

FINDING A PLACE FOR MUSIC THERAPY PRACTICE IN A HOSPITAL CHILD  
DEVELOPMENT SERVICE

Research Exegesis in partial fulfilment of the requirements for the degree of

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## ABSTRACT

This exegesis examines the beginnings of a music therapy practice at a hospital Child Development Service (CDS) in New Zealand, looking at the issues involved in setting up this practice during a student placement over a period nine months. The research is an exploratory case study (Yin 2009) which aims to identify issues through secondary analysis of clinical documentation, using thematic analysis to code and analyse the clinical data. Five core issues were revealed which included: working with team members, interacting with the children's family, issues in the implementation of the intervention, reflections on the student's experience and working within hospital policies and procedures. A case vignette is used to describe an example of arising issues and important factors when working with team members and family. The results of the study suggest that service development is a complex process, showing the importance of collaboration within the multidisciplinary team and involving family members in sessions. In terms of beginning a new music therapy practice in this specific setting, it was found that music therapy was filling a gap in what the child development team could provide. It was also found that there are several factors to consider when establishing a paid position within the service. It is important to create a balance between working within the medical framework philosophy of the hospital and providing a holistic and an empathetic level of care for the families. The project aims to inform other music therapy practitioners and students beginning or establishing work in new settings.

## KEYWORDS

Music therapy; service development; child development; collaboration; family-centred.

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# 1. INTRODUCTION

## 1.1. Context of the Research

This exegesis describes and evaluates a process of music therapy clinical practice at a Child Development Service (CDS) at a city hospital, undertaken as part of the Master of Music Therapy Degree at the New Zealand School of Music (NZSM). The research will examine the issues involved when setting up a new music therapy practice. It will do this by undertaking a secondary review of clinical practice data, critically reflecting on this and looking at the practical, theoretical or philosophical issues that appear. The clinical practice took place on a placement over a period of nine months (approximately 750 clinical hours).

CDS is a unit based in a hospital in New Zealand, and is a “*multidisciplinary, allied health and community based team* ” (Ministry of Health, 2002). CDS consist of professionals who provide assessment and therapy services for children aged 0-16 with delayed development or disabilities. These professionals include: Team leader, Occupational Therapists (OT), Speech and Language Therapists (SLT), Physiotherapists (PT), Clinical Psychologists (ClinPsych), Visiting Neurodevelopmental Therapists (VNT), an administrator and a therapy assistant. A paediatrician also visits weekly to administer assessments. The SLTs on the team provide support for feeding issues rather than speech and language issues. If a child needs SLT support, they are usually referred to the Early Intervention Team (EIT) for this service, which is part of the Ministry of Education (Special Education). The Ministry of Health (2002) states that all CDS in New Zealand accept referrals for children who are identified as having either a physical, sensory or intellectual disability, or a combination of all three, which is likely to continue for

more than six months. Children who are at risk of developing such a disability or have developmental delay are also seen. The service has a core philosophy of being a parent and child-centred service for a wide age range and patient population.

The families who are referred to the service are usually seen by the multidisciplinary (MDT) assessment team, and then referrals are made for the appropriate intervention. Music Therapy was not involved with the MDT team during the placement. Children are sometimes referred from the Special Care Baby Unit (SCBU) for VNT (or sometimes SLT) support if needed. Where, if appropriate, the VNT will provide therapy and support for the family until the child is aged two years. Depending on the type of therapy which was referred, the families either visit the clinic, or the therapists make home visits. In some cases they will visit the child's pre-school or school, depending on what the best environment is for the family and therapist.

The music therapy service was conducted in a similar way to the service provided by other professionals in the multi-disciplinary team at CDS. For individual work, an internal referral was made, I would visit the child and their parental guardian either at home or at CDS, mostly accompanied by the therapist who had referred them. The therapist and I would then arrange weekly sessions, the location of these sessions would be discussed with the family as to where would be most appropriate. Two to three music therapy assessment sessions would take place and then a report would be written. The other therapist and I would then discuss and set potential goal areas and confirm these with the family member. The therapy would then take place for approximately 10 weeks and a summary/discharge report was written at the end. For group sessions, I sometimes assisted with groups that were already being run by therapists at CDS. With support from my supervisor, I also set up a small social skills group for children aged



9-11 with Autistic Spectrum Disorder and Attention Deficit Hyperactivity disorder. A second group was for children aged 2-3 with motor difficulties which was co-facilitated by some of the physiotherapists. Often I would liaise with another music therapist at the early intervention centre, where some of the children I worked with went on to receive music therapy (not through a referral). This service is separate to CDS, and is paid for by parents.

The focus of this research is to enquire and question about where I (the student music therapist) fitted into this service. How did it work? Did it work? How did I deliver a service in this setting? These questions are influenced by varying factors that I experienced during my first few weeks at the placement. I will now explain my motivation for the study in more detail.

## **1.2. Motivation for the Research**

When beginning this placement, I had an aura of uncertainty, as I was aware that it was a completely new placement for the music therapy masters programme. After I began the placement, it was clear that all the staff were excited about the prospect of having a music therapy student on their team. An orientation plan and timetable had been set up for my first two weeks and a desk had been set aside for me to use. I had a meeting with the team leader and my clinical liaison supervisor to discuss how I was to be working in the team. CDS professionals clearly discussed and outlined their expectations from the beginning, and I too indicated my expectations for the team as the placement providers. I had a feeling that it was going to be a good work environment, I felt warmly welcomed by the team and already had a small pile of referrals on my desk and people approached me daily with new ones. I also considered that the team had not had much experience of music therapy before and many were not aware what the

discipline really entailed. Some of the team members though, previously had contact with alternative local services which had employed music therapists. My nominated clinical liaison supervisor also had experience of previously supervising a music therapy student in another New Zealand city.

I felt as though it could work well as a student placement, but still aware that this was completely new to many of the team members. After talking with each one separately, some had many questions and uncertainties about what I was going to be doing. An expectation of me was to be working jointly with team members during my placement, this was apparent as I sensed there was a strong team-focus during my orientation. I felt that I had some challenges ahead of me because it was a new placement and a new environment. The nature of the work was indeed a complex one, meeting the expectations and overcoming them was going to be a challenge. Like, for example, having the confidence to work with other professionals and talking with parents. Having others in my sessions ‘watching’ what I was doing and feeling like an inexperienced student. Also the expectation of writing official clinical notes (which are legal documents), was something I was uneasy about as I had little experience.

### **1.3. My Personal Stance**

I have lived in New Zealand now for nearly six years and I moved here from England. I had completed an arts therapies undergraduate degree, which is not available here in New Zealand. Music therapy is a well established profession in the UK and music therapists are working in hospital child development teams, or the equivalent. For example, a team of six music therapists work at the Chelsea and Westminster hospital in London (Chelsea and Westminster Hospital, 2011). In New Zealand, I am aware of only two music therapists working

for the District Health Board (DHB) – neither in child services. It is important to note the difference in population size as the UK has a population of 62 million people and New Zealand has population of just 4.4 million people (Statistics New Zealand, 2011). However, the status of music therapy as a recognised profession has developed significantly over the past eight years, with the masters of music therapy training programme in Wellington. This began in 2003 substantially adding to therapist numbers. Thanks to this programme and therapists from overseas, there were approximately 62 qualified and registered music therapists in New Zealand (Music Therapy New Zealand, 2011)

To find out more about current music therapy practice in New Zealand CDS, at the start of the placement I contacted other CDS departments in New Zealand. The responses I received influenced my thinking about conducting this research, I only had five responses (out of 33) and I found that no other service had a qualified music therapist working for them and only one had a student before. Four responses said they had some to very little understanding about music therapy. All agreed they would like a music therapist but said there was an issue of budget, or, “yes if they had the money”, or “very unlikely because of the current model of funding”. Therefore, this reinforced the fact that there was little known about the profession and there seemed to be issues with looking at how music therapy could be more cost effective.

#### **1.4. Aims of the Study**

With my personal stance and feelings in mind, I felt concerned. I had feelings of uncertainty regarding my future employment as a music therapist and thought that I would have to work hard at promoting myself and advocating my profession. The aim of the study is to provide a guideline for other therapists, or a summary of the potential issues when setting up new

music therapy practices, specific to Child Development Services. I aim to discover the themes or particular issues that arise from beginning a new music therapy practice. It will also improve my learning as a student and influence my development as a new music therapy practitioner. Therefore, my project aims to inform new music therapy graduates and other practitioners, when they qualify and begin to find work or practice as a music therapist. To achieve this, I am detailing regular aspects of my clinical practice and pose reflective questions in order to answer the research question.

### **1.5. Research question**

“What are the important issues in building a team-orientated music therapy practice in a hospital Child Development Service?”

## **2. LITERATURE REVIEW**

### **2.1. Introduction**

For the literature review, the search terms included ‘music therapy’ along with other terms that related to establishing new roles (e.g. develop, setting up and new service). Further searches were done using such terms as collaboration, teamwork and multidisciplinary music therapy work. Various terms for ‘child development services or centres’ were explored, as the equivalent of this type of service varies internationally.

What I found was an eclectic mix of standardised studies, journal articles, doctorate and master’s theses, reflections on practice and published books. Databases used include: Sage Reference Online, Google scholar, Web Of Science, Scopus, PsycINFO, Medline and ERIC. In the literature review I will discuss three themes relevant to this research study: Developing music therapy services, team working and music therapy in Child Development Services.

### **2.2. Developing Music Therapy Services**

Eight relevant articles were found in this area. The following articles discuss development of music therapy in health and education and the issues that could be involved when setting up new posts. Hills, Norman and Forster (2000) suggest that music therapy is still a relatively new profession in Britain, in relation to other professions that are found in nursing, social work and medicine. As music therapy is a new profession (in New Zealand), it could be argued that music therapists often have to be pioneers, if they are the first in a new setting.

Ledger's (2010a) large scale multi-methods PhD study aimed to learn about music therapist's experiences of developing new services in healthcare organisations. She aimed to uncover a strategy to assist music therapists when establishing new services. The other aim of this study was to explore the facets of a qualitative research process in the context of music therapy service development. She found seven emergent themes drawn from music therapist's experiences and a service development strategy, which are displayed in the figure (table) see below:

Themes	Service Development Strategy
1. Going Solo 2. Looking for a Home 3. Building relationships 4. Accepting the Challenge 5. Insecurity 6. Investment 7. Development Takes Time	Education ↓ Inter-professional Working ↓ Flexibility ↓ Generating Evidence ↓ Investing Time and Energy ↓ Relying on Advocates

Figure 1: Ledger (2010) Findings

However, Ledger concluded that service development is a highly complex process and that there is no simple step by step guide to achieve success. Key issues include *“the pressure to be available, professional, competent and at all times excellent can potentially be overwhelming”*(p.

1). This was a relevant and highly rigorous study which revealed the complex issues involved when developing new music therapy services. It is also set in a healthcare environment, which is similar to this study. In a similar study, Edwards (2005) describes a process of developing a

music therapy programme in a children's hospital in Australia. The findings describe discrete roles for a music therapist as "*emergent and responsive*" and the role of the therapist is required to "*adapt and change*". However, this article focuses on the perspective of the therapist in regards to the client group and clinical outcomes rather than the development of a service. In further research by Ledger (2010b) she undertook an ethnography of the same music therapy service development study and ultimately found several issues. She outlined the inherent complexity of the researcher role which shifted between identities of researcher, therapist, friend and student. Ledger concluded by encouraging ethnographers to consider ways in which they can hold multiple identities in health care settings. This could relate to this study as it is expected that there might be similar issues because the student researcher also had multiple roles.

It was required for Moss (1999) to conduct a small pilot study in order to secure a position in a National Health Service (NHS) facility in the UK. The aims were to offer music therapy to mental health patients and measure the effectiveness of the treatment. If it was proven to be effective, a position would be funded. She did this by looking at the patient and multidisciplinary team member's perspectives of music therapy using both qualitative and quantitative measures. The findings indicated an overwhelming support for the effectiveness for music therapy thus resulting in funding a position. This study examined the issues involved in creating new posts which included providing substantial evidence to support the music therapy service. Another identified issue was that it is useful to look at where music therapy can best be utilised, and the music therapist should aim to work with the multidisciplinary team. A further issue here is that "*the personal uncertainty and effort involved when engaged in proving the worth of one's own profession can be immeasurable*" (p. 58). Although employment was a

positive outcome of this study, it does reveal some interesting issues with creating new music therapy positions.

Konieczna (2009) reflected on the advantages and disadvantages of being a music therapist building a new service in a new environment. In Poland, where music therapy is largely unrecognised, she found that there were issues with people having little understanding, resentment (seeing music therapy as a ‘reward’), challenges with proving her worth and having a lack of supervision. However, she found that being actively responsible for making careful clinical documentation was important. There were advantages of having freedom and she found the work extremely rewarding, stating that *“great people and great facilities do happen, some of them are waiting (even if unaware of it) for music therapists to come”*(p. 2 ). Barrington (2008) raises important issues (supported by literature), about her political view of the challenges and developments of music therapy as a profession. She found that in UK health services, the NHS has increased demands for information, high quality services and transparency regarding codes of conduct and discipline. Challenges for music therapists include balancing clients needs (the discipline) with maintaining, supporting and respecting music therapy as a profession. Both of these examples however, are reflective opinions of practice and not evidence based research.

