

Who says I can't sing?

Musical justice for people
with intellectual disabilities

National Music Therapy Research Centre,
University of Melbourne



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Research and writing by Katrina McFerran
National Music Therapy Research Centre, University of Melbourne



Acknowledgements

This project would not have been completed without the commitment and tireless assistance of many people. Of most importance are those fifty-odd participants who joined in the music groups both at The Salvation Army centre in Brunswick and across the various sites in the Eastern suburbs of Melbourne. These various individuals engaged with great joy and creativity in the music groups, shining brightly as they sang, played and listened alongside their fellow participants. Their carers were crucial to the process of engagement and displayed a generous commitment to the participation of all members. The enthusiasm they brought made the groups sheer delight to observe and as the observer, it was impossible to resist the desire to dance, sing and play while attending each of the groups. Many thanks to all who came.

THE CAPTAIN: The contribution of Captain Jason Davies-Kildea cannot be underestimated in the actual beginning, middle and end of this investigation. His enthusiasm to explore further possibilities for developing the music program at The Salvation Army, Brunswick was central to its success. Jason's skills led to the identification of a funding source, the recruitment of the rest of us in the team and the ongoing management of the multiple persons involved. His own commitment to music was central in the energy that he brought to the project, combined with the belief that all people deserve access to it. His generous sharing of energy and ideas was fundamental to the emerging focus and outcomes of the research.

THE MUSIC THERAPIST: Thanks are also owed to Able Music Therapy for open-mindedly taking this opportunity to compare two music programs and for persisting with their desire to understand the role of music in the lives of adults who have intellectual disabilities. Rachel Nendick's (RMT) enthusiasm and willingness to learn can be heard throughout this document. She made sacrifices within her own timetable to ensure that the music therapy groups were convenient and accessible.

Her beautiful voice and spirit contributed to the connections that the adults were able to make with music. A special thanks also to Cath Russel for joining the team when Rachel was not available.

THE COMMUNITY MUSICIAN: At The Salvation Army in Brunswick, Stuart Lees was the leader of the community music group and the man that had been leading the way in providing music to the many and various folk that access the centre. His own commitment to the power of music is at the core of his program and his gift in sharing music with large groups of people energized those attending.

THE SOCIAL WORKER: And finally to Randall Smith, whose steady and generous participation in the project provided both foundation and back-stop for all involved. Randall was willing to listen openly to emerging ideas about the project and offered insightful opinions when needed. He also made sure that logistical details were addressed and that communication flow was in place. At times, this involved a large amount of work, and this was greatly appreciated.

THE DOLLARS: This project could not have taken place without the generous support of The Salvation Army's Melbourne Central Division Research and Advocacy Portfolio Grant. Both music programs were adequately resourced to undertake the project and the data collection was adequately supported by this funding.

It has been an honour to work with an organization so steeped in a tradition of serving the community and valuing the role of music in doing so. I think I speak on behalf of all people who were involved in the program when I express my gratitude for giving us the opportunity to sing, play and dance in your space. You truly do build community and meet with God in your musical encounters with others.

The Academic – Dr Katrina McFerran,
Faculty of Music, The University of Melbourne

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Executive Summary

I have my own particular sorrows, loves, delights; and you have yours. But sorrow, gladness, yearning, hope, love, belong to all of us, in all times and in all places. Music is the only means whereby we feel these emotions in their universality.

HARRY ALLEN OVERSTREET
(1875 – 1970) AMERICAN
PHILOSOPHER AND TEACHER

This report explores the complementary roles of music therapy and community music for people with disabilities. It compares two existing music programs through The Salvation Army Brunswick and Able Australia, in order to identify overlap and points of distinction. The adult participants in these programs were engaged as co-researchers in the investigation, offering their perspectives through focus group interviews, regular written feedback mechanisms and quality of life questionnaires. These adults included people with a range of disabilities and their carers, both of whom engage in the music programs with equal enthusiasm. The music workers were also acknowledged as active contributors to the musical experience and the results are infused with the opinions from each of these four groups of adults.

More than art, more than literature, music is universally accessible.

BILLY JOEL (1949 -)
AMERICAN PIANIST AND
SINGER-SONGWRITER

The driving force behind this investigation has been the belief that music is a basic right of all people. Although children of all abilities are encouraged to participate in music making, this expectation becomes less common with age. The research team that undertook this project believed that for adults on the edge of society, the potential for connection and expression available through music means that it is more important than ever. Adults with disabilities can successfully participate in musical experiences, from listening to playing, from singing to dancing. It is an opportunity to convey something of one's own identity whilst simultaneously connecting with others in a meaningful way. In acknowledging this belief, it became clear that the most important issue to address through this project was in terms of best practice. What is the most effective way of offering music to this group of people? Is one model of engagement more successful than another? What do the participating adults want?



Without music, life would
be a mistake . . . I would
only believe in a God who
knew how to dance.

FRIEDRICH NIETZSCHE (1844-1900)
GERMAN PHILOSOPHER

The research proposal emerged from an existing community music program delivered by The Salvation Army Brunswick to a range of client groups including people with both physical and intellectual disabilities. Anecdotal reflection on this work suggested a range of therapeutic benefits for participants in the program, including pleasure, active engagement and an enhanced sense of community. Able Music Therapy also provided

music therapy in the Northern suburbs of Melbourne to similar client groups, and these programs had come to the attention of The Salvation Army. In addition to anecdotal reports, music therapy research has identified positive outcomes for adults with disabilities, with literature posing benefits such as improved communication (MacDonald & O'Donnell, 1996; Oldfield & Adams, 1990), increased social interaction (Hooper, 2001), heightened self perception (MacDonald & O'Donnell, 1996; Montello & Coons, 1998), and enhanced motor skills (Oldfield & Adams, 1990; Whyte, 1991). In addition, expressive arts therapy is described in the literature as addressing psychological issues such as isolation and poor quality of life (Seegal, 1990), although these outcomes have not been empirically measured.

Music, the greatest good
that mortals know, And all
of heaven we have below.

JOSEPH ADDISON (1672 – 1719)
ENGLISH ESSAYIST AND POET

Measuring the benefits of musical participation in this context is a challenge for research. Although many, if not most, would instinctively agree that musical participation should result in positive outcomes, it is difficult to identify variables in this endeavor. Quality of life was chosen as the focus of this investigation and the adult participants completed questionnaires measuring objective and subjective aspects of this construct before and after the music groups. However, the concrete intellectual ability of this group of adults means that experience is not easily translated into psychometric properties. Despite careful selection of the tool, many of the adults struggled to grasp the nature of questions and this had implications for the validity of the results. The adult carers who participated in the groups were able to offer more descriptive opinions about potential benefits, but this wealth of information must be understood as representing a third-party perspective. The question of whether the effect of music making fits neatly into the box of empiricism is certainly not addressed in this study, but an attempt has been made through the inclusion of descriptive and numerical data analysis.

We are quite prepared
to admit that our singing,
especially in the open air, may
more closely resemble the
blare of a military band than
the melody of a sanctuary;
but if the people who hear
such singing – prefer it, in fact,
to any other – what then?

GEORGE SCOTT RAILTON
THE SALVATION ARMY,
HEATHEN ENGLAND

Comparing the benefits of one kind of music program to another adds an additional layer of complexity to the investigation. Music therapy theorists have recently begun to consider the overlap between community musicians and music therapists who work with vulnerable clients in the community. A model of community music therapy has been posed (Stige, 2002; Ansdell & Pavlicevic, 2004) that encompasses the wide and various ways in which music may be useful within a community. O'Grady has further refined these understandings by contextualising this relationship within a Continuum of Health (O'Grady & McFerran, 2007). Her research identified that music therapists and community musicians who are working with similar groups of participants will frequently address similar aims, use similar methods and achieve

comparative outcomes. The most significant difference noted was in terms of approach, with music therapists relying on the ethical conventions of the profession while community musicians drew on their personal values. In addition, music therapists sometimes maintained a more traditional approach even within community contexts with regards to program design, documentation requirements and assessment procedures.

Why should the devil have all the best tunes?

ROWLAND HILL

This research compared the provision of music therapy and community music with the intention of addressing the following issues:

- » Enhancing service provision through greater understanding of actual therapeutic benefits of musical participation
- » The identification of more clearly focused, intentional therapeutic strategies
- » Demonstrating understanding of the benefits of complementary clinical and non-clinical music interventions across a healthcare continuum

The result of this particular project is a model of musical participation which has immediate application potential within The Salvation Army Brunswick. Though the initial focus for research has been participants who have an intellectual disability, it is anticipated that the resultant model



may be applicable to a range of distinct contexts including aged care and mental health. The broader aim of the research has been to contribute more generally to community sector knowledge. The information presented here offers specific benefits to those currently involved or potentially interested in providing musical opportunities to clients in their service or in other community service settings.

