<Author's accepted manuscript>

Stige, B. (2018). Partnerships for health musicking: A case for connecting music therapy and public health practices. In: Bonde, L.O. & Theorell, T. (eds.). *Music and Public Health. A Nordic Perspective* (pp. 115-128). Berlin: Springer.

Partnerships for Health Musicking: A Case for Connecting Music Therapy and Public Health Practices

Brynjulf Stige

Abstract

In this chapter I explore relationships between music therapy and public health practice, and I argue that it is about time that we examine these relationships more actively. The notion of public health that I employ is based in the human rights and includes but goes beyond population-oriented prevention of disease to include healthy public policy across sectors in society. With reference to recent practice developments in Norway, I argue that the development of music therapy services in clinics might be connected to an increased focus on music as a public health resource as well. I try to contribute theoretically to an understanding of such relationships through elaboration of the notions of *health musicking* and *partnership.* These notions are used to contextualize the request for user involvement and collaboration that supports the relevance of music as a health resource in contemporary societies. The argument is based in a broad conceptualization of music therapy research and scholarship, to include various health related practices of music, within clinics and communities.

Keywords: Public health, music therapy, health musicking, partnerships, POLYFON knowledge cluster.

Introduction

There are several usages of the notion of public health, so I will position myself by putting forward three statements. First, the notion of public health used in this chapter includes but goes beyond population-oriented prevention of disease to include healthy public policy that can create supportive environments and promote positive aspects of health. Second, such healthy environments include the health care system as well as other sectors in society such as transport, work, education, and culture, so that it is highly relevant to connect practices in clinics and in broader communities. Third, public health strategies are based in the human rights, so that social justice, participation and empowerment are integral rather than additional goals. These statements will be developed throughout the chapter and find support in the World Health Organization's (1986, 1997) formulations of new public health strategies for the 21st century, where – for instance – health promotion is understood as the process of enabling people to increase control over, and to improve, their health.[1]

Textbooks on music therapy often do not discuss music and public health very thoroughly. In the most recent edition of Bruscia's influential text *Defining Music Therapy,* for instance, the notion of public health is mentioned only once and just briefly, with reference to the use of music to facilitate public health education. This, then, Bruscia (2014, Chapter 21) considers an auxiliary practice to music therapy. The judgement is partly understandable, because there is a tradition for thinking about therapy and public health as unrelated and sometimes even competing practices (Turner, 2004). Notwithstanding the many other qualities in Bruscia's text, I still contend that the lack of discussion of relationships between music therapy and public health reflects a limiting conception of music therapy.

[1] In this chapter I provide practice examples from the Norwegian context where I work, so it is also worth noting that these statements find support in the Norwegian law for public health work (Lov om folkehelsearbeid, 2011).

Having said this, I am myself guilty of having co-authored a textbook on music therapy that only briefly touches upon the issue of public health (Bunt and Stige, 2014). In contrast, I have co-authored a textbook on community music therapy where the notion of public health is brought up a number of times and seen in relation to issues such as poverty and social justice, positive health and wellbeing, participation and social capital, and cross-professional and cross-sectorial collaboration (Stige and Aarø, 2012).[2] This could be taken to suggest that public health issues are of limited relevance to the field of music therapy as a whole, although it is relevant to socially oriented subfields such as community music therapy. I would rather argue that community music therapy is one of several recent movements that support the idea that will be discussed in this chapter, namely that it is about time that we re-examine relationships between music therapy and public health more carefully.

I will try to contribute in this direction through elaboration of the notions of *health musicking* and *partnership*, which will be used to contextualize the request for user involvement and collaboration that in some ways and to some degree counters the current tendency to consider health care as industry and business. Developments within healthcare services often share many characteristics from one country to the next, but they are also situated in particular political, socioeconomic and cultural contexts. I will therefore start with some reflections on how WHO initiatives on public health and health promotion have affected music therapy in the Norwegian context where I work myself.

Alma Ata and Ottawa Revisited: Health Promotion within and without the Clinic

The Alma Ata conference set up by WHO in 1978, produced a declaration that highlighted that health is a fundamental human right:

[2] Community music therapy is a socio-musical movement within music therapy, with qualities that could be described by the acronym PREPARE; practices are Participatory, Resource-oriented, Ecological, Performative, Activist, Reflective, and Ethics-driven (Stige and Aarø, 2012, pp. 3-28).

