of this study describe current music therapy practice and its support of competency restoration in patients deemed Incompetent to Stand Trial (IST). Effective implementation of music therapy in this context requires music therapists to understand both the legal and therapeutic goals of competency restoration and to skillfully interpret patients' needs and adapt effective interventions within the constraints of institutional environments. This study presents several key points for consideration.

Defining and Standardizing Goals and Practices

A notable finding of this study is the pressing need for clarity in defining competency-related goals for music therapy. Whether state-mandated or organically integrated, the overarching aim of music therapy remains consistent: to address barriers

that prevent patients from meeting the two primary prongs of competency restoration- understanding legal proceedings and assisting in their own defense. To increase the potential for effective treatment music therapists could consider aligning their individual approaches with these broad organizational goals, tailoring their interventions to support competency restoration efficiently and effectively. Having a concrete understanding of the IST competency framework would support therapists to establish targeted objectives and select appropriate interventions, ultimately improving outcomes. Clear definitions and standardized terminology are essential to developing and generalizing effective music therapy practices for this population.

Time-Sensitive Nature of IST Treatment

Several participants emphasized the importance of developing effective treatment approaches in short-term care model for IST patients, who typically receive limited-term inpatient care with the primary goal of achieving competency and returning to court. Unlike general psychiatric care, IST treatment is uniquely time-sensitive, requiring all therapeutic interventions-including music therapy- to directly support competency restoration. Whether addressing psychotic symptoms, mood regulation, cognitive functioning, or behavior, every treatment modality ultimately serves this overarching objective.

This urgency necessitates the development of time-efficient, goal-oriented music therapy interventions that effectively support competency-related outcomes within constrained timeframes. Throughout the treatment process, patients must not only gain insight into their psychological conditions but also develop a clear understanding of their legal cases. This dual responsibility is necessary for their return to court and ability to

participate in legal proceedings. As a result, IST treatment demands a strategic, goal-directed approach that serves the interests of all stakeholders- patients, hospitals, and the legal system.

Role of Education and Training

The study also emphasizes the critical role of education and training in shaping music therapists' practices. The methods used with IST patients clearly reflected music therapist's training and educational backgrounds. While the music therapy practices described by participants in this study incorporated well- rounded music experiences- including listening, playing, singing, and writing with IST patients- music therapists in the study often favored specific methods more than the others based on their education and training focus.

Music therapists rely on their academic and professional preparation to address the unique needs of IST patients. However, the lack of IST specific training opportunities-both in academic settings and within forensic psychiatric facilities- presents a significant concern. Given the growing IST population and its unique treatment expectations, there is an urgent need to develop specialized curricula, training programs, and workshops tailored to this population. Post-professional advanced training should be prioritized to equip music therapists with the specific knowledge and skills required to address the complexities of working with IST patients. In the interim, mentorship and supervision programs can provide valuable support for music therapists navigating this specialized field, ensuring they are better prepared to meet the needs of this vulnerable population.

Future Research Directions

This study explored music therapy practices for the Incompetent to Stand Trial (IST) population within state hospitals. While this study provides valuable insights on current music therapy practices with IST patients, future research could expand on this study.

Advancing Music Therapy Practices

Further research is needed to deepen the understanding of music therapy interventions that address specific goals within the IST population. This study identified key areas of focus for IST patients, such as symptom management (including mood and emotion regulation), cognitive functioning, behavior modification, and insight development. Investigating the relationship between these goals and the specific music therapy methods used to address them could provide valuable insights into optimizing interventions to meet the unique needs for IST patients. For example, symptom management could be enhanced by developing more targeted music therapy interventions that address specific challenges such as mood disturbances, agitation, anxiety, or hallucinations. A more refined approach to symptom management could effectively mitigate the emotional and behavioral challenges that hinder competency restoration. Additionally, exploring the neurobiological mechanisms underlying music's impact on emotional regulation and cognitive functioning could further help fine-tune interventions, allowing therapists to tailor their methods to individual patient needs.

Another crucial area for future research is the customization of intervention to meet the unique needs of individual patients. Since each IST patient has a distinct combination of cognitive, emotional, and behavioral challenges, it is essential to align

therapeutic methods with their specific competency-related objectives. Customizing music therapy interventions to target a patient's particular deficits—whether in mood regulation, cognitive functioning, insight development, or social behavior—would enhance the efficacy of the treatment. For example, a patient with severe anxiety might benefit more from tailored guided music listening or relaxation techniques, while a patient struggling with aggression might find improvisation or drumming more effective for emotional release and behavioral regulation.

Ultimately, a deeper exploration of how music therapy techniques relate to competency restoration goals would help refine the practices within forensic psychiatric hospitals. By aligning therapeutic methods with specific patient needs and competency targets, music therapy could be even more effective in supporting IST patients in their recovery, as well as improving their overall legal competence. This approach would not only increase the effectiveness of music therapy but also contribute to the growing body of knowledge about how music therapy can be used as a powerful tool in forensic mental health treatment.

Furthermore, for patients transitioning back into the community after resolving their legal issues, further research could explore how music therapy practices support community reintegration, rehabilitation, and long-term well-being.

Time-Sensitive Interventions

Timely restoration of competency is vital to ensuring IST patients' expeditious return to court, which alleviates both legal burdens for patients and financial strains on hospitals due to extended hospital stays. Given this time-sensitive nature, investigating the effectiveness of music therapy for IST population is a crucial area for future research.

Studies should focus on identifying how specific music therapy interventions contribute to competency restoration and inform best practices for improving treatment outcomes. Due to the short-term nature of IST patients' inpatient care and the immediacy of their competency-related goals, future research should prioritize identifying interventions that are both time-efficient and targeted. Studies could explore which music therapy techniques are most effective for achieving competency-related objectives within these limited timeframes.

Influence of Music Therapists' Backgrounds

The findings in the study suggest that music therapists' professional and personal backgrounds significantly shaped their approaches with IST patients. For instance, therapists with experience in developmental disabilities often utilized behavioral and educational techniques, while those with creative art therapy training favored more expressive methods. Future research could investigate how therapists' training, empathy, and personal experiences influence their practices and impact patient outcomes. Additionally, the inclusion of music therapists with relatively short professional experience, especially those practicing during the pandemic, offers a unique perspective. Examining the evolving approaches of emerging professionals in this specialized field would provide important insights into the development of music therapy practices over time.

Specialized Training and Standardization

This study highlights the urgent need for specialized training and standardization in music therapy for IST populations. Currently, while the American Music Therapy Association (AMTA, 2006) provides general guidelines for working with forensic or

mental health populations, no specific resources exist for IST patients. With the growing demand for IST-related services, specialized curricula and advanced training programs are urgently needed to equip music therapists with the skills to meet the complex needs of this population. Future initiatives should focus on developing standardized protocols, training manuals, and Continuing Music Therapy Education (CMTE) workshops tailored to this population to ensure high-quality care and improved outcomes.