Music is an integral part of the Salvation Army – www.salvos.org.au/SALV/STANDARD/PC_60013.html

The Salvation Army has a tradition of music making that stands proudly alongside their community and religious commitments. It is therefore appropriate, and even necessary, for this organization to take the lead on exploring the potential benefits of music participation for members of the community who are disenfranchised. This report speaks specifically to the capacity of The Salvation Army but draws on previous research and political priorities of building inclusive communities in Victoria. It provides one interpretation of applied music making for health in Australian communities.

Key Findings & Recommendations

1

Adults with disabilities value the social opportunities made available through group music making. This was sometimes actively facilitated by the music worker (p.25), and at other times by the carers (p.29), but was experienced by the participants in all groups, regardless of level of disability.

2

Participating in music is an opportunity for adults to transcend their disability. For many participants this was seen in their enthusiastic expression of joy and emotion (p.25 & p.29) and this was supported by the expectations of the music workers who had faith in their capacity for musical expression (p.30).

3

There are distinct differences between music therapy and community music programs. Community Music is frequently described as being about energy and expression, and Music Therapy captured by descriptions of meaningful interactions and self expression at a personalised level (p.22). The properties and dimensions of these distinctive approaches were also clear in the music workers descriptions of their intentions (see Table 2, pp.27-28).

4

These differences do not change the perceived outcomes of participation (p.29). All groups were described as achieving the same outcomes, feeling physically relaxed and contented after groups (pp.25-26), as well as the outcomes related to connection and strengthened identity mentioned above.

5

Service provision could be improved by the inclusion of individual time and greater bridging to the community according to comments made by some carers in centres that offer regular programs for adults with intellectual disabilities (p.36).

A COMPREHENSIVE AND PRACTICAL MODEL OF MUSICAL PARTICIPATION

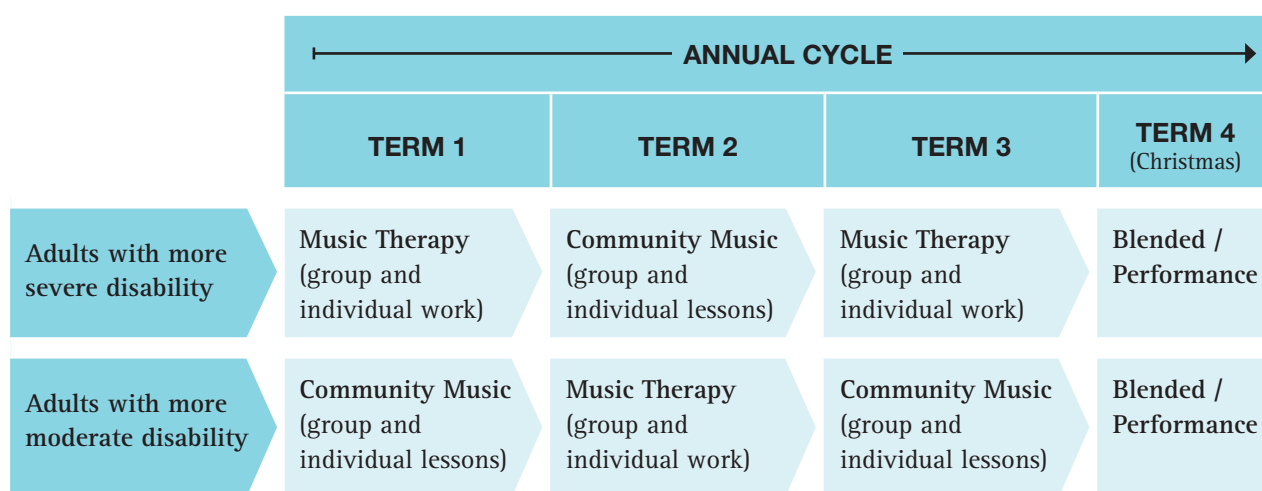
The 'Model of Musical Participation' for The Salvation Army Brunswick is the result of the final analysis of information gathered from all people involved in this project. It is grounded in the data collected across all stages of this study, but is particularly informed by the feedback from carers about the logistics and benefits of the groups (see pp.35-41). It is also strongly influenced by the beliefs held by the two music workers who facilitated the groups.

The model distinguishes between adults with more severe and profound disabilities and those who are more physically active. It acknowledges that whilst both groups benefit from participation in all musical opportunities, the pacing and expectations of music therapy and community music differ. Music therapy is more easily accessible for those

with more complex disabilities and is therefore a useful entry point for musical access. Those adults with intellectual disabilities who are able to dance and sing on the stage using a range of instruments access community music with a playful enthusiasm that fosters the achievement of their own fantasies and musical dreams. Yet, there are benefits for these adults in a more personal and intimate engagement with music, as is available in music therapy. Further, the excitement and pleasure of community music making is also an important opportunity for those adults with severe disabilities in wheelchairs.

The proposed model suggests a rotating application of community music and music therapy, drawing on the strengths and weaknesses identified in each model. This movement between programs aims to reduce any tendency towards monotony, a common phenomenon attached to most programs developed for this client group. It also allows the participants varied and diverse experiences that address different goals and provide contrasting opportunities. It

FIGURE 1 MODEL OF MUSICAL ACCESS FOR TSA BRUNSWICK



facilitates access to music in the first stage, then offers a diverse experience that will solicit diverse responses before returning to the initial connection in preparation to bridge to the community.

Of particular note to this project is the highly regarded venue of The Salvation Army hall in Brunswick that is seen as a crucial element in the success of the community music program. The atmospheric, sensory environment that is created in the Corps and Community Centre contributes to the sense of freedom and fantasy for the adult participants that should not be underestimated. The community music program has been designed specifically for these clients in this space, and functions most effectively in this way. In addition, the large number of participants that are embraced by these programs require a suitable venue.

In contrast, the tailor made programs developed by the music therapist for each individual group are flexible in location and the resources required are mostly of a musical nature. The unique strength of the music therapy program is this responsiveness, and it was particularly valued for those adults with the most profound disabilities, who flourished with the individualized attention, exceeding carers' expectations of participation. This program has the capacity to travel to adults in their own centres, reducing travel time for participants and optimizing funding.

What is missing from both programs is the active utilization of the capacity unleashed through these creative opportunities to bridge to the community. This is particularly relevant given the intentional emphasis placed upon creating an inclusive community environment at The Salvation Army, Brunswick. Music making as a pathway to greater community involvement is a critical component

of a holistic model of Community Music Therapy. Inspired by Community Music Therapy theory, this comprehensive and practical model suggests the dedication of the final term towards community performances. By timing this to coincide with the festive season, it is possible for the musical focus to be on simple Christmas repertoire that can be shared as street performances or in Christmas Carol events. The Salvation Army already dedicates resources to this role as part of fund-raising, and it is proposed that the combined skills and resources of the community music and music therapy programs could enhance this program. It provides a suitable, minimal-pressure opportunity for community participation. It utilizes a long build up of skills and understanding of the individuals involved. It allows the voices and capacity of these adults to be heard and admired in the community. They can be seen and they can be heard.

Requirements

- » Assessment processes that identify overall suitability of a group of adults from each organization
- » Scheduling and Transport logistics for whole annual cycle addressed pre-commencement
- » Adequate, and distinct, resources for each program, as well as for the performance oriented cycle
- » Time allowed for handover between group facilitators between terms

Benefits for Adults

- » Musical access for adults with disabilities
- » Opportunities for the development of social connections with those outside their own service



- » The possibility of transcending their disability through self-expression and identity development
- » Diverse experiences in both familiar and novel locations
- » Community participation in an engaged and empowering way

Professional Qualifications

- » Music therapists are professionally trained musicians with specific skills in designing, implementing and evaluating programs for adults with intellectual disabilities
- » The attributes of a music therapist include: current registration with the Australian Music Therapy Association; an interest in working with adults who have a range of disabilities; a commitment to community engagement and in accessing a range of experiences for all adults
- » Community musicians are talented and caring individuals who have an interest in musical access for all. Each one will bring a different

skill-set based on their personal experiences as musicians and community members

- » The attributes of a music worker in this setting include: an understanding of the influence of music on groups; a belief in the value of music to all community members; a capacity to perform as an individual but to sound like a band; and a genuine interest in the well-being of others

Political Climate

- » The state government has made a commitment to inclusive communities
- » Within this climate funding should be made available to music programs that can address the intentions of this commitment
- » Some funding is tied only to activities that involve physically leaving the service centre
- » Currently, this funding is acquired through annual fund-raising which puts the stability of the program at risk

Identification of a Need

The Salvation Army Brunswick has a history of 125 years of providing social and spiritual services to the local community. Today the Salvos' Brunswick network includes more than 10 social programs running across 3 main streams – Community Services, Youth Services and Disability Services. The programs run from three main sites, two at Tinning St (education, training and support services for youth and a supported employment service for people with disabilities) and the Corps and Community Centre in Albert St. The Albert St site is one of the oldest, continuously operating Salvation Army buildings in Australia. It is also a hub of activity for the local community.

