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**Characteristics of staff interaction with music therapy in a forensic
psychiatric setting: examining the clinical implications.**

A thesis in partial fulfilment
of the requirements for the degree of

Masters of Music Therapy

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Abstract

This study was conducted within a qualitative paradigm, using naturalistic inquiry as the methodology. The primary aim was to discover what sort of impact the attending staff member had on the dynamics of the group music therapy session, in a forensic psychiatric setting. The secondary aim was to establish the features of the interaction between staff and music therapy. Themes of the above two aims were collated to form a template of clinical considerations for the music therapist working with staff in a forensic psychiatric setting. Three male forensic clients participated in five group music therapy sessions. These were co-facilitated by the researcher and a co-music therapy student (CMTS). In addition, six staff members, employed at the research location, were interviewed in order to ascertain their understanding of the staff member's role in the music therapy session and what role they perceived music therapy assuming in a forensic psychiatric setting. Descriptive notes were collected from the video footage of the group music therapy sessions and interviews were transcribed verbatim. Data analysis involved the use of non-cross sectional data organisation. Summaries of the clinical work and results from the interviews indicate that the attending staff member has a strong influence on the interplay and dynamics of the group. Both negative and positive influences surfaced. Education of staff members about music therapy processes and the role of staff members are essential aspects of clinical practice in this setting. Education regarding the above factors reduces anxiety for staff members participating, encourages support of the program, and ensures staff members engage in a way that assists with the therapeutic

process. Finally, the study indicates that communication and dissemination of the clinical work with staff is demanded outside of the music therapy space in order for the music therapy program to successfully meet client needs in a forensic psychiatric setting.

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CHAPTER I

Introduction

Background of the study

Music therapy is still a relatively young profession in New Zealand. The recent establishment of a training program is anticipated to greatly increase numbers of music therapists practising in New Zealand in the near future. As a consequence of a pioneering field, music therapists are obliged to fulfil certain responsibilities. Firstly they need to educate the staff within workplaces about the existence and work practices of music therapy. Secondly, music therapists need to cultivate good communication links, which will encourage healthy working relationships with staff.

This study is set in a forensic psychiatric institution. The term *forensic* is defined in the *The New Oxford Dictionary of English* as: “relating to, or denoting the applications of scientific methods and techniques to the investigation of crime” (Pearsall, 1998, p.718). *Psychiatry* is defined as: “the study and treatment of mental illness, emotional disturbance, and abnormal behaviour” (Pearsall, 1998, p. 1496). Thus, when forensic and psychiatric fields are merged to form forensic psychiatry, there is a combining of legal and mental health issues. The result is, in forensic psychiatric institutions the music therapist and other staff carry the responsibility of maintaining safety, as well as fulfilling normal professional duties.

Staff from herein will be referred to as the multi-disciplinary team (MDT). The MDT has evolved as a commonly used term for a group of health professionals who form a team and work with clients with complex needs (Twyford, Parkhouse and Murphy, 2005). Registered nurses (RN), mental health support workers (MHSW), social workers, occupational therapists (OT), OT aids (OTA), psychiatrists, psychologists and other health professionals make up some of the MDT in the forensic psychiatry setting.¹

In New Zealand, forensic psychiatric institutions that are designed for clients with an ID or both an intellectual disability (ID) and a mental illness have only been established recently. It is this type of institution that is the focus of this research. Definitions of ID and the various mental disorders will be provided in the first section of the literature review.

A definition of music therapy is required before discussing the background and significance of this research project. As music therapy is based on the universal response to music, the clientele that it can potentially benefit is very wide ranging, from the young to old who are physically, socially or emotionally challenged (Hanser, 1999). Brooks and O'Rourke (2002) provide the following definition from a New Zealand perspective:

¹ A list of the abbreviations is available in Appendix A for the reader to refer to.

Music therapy is the use of organised sound and music within an evolving relationship between client and therapist to support physical, mental, social and emotional wellbeing. It is a professional discipline that focuses on abilities rather than disabilities. Music therapy seeks out the positive and healthy aspects of the person. It involves an acceptance of the real person, how she or he feels, responds and acts at a given moment in time (Brooks and O'Rourke, 2002, p.1).

Music therapy in forensic psychiatry in New Zealand (and to a certain degree internationally) is a new therapeutic discipline. Spang (1994) conducted pioneering work in this field in New Zealand and thus provided a starting point on which future work in this field can be based. Outside of New Zealand, the music therapy literature relating to this topic presents good understanding of the typical needs of this population and how their needs can be met through various goals and music therapy methods. Some early examples of literature in this field are from Nolan (1983), Thaut (1987) and Hoskyns (1988).

However, there are gaps in the literature. There is a shortage of articles that document music therapy work in forensic psychiatry with clients who are diagnosed with an ID and a mental illness. In addition, there are few articles that focus specifically on the environment in which the music therapist works in this setting. At present, there is no literature directly focusing on the effect that MDT involvement may have on music therapy sessions, and how the music therapist can integrate MDT member attendance into music therapy sessions.

As a student gathering clinical music therapy experience, the researcher gathered insight from clinical work conducted in the forensic psychiatric setting. There were some aspects of the clinical work that differed dramatically from experiences on other clinical music therapy placements. The researcher discovered that conducting clinical music therapy work in a forensic psychiatric institution demanded a high level of interaction with the MDT. It should be noted that the researcher was also facilitating clinical work with a co-music therapy student. Therefore, interactions occurred with the MDT, the co-music therapy student (CMTS) and clients.

The researcher interacted with the MDT on a number of levels. The researcher and CMTS developed a close working relationship with the OT on site. The OT guided the researcher and CMTS through a long orientation, where in-depth knowledge about each client was relayed. The history, diagnosis and risk-management plan for each client was explained, as were particular safety issues that the researcher and CMTS should be aware of.

It was discovered that collating and processing this information was very important before facilitating music therapy sessions. However, the need for on-going communication to ensure the preservation of safety was also realised as the sessions progressed. Thus, the handover from the OT that occurred before each session was vital to the success and safety of the sessions. The handover can be described as a way of gleaning information about the relevant happenings in the institution since

the previous week. The handover also informed the researcher and CMTS of the presentation of clients that morning. This was essential for safety issues, and also to gain a better understanding of clients' patterns of behaviour and activities they had been involved in.

Furthermore, MDT members accompanied clients to every music therapy session. The researcher interacted in the music therapy session with a RN or MHSW, the OT and the OTA. Usually there was a ratio of one MDT member attending the session per client. The MDT member attending was subject to change, dependent on the shift of that particular day. The researcher discovered that the content and dynamics of the session could change dramatically. This appeared to be dependent on the type of relationship the MDT member had with each client, and the way that MDT member interacted in the session. It quickly became apparent that if there were a music therapist employed in a forensic psychiatric institution, he or she would be reliant on the members of the MDT to facilitate effective clinical practice.

On the basis of these observations and experiences, the researcher wanted to investigate how to build a successful music therapy program in the forensic psychiatric setting. The main focus was on the relationship between the MDT and music therapy and the features of this interaction. The aim was to discover how to build a healthy music therapy-MDT relationship, in order to confidently meet the needs of the client in the forensic psychiatric setting. It should be noted that MDT members accompany clients in music therapy sessions from other populations, such

as the elderly and children with disabilities. While this research project is focused on the specific features of the forensic psychiatric setting, it is anticipated that information concerning MDT interaction with clients in this setting will be transferable, to a certain degree, to the above settings.

Group music therapy sessions were documented in order to examine closely the impact that attending MDT members had on the group. Interviews with members of the MDT were also conducted to ascertain MDT members' attitudes about music therapy, reflections on their role in the music therapy group, and their thoughts about the role of the music therapy program in the MDT.

Research questions:

How does MDT involvement in sessions affect the dynamics of the music therapy sessions?

What features have been observed in the interaction between the MDT and the music therapy program in the setting of a one-year student practicum in forensic psychiatry?

What clinical responsibilities do music therapists need to undertake in order to work effectively with the MDT, in a forensic psychiatric setting?