Limitations

There were several challenges and limitations to overcome in completing this research study. First, the original intention was to collect data from multiple states across the U.S. However, conducting the study during the Covid 19 pandemic presented significant difficulties in recruiting participants, particularly from states outside California. The pandemic caused unexpected delays in responses from prospective participants due to sudden changes in work environments, relocations, illnesses, and job losses, which led to cancellations or dropouts. As a result, the study primarily included music therapists from California and one music therapist from Texas (see table 3), limiting its geographical scope and preventing a more comprehensive examination of the subject. Future studies should aim to include a broader and more diverse range of states and institutional settings to provide a more comprehensive understanding of music therapy practices for the IST population. Expanding the scope would enhance the generalizability and applicability of findings across various forensic psychiatric contexts.

Second, this study included data from music therapists who had only practiced during the pandemic, a period characterized by significant modifications to treatment practices within state hospitals. Recruiting participants was already challenging, and

some music therapists who participated in this study were relatively new to the field and the IST population. As a result, their perspectives on music therapy for IST patients may have been influenced by limited exposure and insufficient familiarity with the broader treatment dynamics of IST populations.

Furthermore, treatment approaches in state hospitals were inconsistent and varied due to unforeseen Covid19 quarantine measures, which introduced additional inconsistencies and further contributed to variability in the findings.

Lastly, goals among IST patients may have temporally shifted, changed, or expanded to address specific needs arising during the Covid19 pandemic. Several music therapists reported observing increased anxiety and decreased motivation among patients during this time. These temporary and circumstantial factors likely influenced the findings of the study, highlighting the importance of considering the unique challenges posed by the pandemic when interpreting the results.

Conclusion

The population of individuals deemed Incompetent to Stand Trial (IST) continues to grow, yet music therapy practices for this population remain underexplored. This study underscores the potential of music therapy as a valuable intervention to support IST patients in regaining competency. Specifically, it highlights the scope of music therapy in supporting competency restoration by identifying key therapeutic goals, including symptom management, cognitive functioning, behavior regulation, and insight development.

Findings revealed that music therapists employed diverse methods tailored to IST patients, including music listening, singing, improvisation, lyric analysis, and

songwriting. A creative approach was particularly prevalent in this context, emphasizing the importance of patient-centered approaches. Participants frequently identified patients' preferred music as a significant aspect of their listening experiences and therapeutic practices, further validating music therapy's adaptability and resonance with this population. These findings demonstrate that music therapy is not only well-received but also grounded in a robust theoretical framework, making it a valuable resource for addressing the goals of the IST population. Additionally, this study found that music therapists must have a clear understanding of IST-specific objectives to deliver effective and targeted interventions.

Nonetheless, while this study provides valuable insights into the application of music therapy for IST patients, the limited research in this area underscores the need for further research. Future studies should prioritize evaluating the effectiveness of specific music therapy interventions and identifying best practices to optimize outcomes for this underserved and growing population.

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APPENDIX A

IRB CONSENT FORM



Research Integrity & Compliance
Student Faculty Center
3340 N. Broad Street, Suite 304
Philadelphia PA 19140

Institutional Review Board
Phone: (215) 707-3390
Fax: (215) 204-4609
e-mail: irb@temple.edu



Approval for a Project Involving Human Subjects Research that is Approved as Exempt

Date: 02-Mar-2023

Protocol Number: 30278
PI: DARLENE BROOKS
Review Type: EXEMPT
Approved On: 02-Mar-2023
Risk: Minimal risk
Committee: A2
Sponsor: NO EXTERNAL SPONSOR
Project Title: Music Therapy Practices for Incompetent to Stand Trial Patients (IST) in Forensic Psychiatric Hospitals: Content Analysis

The IRB approved the protocol 30278.

The study was approved under Exempt review. The IRB determined that the research **does not require a continuing review**, consequently there is not an IRB approval period.

As this research was approved as Exempt, the IRB will not stamp the consent or assent form(s).

Note that all applicable Institutional approvals must also be secured before study implementation. These approvals include, but are not limited to, Medical Radiation Committee ("MRC"); Radiation Safety Committee ("RSC"); Institutional Biosafety Committee ("IBC"); and Temple University Survey Coordinating Committee ("TUSCC"). Please visit these Committees' websites for further information.

Finally, in conducting this research, you are obligated to submit the following:

- **Amendments** - Any changes to the research that may change the Exempt status of this study must be reviewed and approved by the IRB prior to implementation. Examples of such changes are: including new, sensitive questions to a survey or interview, changing data collection such that de-identified data will now be identifiable, including an intervention in the methods, changing variables to be collected from medical charts, decreasing confidentiality measures, including minors or adults lacking capacity to consent as subjects when previously only adults with capacity to consent were to be enrolled, no longer collecting signed HIPAA Authorization, etc. Please reach out to the IRB Staff with any questions about if a change to the study warrants an Amendment.
- **Reportable New Information** - Using the Reportable New Information e-form, report new information items such as those described in HRP-071 Policy - Prompt Reporting Requirements to the IRB **within 5 days**.
- **Closure report** - Using a closure e-form, submit when the study is permanently closed to enrollment; all subjects have completed all protocol related interventions and interactions; collection of private identifiable information is complete; and analysis of private identifiable information is complete.

For the complete list of investigator responsibilities, please see the HRP-070 Policy – Investigator Obligations, the Investigator Manual (HRP-910), and other Policies and Procedures found on the Temple University IRB website: <https://research.temple.edu/irb-forms-standard-operating-procedures>.

Please contact the IRB at (215) 707-3390 if you have any questions.

APPENDIX B

RESEARCH SUBJECT CONSENT FORM

Title: Music Therapy Practices for Incompetent to Stand Trial
Patients in Forensic Psychiatric Hospitals in the U.S.:
Content Analysis

Investigator: Dr. Darlene Brooks, Primary Investigator
Boyer College of Music & Dance
Temple University
2001 N. 13th Street
Philadelphia, PA 19122
(215) 204-8340

Hanna Woo, Doctoral Candidate, Secondary Investigator
DSH-Patton
3102 Highland Ave
Patton, CA 92369
United States of America

Daytime Phone Number: (909) 425-6621

24-hour Phone Number: (909) 224-4745

APPENDIX C

RESEARCH CONSENT SUMMARY

Title of research: Music Therapy Practices for IST Patients in Forensic Psychiatric Hospitals in the U.S.: Content Analysis

You are being asked for your consent to take part in a research study. This document provides a concise summary of this research. It describes the key information that we believe most people need to decide whether to take part in this research. Later sections of this document will provide all relevant details.