Open 6 days a week, the Corps and Community Centre provides a range of critical services to disadvantaged and marginalised people in the local community. From free breakfasts, showers and laundry facilities for the homeless to drug and alcohol counselling and emergency financial assistance, The Salvation Army Brunswick serves hundreds of people each week. More than just a service hub, the consistent emphasis here is the value of community. Emerging from an inclusive and understanding church community, the weekday activities at the Community Centre promote a sense of acceptance and belonging to those that attend. A foundational belief is that everyone is valued and has something to contribute to the community.

The success of this social inclusion policy is evident from a quick scan of those who hang around on an average day. People with drug and alcohol addictions, those with physical and intellectual disabilities, people with mental health issues, indigenous and migrant residents of the community all form part of the daily mix at The Salvation Army Brunswick.

It is from this base that a music program was envisioned that would enable people connected with The Salvation Army to share their own joy in music making with those in the community who had limited opportunity. Initially set up as a community band and choir, with some associated music lessons for people on low incomes, the Salvos music program was noticed by the manager of a local Adult Training and Support Service who enquired about whether they would work with people who had disabilities. An active performance model based on previous excursions through an outreach program into aged care facilities was adopted and has been continually adapted to meet the needs of participants for the past eight years.

The current research was initiated in order to continue growing this music program and utilizing music to its full capacity within the centre. The discipline of music therapy has a history of research and practice with adults who have intellectual disabilities and the possibility of incorporating this knowledge into the already exciting Music Access Program was pursued.



Fact Finding

The literature describing music therapy with adults who have a range of disabilities provides a useful backdrop for contemplating the possible role of music at The Salvation Army Brunswick. Although there is a greater wealth of material describing work with children who have disabilities, work with adults is also documented. In this material a clear distinction is made between those adults who have multiple and profound disabilities, and those with mild to moderate disabilities. The music therapy methods that are described in this literature predominantly rely on live music making methods, with the use of recorded music being rare. The live music methods are often in the form of improvisation, although songs are also used, and the most common method includes improvisational music making within a song format – similarly to the creation of jazz improvisations where a structure is present but a great deal of flexibility exists within that.

Adults with more multiple and profound disabilities require assistance with daily life skills, they are mostly dependent on wheelchairs for mobility, and it is difficult to ascertain intellectual capacity because of the combined disabilities they grapple with. For these adults, music therapy programs have aims that address both physical and basic communication needs. The physical needs involve using music as a motivator for action. This is often in conjunction with physiotherapy or other active programs, where the therapists tailor design musical programs that foster movement of individual limbs or whole body movements. Usually the music is live so that the musician can alter the pace (tempo) and volume (dynamics) of the music in order to best encourage movement on the day for the individual or group. Music is often improvised so that the rhythmic, melodic and harmonic elements

of music are used in the most suitable way, but some familiar songs or recordings may be used.

The kinds of communication goals described for adults with profound and multiple disabilities are usually at the pre-intentional end of the spectrum. They involve engaging the attention of the individual by assessing what musical genres and timbres attract their interest. The assessment of what kind of music inspires participation can be a long process due to the severe nature of the disability, and music therapists spend a great deal of time providing musical opportunities and closely monitoring responses as they work to establish a relationship with the individual or group and to better understand their idiosyncratic needs. The pre-intentional communication skills involve joint attention and goal directed action, mostly around encouraging expressive playing of instruments and the use of the voice in the form of vocal sounds. The music therapist works with a range of adapted instruments that have been altered to make them more easily accessible using small and less controlled movements. They then provide a musical framework that encourages participation and attention and work towards achieving the adult's individual greatest communicative capacity. The musical framework again may be improvised, or may draw on known and preferred songs but use them in flexible ways, extending verses and choruses in order to wait for the individual to respond or to provide encouragement and praise for participation.

For those individuals whose disabilities are less severe, the goals described in the music therapy are more oriented towards skill development and behaviour. The kinds of skills that are promoted are around playing instruments to improve non-musical capacities such as fine-motor skills, gross



motor skills, language skills and most often, social skills. Group work is particularly important with this population as the music serves to provide a framework for social encounters – setting up turn-taking opportunities, encouraging listening and waiting, allowing individual performances and the shared experience of musical accomplishment. Music and drama are sometimes used conjointly in the form of musicals in order to practice different social requirements, often drawing on archetypal tales that include moral and social norms. This overlaps closely with behavioural goals such as waiting, reducing aggression and treating others with appropriate respect. Shared song writing and performance both provide opportunities for

debate, dialogue and mutual decision making. They also emphasise individual strengths and demand compromise in order to achieve group goals. In all these situations, music serves to maintain attention to task and provide a positive atmosphere so that tasks are experienced as enjoyable.

More recently, the profession of music therapy has been responding to the de-institutionalisation of people with disabilities by developing more community oriented programs. These programs have described working in choirs with adults and using performances as a forum for bridging to the community. Music therapy researchers have investigated the ways in which music facilitates community access, sometimes investigating the community within a group home, and at other times assisting adults to access existing community programs. This literature does not prescribe traditional treatment planning that addresses deficits, instead using a resource-oriented framework that draws on the interests and capacities of those involved to direct sessions. A combination of traditional and resource-oriented music therapy strategies were used in the data collection for this project.

Making an Overall Plan

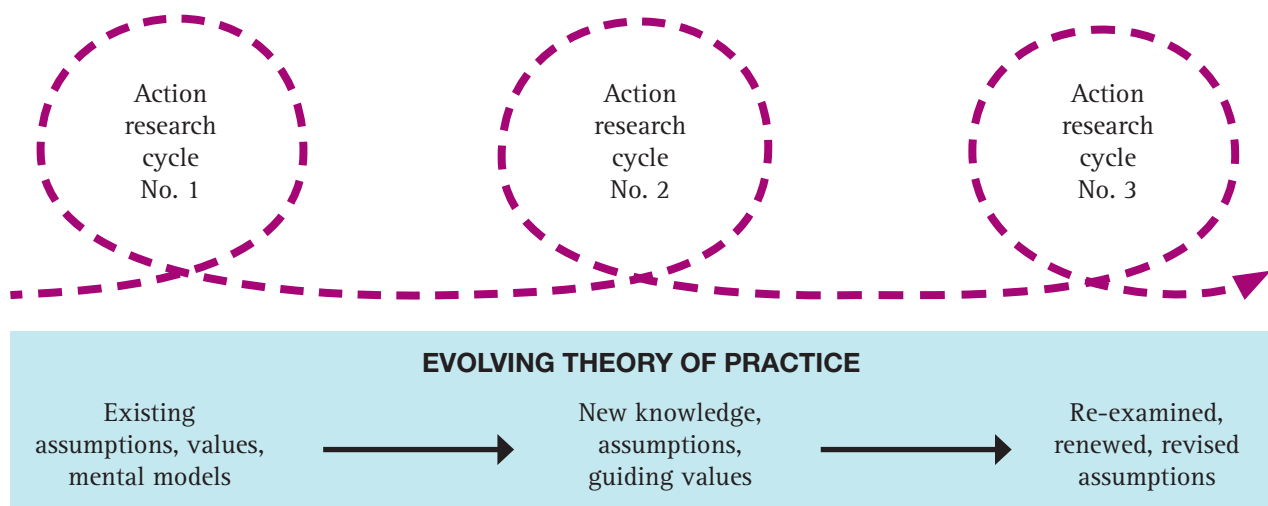
The purpose of this research project was to best convey the needs and wants of this group of adults with intellectual disabilities in relation to musical access. This was addressed using a mixed methods, concurrent, nested strategy within a participatory framework. Quantitative data was integrated with qualitative data at the point of data interpretation, with the intention of cross-validating the perspectives gathered from participants in the music groups. The decisions about each of these methodological elements will be explained in order to illustrate how the plan was constructed.

PARTICIPATORY FRAMEWORK – ACTION RESEARCH

In adopting a participatory perspective, this research project sought to value and represent the opinions of adults with intellectual disabilities. There are a number of schools of thought within the Participatory Paradigm (Denzin & Lincoln, 2005), and it is important that each research team is explicit about the particular approach they have

adopted. This research drew heavily on the ideals proposed by Reason and Bradbury (2001), who have summarized the purpose of Action Research as encouraging and stimulating communication, democratic dialogue and development. The research described in this report purposefully embraced four key principles indicated by this statement. It sought democratic participation in the research by the participants, incorporating both the adults for whom the musical opportunities were designed and the other adults who facilitated their participation. It aimed to empower these adults as musical experts, valuing their childlike (not childish) approach to musical expression, and the enthusiasm and creativity they contributed. It aspired to emancipate a silenced group of community members who are encouraged to be seen and not heard, and encouraged them to sing loudly and express their opinions freely. And it endeavoured to acquire practical knowledge about the most useful and appropriate ways of providing supportive musical opportunities for these adults, by comparing two options for group music making.