> The Conference strongly reaffirms that health … is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector (World Health Organization, 1978).

Some years later, the Ottawa charter for health promotion described the following prerequisites for health:

> The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity. Improvement in health requires a secure foundation in these basic prerequisites (World Health Organization, 1986).

In other words; our health depends on healthy public policy. Consequently, action for health promotion involves all sectors of society and goes far beyond the mandates of health professionals and the health care system.

In the 1980s, when these documents were subject to public debate, community music therapy practices were emerging in Norway, with a focus upon every person's right to cultural participation (Kleive & Stige, 1988). The documents from Alma Ata and Ottawa provided a new context for reflecting upon these developments of rights-based practice, by clarifying relationships between health practices and human rights. Consequently, they challenged the thinking of this author and other Norwegian music therapists struggling to understand relationships between didactic, cultural, and clinical practices of music therapy.

Theoretical implications include the development of ecological and participatory perspectives on music therapy (Stige, 1996, 2002), but only recently has it in my country been possible to explore more thoroughly what the implications for service development could be. Such opportunities were created a few years ago, when the Norwegian Health Directorate included a strong recommendation of music therapy in the guidelines for treatment of persons with psychotic disorders (Helsedirektoratet, 2013). These guidelines represent a legitimate platform for implementing music therapy in all clinics and municipalities nationally. With this

opportunity for the profession, there is a serious obligation as well; the Norwegian system of publicly funded health care is based in the social justice principle that all citizens should have equal rights to health care services. Such equal access in no way exists when it comes to music therapy today, which is a moral dilemma for Norwegian music therapists as well as for health leaders and politicians.

In the area around the city of Bergen, where I currently work, the response in 2013 was to start developing a knowledge cluster bringing university researchers, practitioners, service users, and leaders together, which I will describe later in the article. Here I will exemplify developments by describing the strategies for implementing music therapy within mental health services in Bergen Health Trust (Helse Bergen), a subdivision of the Western Norway Regional Health Authority (Helse vest). This trust is responsible for six community mental health clinics, which together cover an area with a population of several hundred thousand people, almost 1/10 of the nation's total population of about 5 million people.

Until very recently, only one of these six clinics had employed a music therapist, and there were no overall plan for implementing music therapy systematically. In 2015 and 2016 things started to change, however, with a new requirement from the government. All health trusts were instructed to develop medication free services to patients preferring such treatment. The original initiative for medication free treatment came from user organizations nationally. Not only the option of *not* taking such medication should be available, but also high quality psychosocial alternatives, the user organizations have argued for years.[3]

In Bergen, local partnerships were established to implement the new national policy. The chosen model for medication free treatment in our region involves shared decision

[3] The public health department of the Norwegian Health Directorate has created a website which describes users' rights to medication free treatment within mental health services. The website includes several links to websites with information about music therapy, see: https://helsedirektoratet.no/folkehelse/psykisk-helse-og-rus/psykisk-helsevern/legemiddelfri-behandling-i-psykisk-helsevern

making in relation to a range of available services, where music therapy is now added to the list. This creates, for the first time, possibilities for systematic implementation of music therapy in the specialized mental health services in the region. Then, in January 2017, Bergen Health Trust developed a new health promotion strategy that stated that all clinics should have one or more music therapists.

To my knowledge, this is the first health trust in Norway with systematic implementation of music therapy services. When asked, a representative of Bergen Health Trust explains the decision by referring to the disturbing public health fact that people with serious mental health challenges have an expected life span that is more than 20 years shorter than the average for the total population. There are several reasons for this, the representative explains, including drugs and medication and lifestyle issues such as diet and physical activity. He continues by explaining that the health trust has an obligation to employ measures across a wide range in an attempt of alleviating the situation, and that music therapy was included in the strategy both because it was considered an evidence based treatment and a promising part of a health promotion strategy that could empower patients and mobilize resources (Geir Lien in POLYFON-nytt, May 2017).