Why am I being invited to take part in this research?

You are being invited to participate in this research study because you have been identified as a music therapist who works with IST patients in a forensic psychiatric hospital in the U.S.A.

What should I know about this research?

Taking part in this research is voluntary. Whether you take part is up to you. If you don't take part, it won't be held against you. You can take part now and later drop out, and it won't be held against you. If you don't understand, ask questions anytime. Ask all the questions you want before you decide.

How long will I be in this research?

We expect that your taking part in this research will last approximately 45 minutes for an interview section. I ask that you be available through email or phone in case I need any clarification of transcript material or if I have follow-up questions. You will receive your interview transcript for checking accuracy.

Data analysis will begin as soon as interviews are transcribed. I anticipate that this process will begin in April 2023. Data analysis should be completed by August 2023.

Why is this research being done?

The purpose of this research is to explore music therapy practices with IST patients in forensic hospitals in the U.S. As we don't have many resources to understand how and why music therapy is practiced with IST patients in forensic hospitals such as models, method, and technique, and how music therapy meets the need of IST patients, this research would provide valuable information to music therapists and the music therapy profession to understand music therapy practices for patients with IST.

What happens to me if I agree to take part in this research?

If you decide to take part in this research study, the general procedures include:

- filling out consent forms granting your permission to participate and permission to voice record our interview
- scheduling a time for an in-depth interview for approximately 45-60 minutes

I will schedule either an in-person, or a video conference interview (e.g., Skype®, Zoom®), that meets your convenience. After our interview, I will transcribe it and send you the transcription so that you can verify its accuracy.

Transcribed interviews will be kept in a password-secured locked computer for a maximum of five years. Each interview will be protected by a pseudonym and the corresponding names of the participants will be kept in a separate password-protected file known only to the researcher. The transcription from our interview, the recording of our interview, and all data analysis will be stored on the researcher's computer as well as a back-up mass storage device in case the original device becomes damaged and will be secured in a locked storage unit in my home office. Upon completion of the research, all data will be safely destroyed.

Could being in this research hurt me?

There are no known risks of participating in this research. However, while sharing your experience you may remember unwanted memories or feelings. If it happens, you may skip the question or stop the interview.

Will being in this research benefit me?

The most important benefits that you may expect from taking part in this research include a reflective understanding of your work as a professional music therapist working with IST patients in a forensic psychiatric hospital. Your participation may help you conceptualize your music therapy work and re-configure professional perspective of music therapy practice with IST patients.

Possible benefits to others include a promotion of new knowledge in music therapy profession and may provide need-to-know information and practical guidance for interested parties as well as in music therapy training and education about IST patients in forensic psychiatric hospitals.

Who can answer my questions about this research?

This research is being overseen by an Institutional Review Board ("IRB"). An IRB is a group of people who perform independent review of research studies. If you have questions, concerns or complaints, or think this research has hurt you or made you sick, you may talk to the IRB at (215) 707-3390 or irb@temple.edu if:

You have questions, concerns, or complaints that are not being answered by the research team.

You are not getting answers from the research team.

You cannot reach the research team.

You want to talk to someone else about the research.

You have questions about your rights as a research subject.

Additionally, you may contact:

Primary Investigator:

Dr. Darlene Brooks

Director of Music Therapy Program

Boyer College of Music & Dance, Temple University

Presser Hall, 2001 North 13th Street

Philadelphia, PA, 19122

(215) 204-8340

dmbrooks@temple.edu

Secondary Investigator:

Hanna (HyunHee) Woo

Doctoral Candidate, Music Therapy

Boyer College of Music & Dance, Temple University

Presser Hall, 2001 North 13th Street

Philadelphia, PA, 19122

(909) 224-4745

joeunmt@gmail.com

Thank you for agreeing to participate in this research.

APPENDIX D

INFORMED CONSENT FORM

IRB PROTOCOL NUMBER: 30278

PRIMARY INVESTIGATOR: Dr. Darlene Brooks

Boyer College of Music & Dance, Temple University
Presser Hall, 2001 North 13th Street
Philadelphia, PA, 19122

(215) 204-8340 / dmbrooks@temple.edu

PROJECT TITLE

Music Therapy Practices for IST Patients in Forensic Psychiatric Hospitals in the U.S.

PROJECT SUMMARY

The purpose of this study is to understand music therapy practices for patients with IST in forensic psychiatric hospitals in the United States of America. A qualitative approach will be used in a form of interview to explore music therapy services for IST patients that have been provided by music therapists in the U.S.

The research questions that will be explored: In what ways is music therapy practiced for IST patients in forensic psychiatric hospitals? Sub-questions include: 1) In what ways are music methods and experiences used to work with IST patients in forensic psychiatric hospitals? 2) In what ways do music therapists assess, treat, and evaluate IST patients? and 3) In what ways do music therapists determine the goals in music therapy for IST patients?

ELIGIBILITY TO PARTICIPATE

Music therapists who are board certified, work for adult IST patients in a forensic hospital in the U.S., and who practice music therapy with the population will be eligible to participate in this study.

METHOD

Participants will be recruited and will participate in a one-time 45-60 minutes of in-depth interview via an in-person or a video conference interview (e.g., Skype, WebEx or Zoom). Interview will be audio recorded. After interview, the researcher will transcribe the interview and will reach back out to participants in order to check the accuracy of the transcription. Transcribed data will be analyzed. The result will be reported.

CONFIDENTIALITY

All information taken from the study will be coded to protect each subject's name. No names or other identifying information will be used when discussing or reporting data. The investigator(s) will safely keep all files and data collected in a secured locked

computer and cabinet in the investigator's office. Once the data has been fully analyzed it will be destroyed.

APPENDIX E
INITIAL EMAIL INQUIRY

Dear Music Therapist:

You are receiving this email because you are identified as a music therapist who works with IST patients in a forensic psychiatric hospital in the U.S.

My name is Hanna Woo, and I am a doctoral candidate in the Music Therapy program at Temple University. I am conducting a research study in the form of an interview to explore music therapy practices with IST patients in forensic psychiatric hospitals in the United States of America. The purpose of this research is to understand how music therapy is practiced and why music therapy is practiced in the way it is for IST patients in forensic psychiatric hospitals in the U.S. If you are willing to contribute your expertise and experience of working in a forensic hospital, simply reply to this email and you will be contacted for scheduling an interview, and a consent form will be sent for an electronic signature. I will schedule an interview roughly in one week after I receive your response. Your participation is completely voluntary.