Twyford (2009) reflected on developing a model of practice within an Early Intervention (EI) service in the Special Education (SE) sector, at the Ministry of Education (MoE) in New Zealand. She found that music therapy is a specialist service and *“has the potential to contribute uniquely to the collaborative team approach of MoE SE”* (p. 28). Twyford concludes that in order for the music therapy model to be successful, there are several principles that are important: creativity, flexibility (from both parties), collaborative working, consultative and



inclusive working and having a strengths-based approach. Multidisciplinary working seems to be a strong issue emerging from the findings of the literature and is relevant to the setting of this study. The next section will explore music therapy in the context of working in a multidisciplinary team.

### **2.3. Working within a Team**

Humpal (1990) suggests that music therapy may be the one discipline that can enhance and integrate the objectives of other therapies, particularly in early intervention. Twyford and Watson (2008) describe the many benefits of collaborative team working:

*“The majority of music therapists are employed as part of a multidisciplinary team, and their ability to function as active team members is reliant on an ability to collaborate at a variety of levels (which) is considered part of music therapy training”*

(Twyford & Watson, 2008, p. 11)

O’Hagan, Allen, Bennett, Bridgman, Lumsden and Wallace (2004) describe four levels of collaborative working: 1) *Unidisciplinary* is where professionals work side by side in a team but work alone in their own discipline; 2) *Multidisciplinary* is where professionals seek the expertise of their disciplines to assist them in their own treatment process; 3) *Interdisciplinary* is where professionals focus on the client’s needs and put their own therapeutic agendas aside and work collectively as a team; 4) *Transdisciplinary* includes practices with other professional across traditional therapeutic boundaries. Interestingly, they say that working at an interdisciplinary and transdisciplinary way is important for music therapists, specifically in New Zealand. This is because in comparison to other music therapy communities in the world, music therapy has a small professional body resulting in professional isolation. Therefore, consulting

with other similar professions is important. A recent Cochrane review, Zwarentein, Goldman, & Reeves (2009) found practice-based interprofessional collaboration (IPC) interventions can lead to positive changes in health care, and poor IPC interventions can ultimately have a detrimental effect on the delivery of health care. Twyford (2007) found that collaborative working is an essential part of music therapy and *“there is a need for collaborative multidisciplinary approaches to be acknowledged and recognised both within the profession of music therapy itself, within training and within the workforce in which the music therapists are employed”* (p. 28).

In a similar setting to CDS, Fearn and O’Connor (2008) reflect on their work at the Cheyne Day Centre in London, England. They developed an approach called ‘music and attuned movement therapy’ for children with profound physical and learning difficulties. They worked closely with another consistent professional (physiotherapist) *“who act(ed) as a movement facilitator for the child”* (p. 56). This collaborative approach was described as ‘powerful’ because, when disciplines overlapped, practitioners really began to be creative. An issue was how it could be difficult and isolating at times, due to lack of understanding of music therapy by the other team members. In addition, an essential part of the collaboration process was to embrace input, advice and support from other disciplines and have regular post therapy meetings.

Hills, Norman and Forster’s (2000) mixed methods survey of 151 registered music therapists in the UK looked at the characteristics of music therapists’ burnout and job satisfaction in relation to working in a multidisciplinary team (MDT). They found that the difficulties of working in MDT were lack of understanding (from other team members), lack of role clarity and understanding where ones responsibilities lie. Despite these difficulties,

depending whether a music therapist works within MDT or not, neither groups suffered high levels of burnout. The study acquired useful information about the diverse environments and employment circumstances of where and how music therapists are working. There were also similarities found between music therapists working alone and therapists who were working in MDT. Additionally, it highlights *“the satisfaction that can result from working with colleagues from different backgrounds”* (pg. 39). This study produced interesting results about music therapists’ perceptions of their work.

An informative, reflective article provided some honest and personal accounts of music therapists working within multidisciplinary teams (Priestley, Eisler, Odell-Miller, & Ritchie, 1993). These opinions are worth acknowledging here as they discuss some of the issues of being a diverse professional in a team. Jean Eisler, a senior music therapist at the Nordoff Robbins Music Therapy centre in London says:

*“Historically speaking, music therapy has been a late comer...music therapists have had to show that they have something of very real significance to offer and persuasive in pointing out that music therapy should become an integral and important resource for the psychiatric team”*

(Priestley, et al., 1993, p. 23)

On the one hand, another therapist said that working within an MDT could cause tension between people with different or conflicting roles. On the other hand it can create a rich atmosphere resulting in excellent service for clients. Ritchie described feelings of frustration and a belief that *“no-body really understands the role of a music therapist”* (p. 25). Priestley’s thoughts are also on both sides of the fence about the multidisciplinary team, *“I loved it and hated it, but we...cannot do without it”* (p. 27). It could be drawn from this article that there are

clear feelings of not being understood or being dissimilar to other professions. Hobman, Bordia and Gallois (2003) found in their survey of 129 public service employees, that perceived dissimilarity can ultimately have a significant influence on the amount of conflict that an individual experiences, but also on their level of involvement in group tasks.

Other team member's perspectives (i.e. non-music therapists) and their perceptions of the role of music therapy are also of value here, in this case in a paediatric outpatient clinic. Darsie's (2009) quasi-experimental study had two aims, first to examine the initial perceptions of the role of music therapy. This was by identifying areas of role conflict and ambiguity in the context of interdisciplinary working; second, to examine if observing music therapy sessions (videos) acted as an effective education tool for team members. Darsie found that before the videos, there was a perception of role ambiguity about what a music therapist does, and that a number of professionals thought it was to entertain patients when they are not involved in medical procedures, or to provide distraction during a procedure. After watching the video, the results indicated staff had increased awareness of the role of music therapy. Darsie concluded by saying *"as music therapists continue to be integrated into interdisciplinary teams, it is important to determine how other...team members view the role of the music therapist"* (p. 27).

This section of the literature has looked at the benefits and difficulties of music therapists working in multidisciplinary teams, and also the perceptions of other team members in a variety of settings. Only one article identified a similar setting to that of CDS. The following section will explore where and how music therapists are working in a CDS or centre.

## **2.4. Music Therapy in Child Development Services**

There is little research evidence of music therapists working in settings similar to CDS. There was an implication with finding the most appropriate search criteria. This is because a child development service or the equivalent varies in different countries, and may be called something else (e.g. the Charing Cross Centre). Chiang's (2008) thesis reflected on her practice as part of her student placement at a New Zealand CDS. Chiang worked with young children with developmental disabilities and her focus was to examine the carer's perceptions of the music therapy process with their children. She found that her methodology enabled her to reflect upon her own practice as a music therapist and look more deeply into the process. This was relevant to this study as it involved aspects of a music therapy programme in a CDS in New Zealand. It helped to recognise that there is a gap in the research, as this study didn't explore the issues of service development specific to New Zealand music therapists. It was essential therefore, to explore more relevant information from overseas. Farnan's (2007) study recommends a person-centred music therapy service with positive behaviour supports. Farnan suggests music therapists should replicate and standardise intervention techniques and be able to define treatment length and outcomes. In addition they should be able to partner with other team members to add value to the team. Another important role for a music therapist within this client group is the value of being involved with assessment procedures. At the Charing Cross child development centre in London, a music therapist has been a crucial part of the assessment team for some time (Jolly, Finnie, Hall, Newton, & Roussounis, 1977). Dr Hugh Jolly, said that *"any assessment of a pre-school child was incomplete without a contribution from a music therapist"* (Wigram & Saperston, 1995, p. 184). Wigram has been another contributing author in the area of

music therapy as part of assessment, particularly for children with autistic spectrum disorder (Wigram & Gold, 2006). He first developed this assessment procedure at the Harper House Children's service in Hertfordshire, England. Wigram said that "*music therapy can play a very significant role in the assessment process with children who have communication disorders*" (Wigram & De Backer, 1999, p. 70). Wigram (2007) concluded that music therapy assessment may find significant strengths, potentials and resources for a child that other more formalised assessments may not find.

In addition to looking at how music therapy might fit into a MDT approach and how it differed from other interventions, Oldfield (2003) examined the extent to which mothers and children engaged in music therapy groups. She found that a short-term approach working with other team members was useful and cost effective. Aspects of the mother's behaviour, such as her level of engagement, her mood and overall outlook influenced perceptions of her child's involvement in music therapy. Overall the treatment 'package' Oldfield developed was beneficial and had an emphasis on parental involvement.

In her 2006 publication, Oldfield describes specific model of music therapy called 'interactive music therapy' she developed whilst working at the Addenbrookes Child Development Centre in Cambridge, UK. She suggests that a music therapist has a 'unique' role within the MDT, and it appears that most of the therapists there are needed to provide help or advice if there is a specific problem with the child. A music therapist or arts therapist is there to attempt to help with any of these difficulties. Oldfield mentions that it's important to define and establish how the music therapist is best utilised in the team, because of the adequate training and high level of musicianship that is involved in the profession. Oldfield and Flower (2008)

discuss the importance of working with the family of the client. They have seen many advantages of working with families:

*"One part of my brain is automatically focused on the parent and the parent's needs...I have come to depend on the parent as a working partner"*

(Oldfield & Flower, 2008, p. 20)

Oldfield (2006) also adds that the success of the therapy is because of this partnership between the therapist and parent. The parent knows the child and the therapist is the specialist who can draw on her experience.

## **2.5. Summary**

This literature review aimed to inform this study by looking at what recent music therapy research says about service development. The first section found key issues involved in music therapy service development. In countries like New Zealand where music therapy is a relatively new profession, Music therapists' are the pioneers and it is important to provide evidence of the effectiveness of the work, establish where it can best be utilised and to work as part of a team, give clear information, maintain a good quality service and ensure to maintain and respect music therapy as a discipline. Some issues were that there is a lot of effort and uncertainty involved when trying to prove the worth of one's profession, particularly when trying to gain employment. The issues felt by therapists were that people have little understanding, resentment and having a lack of supervision for support. Issues regarding conflicting roles as a student/researcher/therapist relates closely to this research project, all of which will be considered in the process.

The positives of being the first music therapist is having freedom and it being extremely rewarding work. The literature came from varying sources and there were no articles that related directly to setting up a new service in a setting like CDS, therefore there seems to be a gap in the music therapy literature. Further investigation of this gap will further will benefit the value of this study.

The second section explored issues with collaborative working at a variety of levels. The literature said that music therapists often work in teams and it is important that the therapist is able to work at different levels. In New Zealand, it is most effective for a music therapist to work at interdisciplinary and transdisciplinary levels. The literature suggests that music therapists' working in teams is helpful in a health setting. The issues for music therapists working in teams were explored and were similar to the feelings of setting up new services, music therapists can feel they are not understood, are frustrated and struggle to prove their worth in a team. These negative feelings can have an impact of the functioning of the team. It appeared though, that with education and showing actual sessions of music therapy, the team can be helped to understand the music therapist's role. An important factor here is that there is usually a high level of job satisfaction for music therapists, and excellent services are provided when working in a team. Again there was little evidence of exploring issues in a setting like CDS.

The final section aimed to explore relevant literature looking at music therapy in child development teams. Some authors valued person-cantered therapy approaches and standardised techniques, with outcomes and the length of intervention clearly defined. In this setting, there is literature to suggest the benefits of music therapy being part of the MDT assessment procedures.



Oldfield's research and her specific approach pays particular attention to parental involvement in sessions.

### 3. STUDY DESIGN AND ETHICS

#### 3.1. Introduction

This research explores issues in a complex social working environment. Social research involves looking at a methodological framework, this framework is based on Crotty's (1998) stages of methodology. This involves the methodology, methods and the perspective we choose for the project. The chosen methodology is a case study design from an exploratory perspective and uses secondary analysis of data of clinical documentation. The clinical documentation consists of a series of data 'sets', within these sets, three sources of data are analysed. These are medical notes (SOAP), music therapy files and recordings and notes from meetings with team members. The method of thematic analysis is then used to draw out the core themes. These themes are then displayed as the findings of this study. This research process will now be explained in more detail.

#### 3.2. Methodology

Qualitative case study research is often used in social science research. The word 'case' defined as "*a specific, complex functioning thing*" (Stake, 1995 cited by Smeijsters & Aasgaard, 2005). Yin (2009) suggests that case study research is a complex and rigorous methodology and is used in many situations in order to contribute to our knowledge of complex individual, organizational or social phenomena. Case study research allows the researcher to retain the holistic and meaningful characteristics of real-life events, and is also "*a useful type of descriptive research for music therapists*" (Wheeler, 1995). Chaiklin (2000) states that a case study's

greatest strength is simultaneously considering multiple factors. Chaiklin continues by saying that no other form of research allows you to simultaneously see the whole and parts, or move the parts around to create different combinations. Chaiklin also says that the skill in doing this is what leads practitioners and researchers to be characterised as ‘creative’. Case studies do not require advanced or complex statistics. This makes the approach helpful to a humanities student like myself. More importantly, case study research can make important contributions to helping people and professional learning.

With regard to the theoretical perspective, according to Yin (2009), there are three types of case study research: 1) Exploratory, 2) Explanatory and 3) Descriptive. Exploratory case study research is useful for studies that focus on “what” questions, with a goal being to develop “*pertinent hypotheses and propositions for further enquiry*” (p. 9). “How” and “why” questions are explanatory research, because such questions deal with operational links that need to be traceable over time, rather than frequencies or incidence. Descriptive case studies may be used to examine sequences of interpersonal events over time.