CHAPTER II

Literature review

1. Introduction to the chapter:

This chapter will, in the first instance provide a more in-depth definition of forensic psychiatry, a definition of ID and the various mental disorders the client participants in this study are diagnosed with. It will then trace the historical development, both institutionally and clinically, of forensic psychiatry. The focus will be on clients with a dual diagnosis of a mental illness and an ID in New Zealand.

The complexity that exists when researching this particular population is: while all participants have an ID, and have offended, some also have a secondary diagnosis of a mental illness. To accommodate for this, the researcher has undertaken a literature search, which casts out into both ID, psychiatric and forensic fields.

2. Definition of intellectual disability (ID):

The majority of clients that have partaken in this study have a primary diagnosis of ID. A widely accepted definition is from the American Association for Mental Retardation (1992, cited from Brandford, 1997) is:

People with intellectual disabilities are those persons who exhibit substantial limitations in present functioning, characterised by significantly sub-average intellectual functioning existing concurrently with related limitations in two or more adaptive skill areas such as: communication, self-care, home living, social skills, self-directions, health and safety, functional academic, leisure and work. The disability is manifested before the person attains the age of 18 (Brandford, 1997, p. 10). Further diagnostic criteria for ID can be found in Appendix B.

3. Definition of mental disorders:

Kakar (1984, cited in Raghaven and Patel, 2005) defines mental health:

“Mental health is a label, which covers different perspectives and concerns, such as the absence of incapacitating symptoms, integrations of psychological functioning, effective conduct of personal and social life, feelings of ethical and spiritual well-being...” (Raghaven and Patel, p.3).

Diagnosis of a mental illness is complex due to the “lack of objective physical signs of illness or specific diagnostic test” (Raghavan and Patel, 2005, p.20). As opposed to an ID, mental health can fluctuate, and some individuals may fully recover from a mental illness. There are a number of mental disorders that participants in this study are diagnosed with. These include, schizoaffective disorder, borderline personality disorder, and sexual paraphilia. As these diagnoses are in most cases the secondary

diagnosis, a full description is not given in the body of the study. Instead the reader can find diagnostic criteria for these mental disorders in Appendix B.

Offenders with an ID, or an ID and a psychiatric diagnosis in New Zealand are treated within forensic psychiatry, while receiving specific care for their ID and mental illness. Taking this into account, the researcher decided to provide a definition and an historical overview of forensic psychiatric services internationally, and in New Zealand.

4. Definition of forensic psychiatry:

The Mason report (1988) defines forensic psychiatry as: "...training and experiences in the assessment, treatment and care – including...in the community – of persons who have offended, are alleged to have offended or appear likely to offend because of their psychiatric condition" (Brunton, 1996, p.174-175).² This quote offers a simplistic definition of forensic psychiatry. However, in the literature relating to forensic psychiatry, there is a general consensus that definition is problematic. One is immediately confronted with the dilemma of whether to use a medical or legal framework model as a base. The American Academy of Psychiatry and Law (cited in O'Brien, 1998) describes forensic psychiatry as "the sub-speciality of psychiatry in which scientific and clinical expertise, is applied to legal contexts embracing civil, criminal, correctional, and legislative matters; forensic psychiatry should be

² Definition of forensic psychiatry can also be found in Appendix B (Glossary of Terms).

practised in accordance with guidelines and ethical principles enunciated by the profession of psychiatry” (O’Brien, 1998, p.2). This definition clearly highlights the diverse fields and that forensic psychiatry embraces.

In New Zealand, forensic mental health services are facilities for people who require specialised assessment or management, or both. This is usually because they are judged to be dangerous, or have committed, or are suspected, or likely to commit, a criminal offence connected to their mental disorder. The court has decided they need treatment, not punishment. (Mental Health Commission, 2004).

Forensic services clients include those on remand, found unfit to stand trial or acquitted on grounds of insanity. Other clients are referred from prison because they are mentally ill, or referred for forensic care from within the mental health system. Not all forensic clients will have committed violent crimes (Mental Health Commission, 2004).

5. The history of forensic psychiatry in New Zealand:

Brinded (2000) gives an excellent historical account of the development of forensic psychiatric services in New Zealand. There is a pervading theme throughout the literature that within New Zealand and Australia forensic psychiatry is in its early developmental stages. It has suffered from under-resourcing, and role-conflict between the justice and health systems (Glaser, 1996, O’Brien, 1998, Brunton, 1998,

Brinded, 2000). However, the literature also refers to significant changes in health and legal legislation in recent years that have resulted in a greater awareness of forensic client's rights, cultural responsibility, and the development of clinical practice within this area of mental health (Brinded, 2000, Brunton, 1996).

The Mason Committee in 1988 was the first benchmark legislation that established regional forensic psychiatric institutions and brought pressing issues in this field to the fore (Brinded, 2000). The subsequent report, known as the Mason Report, placed the responsibility for the care of psychiatric offenders on the health system. It also focused on developing facilities for, and changing attitudes towards, Maori clients (Brinded, 2000, Brunton, 1996). With the developments in human rights law and the Bill of Rights Act in 1990, definitions for mental disorders were tightened (Brunton, 1996). In 1992, under the Mental Health Compulsory Assessment and Treatment Act, care of forensic patients was extended to the community by compulsory community orders.

5.1 Clients with an ID in New Zealand prisons:

Historically, New Zealand has a trend of institutionalising persons with intellectual disabilities (Brandford, 1997). Recently, with increased knowledge and awareness of human rights, government policy has been altered accordingly. The number of people with an ID in psychiatric hospitals has dropped from 10,492, in 1965 to 4,484

in 1992 (Brandford, 1997). This change reflects more appropriate institutionalisation of individuals with an ID.

Demographically, in the early years of forensic prisons, the inmates selected had a range of ages similar to those in the general prison and were a mix of New Zealand European or Polynesian in ethnicity. Specific population groups within forensic psychiatry have received much more attention over the past ten years (Brinded, 2000, Brandford, 1997). In relation to those offenders with an ID, the New Zealand government in 1994 expressed concerns that legislation for offenders with an ID was not specific enough (Brandford, 1997).

A landmark study conducted by Brandford (1997) arose “specifically from a desire by the New Zealand government to be better informed about the services available for persons with intellectual disability who offend” (Brandford, 1997, p.7).

Brandford (1997) discovered that the prevalence rate of prison inmates with an ID was between 0.3% and 0.37%. Yet, she stated that the correctional system at that time did “nothing to address their special needs” (Brandford, 1997 p.36).

Furthermore, Brandford claimed the correctional system adopted an approach that was more punitive towards those inmates with an ID. Even in a recent study from New Zealand, Brinded (2000) reports that the client with an ID who has offended is grossly under-served, and specialised forensic services are required to meet their needs.

However, there have been rapid developments since that time. Between 2000 and 2005, specialised services have been established for ID clients who have offended. There is now the prospect of another institution for clients with a mental illness and an ID in New Zealand. Furthermore, in 2003 the Intellectual Disability Compulsory Care and Rehabilitation Act was established (Ministry of Health, 2004).³ This act provides for individuals with an ID who have been charged with, or convicted of an imprisonable offence to be cared for in the community (Ministry of Health, 2004). Previous to the establishment of this act, individuals who had offended with an ID were detained under the Mental Health Act.

Despite legislative and institutional developments, in New Zealand and internationally, there is still insufficient literature relating to offenders with an ID. Taylor, Keddie and Lee (2003) state the need for training staff and providing workshops, as there is no foundation of literature on which to base new approaches to treatment.

Summary:

In the last twenty years there have been some dramatic changes to legislation regarding clients who have an ID and a mental illness in New Zealand forensic psychiatric institutions. As a result of this, clinical treatment programs for this population are still in early developmental stages. The next chapter will discuss

³ A definition of the Intellectual Disability Compulsory Care and Rehabilitation Act can be found in Appendix B (Glossary of Terms) for reference.

clients with a dual diagnosis of an ID and a mental illness in more depth, and will describe their specific needs.