There are no known risks in participating in this study. However, it is possible that while sharing your experience you may remember unwanted memory and triggered a feeling by it. If it happens, you may skip the question or stop the interview. There is no compensation provided nor are there any direct benefits to you for your participation; however, through your participation you may be providing valuable information that will improve the understanding of music therapy practice for patients with IST in the forensic psychiatric hospitals and enhance service to IST patients as you provide important and valuable information to the music therapy profession and in training music therapy students.

This project has been reviewed and approved by the Temple University Institutional Review Board (IRB). The IRB has determined that the research procedures adequately safeguard the participant's privacy, welfare, civil liberties, and rights. The chair of the IRB may be reached at Temple University, 1801 North Broad Street, Conwell Hall, Room 401, Philadelphia, PA 19122.

Please do not hesitate to contact me if you have any questions.

Thank you for your interest and consideration.

Hanna Woo, Ph.D. candidate in Temple University
Board Certified in Music Therapy

909.224.4745

e-mail: joeunmt@gmail.com

APPENDIX F

INTERVIEW QUESTIONS

Opening questions

Please tell me about your demographic information (i.e., gender, age, professional credentials, highest education, region of school, region of work, etc.)

Please tell me about your clinical experience with IST patients in a forensic psychiatric hospital (i.e., length of experience, clinical trainings, facility, primary theoretical model, etc.).

How would you describe music therapy for IST patients to people who have never heard of it? (i.e., how does music therapy help IST patients?)

Primary questions

1. How is music therapy treatment conceptualized and developed for IST patients in your practice? (Prompts or follow ups: Facility based, therapist based, team based, etc.)

2. How are music experiences used to work with IST patients in your practice? (Prompts or follow ups: Music listening, music making, lyric analysis, songwriting, etc.)

3. How is music therapy practiced/ implemented for IST patients in your practice? (Prompts or follow ups: method, techniques, interventions, technologies, etc.)

4. How do music therapists assess, treat, and evaluate IST patients? (Prompts or follow ups: assessing areas? e.g., cognitive skills, social skills, communication skills, etc. assessment tools? Treating methods through music or with other resources? Evaluating progress? Observation, interaction, intervention, etc.)

5. How do music therapists determine the goals/domains in music therapy for IST patients? (Prompts or follow ups: perspectives of being competent to stand trial, patients' needs and competency, immediate needs, etc.)

6. Why is music therapy implemented in the way you practice? (Prompts or follow ups: patients' needs, goals, focus of the interventions, facility or systematic reasons, social needs, etc.)

7. How do you see music therapy practice for IST patients in forensic psychiatric hospitals evolving? (Prompts or follow ups: past practices, current needs, future thoughts, and vision, challenges, etc.)

***Questions may be added to expand upon, or get clarification, of the previously provided written statement.*

APPENDIX G

INTERVIEW DATA CODES

Initial Coding:

1. **General significant words** were marked with **yellow highlight**.
2. Underlined words are related to music experiences.
3. **Music Therapy methods/Approaches** were colored with **purple bold** fonts and highlighted.
4. **Music therapy goals** were marked with **black bold** fonts.

Second Stage Coding: Grouping music therapy goals.

1. Words related to **cognitive functioning** goals were marked with **red font color**.
2. Words related to **social and interpersonal** goals were marked with **green font color**.
3. Words related to **coping skills** were marked with **orange font color**.
4. Words related to **reality orientation** were marked with **blue font color**.

Third Stage Coding: Regrouping

1. **Psychiatric Symptoms** were marked with green highlighter.
2. **Behavior & Mood** were marked with blue highlighter.
3. **Cognitive functions** were marked with grey highlighter.
4. **Insight** was highlighted with red highlighter.

APPENDIX H

INTERVIEW TRANSCRIPT EXAMPLE

Q: How would you describe IST patients to people who have never heard of it? So, in other word, how does music therapy help for IST patients? How would you explain it?

A: Yeah, you know how that goes... in fact, I think just last week I had the same conversation probably with 3 different people. Wherever I am, or whoever I'm talking to for whatever reason, if we're waiting for something, someone will ask, "well what do you do for living?" and I'll say, "I'm a music therapist". Then, "So where do you work" and I'll tell them where I work, and they'll ask "well... how does that go? What does that do? How does that work?" I'll give them the classic definition of music therapy. "We're using music or music activities or something that is of musical essence to affect changes that are nonmusical in nature, in this particular population." We're affecting their reality orientation (5:27) because so many of them have so much internal stimuli, and internally occupied. So, we facilitate a way with music to bring them out of that, without forcing it. Music does that. It's a reality orientation in the music activity or we're playing music. A person has to be there, right there. In some instances, where a patient might be hyper verbal, sometimes you can match that with the music. And use music almost like medication. The medication they'll meet that patient almost where they are on a high dose and then kind of bring it down. Because a patient that is so excited and so psychotic you can't just say, "Here listen to this relaxing music." That's not going to work, but you can match their mood with music, which is the ISO principle, you match their mood and slowly bring them back to a calm reality baseline. But we don't really do that much, it can be too time-consuming, the medication does that.

The same can be true for people that are very lethargic or depressed, so music is the therapy. We just have to know how to use which music for different situations.

Q: OK sure. So, we're gonna actually go through the primary questions at this time. The first one is how music treatment is conceptualized and developed for IST patients in your practice? So, this question is like, is it a facility based, or therapist based, or it's treatment team based?

A: I think in the situation, in my practice which is here, we are patient based. We are population based because of the way this population morphs and changes to where you have individuals coming in that are floridly psychotic and potentially violent... you know, impulsive, abusive, and then you are also come-know when the patients have stabilized and are starting to recognize and form in their own mind, a plan of action for the situation in which they find themselves. I think we are patient centered. We are unit centered. We are fluid in how we treat, how we use music as therapy on our unit. We have a lot of constrictions. There's a lot of interruptions. It's very challenging to have everyone understand what we're doing but I think the more we have done music as therapy on this unit, and the more we facilitate the music therapy model, not only for the

patients but for the staff, they are able to see some benefits or to recognize kind of what we're doing. We are not just playing music for the patients; we have a plan. We see the need, and how we can help, how music as therapy can help.

Q: so, it means that then, can we say it's also therapist based as well?

A: Yes, we have to know our abilities. We must be confident of our clinical assessment, whether it's detailed and exact or whether parts are intuitive. It is patient/client centered more than treatment team. I think because of the nature of the facility and the fact that there's so many disciplines that are mostly concerned about their portion; paperwork, documentation of the whole effort, it's difficult. I feel supported by the team, but I don't feel like they have any factual idea of what we're doing, and I don't think that they care or have the time to know.

Q: OK. How are music experiences used to work with IST patients in your practice?
So...