This study is a reflection of current clinical practice and it is to be ethically safe and competent. Therefore, all documentation which is part of usual clinical practice is reviewed as data. A suitable way of looking and analysing data is to use the techniques of ‘secondary analysis of data’. “*Secondary analysis is best known as a methodology for doing research using pre-existing statistical data*”(Heaton, 2004). This simply means to look again and draw knowledge, understanding or interpretations from this usual clinical documentation. It is gathered in the natural environment of the facility.

### **3.3. Methods**

#### **3.3.1. Data Collection**

The raw data was collected as part of normal documentation, which was written daily after each session or when I was having meetings. The data ‘sets’ includes documentation from three individual clients and a group: my first client, one long term individual, one short term individual and a 15 week group. Three sources of documentation from these sets (data sources) were then reviewed in the analysis process, by means of triangulation in order to answer the research question. The data sources were reviewed in two cycles, the first after six months of the placement, and the second cycle at the end of the placement.

#### **3.3.2. Data Sources**

The three data sources include SOAP notes, music therapy case files and notes or recordings of meetings:

- ‘SOAP’ Notes

The medical files kept at CDS include all of the patients’ clinical records and they are organised into six sections: 1) General client details; 2) reports; 3) progress; 4) communication; 5) intervention and 6) miscellaneous. The third ‘progress’ section uses a method of writing called SOAP, an acronym that stands for Subjective, Objective, Treatment, Analysis/Assessment and Plan. SOAP notes are a method of organising information to clearly and systematically record and document the patient’s progress. They demonstrate the therapy process in relation to the needs and problem and identify treatment goals. These notes are written after each therapy session or when there has been important information obtained. These sets of notes are included

as a data source, as they provide detailed information about the whole session. For example, in ‘subjective’, the notes may give details of feedback from other therapists or parental guardians of the client. Or, they may include discussions or reported documents involving the clients and consent matters. The ‘objective’ section includes all of the clinical observations, measurements and findings of the sessions. The ‘analysis’ part is useful as it contains the therapist’s clinical reasoning for the therapy sessions. It may involve the professional interpretation and how the session related to the client’s therapy goals. The ‘plan’ section is useful for practical reasons, as there may be alterations in the therapy process or goal setting, any follow ups for further referrals that need administering, and when the next appointment will be. These notes are a necessity of clinical documentation at CDS. Each professional involved with the client is required to write in them and is therefore part of usual clinical documentation.

- Music Therapy Case files

These files contain any music used or obtained for a session, and information or notes concerning the client. It also includes assessment procedures and reports, goal setting documents, and copies of discharge reports. Any of this documentation would also be copied into the client’s CDS medical file. This is a usual part of a music therapist’s clinical documentation collection.

- Notes or recordings of meetings

These are any notes or recordings of meetings with other professionals in the team, or external professionals also involved with the client (e.g. early intervention teachers). This also includes parental guardians of the client. These notes include meetings from supervision either with my clinical liaison supervisor, or the music therapy supervisor. These notes were written

daily and were essential for the development of my learning and to assist with informing my own practice as a music therapist, where meetings with professionals occur on a daily basis.

The three sources of data are then triangulated for the findings (see below). Triangulation includes researchers taking different perspectives on an issue under study or more generally in answering research questions. This is done by using several methods and/or in several theoretical approaches, thus contributing to promoting quality in research (Uwe, 2007).

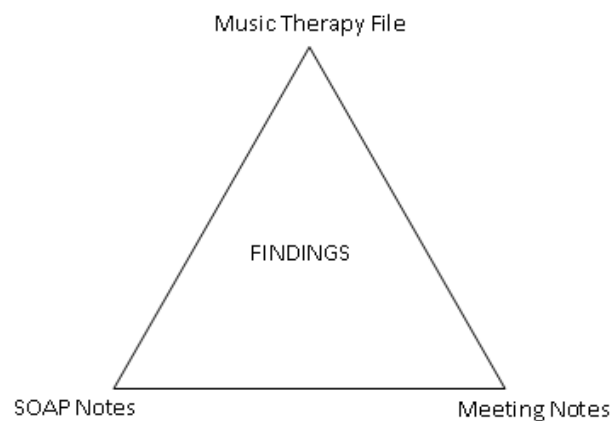


Figure 2: Triangulation of Data

### 3.3.3. Data Analysis

The method of data analysis used in the study is thematic analysis. Dey (1993) describes this as a process of coding, sorting and organising data. Although Yin (2009) does not specifically describe thematic analysis as a method of data analysis, he says that no matter what strategy is chosen, ensure that analysis is done to the highest quality. Braun and Clarke (2006) posit that thematic analysis identifies, analyses and reports patterns or themes within data, and should be seen as a foundational method for qualitative analysis. It provides a flexible and useful research tool, enabling a rich and detailed, yet complex amount of data. Therefore thematic

analysis seems fitting for this type of study. Thematic analysis involves a process, which is described in the figure below:

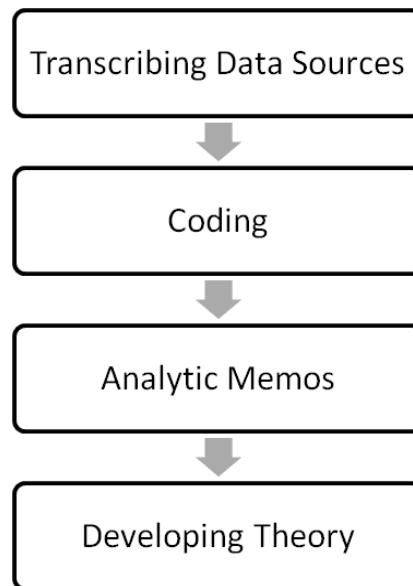


Figure 3: Thematic Analysis Process based on Rickson (2011)

In this study design, an ‘inductive’ approach was used as it involves the researcher looking at the data with an open mind and searching for patterns and regularities. This is in order to formulate a provisional hypothesis to develop general theory or conclusions. A ‘deductive’ reasoning approach was not used because, as Rickson describes, it begins with general ideas which then become more specific. This involves the researcher already having a theory in mind about what the data might reveal and testing the data to confirm the theory (Rickson, 2011). The next paragraph describes the analytic process in the context of this research, based on the writings of Rickson (2011).

The first stage involved transcribing the data sources when necessary (e.g. recordings of meetings). The second stage involved coding. ‘Open’ coding was used for all three data sources, where emerging themes were highlighted and grouped to form categories (meanings, feelings

and actions). The ‘axial’ coding process occurred after this, where the codes were developed more rigorously, by connecting and grouping these codes into categories and subcategories. When conducting thematic analysis, analytic memos were written in a reflective journal to link my thoughts with the original data sources, where relevance to other literature, critical questioning, and suggestions in response to the data was noted. At this stage, a thematic map was made (see Appendix 1: Thematic Map) for both cycles of the analytic process. I also made use of peer reviewing which is *“evaluation of professional performance or products by other professionals and, more specifically, to a set of procedures”* (Sage Publications, 2011). Here I consulted with two other music therapy students during my analysis process, where we looked at the data analysis and proposed themes, with regard to correctly addressing the research question appropriately. Peer reviewing helped this process as I could ensure that the categorisation of the codes fit into the appropriate themes accordingly. At this point, Braun and Clarke (2006) suggest defining and further refining the themes to capture the ‘essence’ of what that theme is about. In addition they suggest organising them in a hierarchical manner with an accompanying narrative. The findings in this paper are presented according to these suggestions.

### **3.4. Ethical Procedure**

This project has been reviewed and approved by the New Zealand School of Music Postgraduate committee. The Chairs of Massey University Human Ethics and Health and Disability Ethics Committees have given generic approval for music therapy students to conduct studies of this type. The music therapy projects have been judged to be low risk and, consequently, are not separately reviewed by any Human Ethics Committees. The ethical considerations in this project are carefully described in the NZSM research project ethical



guidelines (New Zealand School of Music, 2011). See the table below, which describes the ethical process during this project:

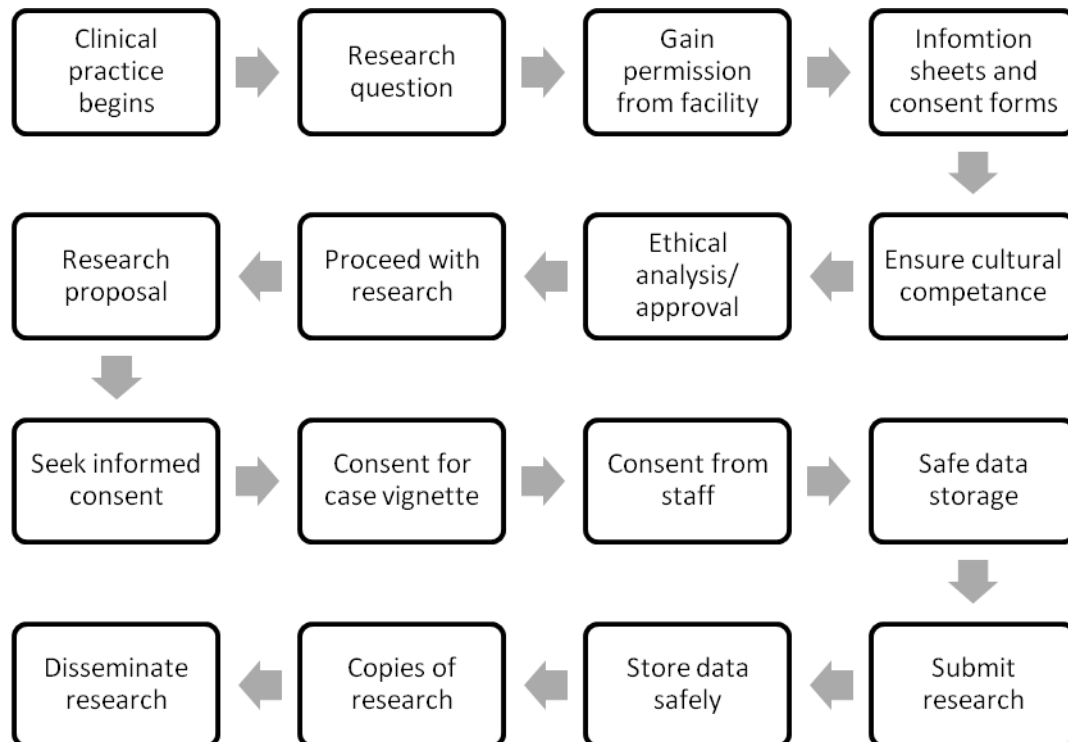


Figure 4: Ethical Procedure

All ethical procedure documentation can be found in the appendices two to seven. These include the permission letter to CDS, letter of approval, information sheets, and consent forms for staff and family involved in the clinical vignette. An example of the contract between a Maori advisor and myself was formulated to ensure cultural competence as part of music therapy practice and during the research process (see Appendix 7: Agreement Form for Consultation with Maori Advisor).

## 4. FINDINGS

### 4.1. Introduction

Five themes emerged from the data using the thematic analysis method (see **Error! Reference source not found.**) in answer to the research question.

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Several related issues were found which then fit into the main themes. The issues are explained in what I consider is the order of significance, rather than how many times the themes were found in the data. A case vignette (after theme 1 and 2) is used to portray how working with the team and family was a key issue in the development of the music therapy service.

### 4.2. Theme 1: Working with the Team

A crucial issue in building a team-orientated music therapy service in a hospital child development service was the quality and characteristics of how I worked and interacted with team members. This appeared regularly in the data and was an important aspect of everyday practice. There were five clear subcategories in this section:

#### a) Collaboration in Sessions

To collaborate means “*to work in conjunction with another or others, to co-operate*” (Oxford University Press, 2011). Out of all four data sets, I consistently worked collaboratively with another therapist in the team in some way. This was displayed in the SOAP notes as: “*Music therapy session @ home, present: Helen (MTS), SLT, (child), (sibling) and father*”. I worked alongside the co-therapist (usually the referrer) in different ways: working together in the

sessions, or during initial sessions to assist with assessment, or the co-therapist would act as an observer of the session. The way of working depended on the needs of the client. This sub-category overlaps with a related student experience sub-category that I will discuss later in the paper (Working Alone, pg. 48). One data set which involved a high level of collaboration was a music and Physiotherapy (PT) group. The main aim for this group was to assist children aged two years and over to achieve gross-motor based movements, where music was the key motivator for the children. The physiotherapist's roles were to support parents and children, and model the certain positions in accordance to the child's goals (e.g. balance on one leg).

b) Consultation

A key issue that regularly came up in the data was consulting about specific therapeutic techniques and discussing goals with the team members. When reviewing referrals, I met with the child's individual physiotherapist and we discussed the child's background information and needs. We both then decided on the goals that we would work on. I worked in a similar way with the individuals and with the groups, where after a series of assessment sessions with their therapist (PT, SLT or VNT), we wrote up a series of music therapy goals appropriate to their needs.