FIGURE 2 ACTION RESEARCH PROCESS



Action Research is typically described as a series of cycles of action and evaluation, often represented figuratively as a spiral. This conceptualization is important in distinguishing Action Research as a framework rather than a methodology. Within this framework, learning from each cycle informs the subsequent cycle and drives the research in an emerging design. This cyclical process is seen to encourage active participation in the research by all those involved, with all the adults in the project being regarded as co-researchers. Action Research contrasts with the more typical model of research where the external expert, usually associated with The Academy, or University, controls the project and dictates its implementation (Rowan, 2001). In this project, the various adults involved in the project offered feedback regularly and this was used to direct the emerging design of both the music groups and the research. The research team included all those involved – the adult participants and their carers, the music workers, the captain and social worker from The Salvation Army and the academic from The University of Melbourne.

MIXED METHODS DESIGN

A concurrent nested approach (Cresswell, 2003) was identified as the most useful strategy for addressing the purpose of this research. This involved the collection of both qualitative and quantitative sets of data at the same time, with the intention of integrating them at the point of data interpretation. In this case the qualitative data was prioritized because the needs and wants of the adults who participated in the music groups were thought to be conveyed most effectively using strategies that value individual perspectives.

Interview data was collected from carers who accompanied the adults with intellectual disabilities,

and qualitative thematic analysis was utilized to identify themes within each data set at each time point. This analysis occurred immediately and the identified themes were used to inform subsequent focus group interviews. All data was then mined at the conclusion of the groups with the explicit purpose of developing a model of music participation that was grounded in the participating adults' perspectives. The themes identified across the project were then cross-validated with results from psychometric tests that gathered the adult participants' perspectives through questions about quality of life at both pre and post the music group.

Psychometric data was collected using the Comprehensive Quality of Life Scale (Intellectual / Cognitive Disability) (Cummins, 1997). The ComQOL is a multidimensional tool that encompasses seven domains, specifically: material well-being, health, productivity, intimacy, safety, place in community and emotional well-being. It also incorporates dual axes, gathering data from both objective and subjective realms. The ComQOL scale is considered to be psychometrically sound by its author, being described as "reliable, stable, valid and sensitive" (p. 9, Cummins, 1997). Data was collected by research assistants not known to participants.

A further quantified measure was also taken in the form of regular session evaluations (CSRS) (Miller & Duncan, 2004), gathered from participants each three weeks. These used four questions via a large-print Likert scale that sought information about the adults' feelings before, during and after the group that day, as well as about their response to the content of the group. The Session Rating Scale has also been tested for reliability and validity by the authors, particularly concurrent validity assessed by comparison with other validated tools of the same measure (p.14, Miller & Duncan, 2000).

These data were collected by the group facilitators and provided them with immediate feedback about the individual's experiences of being in the group.

A final source of qualitative data was collected in the form of interviews with the two group facilitators. These interviews took place at the end of the second cycle and also offered an opportunity to feedback the emerging themes from analysis of interviews with carers to the music workers. These were analysed separately using an axial coding strategy from grounded theory that attempts to identify properties and dimensions of a central category – in this case the intention of the music groups.

ISSUES OF ACCURACY

The validity of mixed methods designs is a complex phenomenon. In this research, the two different strands of qualitative and quantitative data collection and analysis can be understood distinctly. By utilizing three different sources of data to reflect on the same phenomenon, the qualitative criterion of triangulation is achieved. Multiple perspectives arguably provide a depth of insight than cannot be achieved using a singular method. In addition, the comparison of these outcomes at the level of data interpretation adds to the accuracy, or validity. In this research the various perspectives of the adults involved in the group were collected – the adults with intellectual disabilities via questionnaires focused on quality of life; the adult carers via focus group interviews at the end of each term; and the adult music group leaders via interviews at the mid-point of the investigation.

CENTRAL PHENOMENON

In addressing the purpose of this research, a comparison was undertaken between community

music and music therapy groups. This comparison was informed by O'Grady's (2003) theory of overlap between the two disciplines. She proposed that the music participant's position on a health continuum was a more important indicator of the types of musical opportunities offered by music workers than their background and training. For this reason, a non-competitive stance was taken in evaluating the two groups, with the expectation of complementary overlap of experience by the participants in each group. Nonetheless, the research sponsors were interested in better understanding the nuance of difference between the two programs in order to better inform service delivery for adults with intellectual disabilities.

DEFINING MUSIC THERAPY

Music therapy is an allied health profession practised throughout Australia and in more than 40 countries around the world. It is the planned and creative use of music to attain and maintain health and well-being, and may address physical, psychological, emotional, cognitive and social needs of individuals within a therapeutic relationship (Australian Music Therapy Association, 2008). A music therapist undertakes a number of professional activities in providing services. These include assessment, development of goals and objectives, selection and employment of appropriate music techniques, methods and activities, and regular evaluation.

Music therapy focuses on meeting therapeutic aims, which distinguishes it from musical entertainment or music education. People of any age or ability may benefit from a music therapy program, regardless of musical skill or background. A Registered Music Therapist (RMT) is someone who has completed an accredited course of training at

a university. This qualification means that they have trained in various applications of music as a therapy for a range of people right across the lifespan. They have studied all aspects of music performance, history and theory, in addition to psychology, physiology, social theory and models of therapeutic intervention. During that course, students also complete substantial training with clients in a variety of clinical settings.

DEFINING COMMUNITY MUSIC

Community music has been described as group musical activity that “is controlled by the community, engages with the community and is of benefit to more people than the participants” (Cahill, 1998, p. 6). According to Bev McAlister, of the Dandenong Ranges Music Council in Victoria (cited by Cahill), community music is often involved in processes of creation, learning, discovery, celebration, relaxation, healing, and grieving (pg. 3). There is no tertiary training for community music practice. Instead it is individually developed and context dependent, based on a merging of ideals between the musician and the participants or organization who have hosted the project. Typically, community musicians are participatory in focus, with the principles of Community Music Victoria being encapsulated in two slogans: We can all make music, and, making a sounds world together.

MUSIC IN THE SALVATION ARMY

The Salvation Army has a strong and proud history of using music in the service of God. As General of the Salvation Army, Frederick Coutts clearly stated “That’s our tradition – we employ the language and the music of the people” (p. 168 in Munn & Collinson, 2007). From its very origins, brass bands served to proclaim God’s message to

everyday people. In addition, Salvationists joined these very people in their local habitats, “singing in pubs and seedy dance halls” (p. 169), even embracing the ‘devil’s music’ of Rock ‘n’ Roll and achieving pop chart success during the 1960s.

This innovative use of music is indicative of the commitment of The Salvation Army to reaching out to people in need. In this day and age, the dictate for the use of music is that:

“It must be appealing,
engaging, and
most importantly,
life-transforming.”

(P. 181, MUNN & COLLINSON, 2007)

Salvation Army music is made within the context of an overall mission that seeks to fulfill the call of the Christian gospel in service to those in need for the purpose of redeeming the world.

COLLECTING DATA

With the philosophical and methodological scaffolding in place, a logistical plan was created. This plan involved three action phases over three terms:

Phase 1: October/December 2007

Phase 2: February/April 2008

Phase 3: May/June 2008.

A range of data was collected to gather multiple perspectives on the phenomenon throughout these phases as detailed in Table 1. This timetable for collection and analysis of data reflects the tenets of the Action Research approach that

provided the framework for this study. The adult participants' opinions were constantly gathered and immediately utilized. Although the structure was predetermined, the content and process evolved in direct response to this information.

TABLE 1 TIMELINE OF DATA COLLECTION AND ANALYSIS

COLLECTION TIME POINT	DATA COLLECTED	SUBJECTS	ANALYTIC METHOD	ANALYSIS TIME POINT
Pre commencement	ComQOL	Adult Music Makers	Statistical	Conclusion
During Phase 1	CSRS	Adult Music Makers	Descriptive	Immediate
Post Phase 1	Focus Group Interviews	Carers	Thematic Analysis	Immediate
During Phase 2	CSRS	Adult Music Makers	Descriptive	Immediate
Mid Phase 2	Individual Interviews	Music workers	Grounded Theory	Immediate
Post Phase 2	Focus Group Interviews	Carers	Thematic Analysis	Immediate
Post Phase 2	Interviews Facilitators	Music Workers	Axial Coding (Grounded Theory)	Immediate
During Phase 3	CSRS	Adult Music Makers	Descriptive	Immediate
Post Phase 3	Focus Group Interviews	Carers	Thematic Analysis	Immediate
Post Groups	ComQOL	Adult Music Makers	Statistical	Conclusion

Action: Phase 1

RECRUITMENT

The Salvation Army in Brunswick and Able Australia were actively involved in identifying and recruiting appropriate persons for participation in this project. This involved identifying clients with intellectual or physical disabilities, via their caring institutions – usually day programs. Expedited ethics approval was granted by the University of Melbourne (# 0719039) and all participants signed consent forms or had consent forms signed by their primary carers before commencing in the project. One community music group was scheduled for Tuesday mornings from 10:30 – 11:30, and three music therapy groups were scheduled for 1 hour each in various locations in Balwyn, Noble Park and Box Hill.