IA: We do drumming; the experience of rhythmic drumming; not a 'drum circle' because that term can be confusing, but rhythmic drumming; which is using the rhythm and using the actual playing of the drums. It targets so many different areas of growth. It helps with social interaction. It provides patients assistance for a successful experience. Because it's so... it's so close, so physical. The rhythm and making music and hearing rhythm can be discerned as something bigger than each one person. Through their personal effort we see it builds self-esteem, a modicum of camaraderie, and increases appropriate social interaction. Most of all, it is the reality orientation and focus component needed for this IST population. Especially because they have so many concerns of different types emotional, psychological, even spiritual, and physical. And then being socially and physically compressed in a small space is distressing 24/7.
(13:22)

Q: So, you talked about drumming and instrumental playing but what other musical instruments or experiences do you use in the music therapy?

A: Well, we have used critical listening, trying to integrate music on a deeper level. Many of these patients only know one, maybe 2 genres of music, so listening for different instruments, tempo, dynamics, textures, promote focus and attending to detail. Most all the patients will claim that they like music... and they do. They love their music, but they don't know any other kinds of music; so to expose them slowly to different types of music and music listening in a way that they've given consent to listening to something different is the trick and our job. One way we do that is we use recreational listening experiences; playing music that they request; or their preferred songs... and that grounds them into experiences they know. This also becomes a social atmosphere because the IST patients here, don't have access to their preferred music all the time like they did when they were free. So, it's really important that they have time that they feel, that they're, they can hear their music. They feel listened to and have choices. Because it's a shared experience, they are able to wait for their turn, be patient, wait for their piece of

music, and they are almost obligated to be able to listen to someone else's music... I hear them ask; 'Who chose that music? Who chose that song?' or 'You would like it', or they don't; whatever. We use the experience of listening to music to try to reach a different part of the holistic makeup, not just listening to music for recreation; but listening to music and discover how we feel about something else besides music. Sometimes in the request of preferred songs, and I'll play the song, and they'll listen to it for a while and after that song, there's the next song. During all this I may ask them the personal history of why they chose that song... why do they like it. So, they have to think about it a little more, the context of the song rather than just the music. In critical listening we're using music to explore the whole person; not just the recreational, or street cultural side, but also music that utilizes harmonic and melodic and rhythmic archetypes that will cognitively, emotionally, and physically move patients in a way that not usually their 'normal' music listening responses. Musical archetypes that move people to discover deeper emotions; to listen more openly and think about one of the things, one of the experiences of music related activities. I think this population responded to that once they understood how to do it. I think we should do more of it because the more we did it, the better it was. The drawing of the music in the little square grid is taking music into another direction to actually feel the music and be comfortable enough to feel like they can literally draw and color those feelings. What colors does the music remind you of and feels like. I think this is a good intervention for this population. We should do it more because when we did it the first time, we use chalk outside, and someone always has a preconceived idea of what they're going to draw no matter what music is playing. They drew the same thing for every piece. Then we did the little squares and many of them, after comparing them had some of the same colors and shapes as each other for the music selections that was so different yet so emotionally moving. I think that it's easy to understand. It doesn't require great cognitive effort, just a willingness to be open, focus and try. I think songwriting and lyric analysis would be good for this population. For this unit it would be interesting because all the music analysis and lyric analysis that I've done has been maybe specifically for substance abuse. You find the songs that are about using drugs and the whole culture of drinking and whatever so maybe lyric analysis would be interesting because some of this hip hop is so popular, even with some of the older guys? I don't even know if they hear all the words, and I'm not sure what they put it together and really listen to what it's saying. It might be an interesting thing to do, get a classical song against the hip hop song or put them together somehow and see if we can get the participation.

Q: yeah. Sure.

A: Which I think it's hard.

Q: OK. How is music therapy practiced or implemented for IST patients in your practice for example like method wise, techniques, interventions, or any technologies if you use how do you use it?

A: Well, for **preferred songs** we use Bluetooth and a **streaming platform** so we can find the music quickly and keep the group moving, so there **aren't big gaps of silence** between the music. You can **cue** the music we use that technology for all music and it's easy to find **relaxation** music.

Q: Any special approach you use? I know that you have a NMT background, right? Do you think that affects the way you deliver the music therapy?

A: Oh, yeah, I think so, for sure. Because I primarily spent most of my life being a **musician** and wanting to be a good musician and still working on being a good musician, that's all I wanted from an early age. I just wanted to be a good musician then, I still do. Because of the experiences that I've had playing music, being around music and being in the situations where people are listening to music a lot, or studying music, **I approach music therapy as a musician**. I think as a musician and think how music can achieve what we want to achieve therapeutically. The **music is the therapy**, I'm just someone who is organizing and figuring out what music to use and what method or how to deliver it in a way to get the desired results. With this IST population, we're looking for court competency. **Court competency, psychiatric stability, good social interaction and building self-esteem**... something that the patients, can hold on to. I think that if the patients remember something, even just one experience, if that's musical, if that's something that they really liked or they enjoyed or that **touched them deep inside**, even if it's just one day or one hour, the whole time that they're here with us, that's good [H: musical experience?]. Yes, a **musical experience** that was really deep, that they'll remember. Something that will be **a positive trigger, and they'll go back to that day** when it was a beautiful day for them... that I helped facilitate that for the patient, using music. I really feel like that is more of how I approach or the method I intuitively gravitate towards. How can the big world of music use me? How can I see music positive here, even if it's just **their preferred music**? And I can hear something in their **preferred music** that can initiate a positive trajectory. Can I say the right thing about their music without trying to change them or convince them their musical taste is less than therapeutic for their court needs? If I can use what they love about their music and hear it the way they hear it and say something that can help them **to gain that stability** or the **motivation** to move on or any **just a moment of like** "Aha, somebody gets me; wow", that is what I want to do.

Q: Do you have like a specific um theoretical model or method that you kind of choose in therapy usually?

A: You mean like holistic, behavioral... that kind of stuff?

Q: Sure, also sometimes it could be psychodynamic, psychoanalytic, or behavioral...

A: I have a double major in psychology, and from Duquesne University and it's a **holistic approach**, as is the music therapy degree. I specifically chose that. If we are able to get a person think about themselves as a **whole person**, they always have those other interior places, but a **holistic approach** modeling is good, for **drumming**, for the instruments that

we **play**, for **drawing the music** or **talking about it**. Maybe it's not academic or it's bad, but I don't know that I think about a theoretical model anymore when I deliver music therapy.

Q: But I remember (27:22) that you said about patient-center in therapy, right?

A: I guess if I do think about a model; I reference the **ISO principle**; to meet the patient **holistically** where they are; and give them what they need **right then**, not give them something they can't understand. When I meet that patient **where they are** hopefully, I'll be able to **extend the music therapy intervention to meet them there**. They're all different. We're all different.