The other therapists helped to set music therapy goals, this perhaps to give me guidance because I was a student, and to ensure I was setting appropriate goals. I noted in an analytic memo that it was important when discussing specific goals and therapeutic techniques to consult with other therapists about certain positioning of the child (particularly if it was an identified goal). The meeting notes reflected that when I did not seek support I was confused at times and feeling as though it was beyond the scope of my practice, knowledge, and experience. I had to

make sure I was taking their knowledge and putting it into practice in the correct way. This is where it was useful to draw on other's individual expertise by consulting regularly. A discipline like PT is broad, medical, and complex, and is the trained physiotherapist's area of expertise, whereas my area of is musical communication and play. Therefore, consulting enabled us to focus or utilise fully each other's areas of expertise.

c) Communication

It appeared there were several levels of communication occurring at my time at CDS. I have identified these four levels in the diagram below:

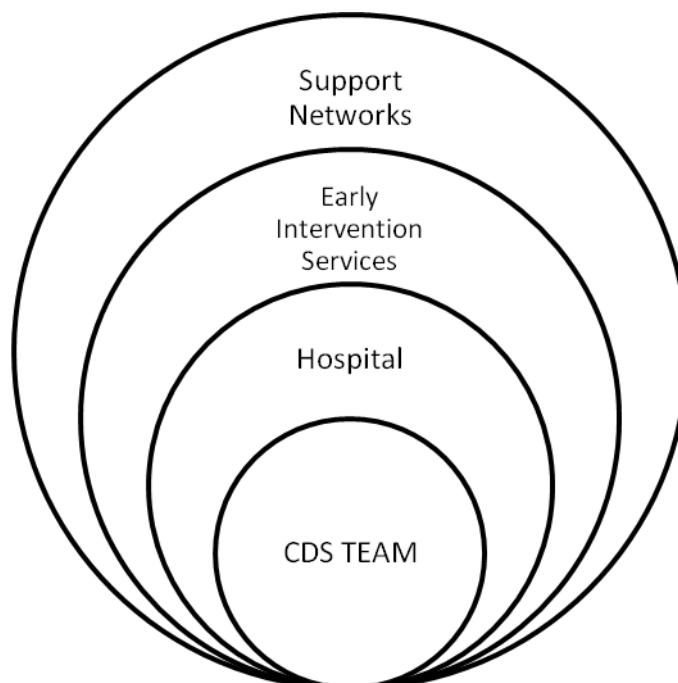


Figure 5: Four levels of Communication

This shows a clear explanation of the various communication contexts. The central circle identifies the direct communication between team members, e.g., asking a VNT for information about a child's developmental stages. The second circle is talking with other professionals within

the hospital, where we may have called the child's paediatrician to discuss the outcomes of a recent appointment, or relay information about a session. The third circle identifies communication to other early intervention or therapy services involved. These were either the local Early Intervention Trust (EI Trust) or the Early Intervention Team (EI Team). Some of the children in the data set I was working with were being seen by the EI Team or were being referred onto the EI Trust for input. I would regularly consult with the music therapist who was placed there. The final circle is communication with support networks, where the team would talk with other services to gain information, support or advice for parents. An example of how this communication was shown in the data is as follows: *"VNT to see (name of child's Paediatrician) to look into genetic counselling/support for Mother"*. A further example of an email sent from me to the local Early Intervention Trust's music therapist can be found in Appendix 8.Email to Music Therapist

d) Briefing and De-briefing

Briefing: *"The action of giving information or instructions relating to a particular situation; information of this kind"*(Oxford University Press, 2011). An issue that was raised from the data was the importance of briefing and de-briefing with the team members. It appeared that for the music and PT group, more time could have been put aside for this so that everyone knew each individual's goals, which staff were available, and what songs I was planning on using. For individuals, as I noted in an analytic memo, the briefing would usually happen in the car on the way to a home visit, or five minutes before for a 'quick catch up'. There was a need for having good pre-session briefing, but the reality was that the time constraints that staff had been an issue.

De-brief: “*To obtain information from (a person) on the completion of a mission or after a journey*” (Oxford University Press, 2011). De-briefing occurred straight after the session, where I would write up notes with assistance from the co-therapist. It would be a chance to discuss and evaluate the session, and decide what we would not change or do differently next time. This is also explained more in section 4.6 b (Critical Evaluation) of this paper.

e) Number of Therapists

During a meeting with a PT, I had expressed a concern with this particular issue and we talked about this in depth. I was concerned that the session had too many adults present, and could be quite overwhelming for the child. This issue also contributed to the process of developing the PT group. I was co-facilitating therapy with two separate individuals with the PT, where up to five adults were involved in a single session with a child. For example: “*Clinic visit present: Mum, Helen (MTS), physiotherapist, therapy assistant, physiotherapy student, sibling and child*”. After a discussion with the PT, she said that having ‘one extra pair of hands’ was a useful way of working when working physically with a child. We both agreed that having more ‘hands’ was quite an indulgent way of working and I thought it would be more cost and time effective if there were less professionals involved. This also sparked an idea to run a group, as both individuals had similar needs, and I thought it would be less obtrusive for the young child receiving therapy and more efficient for the service.

### **4.3. Theme 2: Interacting with the Family**

The second core issue seemed to be how I interacted with the family/Whanau, which is defined as follows:

*“Family is not limited to relationships based on blood ties, and may include: relatives of the tangata whai ora (including a spouse or partner), a mixture of relatives, friends and others in a support network or only non-relatives of the tangata wha ora ”*

(Ministry of Health, 2000, p. vii)

This theme also relates closely to team issues discussed previously, as I worked in similar ways with the family as I did with team members. The subcategories are:

a) Involvement in sessions

The data revealed different levels of participation in which the primary caregivers (e.g. mother or father) were engaged. The way they were involved seemed to be at their discretion and sometimes altered depending on negotiated input from myself or other therapists involved. This was done through careful discussion or encouraging them to take part during the session. The different levels are as follows:

- ...actively in sessions, where the primary caregiver would take part by singing, joining in and supporting child, perhaps providing behavioural reinforcement at times for the child
- ...by observing the session, where the primary caregiver would be sitting away from the therapy space between MTS and child.
- ...for a specific music therapy goal, where the parent may be part of a goal for the child. For example, for one child, an attachment related goal was to increase the distance between mother and child during a session.

I found that primary caregivers not actively participating in the session inhibited the session. I identified this as a personal challenge to be able to talk comfortably and confidently with parents/ primary caregivers about what I needed and why.

Another issue which was raised here was when siblings joined in with the session, mostly the siblings helped with social activities e.g. turn taking songs, but also acted as a role-model for their brother or sister. At other times the sibling might be have been a distraction for the child, or even in one case, the sibling would get quite upset and stressed because their brother or sister was getting more attention. Involving the sibling could perhaps provide extra benefit for the client as it can provide more experiences to encourage social interaction and developing relationships.

#### b) Setting/Discussing Goals

After consulting with the therapists and constructing some initial goals regarding a physiotherapy group, I called the parents, talked about the potential goals and asked if they had any goals of their own, or if there was anything they wanted to change. This issue here shows how it is essential to have negotiation skills, be authoritative, have an expert approach and be educative for the parents when organising a music therapy programme. Over the course of the 15 weeks, the parents filled out a goal sheet, where they could assess and mark their child in accordance with what they had seen in the session (see Appendix 9: Goal Sheet). The therapists, parents and I reviewed these each week and adapted them or made new goals if they were achieved. This tool was effective as the parents could see their child's progression and understand what their child needed to work on. It was also found that the activities and positions were being tried at home.



By involving the parents they felt empowered to contributing to the revision of their child's goals.

c) Generalisation and Sustainability

Generalisation means *“the action or process of forming or expressing a general concept or proposition on the basis of inference from particular instances”* (Oxford University Press, 2011). This issue refers to an importance to how music therapy was generalised to outside of the therapy room. This was often topic of discussion in my supervision meetings, as it seemed to be a pre-conceived expectation of the music therapy service. Some parents could clearly see benefit of music therapy sessions, but did not see how it could benefit them in the outside world. If they didn't have instruments, or weren't 'musical', my role was to help them to use music based activities effectively with their child. However, it was important to emphasise that the therapy was aiming to enable their child to develop key skills for the outside world (e.g. communication, social interaction and movement etc). I also ensured that when therapy had finished, the parents could carry on using these skills, which is where ensuring sustainability plays a part. Sustainability meaning *“capable of being borne or endured; supportable, bearable”*(Oxford University Press, 2011). This is where my role took a more consultative function, by explaining to parents during the session what I was doing, how they could do this at home, or by providing activity sheets, with activities where they didn't need instruments or musical 'talent'. This supported the development of creating a normal enjoyable activity that was shared by the family, where they could sustain and carry on the enjoyment in an ordinary world when intervention stops.

d) Rapport and Trust

This was a crucial aspect of working with the family. I found that in my practice, I needed to establish therapeutic relationship not only with the client, but the family too. This developed over time, and my inexperience as a student music therapist had an impact. Rapport and trust developed once I became more confident with my work, once I got to know the family and their child, but also that we were sharing the moments in therapy together. I did find it difficult to talk with some parents, specifically about their child and the difficulties they were facing in regards to their disability or impairment. Disability was a sensitive subject for parents, and to cope with a diagnosis or the reality of their child's needs was emotionally overwhelming. I found that with support in supervision and as my confidence developed I could talk with parents more comfortably, be myself, have a sense of humour, and have confidence in my clinical knowledge, which was key in order to build up the rapport and trust with not only parents, but with other team members too.

e) Providing Support

It appears that a music therapist plays many different roles when interacting with a family. I found that I would also be there not only to provide therapy for their child, but to provide emotional support, give advice or put the family in touch with services or other team members who could help them with an issue. An example of this was then a mother received an unexpected diagnosis for her child, and was feeling upset and frustrated. With the assistance from the co-therapist, we discussed her feelings around the new diagnosis and put her in touch with a local support group.

f) Consistency

Consistency refers to how regularly the family attended sessions, this closely relates to the discharge policy (pg. 51). The family had to be fully committed and on board with the therapy, and I came across issues with DNA's (Did Not Attend). Consistency of the sessions was interrupted due to lack of attendance, which ultimately affected the outcomes of the therapy in a negative way. The sessions became disjointed and the child's progress often regressed. In order to combat this, I would have discussions with the family to examine if it was the 'right time' for therapy, or if they had transport issues, but also being open to make home visits instead, or calling/texting to confirm the appointment beforehand.

#### **4.4. Case Vignette**

The case vignette displays an example of the importance of collaborative work between a team member and a mother. It shows ways in which these two core themes of working with teams and interacting with the family had positive effects with regards to progress of the child, and the music therapy service at CDS. I have received informed consent from the family and the therapist to present this vignette and have changed names of the child and the Occupational Therapist (OT) for reasons of confidentiality.

***"Jack"***

*Jack was 3 ½ years old when I began working with him. His development was noted as 'unremarkable' up until the age of 18 months when he regressed, losing his speech, communicative gestures and his desire for social interaction. Jack was diagnosed with Autistic Spectrum Disorder when he was 2 years old. Jack was referred for Occupational*

*Therapy (OT) and Speech Language Therapy input from the Child Development Service because he experienced sensory sensitivity and selective feeding issues.*

*Jack was referred for music therapy about 3 months into my placement at CDS. He was referred for potential joint work with the OT, to work on hand skills, engagement with adults, turn taking, imitation and making requests. Music was already thought to be a motivator for Jack as he was attracted by musical toys, the bells at church and his 'mainly music' CD's. Jack was completely non-verbal but was learning to use visual aids to communicate.*

*When I first met Jack and his Mum at home, I was accompanied by Amy (OT). It was clear that Jack had an interest in music, as he would smile when I played Old Macdonald. He took part in fleeting moments of interaction where he would reciprocally tap, briefly and bang on different surfaces. I managed to reciprocate this, and we had a tapping conversation. However, during this session, Jack 'flitted' often and I was unable to engage him, he was easily distracted and had very limited attention.*

*After two weeks of music therapy, Jack's interest grew and he was able to stay in the room with us for about 20 minutes. During some of his initial sessions, Jack liked to stand on the gathering drum and this was a 'no no!' (as he could damage the drum). We lifted him off, which ultimately resulted in a huge tantrum. Mum then began to sing an Irish-jig type tune, using the lyrics of one of Jack's favourite books. Jack stopped crying, immediately sat next to his Mum, smiling and quietly listening to her. Mum and I used this technique regularly in our sessions, and Mum said this was useful during Jack's day, whenever he would get upset. Eventually, the tantrums in the sessions stopped completely and Jack's engagement, interaction with adults, and attention increased*

*dramatically. We introduced a visual aids and play dough into our sessions to help him understand the structure of the session and to encourage some sensory-based play. Initially when he was reluctant to touch and play with it, we sang 'The Wheels on the Bus' and used a toy bus to drive through the play dough, which gained his attention. This progressed to him squashing the play dough and poking the play dough with his fingers, as we sang "the fingers in the play dough go squash, squash, squash".*

*During the middle of his therapy block (out of 13 sessions in total) Jack would greet us at the front door by making eye contact and saying 'ba'. He would continue this until we said 'hello' back to him. The OT wanted to introduce a feeding programme with Jack. Since Jack's attention and engagement had improved with music therapy, she thought it would be a good time to give this a go. So, the feeding would take place for the half of the session, and music for the second half. One big motivation for Jack was the chimes. He would request (or demand!) by vocalising an 'eh' sound, indicating he wanted 'Twinkle Twinkle Little Star'. He liked the chimes swept across his face in-between phrases, where he would smile and giggle. We used this technique as positive reinforcement once he was sitting on the chair, ready for the feeding activities (usually he would stand on the dining table). Jack would then sit at the table for up to 20 minutes at times, Mum, Amy and I would all sing his favourite songs which kept him engaged. This helped afterwards too, where one of his OT goals was to help Jack to sit on the toilet. Mum had a natural and amazing ability to sing and improvise words, (see Appendix 10 ) which was improvised by Mum during our final session.*

*I met with Amy and we discussed that overall the music therapy had a place in helping Jack develop his attention and engagement and to work on a range of goals. She said "if you can't stick and engage with something, you can't develop any new skills". Music*

*therapy helped to fill a gap in what the service could provide as a whole. It provided great interest and motivation for Jack and enabled him to develop occupational therapy goals. The music was helping him in a functional way, whereas before I met the family, Jack was interested in music, perhaps even obsessive. Music therapy opened doors for Jack and his Mum to share loving, meaningful interactions together.*

*Amy also noted that working together was a positive experience and that talking regularly about goals was important (usually in the car on the way back to the hospital). Amy also noted an increase in confidence in the way she interacts, and is able to use music and sing more freely and comfortably with other children she works with.*

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#### **4.5. Theme 3: Intervention**

Other issues in building this service was how the service was delivered, the processes involved and where and how the music therapy was being utilised in the team. An advantage of this was that I had freedom with how I wanted this to be set up and managed, but also learning from other team member's therapy processes.