Complementing this strategy of having music therapists in each clinic, the health trust also supports a project in a local community arts centre. In the project, called MOT82, music therapists work to support and empower participants who previously used mental health services in one of the clinics of the health trust. The project is led by music therapist Lars Tuastad and it gives support to the participants' process of gaining access to cultural activities

and of making music a self-monitored health promoting daily life activity. In this process, collaboration with local musicians, organizations, and authorities of culture is central.[4]

In a very concrete way, this project exemplifies one attempt of reorienting the health sector in a health promotion direction, in line with suggestions made in the Ottawa Charter:

> The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components (World Health Organization, 1986, p. 3).

In order to contextualize the developments described above – where public health objectives, music therapy, and health promotion activities are connected – I will outline the notion of health musicking.

Health Musicking

I have previously argued that the discipline of music therapy could be defined as the study and learning of relationships between music and health (Stige 2002, p. 198). This definition of the discipline supports a broad conceptualization of music therapy research and scholarship, to include various health related practices of music. Music therapy should then be able to contribute to an interdisciplinary discourse, such as the public health discourse, which is also relevant for the development of new perspectives on collaborative music therapy practices across context, as exemplified above.

Inspired by Wittgenstein's (1953/1967) perspective on meaning-making as participation in situated activity, Small's (1998) concept of music as situated activity, and

[4] In Norwegian, there is a description of the project MOT82 in the following website: http://gamut.no/2017/03/07/onsker-a-hjelpe-flere-mennesker-med-psykiske-lidelser-til-a-delta-i-lokale-aktiviteter/

DeNora's (2001) discussion of music and action, I have developed the notion of *health musicking* to communicate the idea that relationships between music and health could be understood as situated processes of participation. Such processes evolve inside and outside conventional music therapy practices (Stige, 2002, 2006, 2012). Originally, I defined health musicking as the appraisal and appropriation of the health affordances of the arena, agenda, agents, activities, and artefacts of a music practice (Stige 2002, p. 211):

Arena: Musicking is a situated activity, linked to a site and situation, and health could be described similarly. There are several sites of interaction to take into consideration, then, such as body, person, dyad, group, organization, and locality. The resources of an arena can be manifold and provide a foundation for the activities that agents take part in. Consequently, an arena is also a site of struggle, between various interests and values.

Agenda: The evolving issues and goals that participants relate to, consciously and unconsciously, constitute the agenda of the activity. Agendas are negotiated more or less openly, and this process can be valuable and/or problematic, by affording communication, collaboration, and conflict, for instance.

Agents: As used here, the term agents refers to the human actors involved in the activity. Agents experience agency to a higher or lower degree, that is; they can be empowered to experience that they have the capacity to influence the flow and direction of the activity. Sometimes agents form alliances in order to enhance their agency, and such alliances can be more or less inclusive, more or less democratic, and so on.

Activities: Broadly speaking, the term activity refers to interactions between organism and environment. More specifically, this includes engagement with music; *listening*, *playing*, *creating*, *performing*, *interpreting*, and *reflecting.* As used here, *interpreting* involves translation of the sounds of music through use of another modality (such as movement, art, or

poetry), while *reflecting* puts the other activities in perspective, usually through verbal or written processing, but also through use of other available modalities.

Artefacts: Health musicking may involve use of several different artefacts, such as for instance musical instruments, musical notation and lyrics, and various forms of recording equipment. The theory traditions that inform the notion suggest that a person's sense of self is constituted through internalization and creative use of cultural artefacts in various social contexts. An example would be: Musical instruments can invite playing and thus participation in a social context, which invites responses from and collaboration with others, which provides experiences that influence one's sense of identity, and so on.

For all the components that I have described above, there are reciprocal processes of shaping involved. An arena allows certain agendas to be negotiated, provides artefacts, affords certain activities, and so on. For instance, the mental health clinic described above provides some of the same artefacts and activities as those provided by the local arts centre and the MOT82 project, and some artefacts and activities that differ. It would be possible to participate in a music therapy rock band in both arenas, for instance, while the mental health clinic has better facilities for individual therapy processes and the arts centre better facilities for music café events. In the same way, agendas may overlap or vary, and they evolve over time. In the MOT82 project at the arts centre, it is more common than in the clinic to examine the possibilities of developing music as a self-monitored everyday activity, for instance.