6. Dual Diagnosis:

Clients with an ID and a mental illness who have offended are a highly specific population. Yet, it is well documented throughout the literature that dual diagnosis is reasonably common for those with an ID (Holland, Clare and Mukhopadhyay, 2002, Barron, Hassiotis and Banes, 2004, Barron, Hassiotis and Banes, 2002, Ahlgreim-Delzell, Dudley and Calhoun, 1999, Raghaven and Patel, 2005). As stated earlier, the participants involved in this study have a variety of presentations. Some have a dual diagnosis of an ID and a mental illness, others present with a predominant diagnosis of a mental illness, while others have a single diagnosis of an ID.

A common theme throughout the small collection of literature relating to this group is the desperate need for more research (Barron et.al, 2004, O'Brien, 2002, Barron, et.al, 2002). However, a small number of studies have contributed to the body of knowledge. O'Brien (2002) provides a useful review of this population, focusing on common measurement scales used. Barron, et.al (2002) presents another very relevant study, which focused on therapeutic outcomes for those with an ID, and often a dual diagnosis, who have offended. The findings of the study revealed that there is a lack of structured therapeutic programming, even in secure settings.

6.1 Needs of individuals with dual diagnosis:

This population presents with very challenging needs. Ahlgrim-Delzell et al. (1999) conducted a study, which analysed the diagnostic and behavioural patterns amongst those with a dual diagnosis of an ID and mental illness. The behavioural patterns were “(1) aggressive/ disturbing behaviour; (2) withdrawal/asocial behaviour; (3) inappropriate behaviours; (4) sociopathic characteristics; (5) suicidal or runaway crisis; (6) pica disorder.” (Dudley et al., 1999, p. 70). These findings indicate a client population group that presents with high, complex needs.

There are particular mental disorders that are more prevalent than others. Personality disorders are highly prevalent, and affective disorders, autism, depressions and suicidal tendencies have also been identified as common mental disorders of clients with an ID (Ahlgrim-Delzell et al., 1999). In the case of this research the participants are diagnosed with schizoaffective disorder and borderline personality disorder as well as an ID. More information about the diagnostic criteria of the above mental disorders is available from Appendix B.

Summary:

It is reasonably common for clients with an ID to also have a mental illness. It is also well documented that clients who have a dual diagnosis present with high needs. However, there is a severe lack of structured treatment programs designed for this population in the literature. This chapter has established the state of knowledge concerning forensic psychiatric services in New Zealand and has provided a brief understanding of the client population on which this study is based. The next chapter will explore the inner workings of the forensic psychiatric institution; in particular, the MDT.

7. Definition of the MDT:

The nature and workings of the MDT is well documented in psychiatric and nursing journals. Journals visited were *Journal of Interprofessional Care*, *Journal of Psychiatric Mental Health Nursing* and the *Australian and New Zealand Journal of Psychiatry*. The MDT as it exists in the health profession, demands an in-depth definition. Mason, Williams and Vivian-Byrne (2002) discovered in the literature review of this topic that there were sometimes over fifty possible meanings offered. By simplifying the term MDT it is possible to construct meaning. *Team* is defined in *The New Oxford Dictionary of English* as: “two or more people working together” (Pearsall, 1998, p.1876). Brill (1976, cited in Twyford et al., 2005) expands on the definition of team:

(A team is)... a group of people each of whom possess particular expertise; each of whom is responsible for individual decisions; who together hold a common purpose; who meet together to communicate, collaborate and consolidate knowledge, from which plans are made, actions determined and future decisions influenced (Twyford et al., 2005 p.)

Twyford, et al. (2005) explains how in the last thirty years the MDT has become an increasingly accepted term for a collection of individuals professionally affiliated with a complex group of clients.⁴

A number of authors tend to apply the term MDT to aspects of work-force strategies, focusing on team structures as well as individuals being accountable for their own roles within the group (Mason and Carton, 2002, Mason et al., 2002, Cott, 1998). Cott (1998) observes that the individual team members determine the definition of the MDT and the team's function. This can be influenced by the professional affiliation of the individual team member. Mason (2002) places importance on defining boundaries between professions and maintains this will lead to a higher functioning team.

8. Functions of the MDT in forensic psychiatry:

⁴ A definition of the MDT is also available in Appendix B (Glossary of Terms) for reference.

There are unique characteristics that define the MDT within forensic psychiatry. Brunswig and Parham (2004) aptly describe the MDT within the correctional or secure setting. In this setting the MDT's are "often organised around a specific group of inmates or clients restricted with a certain problem or difficulty (substance abuse, cognitive impairment), certain level in treatment program (beginning, intermediate, advanced), or location..." (Brunswig and Parham, 2004, p.854). The researcher's observations at the research location confirmed that there were substantial numbers of MDT members allocated to each individual client. Individual clients are allocated an RN who is their key worker, as well as a psychiatrist, psychologist and other health professionals depending on their circumstances.

The complex needs of the forensic psychiatric client mean that a large number of professional staff can be connected to one client. These staff may come both from mental health and legal agencies. Therefore, there is a need for a "co-ordinated and collaborative approach amongst the professionals involved"(Gibbon and Kettles, 2002, p.22). Communication between the various professional disciplines of the MDT is essential when meeting the needs of the forensic psychiatric client.

Mason et al.'s work (2002) has a strong connection to this research. The method that was employed in their study "aimed to solicit the views of the mental health professionals in a forensic setting in relation to their functioning within a number of teams" (Mason et al., 2002, p.566). They discovered that "...teamwork in the

forensic setting is central to the effective care delivery due to the difficulties experienced in forensic practice, where clinical needs, risk assessment and management, and service configuration, often seem at odds with each other.”(Mason et al., 2002, p.565). To summarise, the many facets of care delivery in the forensic psychiatric setting means the MDT must be high functioning.

8.1 Risk management:

Forensic psychiatry clinical work is reliant on the maintenance of safety, due to legal, and mental health issues. Any potential risk situations are implemented into working practices with all members of the MDT through risk management. Hart (cited in Dempster, 1998) describes risk assessment as: “the process of evaluating individuals to (1) characterise the likelihood they will commit acts of violence and (2) develop interventions to manage or reduce that likelihood” (Dempster, 2003, p. 105). Risk assessment is therefore based on estimation of probability of violence rather than prediction.

Implementing risk assessments in the running of a forensic psychiatric unit is heavily reliant on the MDT: “Risk management is dependent on good communications between team members, clear identification of clients’ needs and available resources, including which professionals need to do what, when and how often” (Sharkey and Sharples, 2003, p.4). Clinicians across the board in this setting

have a dual responsibility to carry out their normal tasks required of them, and “extend their skills into the larger treatment environment” (Brunswick and Parham, 2004, p.853). The implication is that professionals working within the MDT in this setting must communicate well with each other, have a very good working knowledge of risk management plans and be able to extend their clinical work into the wider environment of the institution.

8.2 Supportive role of the MDT:

Effective teamwork can help to lessen stress in the forensic psychiatric environment. A high-functioning MDT is reliant on good channels of communication and positive leadership skills (Pethybridge, 2004). Sharkey and Sharples (2003) found significantly higher levels of psychiatric disorder linked to stress in health care workers. Other studies confirmed this finding and relayed how stress was associated with the emotional demands of the environment in forensic psychiatry (Sharkey and Sharples, 2003 Mason and Carton, 2002, Mason, 2002, Cott, 1998).

When discussing how to moderate these stresses, Sharkey and Sharples (2003) identified “the role of social support, team support and role clarity in mitigating the stressful effects of violence against staff or threats of violence” (2003, p.3). Lowe and O’Hara (2000) found when gathering feedback from staff involved in MDT’s

that "...they felt more supported and were less threatened by other professionals now that they were part of the same team"(2000, p. 276). It appears therefore that, a supportive, functioning MDT is crucial in this setting, which is "a tense and sometimes brutal environment for nurse and client alike"(Martin and Street, 2003). As Brooker and Whyte (2000, cited in Mason and Carton, 2000) observed there should be ample opportunities for team members to engage in reflective learning that identifies individual team member's needs, in order to counteract the stresses of the setting.