COMMUNITY MUSIC GROUP

These music groups took place in the church hall at the Salvation Army in Brunswick. Approximately 20 people attended the group with carer support on a weekly basis, arriving in mini-buses and by public transport to take part. The music worker drew on a known repertoire of songs, primarily rock and pop songs from the 60s and 70s and invited participation through providing resources for playing, singing and dancing. A number of pieces of equipment facilitated this interaction, including bubble machines, lighting and electronic amplification. A break for morning tea occurred in the middle of each group and this was considered crucial in establishing a community feel to the group. Each group ended on a high of a favourite song or beat. Participants left wanting more.

MUSIC THERAPY GROUP

The music therapy groups followed a standardized protocol that was creatively implemented in response to the group on a given day. Approximately seven people participated in each group, allowing for a level of intimacy and personal communication in the interactions with the group leader and between themselves. Songs were used for both greeting and closure, and the music therapist selected repertoire based on the known and assessed music preferences of individual group members. The music therapist traveled to each location with a portable set of instruments for participation, and actively encouraged singing and playing as an integral aspect of her sessions. The structure of the sessions intentionally moved through warm-up to peak performance and then wind-down.

Reflection: Phase 1

Focus group interviews were conducted with carers participating in each of the groups at the end of Term 1. These were analysed immediately in order to identify themes in the interviews. The themes that emerged from this analysis depicted music therapy and community music distinctly. The community music group was described as a unique experience that was like being at a live concert where they get to play instruments. One of the male carers was particularly impressed by the volume of the music and said:

“especially with the lights, and the effects that he has, it's the closest thing to a live venue that any of these guys have access to, so it gives them that experience.”

It was important that the participants were able to actually play the instruments rather than just listen, and the fact that the music was live added an important dimension. This was in spite of the fact that the adults electric instruments were not plugged in to any power after the first week, which meant that they did not produce actual sound.

It became apparent in the first focus groups that many of the carers had observed both community music and music therapy groups in different circumstances. The most outspoken carer from the community music group said that he perceived music therapy as being “quieter and more relaxed”. This was also reflected in the comments of a carer from one of the music therapy focus groups. She used metaphor to describe the differences she perceived.

“Community music is like going for a tumble in the surf whereas music therapy is like lying down in a cool refreshing river.”

The perceptions of music therapy were more diverse than this when not being contrasted with community music. A number of themes that emerged from the three sets of focus group interviews reported music therapy as a personalized approach, which allowed for different levels of interaction. One carer explained that:

“The individual focus of music therapy means that each person can get that connection and attention. Their individual preferences and responses are all maximized, whereas in a much bigger setting, some people would be laying there and not happy with the volume and that can't be attended to.”



The focus of music therapy was on promoting meaningful interaction and facilitating communication. This involved the use of clients' names and music preferences and allowing them to make choices, including the choice to stop playing by giving the instrument back or even dropping them. The emotional quality of this musical intimacy was highlighted by one carer who mentioned a female participant that would often cry in response to a musical trigger. The carer said:

"One week it was the piano sounds, and her brothers used to play the piano a lot."

Once the thematic analysis of all focus groups was completed, the opinions expressed by the co-researchers were used to determine the focus for the coming phase. The emerging themes were described to the music workers in order to influence their

group work, as well as the ongoing feedback they were receiving through the collection of responses to the CSRS. In terms of the research process, it was decided that a more focused approach should be used in the next set of interviews in order to broaden understandings of the situation. It was important to examine whether there was more overlap between the two models than appeared to be the case from the first responses. At the end of Phase 1, Community Music seemed to be about energy, expression and 'dancing like no-one's looking', whereas Music Therapy appeared to be about meaningful interaction and self-expression at a personalised level. The questions for Focus Groups 2 would therefore involve posing the responses to the 'other group' and seeing if the carers felt that was also true for the groups they participated in. They would also have the opportunity to comment further on the themes that had emerged from their previous descriptions.

In addition, it was clear that a number of emerging assumptions were present in the data and in the stance of the professionals involved in the research. The assumptions that needed further examination were:

- » That musical participation leads to an improved life merely by being involved
- » That musical expression is a helpful way of expressing frustration and pent up feelings
- » That expressing yourself in music is unique
- » That the physiological experience of music making is healthy.

Action: Phase 2

After a break for Christmas Holidays, the music therapy and community music groups commenced again in February and ran until April 2008. Both music leaders were aware of the perceptions expressed in the focus group interviews and integrated this knowledge into their facilitation of the groups. The community music group leader took the opportunity to attend one of the music therapy groups, picking up on the idea of changing the words of songs to incorporate participant's names. The music therapy group leader reflected on how the information matched with her observations

of community music and contemplated the perception of active music therapy as 'peaceful'. In both cases the level of engagement and participation in the music groups was increasing as the adults became more familiar with the environments and aware of what was possible for them. The carers were also becoming more conscious of the intended outcomes of the music groups through the Action Research process and this seemed to stimulate their own thinking. At the end of the term a second round of focus group interviews were conducted.



Reflection: Phase 2

Where the first round of focus group interviews had drawn on an open-ended approach to interviewing, the second round was approached with a more specific agenda. The carers were asked specifically about the themes that had emerged from the previous groups, both in confirming the interpretation of their opinions and in considering whether elements from the other music group may also be true for them. Perhaps as a result, the responses were much more elaborate in this second approach. The distinctions began to appear more blurred and similarities began to emerge.

The descriptions of music therapy were deepened in response to the reporting on initial perceptions. The one-to-one relationship with the music therapist was described as very special. Carers spoke of a connection that the music therapist made with the individuals in the group through the musical encounter and noted that this was coveted. A number of individual stories were offered as illustrating the importance of this relationship, such as the following.

"Rachel (the music therapist) will come off her chair right in front of this person when she's singing the welcome song or the goodbye song and the client loves that because she knows it is one on one... she'll really speak to this person and say her name

and she knows 'this is about me', so it's really personalised for her. She loves it. She recognizes it's for her."

They noted that the connection was fostered because the attention was individualised. This was particularly strong for the members in the group who had the most profound level of disabilities. Carers described that in music therapy "we stop the group and refocus and do stuff whereas in a big group you just gotta carry on and people get left behind". In addition, the music therapy groups were considered useful when people had limited physical capacity.

"It's more sensitive to the individual, more flexible due to small group size ... the music is an excellent sensory medium."

The connection was not only with the music therapist, but also a social connection with other group members. "They laugh when other individuals are being sung to, acknowledged within the group". The different participants were also described as having an increased tolerance for dealing with group dynamics in the music therapy group, where in other situations they may not cope as well with the demands of that

kind of encounter. One of the music therapy groups involved mostly adults with severe and profound disabilities, who were not able to initiate or even make clear choices about their daily needs. A carer from that group noted that

"In a group like this it doesn't just happen automatically, you've got to connect with clients, otherwise you've got a whole group of individuals."

Aside from social connections, the carers also spoke at length about the way that music therapy engaged the adults. They described increases in concentration as well as interaction. This was often described as an emotional connection because of the special properties of music – "it penetrates to where we can't reach". This also resulted in opportunities for expression, particularly the expression of joy.

"with this particular adult, this is the one place where she finds her voice. We usually have music playing out there and she does this kind of dancing thing all day long ... but she's supposed to have chest and foot restraints but she refuses

to wear them in here ... She's very quiet, all the time. I mean, you'd never know she was in a room, but in here she's screaming and barking at the top of her lungs, having a great time ... in a different group situation she'll usually just blend into the paint."

Afterwards clients were described as being more relaxed. This included being "less agitated", more "calm", "contented" and "tolerant". In reflecting on the physical impact of music therapy for the group with multiple and profound disabilities, the carer commented:

"My guys don't get tired. It gives them energy for the rest of the day. I just think it's a positive for them. They really do get so much out of this group ... I think that the people it works for, it works wonders."

The results from the community music focus group were similar, although less data was generated because less carers were interviewed. Those that were reiterated previous themes such as being beyond the realms of their usual experience.

"They wouldn't be able to experience this normally. Coming here, they can dance and sing. And the big thing is that they feel comfortable doing that. People won't be judging, watching them, look at them. The rest of the week they're all quiet."

They also elaborated on the value of coming to the stage-like venue of The Salvation Army hall in Brunswick as an opportunity for people to fulfill their fantasies. This was particularly noteworthy for the adults who were able to move independently on the stage. The carers described the experience:

"They've taken away their disability – I'm going to sing and dance like a normal person, like a pop star."

The effects of the group were described as beginning before the group and lasting after it had finished. The adults looked forward to it all week, and although they were exhausted after it, this was considered to be a positive.

"On the way back, they ask for the radio turned right up and they continue until after lunchtime, they're still going. They don't come down from that high until after lunch."

The carers also made an important point about the community music group being an individual experience. They noted that although some of the participants may get together and dance, it was more about the sharing of their personal fantasy with someone else, rather than incorporating them into it.

"It's their time. It's almost as though they don't care what the others are getting out of it, but as long as they're getting something, they're cool."

Action: Phase 3

The music therapy and community music groups recommenced for the third and final term at the end of April 2008. The groups were now working towards closure with clients as funding was not ongoing. In the music therapy groups, this involved the creation of a CD for each group including the adults' favourite songs as well as live examples of the adults playing together on instruments and using their voices. In the community music group it was business as usual since the group leader invited members to attend other groups at the conclusion of the current project.