The terms offered here for description of music as health-related activity are developed within a perspective where *participation* is considered central to human development and wellbeing. This is compatible with a bioecological (Bronfenbrenner, 1979, 2005) and cultural psychology (Cole, 1996; Heine, 2015) perspectives on "how humans become human." In no way such sociocultural perspectives should be taken to ignore biological aspects of human development, but less in the direction of sociobiology (Wilson,

1975/2000) and more in the direction of neurosociology (Franks and Turner, 2013). The sociocultural matrixes of the mutually attuned and coordinated bodies that our brains are part of should be taken into consideration.

Partnerships for Health

In describing health musicking above, I clarified that participating agents sometimes form alliances in order to enhance their agency. In the public health literature, alliances that are characterized by trust, collective decision-making, and dedication to shared goals are often labelled *partnerships* (World Health Organization, 1998).

Causes that bring agents together are often complex and multifaceted, so that each partner realizes that collaboration across established lines of differentiation is helpful. Partnerships for health might involve agents in a range of sectors, working on various levels. An almost infinite diversity of goals and actions is imaginable (Amdam, 2010).

Four types of partnerships that might be particularly relevant for music therapy are self-help partnerships, project partnerships, institutional partnerships, and governance partnerships. *Self-help partnerships* for lifestyle changes and social change in a given context are collaborative relationships characterized by a democratic process of collective decision-making. Local and informal partnerships geared towards shared goals of say service development are often called *project partnerships*. Formalized collaboration between institutions are often called *institutional partnerships*, which are more judicially binding than project partnerships. In *governance partnerships* public interests collaborate innovatively with private interests and/or the third sector (civil society) in order to realize shared policy goals (Stige and Aarø, 2012, pp. 274-278).

Different types of partnerships are not mutually exclusive. A governance partnership, for instance, could stimulate self-help partnerships as well as project partnerships and

institutional partnerships. Given the fact that public health work requires healthy public policy, governance partnerships are worth particular attention, and I will elaborate a little bit here upon this type of partnership.

In a study on governance for health in the 21st century, the World Health Organization (2012) examines various governance innovations, including joint action of various sectors in society, and of public, private, and civil society actors as well. Framed in this way, governance for health can be collaborative, similar to what Amdam (2010) calls governance partnerships where public authorities collaborate with a range of agents in order to realize shared goals. Governance partnerships or collaborative governance is often described as democratic, in that it is based on consensus-oriented decision making, but the analysis performed by Ansell and Gash (2007) indicates that outcomes depend on critical variables such as prior history of conflict or cooperation, incentives for participation, and power and resources imbalances. These authors also identify factors that are central in such collaborative processes, including face-to-face dialogue, trust building, and the development of commitment and shared understanding.

Governance partnerships are for instance relevant as collaborative efforts for implementation of new knowledge, and for reorienting health services, in line with suggestions made in the Ottawa Charter (see above). Despite an increasing amount of primary and review studies in the field, it still remains uncertain how and under what conditions change strategies and interventions most effectively can be translated and exchanged to health professionals and integrated in their organizations (Pentland et al., 2011; Flodgren et al., 2011; Flodgren et al., 2012). Recent case and framework studies have been able to identify, however, that major factors in succesful knowledge application are organisational, with leaders playing a vital role in creating and supporting their organisations' process of knowledge implementation (Berta et al, 2010; Mekki, 2015; Ward et al., 2012).

Therefore, to see how governance is managed and carried out in health care services and public health work is needed. In such processes, partnerships might represent alternatives to vertical hierarchies and horizontal demarcations, but they are not without their own limitations and problems. To overcome differences in power or histories of mistrust might be quite challenging, for instance. Consequently, partnerships might run the risk of growing unstable and vulnerable, unless one is able to address and negotiate such issues successfully. The idea of partnerships could also be misused, for instance as a weasel word when power and privilege have not been substantially challenged. Partnerships do not automatically erase conflict and competition, even though they might create a new and different frame for communication and negotiation (Amdam, 2010).

In the following I will present one example of a governance partnership, established in Norway in 2015, in response to the fact that national guidelines did recommend music therapy while implementation was fragmented and unsystematic, in spite of the fact that Norwegian citizens by law have a right to equal access to services.