Summary:

To summarise, definition of the MDT is changeable, depending on the setting in which the team functions, the perceptions and professional affiliations of individual team members, and the needs of the client. In the forensic psychiatric setting various roles for the MDT were identified. The literature claims that a higher ratio of health professionals work closely with individual clients. Collaboration between individual team members in the MDT is essential to ensure effective delivery of care for clients. The literature suggests that an effectively functioning MDT is crucial for risk management of clients. The literature also states explicitly that the stresses of the environment demand a high degree of communication and leadership skills from MDT members, which consequently establishes a good foundation of support

for reflective learning with MDT peers. Now the reader is equipped with sufficient definitions of the wider setting in which this study takes place, the music therapy literature can be discussed.

Music Therapy Literature

9. General overview:

This chapter will provide an overview of therapeutic approaches and development in forensic psychiatry, internationally, and in New Zealand, in music therapy. The section will then address the body of literature that relates specifically to clinical considerations, goals and methods commonly employed by music therapists in the forensic psychiatric setting. Finally, the chapter will outline the roles and features of the interaction between music therapy and the MDT, focusing on forensic psychiatry.

9.1 The forensic psychiatric context

It is well documented throughout the recent literature that music therapy in a forensic setting, is a relatively new field of enquiry (Daveson and Edwards, 2001, Hoskyns, 1995, Thaut, 1987). Because of the lack of literature relating directly to clients who have offended with a dual diagnosis of ID and a mental illness, the researcher extended the literature review into general forensic psychiatric and correctional fields.

The researcher discovered that literature relating to work in the correctional fields identifies many similarities to the forensic psychiatric setting. Davis, Gfeller and Thaut (1992) suggests that a lot of information relating to the correctional setting can be applied directly to forensic psychiatry when differences in institutions, goals, therapeutic milieu and clients are taken into account. Thaut (1987) addresses the challenges for music therapists in the correctional setting. Many of the safety issues and complex needs of the clients he outlined were also documented in the forensic psychiatric literature. However, it is important to be rigorous when assimilating information from both fields as problems can develop when the two settings are not distinguished clearly (Fulford, 2002).

9.2 International contributions

Recently, attempts have been made to collate the music therapy literature that documents work in the forensic psychiatric and correctional fields. In 2002, an

American music therapy journal entitled *Music Therapy Perspectives* dedicated a whole edition to music therapy with mentally disordered offenders. Two in this edition presented very relevant overviews of music therapy in the forensic psychiatric or correctional setting, providing definitions of clinical considerations and challenges as well as methods, techniques and common goals employed by music therapists (Coddington, 2002, Harvoot, 2002).

Daveson and Edwards (2002), based in Australia, produced a similar overview of music therapy in the correctional and forensic psychiatric fields. Both of these have provided the researcher with a sound understanding of the state of music therapy in forensic psychiatry and correctional fields.

England has contributed a more psychotherapeutic approach to the body of literature, compared to America, and has focused more on clinical work in the forensic psychiatric, rather than the correctional field (Hoskyns, 1988, Sloboda and Bolton, 2002). Sloboda and Bolton (2002) stress the rapid development and increase in job opportunities for music therapists in the forensic field in England in recent years and state how music therapy can be applied to psychotherapy in the forensic psychiatric context.

Sloboda and Bolton (2002) explain how the main grounding philosophy for the music therapist is to aim to understand the psychopathology of the offender and to

then provide opportunities for the forensic patient to externalise some of their internal thoughts and feelings.

9.3 Music Therapy in forensic psychiatry in New Zealand:

Spang (1994) details a music therapy program in a forensic psychiatric setting in New Zealand over a two-year period. To the researcher's knowledge, this is the only article that focuses on the forensic psychiatric population in New Zealand at the time of writing. It is therefore a landmark study, as it provides the only evidence on which to base clinical work in this area in New Zealand.

Spang (1994) undertook clinical work at a medium secure unit. Her first clinical priority was to provide a safe environment for all. A typical music therapy session comprised of a large group. Boundaries were well established from the outset through the use of rules. Pre-recorded music was used to establish rapport and develop a relationship with clients. Gradually improvisational techniques were introduced to the group where clients explored different emotions on the instruments provided.

Spang (1994) discovered that the music therapy group provided an apt vehicle for clients to explore complicated emotional processes. The group "moved from being predominately self-centred to one which offered support to one another in a relaxed but securely contained environment" (Spang, 1994, p.20).

The researcher discovered that some of the difficulties that Spang identified as a music therapist in the forensic psychiatric setting were consistent with clinical experience described by other music therapists mentioned earlier in this chapter, for example Thaut (1987) and Harvoot (2002). Some of these difficulties were 'burnout' and the need for regular supervision. The next chapter will detail the specific clinical considerations for music therapists in the forensic psychiatric and correctional settings.

10. Clinical considerations for music therapists in forensic psychiatry:

Therapists working in the forensic psychiatric setting need to be able to "... empathise without sympathy, confront without demeaning, care without carrying, direct without controlling, see manipulation as a poor coping strategy rather than a personal assault, find satisfaction in erratic progress toward limited and clearly defined goals, tolerate the ambiguities and conflicts of the setting, and accept their own limits (Mobley, 1999, p.627).

This quote reflects the complexities of work in the forensic psychiatric field for all therapists. In particular Mobley (1999) expresses the need to be able to maintain a highly monitored therapeutic relationship with clients in order to preserve one's therapeutic output. These concepts also exist for music therapists in the forensic psychiatric setting.

One of the most important considerations for music therapists working in secure settings is safety and security. Secure settings often present with a culture particular to that institution (Thaut, 1987, Glynn 2002). It is imperative that the music therapist is aware of the specific culture in which he or she works (Thaut, 1987). Thaut (1987) explores the reasons behind the intense culture that can eventuate in secure settings. “Imprisonment means drastic limitations on physical freedom, reality stimulation, and emotional ties, thus building behaviour dynamics often permeated by pressure, frustration, anger, and violence” (Thaut, 1987, p.44). Coddling (2002) expands on this concept further, explaining the behavioural ramifications: “The degree to which pathological and often predatory behaviour is demonstrated in prison settings can be more intense, bizarre, and socially consequential. Occurrences of aggressive and manipulative behaviour are common in these settings” (Coddling, 2002, p.57). Therefore, in this intense environment it is imperative the music therapist has a sound understanding of the workings and specific culture of the institution in which he or she works.

10.1 Legal Issues: Therapeutic implications

Legal issues of the respective country affect the way in which music therapy is facilitated in the forensic and correctional settings. The music therapist must be aware of differing laws and cultural attitudes in both correctional and forensic psychiatric institutions. For example, Harvoot (2002) describes a music therapy

program that was established in Holland where it was compulsory for forensic psychiatric clients to attend. In contrast, it was optional for clients to attend a music therapy group in a study by Hoskyns (1995) in England.

Legal and mental health issues assume an omniscient presence in a forensic psychiatric institution. Indeed, forensic psychiatric hospitals are “places of confinement where the values of custody, detention and imprisonment are interposed with those of care, consideration and compassion”(Martin and Street, 2003, p. 544). The literature emphasises the need for the therapist to provide a balance between structure and control without inhibiting expression and support, when facilitating music therapy in a secure setting (Watson, 2002, Cohen, 1987, Glynn, 2002, Mobley, 1999, Spang, 1994). Glynn (2002) describes the dichotomy the music therapist can be faced with when striving to create a relaxed, open therapeutic space, while maintaining an awareness of legal issues, restrictions and boundaries.

No psychiatric patient can be treated if he or she is denied basic comforts and care, and the risks they present cannot be assessed unless they are seen operating in a reasonably relaxed environment. At the same time, the safety and legal aspects of forensic psychiatry demand that the authority structure and boundaries be maintained (Glynn, 2002, p.45).