At this point the two group leaders were interviewed in order to determine a focus for the final group interviews. These interviews asked the group leaders to articulate their intentions and use of music in running the groups. This began with seeking descriptions of what they did, followed

by why they did it and finally the expectations they had of participation. After conducting a broad open coding on the two interviews it became clear that the two leaders approached their work very differently. A comparison was then undertaken using an axial coding strategy from grounded theory analysis. Various properties of the two approaches were identified and the distinct dimensions were documented based on the interview transcripts. The results of the comparison are presented in Table 2. Many differences in approach were identified through this process: from intentions to expectations; from the ways that leaders selected music to be used to the overall shape of the session; from their background understandings of participants to their level of involvement. There was very little apparent overlap apart from the use of music with groups.

TABLE 2 A COMPARISON OF COMMUNITY MUSIC AND MUSIC THERAPY BASED ON THE GROUP LEADERS PERSPECTIVES

MUSIC THERAPY IS...	AXIAL CODING PROPERTY	COMMUNITY MUSIC IS...
A discipline with consistent approaches to practice. Music therapists have models of practice that they draw up on in response to clients	PROFESSIONAL CONTEXT	Individual and influenced by the practitioner. Brings skills from professional work as musician and gradually develops a program specific to the context.
Individuals	FOCUS WITHIN GROUPS	Environment
Choice / control	PROVIDES OPPORTUNITIES FOR:	Fantasy / role-play & Sensory Stimulation
Intimate - circle, facing one another	CREATES ENVIRONMENT	Atmospheric - dark and stimulating
Smaller is better	PREFERRED GROUP SIZE	Bigger is better
To facilitate interaction - with one another and leader / carers	LEADERSHIP ROLE	Non-controlling - leave it up to them

MUSIC THERAPY IS...	AXIAL CODING PROPERTY	COMMUNITY MUSIC IS...
Use names, client preferred songs	STRATEGIES	Set up space, use music to stimulate atmosphere
During improvised musical interactions	EXPECTATIONS OF SOCIAL INTERACTION	Space if individual clients are interested, but not expected.
To engage	ROLE OF MUSIC	To activate
Based on client preference	MUSIC SELECTIONS	Based on decisions about influencing the mood
After period of experimentation, identify preferences of each individual	INSTRUMENT CHOICES	Leave individuals to select - tend to go to the same things
Encouraged at suitable level through communication and group process, depending on level of capacity	LEVEL OF INTERACTION	Instrumentalists may be more self oriented, where those on the floor are more interested in sharing
Accepts disability and works with musical being	APPROACH TO DISABILITY	Encouraged to transcend their disability
Theoretical Learning of aetiology and methods as part of university training	UNDERSTANDING OF DISABILITY	On site learning through experience and workshops
Support instrument playing	ROLE OF CARERS	Participate and assist
Some dance, some work hard to play instruments	PHYSICAL MOVEMENT	Some dance, some play on stage
Gradually bring to a close in preparation for departure	CLOSURE	Leave them wanting more

Reflection: Phase 3

Identifying the vast range of differences in the approach of the group leaders led to further questions to be posed to the adult carers in the final focus groups. The distinct elements were shared in the focus groups and the co-researchers shared their opinion on various aspects of these ideas. They were also asked if there were any outcomes they could see now that were not obvious initially in an attempt to capture any changes over time from their perspectives. Finally they were asked for recommendations about how they would like to see programs being provided.

The most striking feature of these interview was that the distinctions articulated by the group leaders were not understood by the adult participants. When they were described to them, they disagreed and it was only on a rare occasion that any of the co-researchers agreed with the differences being posed. More often they would offer examples of how they felt the group they attended actually addressed the outcomes posited as belonging to the other.

In regards to the community music group, the interviewer focused on the most relevant properties related to what actually happened in the group. She asked about what musical opportunities were provided, the instruments that were available and musical material that was used, the expectations of social interaction and physical movement and the structure of the group. In response, the co-researchers focused on two main benefits of participation – the freedom to express themselves and social interaction. They described the more passive participants as being “more wild than usual” in the community music group, and those with behavioural problems as being “occupied” and “enjoying it”. These diverse outcomes were thought to occur because the music group provided an opportunity to be themselves.

“A chance to express themselves. I think is what it is. Like, it's a chance to get here and no-ones going to look at them if they're using the microphone and they can play the guitars and it's all good.”

Social interaction was considered to be a significant outcome of this community experience, where different adults from different services came together in this atmospheric venue to make music. They grew to know one another and this became more obvious as they went along.

“They get excited when we meet out the front and it's like ‘wow, you're here’.”

They were described as “interacting constantly” with one another, but instead of this being facilitated by the group leader as it was in the music therapy group, it was initiated by the more able group members and the adult carers who considered this to be their role. The carers enjoyed their function in the group as a part of the social dynamic, working “in partnership” with the adults with intellectual disabilities.

"That's more obvious here,
it's harder to be on the same
level in other programs."

In contrast, the group leader was seen as the "entertainer" someone who was inclusive and pleasant, providing music and "a focus for everyone".

These reflections on personal expression and social interaction were echoed in the music therapy groups. The focus on personalized interaction was noted by most of the focus group participants who described a kind of reciprocal engagement that was traditionally difficult to achieve with the adults who had more profound disabilities.

"It's a communication
between Rachel and the
group participants and I think
that because from the start
Rachel has always referred to
them by name and using the
introductory songs and cards,
the choice and decision

making and just being able
to suss out an answer from
them. So there has been a
definite, a lot of steps made."

The focus group participants expressed clear understanding of the group leaders intentions, noting that she grew to know each adult and what they responded to over time. The participants described the music therapist as a skilful facilitator who used pacing and choices in order to make the music opportunities accessible for the different group members. It was this flexibility in leadership, combined with the music that led to the ascribed benefits.

"There was an expectation
(from the group leader) of
growth and development
that perhaps I had not
thought was going to
happen, so having thought
that, I now think it could go
to another level again."

Quantitative Results

DEMOGRAPHICS

Basic data was collected on the participants in this study about age and gender. This information was not consistently answered between pre and post tests, most likely due to the intellectual disabilities of those answering the questions. This resulted in a number of discrepancies in age data. The pre-test information has therefore been used. More males than females attended the groups overall, with no significant differences between the groups as can be seen in Table 3.

TABLE 3 GENDER DISTRIBUTION ACROSS COMMUNITY MUSIC AND MUSIC THERAPY

GENDER	CM	MT	TOTAL
Female	9 (47.4%)	7 (38.9%)	16 (43.2%)
Male	10 (52.6%)	11 (61.1%)	21 (56.8%)
Total	19 (100%)	18 (100%)	37 (100%)

The age of participants varied across the adult lifespan, with the majority of attendees being in their twenties, but also a number of participants in their 40s and 50s. Once again, no noteworthy difference was observed between the groups.

QUALITY OF LIFE

In analyzing the results of the Quality of Life tool, there was no clear distinction between the two groups of participants. The objective measures of quality of life were not likely to change in response to the music groups, since these questions focused in the main on aspects of daily life such as material well-being, health, productivity, safety, responsibility, hours of activity in the community and advice. Two sub-scales of interest were the intimacy and emotional well-being subscales. In reviewing the level of change in intimacy rating, there was a slight pattern of increase evidenced in the music therapy group. Eleven of the 15

FIGURE 3 DISTRIBUTION OF AGE ACROSS BOTH GROUPS

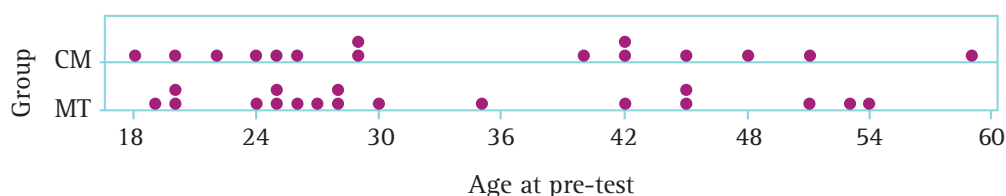


FIGURE 4 CHANGES IN INTIMACY RATINGS ACROSS BOTH GROUPS

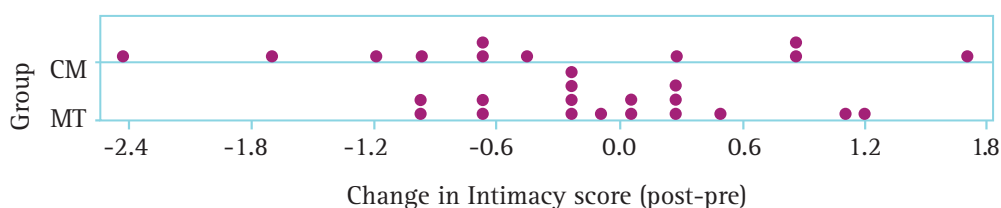
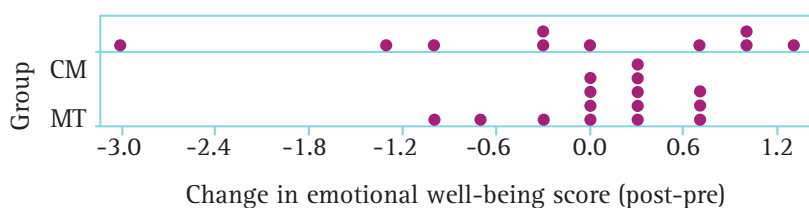


FIGURE 5 CHANGES IN EMOTIONAL WELLBEING RATING ACROSS BOTH GROUPS



participants noted a small improvement, with 4 noting a minor decrease (MT). The scores from the community music group (CM) were more spread across the whole scale as can be seen in Figure 4.