POLYFON Knowledge Cluster for Music Therapy

Since 2013, music therapy has been recommended in several national policy documents in Norway (e.g. Helsedirektoratet, 2013), partly with reference to the evidence on the therapeutic effects of music therapy, partly with reference to music therapy's capacity to promote user-involvement and participation. Such conceptual distinctions are not always clear, however, and perhaps the documents could be said to disguise conflicting narratives (Jacobsen, 2015), where support for innovative and humane care is drawn from narratives of evidence and health economy, with critical examination of current research wanting. This situation both creates a need to implement current knowledge and to examine the status of this knowledge. With Miller, Dalli and Urban (2012), we could perhaps say that there is a need for a critical ecology than can nurture participation, professionalization, and critical reflection.

The planning of POLYFON knowledge cluster for music therapy started in 2013 when the first national treatment guidelines recommending music therapy were published. The cluster was established in January 2015 and in 2017 the partners have committed to a second period of collaboration that lasts through 2020. POLYFON is coordinated by the Grieg Academy at the University of Bergen, and it is established with the goal of developing more and better music therapy services, education, research, and dissemination.

There are more than 10 partners, including three research centres, hospitals, health trusts, municipalities, and a county. Most of the partners are public institutions, while some are non-profit health care organizations, and one is a for-profit health care company. The process of collaboration has revealed that these partners need each other; the health care services need access to research information and to implementation research in order to initiate systematic implementation of a new practice such as music therapy, and the university and the research centres need collaborators in the field in order to develop solid research, education, and dissemination activities of relevance to society.

When we chose POLYFON as the name of the partnership, we thought of it as a metaphor for a collaborative practice where different views could be voiced and related to each other.[5] In Norwegian, the name also works as an acronym: The Y in the centre refers to development of a new professional role ("yrkesrolle"), that could nurture an ecology of change at the levels of Person, Organisation, and Local community (POL), and be nurtured by partnerships involving civil society, the public sector, and the private sector (FON).[6] The interplay between civil society, the public sector, and the private sector is central in

[5] "Polyfon" means *polyphonic* in Norwegian.
[6] Norwegian terms for civil society, the public sector, and the private sector are "Frivillig sektor", "Offentleg sektor", and "Næringsliv" respectively.

POLYFON, because the Nordic political model is based in the premise that these sectors should support, check, and balance each other (Moene, 2003).

Areas of practice in POLYFON include Child and adolescent development and welfare, Mental health services, Treatment of substance use problems, Care for older adults, and Palliative care. Each area has established a cross-professional working group collaborating with user representatives. There is also an interdisciplinary Scientific Advisory Committee, with prominent international researchers from fields such as music sociology, music therapy, substance use problems, and community mental health.[7]

The Proof of the Pudding

As described earlier in the chapter, the participation in the POLYFON knowledge cluster has enabled Bergen Health Trust to systematically implement music therapy in its mental health clinics. I consider it probable that in the next few years, health trusts around the country will make similar decisions. This is important and necessary in a social justice perspective, given that health is a human right (universally) and music therapy a recommended mental health service (in Norway). The degree to which this development is linked to a public health agenda is critical, however, because the guidelines that recommend music therapy are not only describing it as effective treatment, but are also highlighting human rights issues such as involvement, shared decision making, and community participation (Helsedirektoratet, 2013). While equal access to services is a necessary condition, the "proof of the pudding" is always in the eating. So, we need to examine the *use* of music therapy services, in the clinics and in the community, and our appraisal needs to include human rights issues such as participation and public health challenges such as social isolation and marginalization.

[7] There is a website (in Norwegian) established for the knowledge cluster, with information, annual reports, and so on, see: http://gamut.no/polyfon/

These developments are too recent for any systematic evaluation, but we can learn from the project MOT82. As described above, Bergen Health Trust has supplemented its strategy of having music therapists in each clinic with support to this project, which is led by music therapist Lars Tuastad and located in a local community arts centre.[8] The project provides participants with access to community music therapy services if needed, and a central function of the project is to provide support to participants' process of gaining access to socio-musical resources in the local community and of making music a self-monitored health promoting activity in their everyday life.

After about one year, user experiences of the project were evaluated (Bjotveit, Wormdahl, and Tuastad, 2016). All 20 participants that used the services in the summer of 2016 agreed to respond to a survey about their experiences. The survey provided multiple-choice alternatives to most questions, but also space for the participants' own descriptions of their experiences. Participants were invited to reflect upon how often they wanted to come to the arts centre for music and music therapy, which activities they wanted to engage with, and so on. They were also invited to reflect upon how participation in music affected their everyday life experiences.