##### **a) Block of Therapy**

I questioned the amount of sessions that I should provide. With new referrals appearing every few weeks, I questioned that as I only had nine months at the placement, working two and a half days a week, how could I best make use of my time and how many clients should I see in a week? I decided that ten weeks was a manageable block of therapy. One child had a six week block of therapy, one had four sessions (due to many DNA's) and I had a long term client for 13 weeks and a group lasting 15 weeks. The latter two were both extended from an original plan of

a ten week block. The reason for the extension of one was to provide continuity and transitioning to another music therapist. The reason for the group extension was through requests from parents and team members, which is seems to be important in the context of setting up new services, to listen to team members and families and to be adaptable. I found that in ten weeks, I could include an observation, two assessment sessions and seven weeks of sessions where a client would be working on three identified goals. If these goals were achieved, new ones would be set. Only three goals were used at a time, as it was advised by my fellow team members to be a suitable number of goals to be working towards, for me, the therapist and the children themselves.

b) Process and Outcomes

When working in this setting, I found it helpful to use a model to assist in the music therapy intervention process. The model I utilised was based on Wheeler (2005) (see Figure 6: Music Therapy Process) but adapted to be able to fit in with CDS and the other discipline's processes. There was an emphasis shown in the data to keep clear and regular documentation, to set SMART goals (Specific, Measurable, Achievable, Realistic and Time specific) and writing reports at each stage of the process. Having the outcomes of therapy documented regularly is also important.

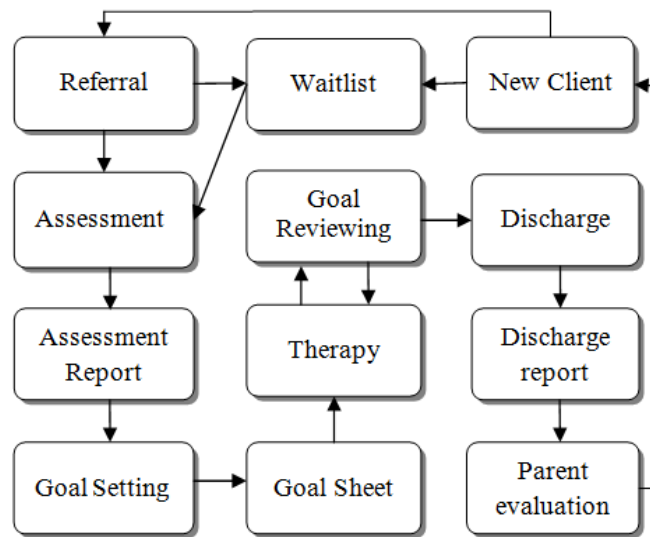


Figure 6: Music Therapy Process

### c) Transitions

Staff from CDS communicated regularly with other early intervention services, and many children went on to receive music therapy at the local early intervention centre. My role also helped the children to transition to the music-rich early intervention centre, where I regularly liaised with the music therapist (see Appendix 8), and forwarded reports and documents regarding the children

### d) Environment

The environment was an important issue for the music therapy intervention, as it seemed to affect the therapeutic outcomes for the therapy. With one child, my first visit at home could only be described as chaotic. The child, who was autistic, regularly walked out of the room (open plan style), was distracted by the many toys and the huge television. Therefore, I asked the parents if we could work at CDS. Unfortunately this also didn't work out well for the family as they



regularly had transport issues resulting in missing the appointments. I gave the parents many options and reminders. Eventually I had to discharge the child from music therapy.

However, for another family, the clinic environment didn't work well for them. The client was a six month old baby and the father asked if we could try the sessions at home. In this case, the sessions worked a lot better as it seemed the baby was more comfortable in his home environment.

#### **4.6. Theme 4: Student Experience**

A key factor in the set up of this service was that I was a student. When first starting at the placement, it was clear that the hospital would not pay a music therapist as I had discussed this frequently with management, but having a student was a good way of introducing it. This section reveals issues with being a student and issues with an application for funding to the DHB to employ a music therapist at the service.

##### **a) Working Alone**

I experienced some frustrations and uncertainties about whether I should be working alongside other team members. I was a student I felt I may have needed 'supporting', and sometimes I felt that I should be working on my own, because "*that's what a music therapist does*" (written in an analytic memo). There were times where I worked on my own where I felt out of my depth, this was because of having worked with other therapists and still finding my feet as a student. Therefore, working with others seems to be an important issue in the context of the research question but also the fact that because I was a student, it was significant that I actually needed to be working with others to supervise my work.

This category seems to overlap with the collaboration category from theme one). I discussed this with my clinical liaison supervisor and she advised that co-working was part of their service and happened regularly, but also that it is 'best practice'. It also depended on the child's needs, specifically if they had many physiotherapy goals, I would need advice and support in the session from a physiotherapist. However, with an autistic child, I felt that having an extra therapist there seemed to negatively affect how I could build a therapeutic relationship with the child.

b) Critical Evaluation

An interesting aspect of the practice was my learning and development as a student during the placement. The clinical placement was part of training therefore a learning process. There were a number of times where I would partake in critical thinking: in supervision, after sessions and in meetings with other team members. I felt that an important issue was to critically reflect and evaluate my practical work, asking myself questions like "what went well?", "what didn't go well?", and "what could I do better next time?". This was apparent from my first client. I would regularly talk with the SLT about sessions and she supported me with evaluating the session. For example, she supported me when the father of a client we were working with found a mistake in a report I had written. I reflected in a memo that I had felt terrible about this, and was hard on myself. The SLT reminded me that I was a student, I was still learning and the father was trying to help my development as a student, which helped put things into perspective.

c) Employment

During my time at CDS, I worked hard to establish my position within the team and advocate music therapy for the team members and families. This was indeed my motivation to conduct this research, and because of this hard work, my clinical liaison (who had previously supported another music therapy student to gain employment) was willing to support me in an application for funding for an ongoing position.

This was very much a challenging process. Initially, gaining permission to make the application to the DHB was denied by the team leader at CDS because of lack of funds, this left me with feelings of frustration and insecurity about the value of my profession. There were discussions about frustrations that allied health professionals have when the authorities only accept medical, quantifiable evidence. Certain stigmas are also attached to professions. People are misinformed and have little understanding of the profession of music therapy. I wrote in my notes that it wasn't the team members or the parents that needed the convincing (as they could see the benefits), but the hospital management.

I was left with the challenge of how does a music therapy student convince hospital management of the value of music therapy? The team leader agreed to support an application to the DHB for a music therapist position. This consisted of a cover letter from the team leader and a letter from a parent. This letter was useful in this application because the parent was also a member of the management team at the hospital. I also sought support from one other registered music therapist who managed to gain work in the DHB who advised me that the application needed to include a clear job description, positive parental feedback, and a salary guide. A letter

was also composed and sent on my behalf by Music Therapy New Zealand, where I assisted by writing a short literature review which showed effectiveness for music therapy for this client group (see Appendix 11).<sup>1</sup>.

#### **4.7. Theme 5: Hospital Policies**

This section reveals issues about my own challenges, understanding and learning of how to use and adapt to CDS policies, procedures and medical/family philosophy, with some clear resistance particularly to the ‘discharge’ rule.

##### **a) Discharging**

At the hospital, there was a policy that if a patient were to miss two appointments without notification, they would be discharged from the service. One child I was working with, after numerous DNA’s, had to be discharged. I was sensitive about meeting families’ needs so making the decision was difficult as I could see how music therapy could help. I found I would give them many ‘chances’ to get to sessions and was vigilant about calling and re-arranging appointments. The other side of this is considering the amount of time and resources that go into setting up a session. I could have been providing the service to another family, as CDS had many children on the waitlist for services. An issue was trying to create a balance between providing the best care for the family and staying within the hospital policies.

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<sup>1</sup> During the time of completing this exegesis, colleagues at the hospital continued to advocate on behalf of the inclusion of a music therapy service. As I finished revising the document for library submission, I learnt that sadly the application for funding was ultimately unsuccessful at a time of financial stringency within the District Health Board. Despite this result I nevertheless felt that the work was worthwhile because high level management within the DHB learnt about the contribution and value of including music therapy in child development services.

b) Documentation

As part of the hospital structure, it was a challenge to manage the amount of paperwork and electronic systems such as organisation demands. Much of my time was spent doing this, and being organised and prepared was an important issue. All written reports had to have two copies, one for the family, and one for the medical file, additional copies were needed for any other professionals' involved (e.g. early intervention teacher or the music therapist at the early intervention centre). All paperwork had to be checked and co-signed by my clinical liaison supervisor, which was a procedure done for all students working at CDS. With any new client, this was the amount of paperwork required for the music therapy service to work in accordance to the CDS procedures:

1. Referral- sent to team leader for prioritising, then put through electronic system
2. Accept referral or put onto waitlist computer document
3. Contact parent, send out music therapy information leaflet and make appointment cards
4. Conduct assessment- assessment form
5. Write an assessment report- send to parent, one copy for medical file
6. Clinical notes after each session
7. Goal sheets- update and change when necessary
8. Summary report- half way through therapy if long term
9. Discharge warning letter- if two appointments are missed
10. Discharge report- summarising the process of therapy

c) Caseload Management

I had the responsibility to decide how many children I could manage to see, but also needed to consider the level of paperwork and planning time involved. At one stage it was documented that I was quite overwhelmed with the caseload, as I found it difficult to say 'no' to new referrals. On top of this, experiencing a personal loss caused me to experience some symptoms of therapist's burnout. Burnout is "*a complex physiological response of individuals in difficult person-to-person relationships as part of their everyday working life*" (Hills, et al., 2000, p. 33). This was an important issue regarding managing the caseload and dealing with personal concerns. I will stress the importance of clinical supervision, taking some time off and creating a manageable timetable. After talking with other team members it seemed that burnout was a common issue with working in the service due to the large number of children on waitlists.

d) Rooms and Instruments

When planning I needed to ensure I complied with the room booking system CDS utilised. In one instance, I needed to use two rooms so that the mother and the co-therapist could observe the session through the two way mirror. This was not always easy, unless both rooms were booked far in advance as many other therapists used the room too. In a team meeting, it was suggested that I should make a permanent space in what we called the 'old gym', it was a good space but distanced quite far away from the CDS unit and I had feelings that I could feel quite detached from the service. This was resolved by conducting my groups (due to a higher level of noise) in this room and providing individual sessions in the CDS unit.

Another issue was ensuring I had the correct equipment for my work, I provided most of my own instruments, and some instruments (a set of chimes) were purchased for me by the

department. This meant that when I finished the placement, the chimes would stay at CDS and be used by the other therapists when I had left. I did advise the other therapists too, of how they could use these in their work with the children. The other issue with instruments was transporting them room to room and going on home visits. It was important to carry them safely and ask for assistance if needed, as it could result in being quite a strenuous procedure.

#### **4.8. Summary**

The data revealed some issues involved when beginning a new music therapy service, it seems that the key features are to work closely with the team, by collaborating or consulting with them where possible in order to draw knowledge and feed off their expertise, and vice-versa. It also seems that way when working with the family, after all, they are the experts when it comes to their child. There are also issues regarding working with the family, where families I worked with were participating in the sessions in different ways. The case vignette shows the benefits of working collaboratively with the parent and occupational therapist, learning and utilising their skills and knowledge in order to improve therapeutic outcomes.

The three other themes found issues in the practical applications of music therapy itself, e.g. how many sessions should I do? Where is the best place to work with a child? Or, the importance of following a process and ensuring clear, documented outcomes. There are issues here that are specific to hospital services, and that it is important to work within the philosophy of the hospital and align with current policy, but also thinking about the family situation and adapting to meet their needs. An important aspect of the findings is that they are all taken from a student's experience, and there could of course be particular differences if data was gathered by a qualified professional. Elements of professional practice were considered however, as some

meeting notes included information on the process of applying to set up position by myself, the student music therapist for when I had qualified as a music therapist.



## 5. DISCUSSION

### 5.1. Introduction

This section of the exegesis aims to explore the five key themes in more detail. This will be done by looking at the themes in more detail from a theoretical perspective. To highlight these theoretical perspectives, examples from music therapy literature and from the data will be used.