10.2 Supervision:

As a result of this challenging environment, regular supervision, constant reflection and support from the MDT is a very important clinical consideration for music therapists in this field (Daveson and Edwards, 2001, Thaut, 1992). Spang (1994) found that after two years of working within this setting and client population she was “personally drained and struggling to maintain...therapeutic input” (Spang, 1994, p.26). Daveson and Edwards (2001) noticed that articles detailing music therapy work in forensic psychiatry often include the therapist’s own responses and reflection on the work.

10.3 Self-reflection and personal supervision:

Daveson and Edwards (2001) refer specifically to the music therapist’s beliefs as an individual and the importance of being self- aware. Beliefs that could potentially surface as counter-transference in this setting include: beliefs towards criminal activity, mental health, physical, sexual and substance abuse, and opinions concerning rehabilitative versus punitive models of criminology (Daveson and Edwards 2001). It is important to maintain high self-awareness, and not allow counter-transference to effect the therapeutic output of the music therapist in this setting.

Summary:

To summarise, there are many challenges the music therapist needs to consider in the forensic psychiatric setting. The literature reports that legal and mental health issues impact on the culture of a secure environment. This presents the music therapist with unique and challenging clinical considerations. The literature also emphasises the importance of understanding the culture of the particular secure setting in which the music therapist works. It is the music therapist's responsibility to create a non-threatening environment for clients, with firm, established boundaries. In addition, the music therapist must monitor counter-transference issues that may surface in relation to their own personal beliefs and attitudes. The importance of seeking personal supervision and support from fellow MDT members is stressed in the literature. The next section will discuss in more detail the various music therapy goals and methods music therapists employ in forensic psychiatric and correctional settings.

11. Music therapy goals in forensic psychiatry and correctional settings:

While maintaining well-honed personal therapeutic skills is vital for the well being of both therapist and client, the use of music in the music therapy session can also contribute to the establishment of firm boundaries and a trusting relationship. "Once a sense of safety was established, music allowed the flexibility to introduce

challenges while sustaining support” (Cohen, 1987, p. 220). Harvoot (2002) concurs and states, “without the containing musical environment a patient will decline to explore his emotions and refuse to express himself musically or verbally” (Harvoot, 2002, p.124). Music can thus contain as well as provide support.

It is well documented in the literature that the non-verbal nature of music is an effective way of communicating with forensic psychiatric clients who often find verbal communication difficult (Nolan, 1983, Coddling, 2002, Cohen, 1987, Sloboda and Bolton, 2002, Hoskyns, 1988, Thaut, 1987, Fulford, 2002). Sloboda and Bolton (2002) state that providing insight, through the use of a non-verbal medium like music is particularly helpful for clients to reflect on emotional experiences.

However, she stressed the importance of encouraging clients to then reflect verbally on these experiences. “...if no such insight or understanding is evident, a patient would often be considered too great a risk to be discharged” (Sloboda and Bolton, 2002, p.134).

The non-verbal nature of music therapy has also proved to be very effective with clients with an ID. A client with a severe ID must develop non-verbal means of communication: “Music is an ideal tool...because the therapist can use melody, rhythm, tempo, pitch, dynamics, and lyrics to develop expressive language” (Davis et al.,1999, p.82).

Thaut (1987) found that music therapy could also act as a bridge towards greater social interaction and participation, in a correctional setting. Similarly, music therapy research relating to clients with an ID has proved that music therapy can encourage communication and enhance social interaction (Garwood, 1988, Davis, Wieseler and Hazel, 1983, Davis et al.,1999)

There were other goals documented in the forensic psychiatric and correctional literature aside from expressive, social and communicative goals mentioned.

Codding (2002) conducted a very insightful survey of music therapists in forensic psychiatry. She discovered that the clinical objectives cited most frequently by music therapists were: providing a non-threatening, motivating reality focus, increasing self-esteem, increasing self-control in a structured environment, inducing relaxation, promoting knowledge and using coping skills and stress reduction techniques.

12. Music therapy methods and techniques used in forensic psychiatry and correctional settings

The next logical step is to discuss what methods and techniques are used to realise the goals described in the previous section. There is a reasonably wide variety of music therapy techniques used with the forensic psychiatric and correctional populations. Davis et al. (1992) summarises the main methods used with forensic clients as; guided music listening and counselling techniques, improvisation and

music for relaxation. Daveson and Edwards (2001) also provided a useful overview of music therapy in prisons, which outlines some common goals used in the correctional setting, with application for forensic psychiatry. Some of these included:

12.1 Improvisational techniques

Improvisation is cited often throughout the literature as a successful way for clients to express emotion and function in a group (Harvoot, 2002, Reed, 2002, Watson, 2002, Fulford, 2002, Boone, 1991, Cohen, 1987). Watson (2002) focuses specifically on improvisational drumming for male sex offenders. She found that the drumming provided an apt release for those clients who were cognitively impaired as, “they were not continually challenged to understand new concepts and vocabulary” (Watson, 2002, p.109).

Fulford (2002) explains how improvisational techniques can be easily adapted for clients with lower cognitive levels. She found that any level of participation in improvisational music was effective in increasing communication skills and improving mood or behaviour.

12.2 Songwriting

Songwriting is often used as a technique to express emotional issues, and like improvisational techniques, it can be altered to suit the cognitive functioning of the client (Gallagher & Steele, 2002, Daveson and Edwards, 2002, Boone, 1991).

12.3 GIM (Guided Imagery and Music)

Guided imagery and music is “a depth approach to psychotherapy in which specifically designed programmed classical music is used to generate a dynamic unfolding of inner experiences...” (Wigram, Pederson and Bonde, 2002, p.115). Nolan (1983) explains the use of insight orientated guided imagery and music, as well as supportive group therapy, through case vignettes of a short-term forensic patient. This provides a good example of how these two methods can be successfully melded in a treatment program in the forensic psychiatric setting.

Summary:

Amongst the small collection of literature, music therapy goals and methods for this population are reasonably well documented. It was discovered that social and communicative goals that are cited in the forensic psychiatric and correctional literature are also cited in the ID literature. Thus, some consistency is found between the forensic psychiatric and ID populations. This overlap of fields is especially relevant for this study that focuses on clients with a dual diagnosis of an

ID and a mental illness, as the music therapy literature to date concerning this population is very limited.

As stated earlier, the literature identifies a number of clinical challenges for the music therapist in this setting. Support from the MDT was claimed to be of immense importance in order for the music therapist to maintain good therapeutic skills. The next chapter will discuss further the workings of the MDT in forensic psychiatry and the features of the interaction between the MDT and music therapy in this setting.

13. Music therapy in the MDT

13.1 Attendance of MDT members to music therapy sessions:

MDT members attend music therapy sessions in numerous settings, including children with disabilities, the elderly, mental health and forensic psychiatry. Brooks and O'Rourke (1992) place emphasis on support from MDT members when discussing clinical work with the elderly: "It is a good idea to have a helper, to be a support in conversations, hand around books and instruments etc, so long as the person understands the therapeutic aims of the work and does not see it as merely entertainment!" (Brook and O'Rourke, 1992, cited from Bright, 1989, p. 21). Hence, an understanding of the therapeutic process is important, to ensure the attending MDT member complements the clinical work.

13.2 Responsibilities for the music therapist in the MDT:

Brooks and O'Rourke (2002) concluded that it is vitally important for future music therapists in New Zealand to be able to work effectively as part of the MDT.

Responsibilities of an effective music therapist working in the MDT are described as:

1. The willingness to undertake clinical or management advice
2. Offer support and assistance to the MDT
3. Condense and present information in a direct and meaningful way
4. Possess the ability to work autonomously and be responsible for one's own practice.

Responsibilities for the music therapist also extend to educating the MDT about music therapy. The literature reports a direct link between the education of the MDT about the processes of music therapy and support of music therapy from the MDT. With relation to the elderly population Brooks and O'Rourke (1992) state that "It is important to be aware that, unless management has an appreciation for, and a commitment to music as integral component of environment culture and health music's power to maintain or to restore well-being among the elderly will be limited and less effectual" (Brooks and O'Rourke, 1992, p.15). Therefore, educating the MDT not only incurs more support, but also directly influences the effectiveness of the clinical music therapy work.