Preferences varied, as exemplified by the range of activities that participants were interested in: 10 participants wanted to learn an instrument, 9 wanted to play in a band, 8 wanted to take part in a music discussion group, 8 wanted to join the weekly music café, 7 wanted to record in a studio, 7 wanted to write songs, 6 wanted to take part in music listening activities, 6 wanted to join concerts, 6 wanted to learn to sing, 6 wanted to learn more about the theory of music, 5 wanted to produce music in a studio, 4 wanted to dance, 3 wanted to

[8] The project is co-funded by the Western Norway Regional Health Authority, Bergen Health Trust, the city of Bergen, and the foundation ExtraStiftelsen.

sing in a choir, 2 wanted to take part in a drum circle, 2 wanted to work with lyrics analysis, and 2 wanted to play in a marching band (Bjotveit, Wormdahl, and Tuastad, 2016, p. 12).

While preferences will vary from place to place and group to group, the diversity demonstrated above should hardly surprise us. Participant preferences are coloured by cultural conditions, but obviously also by individual characteristics and life histories. More striking, perhaps, is the fact that there are some issues where participant agreement is quite substantial. All 20 participants chose the "satisfied" or "very satisfied" alternatives when evaluating their experience of the activities they had taken part in, and 14 out of 20 found that the music activities had become a very important part of their everyday life. Also, a majority of the participants found that the activities allowed for user involvement in a satisfactory way (Bjotveit, Wormdahl, and Tuastad, 2016, pp. 13-21).

17 out of 20 participants found that participation in the music activities made it easier to interact socially with other people, as illustrated by the following quotes:

> "[It's the] Only social [thing] I do during the week."
>
> "MOT82 has got me out of two years of isolation and allowed me to participate in other therapies."
>
> "Here you meet people with shared interests."
>
> "Music therapy balances negative emotions so they do not stand in the way of social interaction with other people."[9] (four different participants in MOT82, in Bjotveit, Wormdahl, and Tuastad, 2016, pp. 12-17).

When asked about whether or not the participants had any advice to give about future developments of music therapy and music activities in the community, one participant responded:

> Good therapy / follow-up costs a lot of money. In the long run, bad follow-up is a lot more expensive. You should dare to be adventurous, to think big, to think holistically,

[9] These quotes are presented here in my translation of the Norwegian originals.

> and to think in long-term perspectives! (If music therapy enables me to work; what does it cost to offer music therapy services versus the payment of disability benefits / hospital stays?) You do the math! (participant in MOT82, in Bjotveit, Wormdahl, and Tuastad, 2016, p. 26).

The math that the health authorities usually ask for, is performed in the Cochrane reviews and meta-analyses that inform the treatment guidelines where music therapy are recommended (e.g. Mössler et al., 2011; Gold et al., 2009). Increasingly also, we could expect the request for studies that calculate the health economics involved, as indicated in the participant quote above. In addition to the math, we need to bring forward the narratives of the people who use and experiences the services, however. There are good reasons to suggest that the processes and effects of music therapy depend upon participants' use of music in context (Stige et al., 2010; Ansdell, 2014), and studies of participant contributions will be key (Rolvsjord, 2015).

Concluding Remarks

In a classic article within community psychology, Julian Rappaport stated that "Having rights but no resources and no services available is a cruel joke" (Rappaport, 1981, p. 13). In this chapter I have described the development of music therapy services in mental health clinics as a resource for the realization of health as a human right, with practical implications for community and public health issues such as social isolation and marginalization.

Music therapy's relevance to public health depends upon several factors. Implementation of music therapy in the health care sector is a necessary yet insufficient condition. Music therapists ability to think and work across sectors, and their capacity to embrace objectives such as positive health and community participation will be key. I have tried to develop a case for a theoretical understanding of music therapy which highlights connections between clinical work and community work, with participation and collaboration as one of the common factors. The term *health musicking* was presented as one theoretical notion that could illuminate how situated participation is central to how music helps, within

clinics and communities. The relevance of Bolger and Skewes McFerran's (2013) discussion of how music therapists need to care for the sustainability of practices towards self-supporting music projects follows.