The emotional well-being scale displayed a similar pattern, but with less inclination towards improvement, and the majority of the participants in the music therapy group remained very stable or slightly improved (MT). Again, the results from the community music group were spread across the scale (CM).

The subjective scales were of great interest to the researchers because they provided a perspective on how important and satisfying the objective measures were to each individual. If the objective results had offered any indication of a pattern,

these results could have been used to further qualify them. However there were many challenges in soliciting this information from the group because the nature of intellectual disability suggests a more concrete understanding than a subjective quality of life measure is addressing. In addition, the test itself was designed to first assess the degree to which each individual could make and communicate these judgements using a visual rating scale. This process was lengthy and complex, and the research assistant was not convinced that the results provided an accurate reflection of the individual participant's views on the subject. As a result, a different number of categories were used for different individuals which made it hard to compare results across groups. Expressing the scores as percentages was thought to be the best way of doing this, however it was still not ideal. Finally,

the scores are averaged, based on the percentage and so specific relationships to each sub-scale are difficult to discern. Keeping these qualifications in mind, the participants reflections on the importance of the indicators of quality of life offered was only minimally changed between pre and post testing, and a similar spread across the satisfaction with their present situation was also clear.

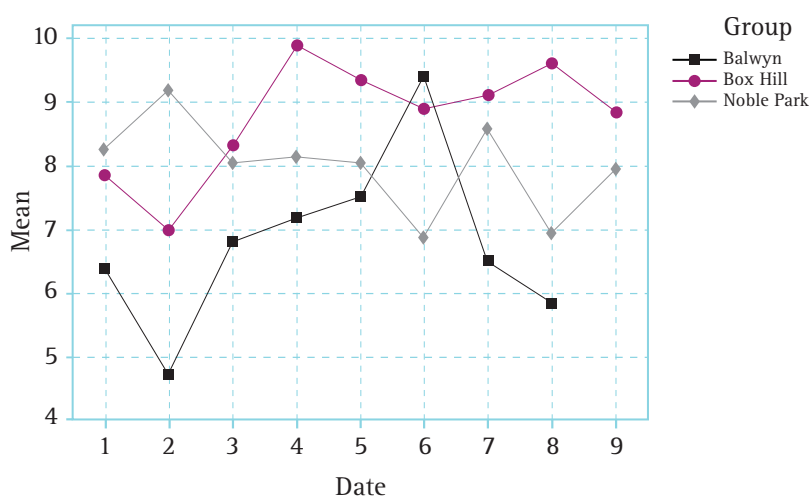
In sum, the test proved too challenging for most of the participants in the study, so that in total only 25 responses were received. Of these, the research assistants only felt confident that a small number were a useful indicator of actual experience for the individual involved. Since these kinds of tests are designed to reveal trends in larger groups, it is not surprising that very little could be observed. The qualitative data has therefore filled in understandings that were not strong enough to be identified as patterns in the quantitative data.

SESSION SATISFACTION SCALES

Analysis of the Session Satisfaction scales did not reveal any persistent patterns. The data collected by the community music groups was fairly inconsistent and used a different scale to the music therapy group and therefore it was not possible to compare the two groups to one another. However the music therapy group responses could be used to compare the three different groups to one another, as well as to determine if there was any improvement across time. The questions in this tool asked about whether the individual was looking forward to attending the group, whether they liked what happened in the group, whether they felt better after the group and then an overall response to the group in terms of whether they would like it to be the same or different afterwards.

The results of the analysis indicated that some sessions were received more favourably than others and that this did not necessarily improve or worsen over time. Once again, these results

FIGURE 6 SESSION SATISFACTION SCORES FOR THE MUSIC THERAPY GROUPS



need to be understood in context of the small numbers involved in the study. A closer analysis of the comparison between the three music therapy groups reveals that the 'Balwyn' group consistently indicated the lowest level of positive responses. This group consisted of adults with the most profound disabilities of all groups and were the least likely to have been able to answer the questions. The 'Box Hill' group appeared to show the most favourable responses to the overall question of how much they had enjoyed the group, and this remained steady across all the session data collected. This group consisted of adults with the highest intellectual capacity. The 'Noble Park' group had the most varied responses, seeming to move up and down at each time of testing. This may have been a response to the individual session, or it may indicate that the tool was not experienced consistently by them. Figure 7 shows the responses to question 3, which asked about whether each

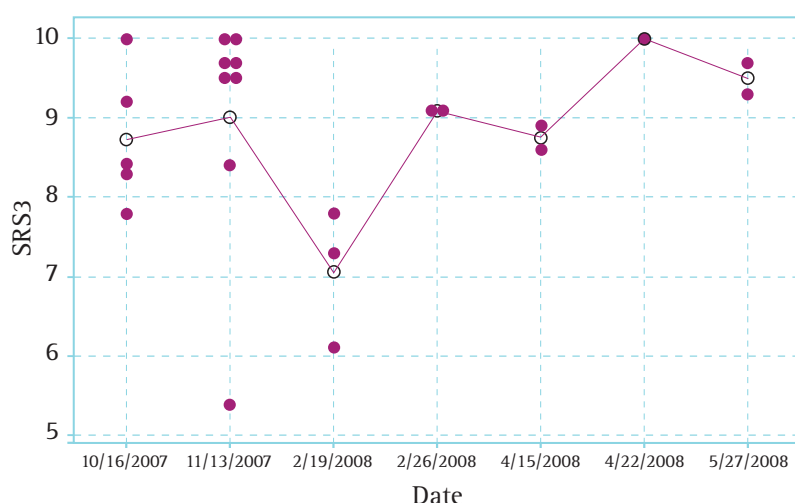
participant felt better after the group. The patterns captured here were similar across the questions.

The community music group data was similarly inconsistent and marked by jagged patterns of responses. In comparison to the music therapy group, the participants in the community music group could be broadly considered to have a similar level of disability to those in the Box Hill and Balwyn groups. Overall their intellectual disability was less profound although there were some individuals in the group with severe intellectual disabilities.

SUMMARY OF QUANTITATIVE RESULTS

The tools used in this study did not generate any significant results. From a conservative perspective, nothing can be said about the data due to the minimal patterns observed and the small numbers involved in the study. Yet some greater improvements were seen in the subjective quality of life measures, and these were more evident in the music therapy groups than the community music groups. The session satisfaction scales were more useful to the music workers at the time data was collected, offering immediate feedback about the perceived value of the sessions. Overall, this data was sporadic however and no consistent trends could be seen across time.

FIGURE 7 'FEELING BETTER AFTER THE GROUP' SCORES FOR MUSIC THERAPY GROUPS



Conclusion – Piecing together a model of service provision

LOGISTICAL FEEDBACK

Throughout the focus group process, the carers were asked for feedback on the program. Whilst this was focused on the nature of the music program in the main, participants often had concrete suggestions for developing the program or supporting the way that the program was running. These were specifically sought in the final focus group interviews where the adults were asked for recommendations about continuing service. This feedback has been compiled under the following themes.

The Salvation Army hall in Brunswick is a great venue

One of the focus group participants was able to reflect on the quality of the community music program at the Salvos in comparison to the program the same group facilitator offered at the participant's own centre.

"It's very different because he doesn't have as much amplification so it's not as loud, and wouldn't get that aspect of it, and you don't get the lights, so it's very different, and I much prefer it here because of the venue. They do bring a box of instruments,

and there's a lot of dancing and stuff, but if you were to put it on a scale it would be a 2 compared to this which is a 10. It's light not dark like this."

This particular carer was very impressed by the loud volume of the program as can be heard in this feedback, and volume does need to be taken into account when musical programs are staged in other centres. Music programs of any kind involve noise and most facilities are not designed to deal with beating drums and enthusiastic percussion playing. Another carer noted that their funding for participation was tied to community participation and therefore being able to travel to a venue, at least some of the time, was critical for them.

"Yes, the venue is great and we wouldn't access the program if it just came to us because we're about community inclusivity."

Another carer who was commenting on the music therapy groups was able to turn this around to justify the community element of an inhouse program.

"An external person who knows what they're doing with music, to me that sets the program apart from other programs that we do... This is unique in that somebody comes to this premises and gets to work on our site, comes to us, so there's still that interaction with a member of the community, but it's done here as opposed to we go to a particular community venue."