Two examples from the literature illustrate the importance of educating the MDT. Brooks and O'Rourke (2002) conducted a survey, which sought to ascertain whether thirty hospitals in New Zealand, would be willing to employ a music therapist. The results were overwhelmingly negative. Reasons for this were: a lack of knowledge about music therapy and research-based evidence, the belief that functions of a music therapist were already encompassed in other therapies like play therapy and occupational therapy, and additional new therapies were not always viewed as a priority. To summarise, Brooks and O'Rourke (2002) established that ascertaining MDT's attitudes and increasing understanding about music therapy is vitally important. They maintained this fosters a positive, supportive relationship between the MDT and the music therapy program.

Writing from America, Choi (1997) examined other health professionals' attitudes towards music therapy and what role they perceive the music therapist assuming in the MDT. Results of the study showed that perceptions of music therapy were differentiated by the professional disciplines. Psychiatrists viewed music therapy as a less than essential therapeutic intervention, yet psychologists and social workers valued music therapy for its therapeutic recreation. MDT members who had observed music therapy sessions rated it more highly than MDT members who hadn't. Thus Choi (1997) indicates the importance in educating the MDT, through observation of music therapy, to ensure understanding and support.

13.3 Features of the interaction between music therapy and the MDT:

Watson (2003) presented a perspective on the relationship between the MDT and music therapy outside of the forensic psychiatric context. The music therapist in this case was working in a community team for people with learning disabilities. Some of the features of the interaction with the MDT are outlined. “ (Clinical music therapy) work is reviewed in supervision, in discussion or review meetings with the client, parents/ carers or MDT” (Watson, 2003, p.104). Brooks and O’Rourke (1992) mention a similar interaction between music therapy and the MDT in clinical work with the elderly. Wigram et al. (2001) detail the above process when referring to music therapy with children with disabilities. They add that reports should be made in conjunction with the physiotherapist, speech therapist and others. Thus, in a wide array of settings, the music therapist collaborates closely with the MDT through meetings, supervision or discussion.

14.The MDT and music therapy in forensic psychiatry:

While the demands of the setting and the need for support from the MDT was emphasised in the literature, the relationship with the MDT and music therapy is not focused on specifically in the forensic psychiatry or correctional literature. Nonetheless, several insightful articles surfaced which mentioned the interaction between music therapy and the MDT in the forensic psychiatry and correctional literature.

In comparing forensic psychiatry and general psychiatry, Sloboda and Bolton (2002) observed that "... there were striking differences between general and forensic psychiatry, in particular the staff/patient ratios, and the nature of the contact with the MDT" (2003, p.135). Sloboda and Bolton (2002) found the therapeutic intervention was much more intensive in forensic psychiatry, with a substantial number of therapists focusing on one individual. The need for music therapy to complement other therapeutic interventions was stressed. Contrarily, in general psychiatry, where there is a much higher turnover of clientele, the music therapist sometimes held the main therapeutic responsibility for the client.

14.1 Levels of support:

Music therapists naturally seek differing levels of communication and support from the MDT in all settings. In relation to the forensic and correctional settings, Spang (1994) and Thaut (1987) sit at opposite ends of this spectrum. Spang (1994) writes that during her preparation for music therapy sessions with forensic psychiatric clients she purposefully did not read case notes as she felt that "too much information could impede my ability to remain impartial" (Spang, 1994, p.18). By contrast, Thaut (1987) stresses the importance of obtaining information about clients in the correctional setting: "in individual and group interactions, the music therapist has to be aware of prison-specific behaviour patterns" (1987, p.45).

14.2 Types of professionals in the MDT in forensic psychiatry:

Harvoot (2002) provides a good overview of other professionals in the MDT that a music therapist potentially could be interacting with in a forensic psychiatric institution. She describes a team that consisted of a psychologist, a psychiatrist, a music therapist, a psychomotor therapist, an art therapist, a unit head, a patient's mentor and a social worker.

14.3 Characteristics of the interaction between the MDT and the music therapy program in forensic psychiatric treatment:

Harvoot (2002) describes a period of seven weeks of observation that took place for each client. After this had occurred, the MDT then devised a treatment plan. The treatment goals and objectives of music therapy were "stated in close collaboration by the patient and staff" (Harvoot, 2002, p.124). Similarly, the MDT assumed a strong presence through the referral, assessment, and treatment of the client in the case study cited by Sloboda and Bolton (2002) in a forensic psychiatric setting. Background information was gathered from the psychotherapist and psychiatrist. The clinical team then presented a formal referral for music therapy. The music therapist and the clinical team then collaborated and agreed on goals.

Fulford (2002) mentions the interaction between MDT members and clients within the music therapy session. She states that MDT members must be able to encourage verbal or musical processing where appropriate: "Each part of the session requires

the intervention of staff to allow the particular patients served the opportunity to get the maximum benefit from the interactions without overwhelming them or making them feel inferior” (Fulford, 2002, p.114). The potential for the attending MDT member to influence client behaviour within the music therapy session, is explicitly expressed.

14.4 Importance of support from the MDT:

Sloboda wrote this when reflecting on music therapy treatment: “ I consider any positive changes to be a result of staff working closely together and being able to hold the counter-transference on a team level. I am not attributing these changes to music therapy in isolation but rather making a case for music therapy with the MDT” (Sloboda and Bolton, 2002, p. 140). This is an obvious reflection on the positive outcomes of co-operation and good communication between the music therapist and the MDT.

By contrast, Langan, Williams and Athanasou (1999) experiences of the MDT, when working as music therapists in a forensic psychiatric setting, were very different. A definite division existed between MDT members who attended the music therapy session and those who did not. Support and co-operation from the MDT was often minimal and resulted in “the staff culture..(working)..against the best possible environment for music therapy”(Langan et al., 1999, p. 282). Sloboda and Bolton (2002) and Langan et al. (1999) represent the positive and negative extremes of

working with a MDT in the forensic psychiatric setting. Both studies also illustrate the enormous impact the MDT can have on the success of a music therapy program in this setting.

14.5 Extending music therapy into the wider institution: benefits for the MDT.

Glynn (2002) illustrated how clinical music therapy work can be integrated and understood in the wider context of the institution. Brunswig and Parham (2004) also stressed the importance for all clinicians in forensic psychiatry to extend and relate their work outside of their working arena.

Glynn (2002) examined patterns of relationships that occur frequently in music therapy groups in a medium secure forensic psychiatric unit, which reveal distinctive characteristics of forensic patients and the institution of which they are a part. The study suggested “parallels between the structure of the wider institution and aspects of these patients internal worlds” (Glynn, 2002, p. 43).

The following quote stresses the importance of the music therapist to view one’s clinical work in the context of the wider institution:

The nuances and complexities of the work (music therapy) have to be communicated and thought about with the MDT. The thinking needs to address how in this

particular treatment a patient forms relationships that may be in stark contrast to those he or she reveals in the context of other treatments (Glynn, 2002, p. 61).

Glynn (2002) then explains how clinical feedback about music therapy sessions can inform the MDT. Music therapy can help raise an awareness of roles that are “induced in them (MDT members) by patients and reinforced by the anxieties that work in forensic psychiatry arouses” (2002, p.61). Therefore, he holds that the music therapy group has the potential to offer the MDT new insights into client behaviour, as well as help the MDT to explore counter-transference issues that may surface as a result of working in close contact with clients in this setting.

Summary

A few significant articles addressed the relationship the music therapist has with the MDT, in forensic psychiatry and other settings. The literature established a strong link between educating the MDT about music therapy and support of the music therapist and music therapy program. Music therapy clinical work was generally monitored closely with the MDT in the forensic psychiatric setting, and this level of communication was highly valued by music therapists and the MDT alike.

CHAPTER III

Method

1. Methodology

This research project was conducted within a qualitative paradigm, which embraces the complex and intricate processes that are part of music therapy and interviews. Wheeler (1995) describes qualitative research within the music therapy context as focusing on the “entire phenomena that have not been reduced to specific variables” (Wheeler, 1995, p.68).