I have used the term *partnerships* to highlight the collaborative nature of processes that can increase music's availability as a health resource in society, and I have described the notion on several levels of analysis, from participant empowerment in self-help partnerships to the social change that governance partnerships might have the capacity to stimulate.

Perhaps in the future, it will be relevant to talk about *health musicianship* in ways similar to how health literacy today is used as a term to describe "the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health" (World Health Organization, 1998). The participants in MOT82 remind us, however, that music as an individualized health resource will only be part of the picture. Music is a social process; it invites community participation and allows for opportunities to challenge social isolation and marginalization. Health musicianship evolves through participation in the health musicking of communities of practice.

References

Amdam, R. (2010). *Planning in health promotion work. An empowerment model.* New York: Routledge.

Ansdell, G. (2014). *How music helps – in music therapy and everyday life.* Farnham, UK: Ashgate.

Ansell, C., & Gash, A. (2007). Collaborative governance in theory and practice. *Journal of Public Administration Research and Theory*, 18:543–571. DOI:10.1093/jopart/mum032

Berta, W., Teare, G. F., Gilbart, E., Ginsburg, L. S., Lemieux-Charles, L., Davis, D., Rappolt, S. (2010). Spanning the know-do gap: Understanding knowledge application and capacity in long-term care homes. *Social Science & Medicine,* 70 (9), 1326-1334.

Bjotveit, A.; Wormdahl, E.D., Tuastad, L. (2016). Evaluering av prosjektet MOT82. MusikkOppfølgingsTilbud for mennesker med psykisk lidelse i Åsane [Evaluation of the project MOT82. Musical follow-up activities for persons with mental health challenges in the district Åsane in the city of Bergen]. Bergen: Bjørgvin DPS, Helse Bergen [Bergen Health Trust].

Bolger, L., & Skewes McFerran, K. (2013). Demonstrating sustainability in the practices of music therapists: Reflections from Bangladesh. *Voices: A World Forum for Music Therapy, 13*(2). doi:10.15845/voices.v13i2.715

Bronfenbrenner, U. (1979). *The ecology of human development. Experiments by nature and design.* Cambridge, MA: Harvard University Press.

Bronfenbrenner, U. (Ed.) (2005). *Making human beings human: Bioecological perspectives on human development.* Thousand Oaks, CA: Sage Publications.

Bruscia, K. (2014). *Defining music therapy* (3rd edition). University Park, IL: Barcelona Publishers.

Bunt, L., & Stige, B. (2014). *Music therapy: An art beyond words* (2nd edition). London: Routledge.

Cole, M. (1996). *Cultural psychology. A once and future discipline.* Cambridge, MA: The Belknap Press of Harvard University Press.

DeNora, T. (2000). *Music in everyday life.* Cambridge, UK: Cambridge University Press.

Flodgren, G., Parmelli, E., Doumt, G., Gattellari, M., O'Brien M. A., Grimshaw, J., Eccles Martin, P. (2011). Local opinion leaders: effects on professional practice and health care outcomes. *Cochrane Database of Systematic Reviews* [Online]. Retrieved from: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000125.pub4/abstract.

Flodgren, G., Rojas-Reyes M. X., Cole, N., Foxcroft D. R. (2012). Effectiveness of organisational infrastructures to promote evidence-based nursing practice. *Cochrane Database of Systematic Reviews* [Online]. Retrieved from: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD002212.pub2/abstract.

Franks, D.D., & Turner, J. H. (Eds.) (2013). *Handbook of Neurosociology.* New York: Springer.

Gold, C., Solli, H.P., Krüger, V., Lie, S.A. (2009). Dose-response relationship in music therapy for people with serious mental disorders: Systematic review and meta-analysis. *Clin Psychol rev* 2009;29(3):193-207.

Heine, J.H. (2015). *Cultural psychology* (Third Edition). New York: W.W. Norton & Company

Helsedirektoratet (2013). Nasjonal faglig retningslinje for utredning, behandling og oppfølging av personer med psykotiske lidelser [(Norwegian) National guidelines for assessment, treatment and follow-up of persons with psychotic disorders]. Oslo: Helsedirektoratet.