Q: I agree. How do you assess, treat, and evaluate IST patients? So, in other words, what kind of things you assess, you treat, and you evaluate when you do the music therapy with them?

A: I look at **focus**. I look at **engagement**. I listen to the **responses to the concepts** they must know. If what I'm doing is remotely successful, if what I'm trying to convey is taking hold, or I look to evaluate, if there is any place for these concepts to take hold. I look at **retention from one session to the next**. I think the **drumming** is perfect example. We look around, we see who's **playing on the beat**. We see who is **ahead of the beat**, we see **who's louder**, who's **way under** everyone. We gauge **reality orientation** by **focus** and **attention**. We have the warm-ups that inform us of things like that. **Who's here, who's not here**, as far as **mentally, emotionally, and creativity**. Where the patient is **willing to go**, are they **brave** enough to go out there by themselves and **solo**, or are they **too shy**, or how much **tolerance for the group** does each individual have. I gauge all of that and more during one of the groups... 'Oh, we just lost that guy over there... he's not with us anymore, how do we **bring him back into the groove** of the group. (30:44) It's hard to do, you know, and we do this a lot of times throughout the group. It's about **playing back and forth** in **drumming**. I equate that to their **communication** style too. Later when I'm communicating with them outside of the music therapy setting, I have a better idea of what they **tolerate** or how they can **respond**.

Q: How do you determine the goals or domains in music therapy for IST patients? For example, like perspectives of being competent to stand trial, or patient's needs, incompetency, or immediate needs, etcetera.

A: Well, this whole thing has been new to me especially since all this **violence** and all the **craziness** and stuff like that **on the unit** recently, and to be honest with you, I'm just removing myself from that. Now **I recognize this is the norm on an IST unit**. As far as I know this is what the facility wants and they're the ones paying us. Our job, when get *them, is to **slow them down**, get them to **focus** and be able to **concentrate, remember things**, become more **mentally aware**, rather than emotionally and internally occupied. That's what we want to do and the more that we can **challenge them** without alienating them **with music and creativity** and even **cognitive skill** building with **tone chimes or xylophones** that's what you know we do. (33:10) Of course, we care about the

patients...their well-being and everything but *the whole point of them being here and the whole point of us using music therapy is to get them to be able to focus and interact appropriately and be cognitive, cognizant of their mental capabilities and limitations.*

Q: Why is music therapy implemented in the way you practice? So, when you implement music therapy in your practice with this patient, is that based on the patient's needs, goals, etc.?

A: Yeah, I think it's the patients' needs

Q: You also talked about like facility and hospital needs, right?

A: Yes, the patients' needs right now should be also the hospital/facility's needs. We work with the patient's needs in their life right now. If we were on a longer-term unit, not IST, then different needs can come into play. There is a vital and almost an urgent need for these IST patients to chill out and gather reality. That's their need and the facility's need is for us to support them, with music. It's so perfect because it's so uplifting, it's so spiritual, music touches everyone one way or another. It's non-threatening so it's a perfect vehicle for having IST patients become more social, more focused, less psychotic in tandem with the medications. The medications can throw them off and it can debilitate them for an unknown period of time. Not only the way in which we implement music therapy, but the idea is also normalizing and something different, new to them. Music therapy fills all kinds of needs all at once. It's like a musical Big Mac.

Q: Yes, it is. Do you see the difference in between music therapy for IST patients and music therapy for general patients with mental illness? Are there any differences in treatment?

A: With IST patients, there's a little bit more of an urgency to our music therapy interventions, I think. The sessions have a 'right here, right now' kind of feel. IST units have some limitations that you don't have with the long-term patients just because of the prevalence of acute psychosis, and the trauma and complications with their legal issues. For the long-term patients, most legal problems are far in the past. They don't have that problem anymore and so then it's more about quality of life and making changes that are bigger in their lives or making changes in individual growth areas. Whereas for the IST, the difference in the music therapy (even though individual growth is gonna happen) we are primarily looking at elements needed for court competency. But we are in the business of individual growth... but I mean everything we do we want somehow to light a light somewhere but it's so complicated. Here it's complicated by the legal urgency, and the medications, and so it doesn't feel quite as urgent. For instance, we can have a plan to do this 12-week music therapy group and the first week, we have 6 people there, and the next week, among those people, 2 of them are either gone or not interested and there's new patients and you have to start all over with that 12-week plan. So, to have a continuum that is long reaching is difficult. On IST I feel like music therapy is almost like a sniper fire or something, you have the target goal here and now, you're going to have to figure out the trajectory of attaining goals quickly. You're going to pull the right

tools for it, you're going to go in and then you're going to get out. It's hard to have a real idea of what exactly is going to happen, at least I haven't gotten there yet with IST, but it's getting easier.

Q: So, what you're saying is that for the IST patients, their times are limited so the pressure to get ready to be competent is not only from the patient but also from the system like the hospital or the courts. So, it feels more like we should do a short-term target.

A: Yeah, that's exactly right. The **psychosocial support** that music therapy offers is **as important as the actual music therapy**. Whereas in the long term, music therapy can have, have more pointed goals. We know what music therapy intervention will do. It will **increase focus**. It'll do this, **right here, right now**. On the longer-term units, you can expand more. You can do more. IST is a **high compression environment**, and the staff don't understand what music therapy is or what it can do; maybe that's partly our responsibility. (41:08) They understand what psychology is. They understand social work, psychiatry. They understand what RTs are. but they don't really know what music therapy is and they don't seem to care. I mean... that's fine I'm not banging that and that's also true on the longer-term units and when I was there, I knew that I have this music therapy room with instruments, I'd have these patients, and it wasn't really going to change for a certain amount of time. I had this group to **write songs** with for 12 weeks so that they could be there from the beginning to the end. Here, that's not the case. We have **immediate specific goals attached to court competency**.

Q: It feels more like we are working here like...it's kind of like urgent care, right?

A: Yeah, we're **urgent care, using music**.

Q: So, we don't know who's coming in, but we got to treat right there at the moment and we're going to send them back, right?

A: Right... and we know that's what **drumming** groups do. I was in the conference today and one of the patients who I never hear of him talk hardly at all, but he comes to the **drumming** group every once in a while, and the psychiatrist asked, 'which groups do you like' he says, uh... 'I like the music. I like the drumming', and I'm thinking like 'dude, I only saw you maybe once or twice', but I thought 'wow'. So, we know what those groups do, and I think in IST music therapy, we have to be very much like a spear. We have to have our quiver filled with arrows of **today' needs**. We are **doing focus today**, we are doing **emotional growth today**, we're doing **cognitive skill building**. So, we really must **be pointed** and **focused on our delivery**.

Q: What you are saying is that we are like a special force.