Other carers made less explicit reference to the importance of the stage in the Salvos Hall as providing a basis for fulfilling fantasies and 'going beyond their disability'.

"Their fantasies come true – there's the girl that always sings and dances, but she looks beyond us down here, to the bigger

audience out there, not just us. It's like a dream fantasy that's coming true for her."

This enjoyment of the venue was in spite of some of the more intimidating aspects of the location, particularly due to the number of people with conspicuous mental illness that access support through the Salvos.

"Clients have been quite frightened by the street people and the level of mental illness. There's one of them that comes in and stares at us, and that's quite daunting, because we don't know her and what kind of response she needs to keep her contained."

An alternate term basis

Most of the carers in the four focus groups were happy with the model being provided for them at that time. They felt that the length of programs was suitable and that a weekly format was useful for "structure and routine". One adult carer who had participated in the music therapy groups did note that there was potential for

any program to grow stagnant and made the innovative suggestion of alternating terms.

"I would like to see something perhaps on an alternate term basis. There's always that risk of over-kill, or what I refer to as outstaying the welcome. I feel that a term is sufficient enough to build up that level of anticipation and routine, but it doesn't have to just continue on and have the risk of seeing the level of interest plummeting."

This suggestion matches with many professionals' experiences with this group of service recipients. The challenge to find novel programs is multiplied by the complex needs of the participants and is often overlooked for practical reason such as availability of options and suitability. This does not mean that the idea is not important. It may be particularly so.

The importance of individual opportunities

Another carer from a different music therapy group also made a novel suggestion about

valuing the individual, yet social time that was afforded by music therapy. She suggested running smaller groups that alternated each week.

"To have 2 hour with say 2 people one week, then 1 hour with another 2 or 3 another week to give opportunity for other people who were not able to access it this time."

This model is growing closer to the kind of music therapy programming that occurs in special schools, where individual time is valued in order to foster skill development and personal growth. Whilst great benefits are perceived from this model of intervention, it is not a model that has been supported in the adult sector which has a more overt focus on community inclusion. It is possible that this is simply because it costs more to provide individualised services to clients and service providers are usually under-funded in this sector.

COMPARISONS OF COMMUNITY MUSIC AND MUSIC THERAPY GROUPS

A number of the participants in the focus groups made reference to their experience with both types of music groups outside this project. This provided a useful opportunity to ask them to articulate the differences that they perceived, although they were not a direct reflection on the two programs being

provided here. The carer who was vocal about the need for volume felt the difference was significant.

"The closest it (community music) comes to is music therapy, with music therapists. That was always very quiet. When we actually used trained music therapists, it was very quiet and calming, and if the guys actually broke out in loudness, they were asked to calm down...Most of the music therapists I've come across are very quiet – music is meant to be felt, it's an active thing, so you need to have it louder than just quiet guitar."

Although it is not true to say that music therapy groups are always quiet, the distinction between the two is a valid one in terms of intention. This difference was also the focus of other carers who contrasted music therapy to community music programs they had accessed.

"The people who benefit mostly from the facilitated Disco are the front row participators, and the others can't connect so well."

It is noteworthy that a facilitated disco is quite different to the community music program designed for The Salvation Army Brunswick, which is live and offers a range of instruments to the adult participants. Another carer commented on the response of her client, who particularly enjoyed the opportunity to be involved in the selection of songs.

"She used to go to a music group last year with a different carer but most of the time, in fact, every time she would crack it big time and have to leave after ten minutes ... and I was hesitant thinking, "How's this going to go?" but I tend to think they would sing the songs and other guys trying to sing the songs, it wasn't

... up to her standard and it
... was spoiling the music ..."

The program being described was run in a local RSL venue and was designed more for adults with mental illness and therefore the lack of connection may equally have been related to the fellow audience members.

The importance of instruments was also noted by one carer, who felt that simply attending a singalong didn't offer as many opportunities to a diverse group of adults with disabilities.

"We had a concert here two months ago ... and they invited a Scottish guy who led the group in song and I think that kind of forum, where there's no instruments, if you don't have a voice, I mean that really favoured verbal ambulant people."

Whilst it was useful to hear the comparisons made between music therapy and community music groups, the outside music experiences being described did not have much in common with the community music program from this project. This finding illustrates the importance of

a specifically designed program for the proposed audience. The Salvation Army Brunswick program has developed over a number of years and is designed for the specific venue and the people who attend. This is the strength of the particular community music program investigated. The music therapy program, in contrast, followed a systematic and standard session plan and process that was based on theory and research about working with this people who have a range of disabilities. It was flexible to the individuals within the group, but the structure was consistent.

COMMUNITY MUSIC THERAPY THEORY: A PHILOSOPHICAL APPROACH

"Through collaborative musicing it is possible to mobilize resources for the benefit of individuals and communities."

(STIGE ET AL, 2009)

Recent theorizing in the field of music therapy has led researchers to investigate very similar situations to the one being examined here. Music therapy has responded to the increased community focus in service provision for people with disabilities by considering new models of practice. After a period of undocumented and practical exploration by clinicians internationally, this new model of

work was identified and scrutinised. The resulting theory is infused with a participatory inclination, growing as it does from practice in Scandinavia where the tradition of social justice is strongly advocated. It recognises that: “Music as a social phenomenon is both a very common thing and potentially also a very special thing” (Stige et al, 2009), and encourages music therapists to work flexibly in order to establish situations that enable each participant to participate in a way meaningful for him or her. Community inclusion has been actualised in these models through performance, with music therapists supporting groups to participate in local activities and to create CDs of their own musical output. This bridging to the community is considered to be essential in the model of community music therapy that is proposed for working with adults who have disabilities. The connecting potential of music is seen as the most important contribution that can be made in that context, and contrasts with the models developed in prior decades that focused only on social relating within the group.

THE MUSIC SPACE MODEL: A MORE PRACTICAL MATCH

A distinct but related model of music therapy practice that has emerged from Britain is the concept of Music Space (www.musicspace.org). The involvement of the community is once again seen as critical, but the sole utilisation of music therapists as the music workers is avoided. Bunt’s conception is built around an actual ‘Music Space’ which is based in the community and provides the full spectrum of music services (Bunt, 2004). This includes music therapists running individual and group sessions, as well as community musicians running larger group projects, and collaboration towards performances. A progression through

services is usually anticipated, with individual work being used to engage the musical aspects of each person and determine preferences, needs and desires. From here, group work is offered, and if successful, leads into participation in blended community choirs and musical groups. In this case the performance aspect is not a requirement and when it does occur, often incorporates a practical, fund-raising orientation that does not always rely on the participation of people with disabilities and illness.

THE DUAL ASPECT PROCESS MODEL: CLARIFYING PERSPECTIVES

One further model with relevance to the results that have emerged from this study comes from research in Intensive Interaction. Intensive Interaction is a way of communicating individually with people who have a severe disability that utilises similar strategies to those found in traditional music therapy practice – close listening, and interpreting and valuing of non-verbal communication attempts that are responded to in a mother-infant interaction style using mirroring and extending. In examining the intentions of practitioners, Firth (2008) identified two approaches with two separate intentions. The first is titled a ‘Social Inclusion Process Model’ which focuses on an unconditional and personal acceptance of communication strategies and often results in an initial “relatively rapid expansion of someone’s sociability and communicative practice”. This is often evidenced in individual music therapy work, where people who were considered non-communicative prove that this is not the case in responding to opportunities to participate in music. The second model is the ‘Developmental Process Model’ which is usually employed by allied health professionals such as

Speech Pathologists or Music Therapists. This is often focused on long term achievements of improved communication skills that lead to an extension of communication skills more broadly. It is often the focus of practice in special education with children who have disabilities and again, best served in individual contexts. These models are not mutually exclusive, but they do suggest a different intention on the behalf of practitioners. In the current political climate for adults with disabilities, both aspects should be valued, however the emphasis on social inclusion and the solicitation of latent communication skills seems most relevant.

In contemplating these three potential models for relevance to this project, the importance of social inclusion is commonly represented and connected to this is the fact that social inclusion relies upon basic communication skills. Music is an inherently social event, which has been reinforced by the feedback from focus group interviews. The successful connections that have been established in both the community music and music therapy programs could be better achieved through supplementary individual work and better utilised by bridging to the community. This creates logistical challenges around scheduling and planning that may not appear initially attractive.

Taking this into account, a new model has been proposed for The Salvation Army Brunswick that may have relevance for other significant service providers in the field of Adult Disability. This model emphasises social inclusion, draws on the diverse intentions of the two types of music programs, and incorporates the logistical suggestions made by individuals who participated in this program. The pièce de résistance is the final stage of community performance, incorporated into traditional community performance period of The

Salvation Army – carol singing. This provides an appropriate and feasible opportunity for the adult participants to contribute to the community, as well as receive from it. It draws on the need for all to experience the gift of giving, whilst also providing these adults with an opportunity to be heard. Who says they can't sing after all? We should all have the chance to hear these important voices and to value diversity in the Australian community.



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