2. Definition of naturalistic inquiry

Within the qualitative paradigm, the researcher employed a naturalistic inquiry methodology for this research project. Naturalistic inquiry is defined by Aigen (2005) as “the studied commitment to actively enter the worlds of native people and to render those worlds understandable from the standpoint of a theory that is grounded in the *behaviours, languages, definitions, attitudes and feelings* of those studied” (Aigen, 2005, p.352). Thus, naturalistic enquiry aims to gather insight into the patterns of interactions that occur in the participant’s natural environment.

The naturalistic paradigm insists that there is no single objective reality, human judgements are not value-free, one cannot make time and context free

generalizations, there is no cause and effect relationship and the relationship between the knower and the known is inseparable and interactive (Aigen, 2005).

Operational naturalistic inquiry demands that the researcher is the main vehicle for gathering data. As a result naturalistic inquiry encourages the active engagement of the researcher with the participant. The researcher is also the music therapy student, facilitating clinical music therapy sessions in this research study. Consequently, it was impossible to maintain absolute objective distance from participants.

Foundation of naturalistic inquiry states that “ there is no need for the researcher to stand apart from the area of study in order to avoid influencing it because there is no such thing as the undisturbing observer of a social situation” (Aigen, 2005, p.354).

Therefore, naturalistic inquiry was the most applicable method, as it allowed the researcher to be actively involved in the research process.

Characteristics of data collection and data analysis in naturalistic inquiry will be discussed later in this chapter.

3. Method

Revisiting the research questions of this study at this point will link the main thrust of the study with the method procedures for data collection and data analysis chosen.

3.1 Research questions:

How does MDT involvement in sessions affect the dynamics of the music therapy sessions?

What features have been observed in the interaction between the MDT and the music therapy program in the setting of a one-year student practicum in forensic psychiatry?

What clinical responsibilities do music therapists need to undertake in order to work effectively with the MDT, in a forensic psychiatric setting?

4. Research population

In this study, a group of three male clients who had been receiving music therapy at a forensic psychiatric unit were asked to participate in the study. Further demographic details about the clients background information is given in Chapter IV (Clinical summaries of the sessions). In addition, six MDT members working at the unit were interviewed.

4.1 Client participants:

The clients' allocated key worker thoroughly explained the information sheets to each individual client participant. Consent forms were signed when the clients had decided to participate in the study and the information sheet was fully understood.⁵ All client participants were adult males, who identified themselves as New Zealand Maori and are detained permanently at the institution where the research took place.

The rationale for including the documentation of the group music therapy sessions was to extract examples from the data gathered to highlight any specific influences the attending MDT member had on the dynamics of the session.

4.2 MDT participants:

The researcher anticipated that there be at least one RN, one MHSW, one OTA, and one psychiatrist interviewed. This was in order to gain well-rounded, rich and varied views from the MDT.

The researcher also interviewed the CMTS. The CMTS was not a registered health professional. However, the CMTS fulfilled a role, clinically, that was very similar to that of a registered professional music therapist. The researcher therefore considered the CMTS a member of the MDT for the purposes of this study. As a co-facilitator of the group the CMTS was able to offer a fresh perspective on the focus of the inquiry, and add validity, distance and objectivity to the researchers perspective.

⁵ Copies of the consent forms and information sheets is available in Appendix C

4.3 Location of the Interviews

All interview participants were interviewed at the research location, with the exception of

the CMTS who was interviewed at Massey University.

5. Selection Criteria

The study sample comprised of participants who met the selection criteria outlined below.

5.1 Client participants

Clients participating in the study were required to meet the following criteria:

1. The client participant must be receiving group music therapy
2. The client participant must have read and understood an information sheet about the research project and signed a consent form
3. If the client participant was unable to read the Information and sign the consent form, the participant must have a care worker available to assist with this process.

5.2 MDT participants

MDT members involved in interviews were required to meet the following criteria:

1. The MDT participant must be employed at the institution at the time the research was being conducted (with the exception of the CMTS)
2. The MDT participant must have read and understood the information sheet about the research project and signed a consent form
3. The MDT participant must have attended music therapy sessions (with the exception of the psychiatrist).

6. Selection process:

6.1 Client participants:

For client participants, individual key workers assisted in relaying material from the information sheets to the clients. The researcher was absent during this process to reduce any possible coercion the client participants might have experienced. As the clients in this study presented with vulnerabilities, the researcher ensured key

workers emphasised clearly that clients were free to decide not to participate, and could withdraw from the study at any time.

6.2 MDT participants:

MDT members were asked to participate via an email sent by the OTA. The OTA sent an email to all MDT members currently employed at the location where the research was conducted. This was to limit coercion to participate in the study, which may have occurred if the researcher had asked MDT members directly. MDT members were then given information sheets to read. Once the potential participant was confident they understood all aspects of the research project, and had made the decision to participate, the consent form was signed.

When interviewing members of the MDT, the researcher was interested in:

1. The MDT members' thoughts about music therapy
2. How they thought a music therapy program could operate within the MDT
3. Improvements that could be made to the music therapy program.⁶

⁶ A list of the guideline questions included in the interviews can be found in Appendix D

The researcher did not use the above guidelines when interviewing the CMTS. In this case the researcher asked the CMTS to discuss experiences of co-facilitating a music therapy group with attending MDT members. The researcher also asked her to clarify other interactions experienced, outside of the music therapy space, with the MDT.

7. Music therapy procedures and data collection

7.1 The group music therapy sessions

Each music therapy group session lasted for thirty minutes and occurred once a week. Data was collected from five music therapy sessions with this group.

Descriptive notes were taken from the five sessions involving the group of three participants who were receiving music therapy at the location. The researcher, with full consent from participants, also videoed the sessions. These were viewed after the sessions and used to analyse the interactions in the group thoroughly.

7.2 Example of a typical group music therapy session:

Music therapy sessions usually began with a greeting to clients and a brief chat about the happenings of the last week. Clients were then given a choice about what activity they would like to proceed with. Only two choices were offered, and could

range from a rap about happenings in the unit, or a call and response improvisation between two clients. Each session would end with a closure song. Two songs were offered and the clients collectively agreed on a song to sing. One of the clients would then close the session with a *karakia*. A *karakia* is the Maori word for prayer.

7.3 The physical set-up of the music therapy group:

Seven chairs were set in a circle with enough space for a drum to fit between each chair. This was to accommodate for the three clients receiving music therapy, the researcher, the CMTS, the OTA, and RN or MHSW. A low table was placed in the middle of this circle. A wide variety of small percussion instruments were arranged on top of the table. Outside the circle stood larger instruments such as a keyboard, a bass drum, and a cello and a piano accordion. On a shelf next to the circle there was an Autoharp, flute, chime bars and a small harp.

7.4 Therapeutic orientation:

The underlying therapeutic orientation held by the co-facilitators was client-centred. The term client-centred relates to development of trust between the therapist and client: "It allows clients considerably more power and decision-making in the therapy process, such as choosing the frequency and length of their therapy, whether

they want to talk or be silent, what they want to explore and enables them to be the architects of their own lives” (Wigram et al., 2002, p.66).

7.5 Therapeutic roles for the researcher and CMTS:

All music therapy sessions were co-facilitated by the researcher and the CMTS. The researcher and CMTS planned music therapy sessions together. The co-facilitation approach was not hierarchal. Instead the researcher and CMTS fluctuated between leading and co-leading activities in the session. The researcher and CMTS did not decide prior to the session who was to led each activity.

7.6 Role of the attending MDT member in the group music therapy session:

The same OTA attended every music therapy session. An accompanying MDT member also attended. The accompanying MDT member could be either a RN or a MHSW and usually differed each week due to rotating shifts for the MDT. The presence of the OTA and an accompanying MDT member in the music therapy room met the safety procedures of the institution.