A: Yes, but nobody knows it, clinical and nursing staff don't really know what we're doing

Q: But they know, I'm sure.

A: Oh... staff know we're **playing drums** out there.

Q: Well, the last question is how do you see music therapy practice for IST patients in forensic psychiatric hospitals evolving?

A: I think there's definitely room to grow. And I think that the longer that you work it the more effective your program becomes. **You're the space that you have**. I think our music therapy program for IST in this building could improve 75% almost in a month if we had a space that was **a music space** where we could bring patients. It would be that we knew exactly where, what instruments we have, where we know the time and logistics. It's not our fault the music therapy groups suffer. It's not the fault of the facility because the COVID thing threw everything out of whack, at least treatment space wise. But really, even if the ID team doesn't think about why this guy, who never talks, you hear what he says about liking **drumming**. But they don't think of the importance or clinical relevance of that. But the more that we do that, like art and dance therapy; but especially, music therapy because it's music, which is non-threatening, non-invasive; it's just everywhere.

Q: so, you see... what you're saying is then, music therapy can be improved so much in there...

A: **The potential for music therapy to treat IST patients is tremendous**. I'm not sure right now if the conventional treatment for IST patients is willing to make room for music therapy. I think it would have to be a different type of facility rather than a giant state hospital system that has wholesale therapy, out of necessity. If our unit had 25 people on it rather than 50, we'd have a better chance, a lot better chance of achieving desired outcomes faster. But the way it is right now, we're going to go largely unnoticed for a long time because medication is a big part of treatment, the biggest.

Q: You know that IST patients are very acute patients, and their symptoms are hardly managed when they come to the unit. So, when we have these many patients in the unit, it could be pretty hectic.

A: Yeah, and I think also that IST units or the IST treatment of patients needs to be reconsidered. The unit receives patients that are brand new admits and putting them in close living conditions with patients that are just beginning to stabilize and patients that are stabilized, that's not in the best interests of the more stabilized patient, **so you constantly have destabilizing factors**, rather than progression as a unit from acuity to stable. We could bring competency quicker **if the patients are at compatible levels of stability and psychosis**. I think the conventional wisdom though is that the higher functioning brings along the lower functioning.

Q: We have a long way to go... I mean a lot further to grow.

A: Yes, there are a lot of things to improve upon.

Q: Yes, thanks for your time and I appreciate your willingness to the interview.

APPENDIX I

MASTER DATA SHEETS

Music Experiences		Listening	Playing	Singing	Writing	Discussing			
<i>P1</i>	x	14	x	7	x	2	x	A4 T1	
<i>P2</i>	x	6	x	6	1	x	4	x	A2 T1
<i>P3</i>	x	3	x	3	4	x	2	x	A2 T1
<i>P4</i>	x	3	x		2	x	5	x	S1 T1
<i>P5</i>	x	5	x	10	8	x	12	x	D1 A2 T4
<i>P6</i>	x	10	x	3	7	x	3	x	D1 T4
<i>P7</i>	x	2	x	3	3	x	1	x	A1
<i>P8</i>	x		x			x	2	x	A2 T3
<i>P9</i>	x	6	x	3	3	x	1	x	D1 A2
<i>total</i>		49		35	28		32		34

Theory and Approach

ISO principal	Holistic	Humanistic	Behavioral	NMT	Patient-center	Mindfulness	Strength based	Creative MT	Reality Orientation	Multi-cultural
P1	5	0	0	1	2	3	0	0	6	0
P2	0	1	0	0	0	0	0	2	0	0
P3	0	0	0	0	0	2	0	5	0	0
P4	1	2	2	0	0	2	0	6	0	3
P5	1	0	0	0	0	2	5	14	0	0
P6	0	0	3	0	0	3	0	0	2	1
P7	0	0	1	0	0	1	5	0	0	0
P8	0	0	1	0	0	0	0	0	0	0
P9	1	0	9	2	1	1	0	4	2	0
Total	8	3	16	3	3	14	10	31	10	4

Methods

	Music listening (preferred)	Critical Listening	Listening & drawing music	Listening (background)	Music video	Music making	Meditation/Relaxation
P1	Request: 2 Preference: 6 Choice: 1	2	3	Recreation: 1	0	0	1
P2	Preference: 1 Choice: 3	0	0	Drawing: 1 Art: 2	0	Music making: 3 Band: 2	0
P3	Request: 1 Preference: 1	0	0	Art: 1 Exercise: 1	0	0	2
P4	Choice: 2	1	0	Art: 1 Poetry: 1	1	2	Meditation: 5 Yoga: 1 Mindful exercise: 2 Relaxation: 2
P5	2	2	0	0	0	2	6
P6	6	0	0	0	3	2	1
P7	2	1	0	0	0	1	0
P8	0	0	0	0	0	0	2
P9	4	0	0	0	0	1	0
Total	29	6	3	8	4	13	22

Methods (Cont.)

	<i>Sing-along/ Singing</i>	<i>Lyric analysis</i>	<i>Role play</i>	<i>Improvisation</i>	<i>Tone chime</i>	<i>Drumming</i>	<i>Songwriting</i>
<i>P1</i>	0	3	0	1	1	10	1
<i>P2</i>	1	2	0	8	0	3	3
<i>P3</i>	Sing-along: 2 Sing:2 Karaoke: 1	2	2	1	1	Drumming: 3 Drum circle: 1	Songwriting: 1 Writing song: 1
<i>P4</i>	2	1	0	2	0	Drum circle: 4	Songwriting: 1 Writing lyrics: 2
<i>P5</i>	Sing: 5 Sing-along: 3	6	0	13	1	Drumming: 7 Drum circle: 1	Songwriting: 6 Writing lyrics: 3
<i>P6</i>	Sing: 4 Singing: 2 Sing-along: 1	3	0	0	0	Drumming: 2 Drum circle: 3	1
<i>P7</i>	Karaoke: 3 Sing: 3	2	0	0	2	2	Writing lyrics: 1
<i>P8</i>	0	3	0	2	0	0	2
<i>P9</i>	3	4	0	6	0	4	1
Total	32	26	2	33	5	40	23