### 5.2. Collaboration

So far I have found issues with setting up a team orientated music therapy practice, which include: collaboration in sessions, discussions with therapists, consulting in reference to specific techniques or goal areas, four levels of communication, issues with briefing and debriefing and the issue of having too much input from adults in some sessions. Therefore, it seems important to interact with team members, learn from them and also to provide and accept support, and this is what is needed for effective collaboration to occur. Interacting with staff not only affected the overall outcomes of the music therapy service, but also how the team members influenced my work, and vice versa. This is because I learned skills and techniques specific to various disciplines, which extended my knowledge of my practice and supported others' methods of practice. These types of interactions fit into the definitions of the levels of collaboration. In particular, multi-disciplinary and transdisciplinary levels (see pg. 16 for definitions). Therefore the core concept here is the idea of collaboration and the benefits of this in music therapy practice and how this affects the development of the service.

An example of this in the data was in a discussion with my clinical liaison supervisor. We discussed that collaborative working may seem indulgent and expensive. However, *team members perceived that joint working do have improved outcomes*. Additionally, during a debrief session with a physiotherapist after the music and physiotherapy group, we discussed that collaboration was “*best use of practice*”, and it is important to understand where your skill or area of expertise is best resourced. A further aspect of effective collaboration is knowing one’s own area of expertise and limitations.

There is a strong evidence base for multi-disciplinary working and therapeutic goal achievement. In the CDS service specification it states that the planning and provision of service to ensure effectiveness is to have a “*multidisciplinary allied health team approach that will facilitate each child’s achievement of developmental milestones*”(Ministry of Health, 2002). A project by the Ministry of Health sought out models of integrated effective provision, and argued that is essential for agencies to establish collaborative practices. They require that the people actively involved in a student's life develop ways of working together as a team. For effective team work to occur, an important requirement is the commitment of individual team members to the team - to sharing their own knowledge and respecting the contribution of others (McDonald & Caswell, 2001).

Interestingly, Ledger (2010a) found that inter-professional working was a crucial part of their service development strategy. Twyford and Watson (2008) also emphasised the importance of collaboration in music therapy practice. They say that collaboration is effective in professional, political and personal ways *and* the success of a team is dependent on the type and characteristics of each team member where “*each team member brings a variety of professional*

*knowledge, expertise, skills and personal characteristics to a team*”(p. 13). At CDS, working collaboratively helped to develop the music therapy service on different levels. Working with others added to the professional input that the child received because of the wide range of skills and expertise provided. Outside of the music therapy sessions, interacting with team members provided me with support and guidance with the technicalities of setting up and managing a music therapy service.

It appears that collaboration is a concept that did not just involve members of the professional team. Involving parents in music therapy sessions helped with the development of the music therapy service, this relates to how I influenced the parents to become involved in their child’s therapy.

### **5.3. Involving Family**

The subcategories in the second theme ‘interacting with the family’ had an over-arching notion that the family members, or primary caregivers, were always involved in the music therapy sessions in some way or another. It is suggested that in Child Development Services that “*Whanau, families, caregivers and advocates*” (Ministry of Health, 2002, p. 2) who are associated with the client are to be included in the provision of service. The data suggests that music therapy honoured this commitment. In a meeting with the physiotherapy team and my clinical liaison supervisor we discussed what role I had in the team, the issue of including parents, children and therapists, and what the advantages of these were. My role as a facilitator was to maintain the flow of the session and to set expectations for the parents to help their children. I encouraged the parents to act as co-facilitators in sessions in order to help their child gain independence and grow. I was influencing the long term growth of the children by

equipping parents and giving them the foundational skills by modelling specific techniques. A father of a child I worked with (written in the music therapy case file) expressed that because he was involved in music therapy, he felt that his input was valued. He also mentioned that they (the parents) had some control of the programme, and that he could carry on with certain activities during the week.

Therefore, involving family in the music therapy service supported the notion that specifically in CDS, the way a music therapists works and influences family members really does benefit the service as a whole. Providing a supportive and high quality therapy service where the families feel involved and valued, and providing them with ideas and tools energises and resources them to help their child. ‘Caring for the carers’ is an additional important aspect for helping young children with developmental disabilities.

Involving family in music therapy has been explored increasingly in music therapy literature and research (Nicholson, Berthelsen, Abad, Williams, & Bradley, 2008; Oldfield, 2003, 2006; Oldfield & Flower, 2008; Oldfield & Nudds, 2004; Shoemark, 2008). Amelia Oldfield is identified as a key author in this area of study, but she suggested in 2003 that the area of involving family is “*an unusual area for music therapists to work in*”(Oldfield, 2003, p. 36). She observed that involving parents helps them to understand how to interact with their children, boosts their confidence, and that they also enjoy it. Oldfield feels it is important to include a parent or carer in music therapy work with pre-school children because together they create a partnership. Success can be found in this partnership where both parent and therapist can work intuitively together.

When working with young children the efficacy of music therapy service can be supported by involving family members, Nicolson et al (2008) support this, they suggest that during infant and toddler years, *“the quality of children’s social interactions with their primary caregivers is of considerable significance to healthy development”* (p. 227). They developed and evaluated ten week early childhood music therapy parenting intervention groups run by registered music therapists in Australia. The results of this large-scale quantitative study found that out of 358 parents of children there were significant improvements in the children’s behavioural, communicative and social play skills, but also in the parents’ overall mental health.

#### **5.4. Filling a Gap**

The findings suggest that I had an element of freedom and responsibility with setting up the music therapy service. I could decide how long the block of therapy would be, how I managed the process of therapy and how to assess outcomes, I could decide to work independently with individual children but I felt more comfortable working with team members. In general, music therapy was a valuable asset to the team as a whole. To look at this hypothetically, I feel that the music therapy practice I set up was filling a gap in CDS. The holistic nature of music therapy enabled children to be assisted on a variety of levels. A VNT suggested:

*“Music is something that all children enjoy, and could be considered a childhood occupation. There are some areas of a child’s development we do not really focus on, like communication, interaction, concentration and turn taking (where) music therapy plays a part. Music is a key motivator for children...it adds another aspect we can’t necessarily provide for”*

(VNT Feedback, Music Therapy File, September 2011)

The goal areas of communication, interaction, concentration and turn taking, which the VNT is drawing upon here, are all goals in which a speech language therapist may work on. Since the speech and language therapists at CDS are assisting with feeding skills only, there is a gap. There is evidence to suggest that music therapists can help children with disabilities to achieve a broad range of goals, specifically speech and language goals. For example, a recent study by Naylor, Kingsnorth, Lamont, McKeever, & Macarthur (2011) found *that “music may be used to...facilitate verbal and nonverbal communication”*(p. 16). Further, McCarthy and colleagues (McCarthy, Geist, Zojwala, & Schock, 2008) found that music therapists helped children speak more clearly, and that music therapists were *“responsible for covering a wide range of goal areas with individuals with multiple types of disabilities”* (p. 412). Therefore, music therapists not only assist with helping children with disabilities achieve speech and language goals, but also a wider range of goals.

### **5.5. Empowerment**

The core issue I want to focus on here is the influence I had on the team in general and to think in the context of music therapy as a profession. The data shows a personal process which I went through during my placement. I developed a strong sense of mission and I wanted to empower, educate families and work well with the staff. It was new and exciting for me, I talked with staff (education), I structured a music therapy programme, I implemented the programme, and I talked with staff and parents and got their feedback (evaluation). The outcome of my work at the hospital was extremely positive and resulted in staff and parents supporting me actively to apply for a paid, music therapy position. I think that empowerment is a crucial element of setting

up new services in new environments, in order to convince others that music therapy has value and is necessary in any health team.

There were many situations that were raised in the data surrounding empowerment, but on the other side of this were many feelings of my own insecurity, doubt and frustration about influencing the hospital to have a music therapist position. It was an easier, cheaper option for the hospital to have a student. When beginning the placement, I asked “how could a music therapist come to be employed at the hospital?”, and the response was to provide “proof and cost”. These doubtful moments were a result of arising issues around cost and funding. Music therapists are rarely employed by the Ministry of Health in New Zealand, therefore I felt as though I had “the weight of the profession on my shoulders” (Meeting with clinical liaison supervisor, July 2011). However the active support and enthusiasm I experienced from my colleagues and from families who had been involved in the service was clear to observe in the data too, and I was myself ‘empowered’ to think that the work would be valued enough by the people at the grassroots to warrant further efforts to negotiate with the managers in the District Health Board. Thus there was mutual empowerment at work here.

## **5.6. Advocacy**

I developed a new-found passion for advocating and being a pioneer of establishing music therapy in New Zealand. Finding employment as a new graduate is important and is rarely written about or researched.

An Australian article written by Abad and Williams (2009) discusses the critical issues around funding and employment conditions of music therapists’ in Australia. This reflects on their very successful, well researched and funded ‘Sing and Grow’ music therapy programme.

They discuss that the one key issue around sourcing and maintaining funding is having quality data that provides an *“unequivocal evidence base for music therapy’s positive impact on people’s health and well-being”* (p. 57). Another issue they raise in order to improve working conditions for a music therapist is to raise the profiles of music therapy in the community sector *“this will lead to better understanding and more realistic expectations of music therapists”*(p. 60) . Ledger’s (2010a) findings also support this idea. She concluded that education, working inter-professionally, being flexible, generating evidence, investing time and energy, and relying on advocates were crucial issues when establishing new therapist’s positions. From each of these projects, and indeed the current study, *education, empowerment and evidence* are all vital issues for beginning a new music therapy service.

### **5.7. Working in a Hospital**

I have already raised some key issues about setting up new practices and now wish to draw upon issues in working within the philosophy of the hospital. The service specification outlines detailed ways in which the CDS department should run. It is described as being ‘non medical’, has a strong focus on helping and educating families, and it provides a ‘centre of excellence’ to meet the needs of children who have disabilities. In the beginning I was faced with challenges of trying to keep up with the hospital documentation, writing clear clinical notes, making decisions to discharge a family, and also being able to manage my own caseload.

I think for the new service to work, it was important to follow the rules and meet the facility’s expectations, but also be ‘human’ about the decisions I made. CDS followed the DHB policies and procedures systems as they are part of the hospital. Procedures included such areas



as booking appointments, booking rooms, making referrals, discharging and managing long waiting lists, but also having strong, measurable outcome based attitudes.

There seems to be somewhat of a contradiction in terms here. Although CDS is described as ‘non-medical’, I did get a sense that CDS functioned in quite a ‘medical’ way, because it was a department of a hospital. Therefore, this could create some tension or issues within the service. I think that the music therapy service and other disciplines worked in a very humanistic way, plus, CDS is described as being a family and child-centred service. Thus, music therapy fits well with CDS, though not without coming across policy and procedure issues. An example of this is shown in the music and physiotherapy group. The physiotherapy served as the physical and medical focus, and my role was to provide the ‘human’ aspect to the treatment. Physical goals were a priority, but the music had natural and non-medical qualities that enabled the children to participate. In one case, it helped one child to overcome a fear of going to the hospital.

Here it is important to consider the models within which music therapists’ work. Music therapy with young children often has a developmental focus and sits quite comfortably alongside a medical philosophy. Perhaps this is something to consider for any future work with children is to explore working from a developmental focus, because I felt I was working from a more humanistic therapeutic model at CDS. Music therapy training in New Zealand has a strong humanistic focus, and has been written about in pioneering music therapy literature. *“The work of many music therapists seems to fall within a humanistic framework”* (Bunt, 1994, p. 43). Bunt says that humanism has an emphasis on growth rather than treatment. Music therapists work to maximise this growth and potential in clients. A staff member at CDS commented that perhaps a medical background can further empower the profession. An interesting argument to consider is

how music therapy might work more effectively alongside medical standards. This is raised by Proctor (2002, cited by Barrington, 2008). He suggests that music therapists should seek more support from medical authorities. This is because “individual music therapists are simply reluctant to abandon the status and authority that medicalism confers on them” (p. 70). This perhaps is a key idea in relation to introducing music therapy as a profession in the medical field, that music therapists could be more flexible, and could seek support to help the growth of the profession.

### **5.8. Limitations**

The chosen methodology may have had an impact on this study as it involved secondary analysis of data, which is looking again at clinical documentation. I wrote most of the data myself, so it is clear that this study is strongly influenced by my perspective. In an effort to ensure validity during the thematic analysis process, I made use of peer reviewing, which helped to ensure the process was done correctly and the codes closely related to the themes chosen. I shared my work with two fellow students studying with me, and they checked codes, asked questions and helped to balance the meaning of my interpretations. Following this I made some small adjustments to my codes and categories to reflect their observations.

A further limit of this study could be that it is an investigation of one specific service in New Zealand, which draws on the experience of one music therapist who is also a student on clinical placement. Therefore it would be difficult to apply these findings to other facilities internationally and within New Zealand and to developing music therapy services in other related areas.

The study did give some interesting results. However, it could be useful to examine these issues on a wider scale. Perhaps developing research with other music therapists and CDS teams around New Zealand or internationally, particularly mixed methods studies which would combine quantitative analysis of patterns of employment, and rich interview or focus group data from varied team member perspectives.

## 6. CONCLUSION

This case study aimed to examine the issues involved when setting up a team-orientated music therapy programme in a hospital Child Development Service. The findings indicated strong themes with working with team members and families. It is important to interact with team members, learn from them and provide and accept support in the work. This helped in the development of the music therapy service at CDS. Findings and literature suggested that collaboration is 'best practice' and it is important to be flexible and a committed member of the team. Another important issue with a team orientated service is to share knowledge, expertise and to be aware of one's own skills and limitations. When working with families, the way the music therapist influences parental involvement was an important factor in the development of the service. Encouraging the parents to be involved, making them feel valued, providing them with skills and knowledge (education) to use in day to day life was important for the families at CDS. This ensured that the family and their child were receiving a good quality and useful service.