Jacobsen, F. (2015). Understanding public elderly care policy in Norway: A narrative analysis of governmental White papers. *Journal of Aging Studies*, 34: 199–205. doi.org/10.1016/j.jaging.2015.04.006

Kleive, M., & Stige, B. (1988). *Med lengting, liv og song* [With longing, life, and song.] Oslo: Samlaget.

Lov om folkehelseabeid (2011). [The Norwegian law on public health work]. Retrieved from: https://lovdata.no/dokument/NL/lov/2011-06-24-29

Mekki, T.E. (2015). How do the characteristics of context influence the work of facilitators when implementing a standardised educational intervention targeting nursing home staff to reduce restraint in dementia care? Unpublished PhD thesis. Edinburgh: Queen Margareth University.

Miller, L., Dalli, C., Urban, M. (Eds.) (2012). *Early childhood grows up: towards a critical ecology of the profession.* London: Springer.

Moene, K. (2003). *Equality under pressure. Challenges for the Scandinavian model of distribution.* Gyldendal Norsk Forlag. Oslo, 2003. (with E. Barth and M.l Wallerstein).

Mössler, K., Chen, X., Heldal, T.O., Gold, C. (2011). Music therapy for people with schizophrenia and schizophrenia-like disorders. *Cochrane Database Syst rev,* 2011;(12):CD004025.

Pentland D., Forsyth D.K., McCiver D., Walsh M., Murray R., Irvine L., Sikora S. (2011). Key characteristics of knowledge transfer and exchange in healthcare: integrative literature review. *Journal of Advanced Nursing*, 67(7), 1408–1425.

POLYFON-nytt (May 2017) [news bulletin for POLYFON knowledge cluster for music therapy: Retrieved from: http://us10.campaign-archive2.com/?u=fc278c0573acd4be3c76e7f49&id=189c62cb04]. Bergen, Norway: GAMUT – The Grieg Academy Music Therapy Research Centre.

Rappaport, J. (1981). In praise of paradox: A social policy of empowerment over prevention. *American Journal of Community Psychology*, 9(1), pp. 1-25.

Rolvsjord, R. (2015). What clients do to make music therapy work: A qualitative multiple case study in adult mental health care, *Nordic Journal of Music Therapy*, 24(4), 296-321, DOI: 10.1080/08098131.2014.964753

Small, C. (1998). *Musicking. The meanings of performing and listening.* Hanover, NH: Wesleyan University Press.

Stige, B. (1996). Music, music therapy, and health promotion. In: *Report. International UNESCO-conference, Oslo, September 1995.* Oslo, Norway: The Norwegian National Commission for UNESCO.

Stige, B. (2002). *Culture-centered music therapy*, Gilsum, NH, Barcelona Publishers.

Stige, B. (2012). Health musicking: A perspective on music and health as action and performance. In: R. MacDonald, G. Kreutz & L. Mitchell (eds.) *Music, health and wellbeing* (pp. 183-195). New York: Oxford University Press.

Stige, B., & Aarø, L.E. (2012). *Invitation to community music therapy*, New York: Routledge.

Stige, B., Ansdell, G., Elefant, C., Pavlicevic, M. (2010). *Where Music Helps. Community Music Therapy in Action and Reflection.* Farnham, UK: Ashgate.

Turner, B. (2004). *The New Medical Sociology. Social Forms of Health and Illness.* New York: W. W. Norton & Company.

Ward, V., Smith, S., House, A., Hamer, S. (2012). Exploring knowledge exchange: A useful framework for practice and policy. *Social Science & Medicine*, 74, 297-304.

Wilson, E.O. (1975/2000). *Sociobiology: The new synthesis.* (25th Anniversary Edition). Cambridge, MA: Belknap Press of Harvard University Press.

Wittgenstein, L. (1953/1967). *Philosophical investigations.* Oxford: Blackwell.

World Health Organization (1978). The Alma Ata conference on primary health care. *WHO Cronicle, 32*(11), pp. 409-430. See also: http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf

World Health Organization (1986). Ottawa charter for health promotion. Geneva: World Health Organization.

World Health Organization (1998). Health promotion glossary. Geneva: World Health Organization.

World Health Organization (2012). Governance for health in the 21st Century. Copenhagen, DK: World Health Organization, Regional Office for Europe.