Goals	<i>Emotion (E)/ Mood (M)/ Emotional regulation (ER)</i>	<i>Focus/Alertness (psychiatric reason)</i>	<i>Well-being</i>	<i>Cognitive function</i>	<i>Self- expression</i>	<i>Self-awareness</i>	<i>Empowerment/ Self-esteem/ Confidence</i>	<i>Stress/ Anxiety</i>
<i>P1</i>	E: 5 M: 3 Calm: 1	Focus:12 Attention: 2	1	Retention: 1 Cognitive skills: 4	0	Awareness:2 Self-awareness:1	Self-esteem:2	Distress: 1
<i>P2</i>	E: 1	Distraction from voice: 1	0	Retention:1 Cognitive skills: 3	3	0	Take control:1 Self-esteem:1	Stress: 1
<i>P3</i>	E: 2 Calm: 2	Focus:1 Being present: 1	0	Retention: 1 Conceptualize:1	0	Mindfulness:2 Awareness:1	Confidence:1	Discomfort: 1
<i>P4</i>	ER: 3 M: 2 Calm: 1	Concentration: 2 Attention: 3	Wellness: 3	3	0	Mind-body: 2	Ability to go to hot seat: 1 Tolerate attention: 1	0
<i>P5</i>	Mood: 3	Attention: 2 Eye contact: 2 Focus: 1	0	Following along: 2	4	Mindfulness:2 Awareness:1	In control: 1 Empowerment:4	Stress: 4
<i>P6</i>	Anxiety: 1 ER: 1 E: 5 M: 5	Attention:18 Being present: 1	0	Understanding: 3 Focus: 6 Attention: 11	1	Being present: 1 Awareness: 2	Feel satisfied: 1	Stress management: 1 Anxiety: 1
<i>P7</i>	1	Eye contact: 1 Attention:1 Focus:1	0	Cognitive skills: 3 Reading:1 Retain: 1 Following along: 1	Self- expression: 2 Expression: 7	Mindfulness:1	Control:1	Stress:1
<i>P8</i>	Calm: 5 E: 2	0	0	Cognitive skills: 5 Memory: 3	2	0	Confidence: 2	0
<i>P9</i>	5	Focus:1 Eye contact:1	0	1	4	0	0	Distress: 3
	47	51	4	23	15	16	13	

Goals Cont.								
	<i>Relaxation/ Calm</i>	<i>Interpersonal skills</i>	<i>Social skills</i>	<i>Motivation</i>	<i>Life skills/ ADL</i>	<i>Leisure skills</i>	<i>Court material/ Learn knowledge</i>	<i>Coping skills</i>
<i>P1</i>	Relaxation: 1 Calm: 1 Inner peace: 1	Tolerance:1 Communication: 1 Appropriate interaction: 2	Openness: 2 Social skills: 1 Appropriate interaction: 4 Turn taking: 1	Motivation: 1 Engagement: 1 Participation: 1	0	0	Competency: 1	Coping skills: 1
<i>P2</i>	0	Tolerance: 2 Communication: 1 Cooperate w/ attorney: 3	Turn taking:1 Sharing: 2 Self-control: 1	Participation: 1 Engagement: 1	Life skills:5	Leisure: 1	Competency: 4 Court material: 3	5
<i>P3</i>	Relax: 1 Calm: 2	Communication: 1	Turn taking: 1 Eye contact: 1 Flexibility: 1	Participation: 1	Fun fitness: 1	0	Court material: 7 Learn Competency: 1	3
<i>P4</i>	Relaxation: 3 Calm: 1	Public speaking: 1 Communication: 3 Togetherness: 2 Community: 5	Listening: 1 Flexibility: 3	Motivation: 2	0	0	Competency music: 2 4 Court material: 1 Learn knowledge: 1	2
<i>P5</i>	Relaxation: 7	Appropriate interaction: 1 Communication: 1 negotiate:2 collaborate: 4	Social cues: 2 Sharing: 1 Following directions: 1 Respectful: 1 Eye contact: 1	Motivation: 6 Participation: 2	0	0	Learn legal: 3 Court material: 1	1
<i>P6</i>	0	Communication:12 Working w/ attorney: 11 Receptive to feedback: 3	Flexibility: 6 Work w/ peers: 2 Take turns: 3 Following directions: 3	Motivation: 4 Engagement: 3	0	11	Legal stuff: 2 Learn knowledge: 4	11
<i>P7</i>	Stress management: 1	Receptive to feedback: 2 Appropriate behavior: 2 Working cooperate:	Cooperation: 4	0	Set goals: 1 Selfcare: 1	0	Court material: 2 Learn knowledge: 1	3

Goals Cont.

P8 *Relaxation:* 2 *Communication:* 5 *Eye contact:* 1 0 0 *Court material:* 1 2
Irritation/ *Trust issues:* 1 *Take turns:* 1 0 0 *Court knowledge:* 9
agitation: 2 *Appropriate* *Cooperation:* 0 0 0
Calm: 5 *behavior:* 4 4 4 0

*Relationship
w/ others: 1*

P9 *Anxiety:* 1 *Collaborate:* 1 *Eye contact:* 1 *Participation:* 2 0 0 *Competency:* 2 *Distress*
Stress *Conversation:* 4 *Sit still:* 1 *Engagement:* 3 0 0 *tolerance*
tolerance: 1 *Appropriate* *Openness:* 1 0 0 0
behavior/interaction: 1 0 0 0 0
1 80 53 28 8 12 47 28

Goals (Cont.)

	<i>Symptoms/ Psych stability</i>	<i>Trauma</i>	<i>Insight</i>	<i>Reality orientation</i>	<i>Spirituality</i>	<i>Building trust</i>	<i>Choices/ Expand limitation</i>	<i>Quality of life</i>	<i>Maladaptive behaviors</i>
<i>P1</i>	Psych stability: 2	1	Aware: 1	5	2	Be open: 1 Feel listened: 1 Feel supported: 1	Choice: 1	0	Impulsivity: 1 Violence: 2 Chill out: 1
<i>P2</i>	Voice: 1	0	Insight: 1	0	0	0	Limit: 1	0	Impulse control: 1 Anger: 1 Danger: 2
<i>P3</i>	Stability: 1	0	0	0	0	0	0	0	0
<i>P4</i>	Symptoms: 6	Healing: 1 Trauma: 3	6	Orientation: 2	1	Rapport: 2	Choice: 3	0	Impulsivity: 2 Challenged behaviors: 1 Maladaptive behaviors: 1
<i>P5</i>	Psychosis: 1 Symptoms: 4	Healing: 1	1	Why they are here: 1	0	0	Choice: 1 Control: 1	0	Agitation: 2 Escalation: 2
<i>P6</i>	Symptoms: 3	0	0	Rational thought: 3 Reality orientation: 3	1	1	Choice: 1 Expand limitation: 1	0	0
<i>P7</i>	Psychosis: 4 Stability: 2	0	0	Rational thought: 1	0	0	Choice: 2	5	Impatience: 1
<i>P8</i>	3	0	0	0	0	Trust: 1 Open up: 6	0	0	Appropriate behavior Calm behavior Behave: 7
<i>P9</i>	0	0	0	0	0	Open up: 2	0	1	Appropriate behavior: 4
	27	6	9	17	4	15	11	6	28