A key issue with building the music therapy service, which was quite surprising, was that the music therapy was filling a gap in what the service could provide. This was indicated by a comment made by a staff member and is perhaps due to music therapy's holistic nature. In particular, CDS lacks provision of support for children who need therapeutic input to their speech and communication skills. As referenced in the discussion section, it was found that music therapists are able to help children achieve these goals that even some SLTs cannot.

Finally, there are three important issues to consider when beginning new music therapy positions and setting up employment as a music therapist. These are education, empowerment and evidence. Study findings and supporting literature (Darsie, 2009; Ledger, 2010a) indicate that it is valuable to inform colleagues and parents on what music therapy is, and what a music therapist does. It was also important for me to advocate music therapy, be passionate and empowered about what I was there to do, and not become disheartened. Additionally a key aspect of creating new roles, particularly in medical settings, is to provide solid, evidence based research to support the application. Music therapy service development is a complex process involving many issues, but the outcomes of and response to my practice has suggested that there can be an invaluable place for music therapy in a New Zealand Child Development Service.

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## APPENDICIES

### Appendix 1: Thematic Map

Colour Code	Category	Sub-Categories
GREEN	Team	<ul style="list-style-type: none"> <li>• Collaboration in sessions</li> <li>• Setting/Discussing goals</li> <li>• Communication level 2,3,4</li> <li>• “Too many adults”</li> <li>• Briefing and Debriefing</li> </ul>
YELLOW	Engagement with family	<ul style="list-style-type: none"> <li>• Involvement in sessions</li> <li>• Involvement in goal/activity</li> <li>• Generalising/Sustaining</li> <li>• Listening</li> <li>• Rapport and Trust</li> <li>• Setting/Discussing goals</li> <li>• Providing support</li> <li>• Consistency</li> </ul>
PURPLE	Intervention	<ul style="list-style-type: none"> <li>• Block of therapy</li> <li>• Structure</li> <li>• Outcomes</li> <li>• Process</li> <li>• Transitions (other services)</li> <li>• Environment</li> </ul>
ORANGE	Student Experience	<ul style="list-style-type: none"> <li>• Working alone</li> <li>• Critical learning</li> <li>• Justification</li> <li>• Creation of new role</li> <li>• Employment</li> </ul>
PINK	Hospital Policies	<ul style="list-style-type: none"> <li>• Discharging</li> <li>• Documentation</li> <li>• Writing clinical notes</li> <li>• Burnout</li> </ul>
BLUE	Practicalities	<ul style="list-style-type: none"> <li>• Rooms</li> <li>• Instruments</li> </ul>

## Appendix 2: Permission Letter to Facility



**Miss H. S McGann**  
**New Zealand School of Music**  
**Mt Cook Campus**  
PO Box 2332  
Wellington 6140  
New Zealand  
1<sup>st</sup> June 2011

Team Leader  
Child Development Service  
(address)

Dear (name),

RE: MASTERS OF MUSIC THERAPY PROGRAMME: RESEARCH COMPONENT

This letter is to request permission to undertake a research project at the Child Development Service (CDS) between today's date 1<sup>st</sup> June 2011 and the end of the academic year February 2012.

I am studying at the New Zealand School of Music, Victoria University of Wellington and Massey University, and I have been at the service since March 2011 undertaking clinical placement as part of the Masters of Music Therapy degree.

As part of this master's degree I am also required to undertake a research project leading to a thesis. The project is titled 'Finding a place for Music Therapy practice in a Hospital's Child Development Service'. I intend to examine the important issues in building a team-orientated music therapy practice in this setting.

The proposed research will describe and evaluate a process of music therapy clinical practice at CDS. As part of the second year of the Master of Music Therapy degree, it is a requirement to research an aspect of clinical practice and undertake a secondary review of clinical practice data, critically reflecting on this data in the form of an exegesis. Clinical practice data must be part of usual music therapy clinical practice documentation and includes:

- Assessment procedures/reports
- Notes from observations of clients
- Session plans
- Meetings with parents/guardians/team members/clinical supervisors (videos, recordings, notes)
- Sessions (videos, recordings or notes)
- Medical notes
- Evaluation of service (anonymous form filled out by parents or guardians and team members)

Ethical analysis of this project will meet the general standards for the Code of Ethics for the Practice of Music Therapy in New Zealand (2006) and the Massey University Code of Ethical Conduct for Research, Teaching and Evaluations Involving Human Participants (2010). The NZSM Academic Committee has approved my proposal for research as part of Masters of Music Therapy Programme and subject to all ethical procedures being in place, my research project can be undertaken as outlined in the proposal (available on request).

The written exegeses will contain two case vignettes based on clinical work to highlight the aspects of the study. The exegeses will be written in the form of a case study using thematic analysis as the model of data analysis. The case vignettes aim to illustrate some of the ideas I will be developing. In order to use any such clinical material, I will be seeking informed consent from the parental guardian on the behalf of some of the clients I work with. This is because they are children under the age of 16 and their ability to give informed consent may be compromised due to their disabilities and/or age (e.g. speech, language and comprehension difficulties).

However, in some circumstances, the children are able to understand and give assent. In this case it will be obtained from both the child and the parental guardian. Informed consent will also be required from any other parties involved, for example to use notes from supervision or meetings with colleagues. An information sheet will also be provided for all parties involved.

The final copy of the research exegesis will be deposited in the NZSM libraries at Massey University and Victoria University of Wellington. A summary of the results will be provided for the placement staff and copies of summary and vignettes will be provided for clients, families and team members. The full thesis will be presented at the end of the academic year in a formal presentation for NZSM supervisors, students and music therapy practitioners, and for team members at CDS.

If you have any questions or would like to receive further information about the project, please contact me on:

Phone: (number)

Cell: (number)

Personal email: (email)

Hospital email: (email)

Alternatively you can contact my supervisor, (name), Director of Masters of Music Therapy Programme, at the New Zealand School of Music at Massey University Mount Cook Campus:

Phone: (number)

Email: (email)

Yours Sincerely  
Miss Helen S. McGann

### Appendix 3: Information Sheet for Team Members



#### Finding A Place for Music Therapy Practice in a Hospital Child Development Service

#### **INFORMATION SHEET FOR CHILD DEVELOPMENT SERVICE TEAM MEMBERS**

Researcher: Helen McGann BA (Hons), New Zealand School of Music, Victoria University of Wellington and Massey University.

I am a student from the New Zealand School of Music (NZSM). As you may know I am working at the Child Development Service (CDS) for my clinical placement. As part of my training I have to research an aspect of my work in detail, by looking at all of the documents that I have kept since being at CDS. I have chosen to look at the issues that are encountered when setting up a new team-based music therapy practice. I thought that this would be useful to look at because CDS have not had a music therapist or student before. I am doing this to help other music therapists and students who might need to set up a similar service.

I will be undertaking a 'secondary review of clinical practice data' which simply means to look again and draw knowledge, understanding or interpretations from it. This will be then written up in an exegesis, which is a 12-15,000 word research paper. The documents I will be looking at are:

- Music therapy case notes e.g. assessment forms, session planning
- Notes or recordings of meetings with parental guardians of children, CDS staff members and music therapy supervisors
- Recordings or videos of children's music therapy sessions
- Medical notes

All of these documents were generated as part of my usual practice, to enable me to have enough information about a child, to track progress and to plan sessions. When looking at all of this data, I am hoping to find several themes which relate to the question that I am trying to answer. I will look at practical, theoretical or philosophical issues that come up when setting up a new music therapy practice, and will describe how I work with other therapists.

As part of the exegesis I have to include a case vignette to illustrate a point I am making in my exegesis. This may involve including information about one or more of the children I have worked with. I will seek informed consent from the parents or guardian of those children, to use information that is directly related to their child. If they agree for me to use the information about their child, I would not use any real names or names of places (e.g. CDS) in the exegesis, or any other publications or presentations arising from the work. As my research involves secondary analysis of data, there will be no change to my practice and there is no expectation that children will attend extra sessions.

As a staff member at CDS, the information I have collected includes notes and recordings from discussions we have had during my time at CDS. In order for me to use this information, consent is also required. Again, no real names will be used at any point in the presentation of this work.

The analysis will either take place at CDS or at my place of study (home), where the notes will be kept securely, any details will be blacked out and not visible (e.g. name, dob, NHI number, address). All clinical documentation will be returned to CDS at the end of the study, while consent forms and other documentation only relating to the research will be given to the music therapy programme supervisor for secure storage at the NZSM for a period of ten years after which it will be destroyed.

This project has been reviewed and approved by the New Zealand School of Music Postgraduate committee. The Chairs of Massey University Human Ethics and Health and Disability Ethics Committees have given generic approval for music therapy students to conduct studies of this type. The music therapy projects have been judged to be low risk and, consequently, are not separately reviewed by any Human Ethics Committees. The supervisor named below is responsible for the ethical conduct of this research. If you have any concerns about the conduct of this research, please contact the supervisor or, if you wish to raise an issue with someone other than the student or supervisor, please contact (name) telephone (number), email: (email). Approval has also been granted by the [REDACTED] District Health Board to conduct this project in the hospital.

All parents or guardians of the children and CDS staff involved in the research will receive a summary of the research including a copy of the vignette, and the results of the study will be presented to CDS, at music therapy conferences, or perhaps published in a music therapy journal.

If applicable, please sign the attached consent form and return it to me to the following address: (address). If you agree to sign the form and then change your mind, this will be fine as there are other CDS staff members that I have been working with who I can approach. If you have any other questions or need more information, please do not hesitate to contact me, Cell: (number) Ph: (number) or email: (email).

Alternatively, you can contact (name), research supervisor and director of Masters of Music Therapy Programme, at the New Zealand School of Music at Massey University Mount Cook Campus. Ph: (number) or email (email).

Or, (name), clinical liaison and occupational therapist at CDS. Ph: (number) or email: (email)

Yours Sincerely

Miss Helen S. McGann  
Student Music Therapist

## Appendix 4: Information Sheet for Parents or Guardians



### Finding A Place for Music Therapy Practice in a Hospital Child Development Service

#### **INFORMATION SHEET FOR PARENTS OR GUARDIANS OF CHILDREN**

Researcher: Helen McGann BA (Hons), New Zealand School of Music, Victoria University of Wellington and Massey University.

I am a student from the New Zealand School of Music (NZSM). As you may know I am working at the Child Development Service for my clinical placement. As part of my training I have to research an aspect of my work in detail, by looking at all of the documents that I have kept since being at CDS. I have chosen to look at the issues that are encountered when setting up a new team-based music therapy practice. I thought that this would be useful to look at because CDS have not had a music therapist or student before. I am doing this to help other music therapists and students who might need to set up a similar service.

I will be undertaking a 'secondary review of clinical practice data' which simply means to look again and draw knowledge, understanding or interpretations from it. This will be then written up in an exegesis, which is a 12-15,000 word research paper. The documents I will be looking at are:

- Music therapy case notes e.g. assessment forms, session planning
- Notes or recordings of meetings with parental guardians of children, CDS staff members and music therapy supervisors
- Recordings or videos of children's music therapy sessions
- Medical notes

All of these documents were generated as part of my usual practice, to enable me to have enough information about a child, to track progress and to plan sessions. The reflective journal is a key aspect of the documentation as it contains personal reflections, on my own learning processes and critical thinking about the work I do, in order to improve my practice.

When looking at all of this data, I am hoping to find several themes which relate to the question that I am trying to answer. I will look at practical, theoretical or philosophical issues that come up when setting up a new music therapy practice, and will describe how I work with other therapists.

As part of the exegesis I have to include a case vignette to illustrate a point I am making in my exegesis. This may involve including information about one or more of the children I have worked with. The attached consent form is to ask for your permission to use your child's information in the exegesis. I would not use any real names or names of places (e.g. CDS) in the exegesis, or any other publications or

presentations arising from the work. As my research involves secondary analysis of data, there will be no change to my practice and there is no expectation that you and your child to attend extra sessions.

The analysis will either take place at CDS or at my place of study (home), where the notes will be kept securely, any details will be blacked out and not visible (e.g. name, dob, NHI number, address). All clinical documentation will be returned to CDS at the end of the study, while consent forms and other documentation relating to the research only will be given to the music therapy programme supervisor for secure storage at the NZSM for a period of ten years after which it will be destroyed.

This project has been reviewed and approved by the New Zealand School of Music Postgraduate committee. The Chairs of Massey University Human Ethics and Health and Disability Ethics Committees have given generic approval for music therapy students to conduct studies of this type, The music therapy projects have been judged to be low risk and, consequently, are not separately reviewed by any Human Ethics Committees, The supervisor named below is responsible for the ethical conduct of this research. If you have any concerns about the conduct of this research, please contact the supervisor or, if you wish to raise an issue with someone other than the student or supervisor, please (name), telephone: (number) email: (email). Approval has also been granted by the [REDACTED] District Health Board to conduct this project in the hospital.

All parents or guardians of the children and CDS staff involved in the research will receive a summary of the research including a copy of the vignette, and the results of the study will be presented to CDS, at music therapy conferences, or perhaps published in a music therapy journal.

Please sign the attached consent form and return it to me at the address below, or in person. If you agree to sign the form and then change your mind, this will be fine as there are other families that I have been working with who I can approach. If you have any other questions or need more information, please do not hesitate to contact me or my supervisors.

(Name) research supervisor and director of Masters of Music Therapy Programme, at the New Zealand School of Music at Massey University Mount Cook Campus.

Phone: (number) or email : (email). Or (Name) clinical liaison and occupation therapist at CDS. Ph: or email (email).

Yours Sincerely

Miss Helen S. McGann  
Student Music Therapist



## Appendix 5: Consent Form for Team Members



### Finding A Place for Music Therapy Practice in a Hospital Child Development Service

#### **CONSENT FORM FOR CHILD DEVELOPMENT SERVICE TEAM MEMBERS**

I, ..... (name) give consent for information regarding my work at the Child Development Service (CDS) which has been collected for clinical purposes to be used in the outlined research project in order to fulfil the requirements of the Master of Music Therapy at the New Zealand School of Music.

I understand that notes or recordings of meetings that I may have with the student will be used for reflection and analysis for research purposes.

I understand that my confidentiality will be maintained at all times, my real name or personal details will not be used at any time in the process of this study and not used in any final publications or presentations arising from this research.

I understand that analysis will take place at CDS or at the student's place of study and all information will be kept secure with any personal details be blacked out and not visible or traceable.

I understand that all information and this consent form will be either returned to CDS or given to the music therapy programme supervisor at the end of the study. The information will be kept securely and destroyed after ten years.

I understand that the student will provide a summary of the research for me, and that the results of the study may be presented to CDS, at a music therapy conference, or be published in a music therapy journal. I understand that I can withdraw at any time during the process of this research.

Signed.....  
Print Name.....  
Date.....

## Appendix 6: Consent Form for Case Vignette



### Finding a Place for Music Therapy Practice in a Hospital Child Development Service

#### **CONSENT FORM – FOR CASE VIGNETTE**

I, ..... (parental guardian name) give consent for information regarding my child .....(child's name) which has been collected for clinical purposes at the Child Development Service (CDS) to be used in the research project in order to fulfil the requirements of the Master of Music Therapy at the New Zealand School of Music.

I understand that as part of the requirement for her Music Therapy Clinical Placement, a detailed case vignette which outlines an aspect of the research project will be written. This case vignette may include background information concerning my child.

I understand that my child's confidentiality will be maintained at all times, his/her real name or personal details will not be used at any time in the process of this study and not used in any final publications or presentations arising from this research.

I understand that my child's music therapy would continue in its usual way if I agree for my child to be apart of this case vignette, but also if I decide to withdraw from the study.

I understand that analysis will take place at CDS or at the student's place of study and all information will be kept secure with any personal details be blacked out and not visible or traceable.

I understand that all information regarding my child and this consent form will be either returned to CDS or given to the music therapy programme supervisor at the end of the study. The information will be kept securely and destroyed after ten years.

I understand that the student will provide a summary of the research and copy of the case vignette to me, and that the results of the study may be presented to CDS, at a music therapy conference, or be published in a music therapy journal. I understand that I can withdraw at any time during the process of this research.

Signed.....  
Print Name.....  
Date.....

## Appendix 7: Agreement Form for Consultation with Maori Advisor



### AGREEMENT FORM FOR CONSULTATION WITH MĀORI ADVISOR

#### Relevance and Responsiveness to Māori

To meet the requirements for the Master of Music Therapy research project titled: *“Finding a Place for Music Therapy Practice in a Hospital Child Development Service”*, care should be taken to ensure cultural needs are met in the student’s clinical practice. As the Ethical Guidelines for NZSM526 Research Projects (2011) states:

Music therapy has similarities with the Māori philosophy towards health because it is based on a wellness or holistic health model. It fits well with the concept of Te Whare Tapa Wha, outlined by Mason Durie, which described the four cornerstones (or sides) of Māori health as whānau (family health), tinana (physical health), hinengaro (mental health), and wairua (spiritual health).

It is integral to training to be an allied health practitioner in New Zealand to learn to collaborate with Māori and to understand issues in health in keeping with the Treaty of Waitangi. Students are advised to take the opportunity in developing their research to think in depth about the implications of their research for Māori, and to benefit from cultural guidance provided by local Kaumatua or Māori advisor. Thankyou for agreeing to help advise on this project and the NZSM music therapy department values any advice or guidance you would like to offer.

Name of Māori advisor: \_\_\_\_\_

Occupation: \_\_\_\_\_

Any specific comments on the research:

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I agree that I will advise \_\_\_\_\_ (student) during the process of the clinical practice/research project to advise and assist with their understanding of Maori health issues.

Signed \_\_\_\_\_ (advisor) Date \_\_\_\_\_

Signed \_\_\_\_\_ (student) Date \_\_\_\_\_

## Appendix 8: Email to Music Therapist

From: Music therapy colleague To: Helen McGann

Date: 22/08/2011 8.01 p.m

Subject: [REDACTED] MT

---

Hi Helen

Thanks for your email and thanks so much for the discharge report you sent us. [REDACTED] is doing really well- he has lots of potential and his Mum is great to work with. I can see that his separation anxiety from Mum will be slow work but he is building relationships with the therapists at [REDACTED] quickly.

We also had another little boy called [REDACTED] start with us at the same time. Did you work with him too? (I can't remember his last name).

How is everything going with you?

Kind Regards,

[REDACTED]

*On Mon, Aug 22, 2011 at 3:05PM, [REDACTED] <[REDACTED]@[REDACTED]> wrote:*

Hi [REDACTED]

Just a quick email, just wanted to know how [REDACTED] was getting on?

Helen

[REDACTED] Hospital>>> [REDACTED] 27/07/2011 11.21am.>>>

Hi Helen,

Yes [REDACTED] is coming into a Tuesday morning at [REDACTED] so I will be working with him. I would love to have a copy of his closing report – that would be very helpful.

Thanks for contacting me and I hope your placement continues to go well.

Cheers,

[REDACTED]

*On Tue, Jul 26, 2011 at 2.13PM, Helen McGann <[REDACTED]@[REDACTED]>*

*wrote:*

Hi [REDACTED],

Helen McGann here from CDS at the hospital, I'm just emailing you regarding [REDACTED]. He is starting [REDACTED] next week but I wasn't sure if you or [REDACTED] will be seeing him? I have been working with [REDACTED] for a little while now and thought it might be useful to discuss how he got on in our music therapy sessions. I could also send you a copy of his closing report, it should be finished by next week.

I hope you are well, my days are getting pretty full so I can't come and visit any time soon I'm afraid.

Thanks, Helen

## Appendix 9: Goal Sheet

Date _____					<b>My Goals</b>	
					Joe Bloggs	
1. Joe can stand on one leg without help						
1	2	3	4	5		
Where we're at now	Getting there	Sometimes	Almost there	Achieved!		
2. Joe can clear the floor when jumping						
1	2	3	4	5		
Where we're at now	Getting there	Sometimes	Almost there	Achieved!		
3. Joe can wriggle on the floor when commando crawling						
1	2	3	4	5		
Where we're at now	Getting there	Sometimes	Almost there	Achieved!		

## Appendix 10: The Toilet Song

### The Toilet Song

for Jack

By Mammy

Voice

Sit ting on the toi - let like a big boy

3 sit - ting on the toi - let like a big boy

5 he sat on the toi - let

6 ma - my's mak - ing it up as she goes a - long! (Laughing)

8 Shall we sit back down on the toi - let seat?

10 sit on the toi - let like a big boy. (Sits down, praise and cheering)

12 (OT singing too)  
Good sit - ting on the toi - let like a bi - g boy!

Mum says "that's the longest he's ever sat down!"

## **Appendix 11: Application Letter**

To Whom It May Concern,

### **About Music Therapy**

Music therapy is the planned use of music to assist the healing and personal growth of people with identified emotional, intellectual, physical and/or social needs (Music Therapy New Zealand, 2009).

### **Music Therapy in New Zealand**

The Master of Music Therapy programme (MMusTher) was established in 2003, and thus music therapy is a new but rapidly growing profession in New Zealand. The Music Therapy New Zealand (MThNZ) registration board was established in 2000 and, at that time, music therapists who had trained overseas or with the New Zealand Society of Music Therapy Accreditation Programme were invited to apply for registration.

### **Training**

The New Zealand School of Music (NZSMT) offers a two-year Master of Music Therapy programme to prepare students for the professional clinical practice of, and research in, music therapy.

### **Registration**

Appropriately qualified persons can apply to be registered with the New Zealand Music Therapy Registration Board (Music Therapy New Zealand, 2009). The Board maintains a register of music therapists who are registered in New Zealand and issues three-year practising certificates to those who meet the specified criteria. Evidence of continuing music therapy education and professional activities, and ongoing supervised practice must be supplied. The objectives of the registration system are to:

1. Ensure that only people who are qualified to practise are able to create and maintain a physically and emotionally safe environment for a client, adhere to the NZSMT/MThNZ Code of Ethics, and use the term New Zealand Registered Music Therapist;
2. Provide a benchmark for quality assurance as occurs with other professions;
3. Provide employers, contracting agencies, and individuals with assurance that the qualification and professionalism of music therapists meet appropriate standards;
4. Ensure that music therapists maintain their personal development and professional skills;
5. Provide a process for grievances and complaints to be objectively evaluated and appropriate sanctions applied.

There are currently 50+ Registered Music Therapists in New Zealand. Practitioners work in a wide range of medical, rehabilitation, and education settings.

### **Professional Recognition**

In order to be recognised as health professionals in New Zealand the Health Practitioners Competence Assurance Act, and the Allied Health Professional Associations' Forum, argue that a profession needs:

- A relevant tertiary qualification
- A recognised system for monitoring ongoing competence
- Professional standards of practice and
- A professional code of ethics

Music Therapy New Zealand (MThNZ) meets three of the above criteria and is currently developing standards of practice (due for completion early 2012) to enable them to become a member of the Allied Health Professional Associations Forum NZ.



Music therapists are identified as specialists who can provide a service to children who have high or very high special education needs via the Ministry of Education's Ongoing Reviewable Resourcing Scheme (ORRS) (Ministry Of Education, 2006).

### **Music Therapy Recognition within the UK Health Sector**

Music therapy is a recognised health profession in the UK regulated under the Health Professionals Council (Health Professions Council, 2010). "Music Therapist" is a protected title that can only be used by a suitably qualified and registered professional. Music therapists are classified within the group of Art Therapists and have to meet the required Arts Therapists Health Professionals Council standards of proficiency.

The national profiles for music therapists, as a part of the art therapists' professions, have been sanctioned by the UK Department of Health (DOH). Factor 2 within the profile, "Knowledge, Training and Experience" specifies that since music therapy professionals require a master level training to enter the profession, the commencing salary is at Band 7 within the NHS Agenda for Change (British Association of Arts Therapies, 2010).

### **Music Therapy Evidence Base**

The Ministry of Health (2002) states that all Child Development Services in New Zealand see children who are identified as having either a physical, sensory or intellectual disability, or a combination of all three, which is likely to continue for more than six months.

In Australia, there is a major government-funded and well-researched music therapy programme called 'Sing and Grow'. Nicholson, Berthelsen, Abad, Williams & Bradley (2008) provided evidence of the potential effectiveness of this programme in early intervention. The 10 week music therapy programme for children (aged 0-5) and their parents helped to promote positive parent-child relationships, children's behavioural, communicative and social development. Significant improvements were found in all of these areas.

### **Music Therapy and Autistic Spectrum Disorder (ASD)**

There is a growing amount of positive research with children with ASD. A Cochrane Review (Gold, Wigram &, Elefant, 2006) found that three out of 24 studies that were able to be included, gave results indicating that music therapy may help children with ASD to improve their communicative skills. However, more research was needed to provide in-depth examination of the effects of the intervention. Since then, further standardised studies have been done to examine the effects of music therapy for children with ASD, with significant results. A randomised exploratory control study by Kim, Wigram and Gold, (2009) found significant evidence supporting the value of music therapy in promoting social, emotional and motivational development in children with autism. A systematic review (Rossignol, 2009) found that music therapy was a 'Grade A' (most recommended) treatment for children with ASD.

### **Music Therapy for Children with Developmental and Physical Disabilities**

There is also a growing amount of research for children with learning or developmental disabilities (DD). Grosz, Linden and Osterman (2010) found music therapy played an important role in positive development of speech. A further study by Krikeli, Michailidis & Klavdianou, (2010) demonstrated that there are significant calming and mental health benefits of music therapy for children with DD. A study by Wetherick, (2009) found that music therapy with children with DD has a significant role in supporting children and parents. Sussman (2009) showed music therapy helped children with disabilities help to sustain attention and partake in shared attention activities. Gilboa & Roginsky, (2010) found music therapy was effective in treating children with cerebral palsy.

## Recommendations

Music Therapy New Zealand respectfully requests that:

Registered Music Therapists are recognised as Allied Health Professionals within the health sector.

We anticipate that with a Master's degree, the music therapist's starting salary would be at Step 3 of the PSA Allied, Public Health & Technical Multi Employer Collective Agreement, 1 April 2010 - 30 April 2012.

If you have any questions, please feel free to contact Dr. Daphne Rickson, MTNZ president and music therapy lecturer. Phone: 04-801-2794 extn. 6410, or email: [d.j.rickson@massey.ac.nz](mailto:d.j.rickson@massey.ac.nz).

Signed:

Name:

Date:

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