Attending MDT members were invited to participate actively in the group. MDT members were free to decline this offer and were never coerced into active involvement in the group by the researcher or CMTS. If MDT members agreed to be

involved in the session they sat within the therapeutic space, which was clearly defined as a circle in this group. The individual MDT member naturally determined the degree and style of participation. The researcher and CMTS provided a handout, which outlined the roles for the MDT member in the session. The handout emphasised the importance of the balance between participation and facilitation for MDT members.

There were several reasons for the inclusion of MDT member in the group. Firstly, even though there was a larger ratio of MDT members to clients, there were three clients in the group. With seven people in total, the group did not appear overcrowded or unbalanced. Secondly, while the researcher and co-therapy student were the main facilitators, MDT members were asked to encourage and support clients where possible. Thirdly, in a group where goals mainly related to social and communication issues, participation of the MDT member served as a good behavioural model for clients.

8. Interview procedures and data collection:

Interviews were based on a semi-structured informal interviewing technique. All interviews were taped by a dictaphone and transcribed verbatim.⁷ Any inaudible material was transcribed as 'xxx'.

⁷ Full transcriptions of the interviews can be found in Appendix F.

8.1 Definition of semi-structured interview technique:

Kyle (1983, cited in Hogan, 1997) describes the semi-structured informal interviewing technique as “neither a free conversation nor a highly structured questionnaire. It is carried through following an interview guide, which rather than containing exact questions, focuses on certain themes. The interview is taped and transcribed word for word. The typed out version together with the tape constitutes the material for the subsequent interpretation of meaning” (p. 174).

8.2 Validation for use of the semi-structured interview technique:

This interview technique was chosen as this ontological position suggests “people’s knowledge, views, understandings, interpretations, experiences, and interactions are meaningful properties of the social reality which your research question are designed to explore” (Mason, 1998, p.39).

Hoskyns (1998) interviewed six probation MDT members individually in a research project. This research aimed to determine their thoughts and opinions about the effects of music therapy and it’s place in the general program. These provided the researcher with a useful and relevant benchmark to create general questions for the interviews with MDT members. Some questions that Hoskyns (1998) included were:

“What sorts of changes do you observe in clients after 12 weeks at the Centre, and what would you say are clients most common criticisms of music therapy?” (Hoskyns, 1995, p. 31).

8.3 Specific style of interviewing employed by the researcher:

The interviewer, during interviews, asked questions based on the above themes. The style of questioning was based on Hogan (1997) who conducted interviews with patients with a terminal illness, who had received music therapy. She used original or primary questions, to begin the interview. In this study, the primary question was often to do with a memorable music therapy experience. This allowed the interviewee to disclose as much information as they desired, and for the interviewer to ascertain the style and direction the interview would assume. Hogan (1997) also used probing or secondary questions once the interview had commenced. In particular, reflective probing was utilised. Hogan describes this as “reflecting a phrase back to participants or repeating key words in the participants descriptions in order to gain a more accurate description of their experience” (Hogan, 1997, p. 45).

9.Data analysis and presentation

9.1 Data analysis and presentation of the music therapy sessions:

Data collected from music therapy sessions was collated and each session was presented in the same layout to maximise comparison between sessions. This layout consisted of a brief description of the handover received that morning, the presentation of clients, a short summary of the session and a reflective commentary from the researcher's point of view.

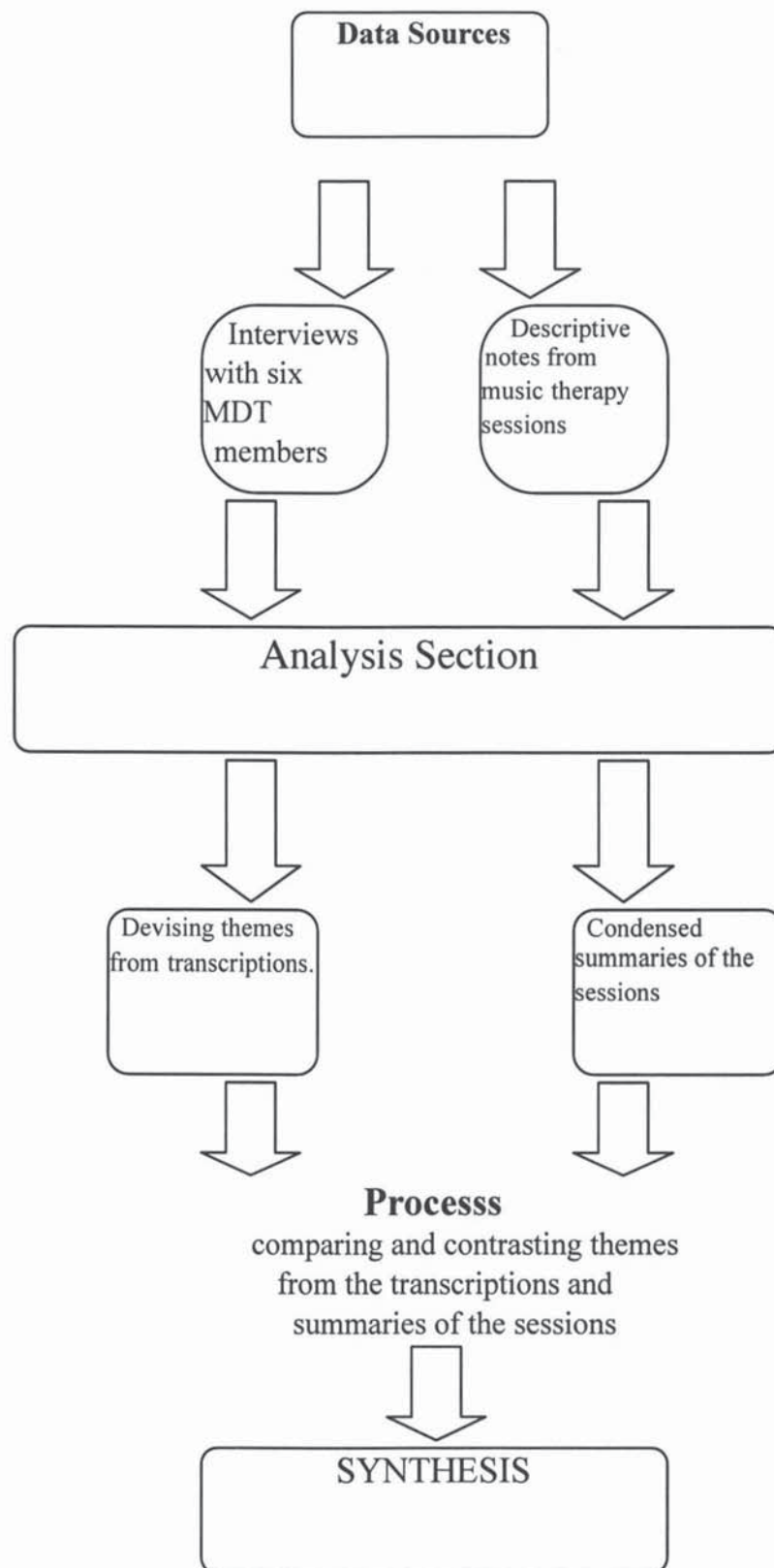
The reflective reading was included at the end of each music therapy session to enable the researcher to assert her role in the process. The justification for inclusion of the commentary is because the researcher is "...inevitable and inextricably implicated in the data generation and interpretation process..." (Mason, 1998, p. 109). The template was modelled on the work of Glynn (2002) who also included a commentary from the researcher, giving a personal overview of each session.

9.2 Data analysis and presentation of the interviews:

Analysis of the interviews was conducted through by a search for themes. This was in accordance with principles of naturalistic inquiry. Aigen (2005) states that: "...it is characteristic of naturalistic inquiry to use labels that primarily reflect how participants in a study conceptualize or construct the nature of their own experience" (Aigen, 2005, p.358). Each interview was scanned for common words and themes. The interviews were then summarised under each thematic heading.

The same headings were used for all the interviews with the exception of Interview # 6. This was because the focus of the interview with the CMTS was geared towards the clinical work. In particular the researcher wanted to determine the CMTS's experiences of co-facilitating a music therapy group in this setting with MDT members. The researcher was also interested in any other interactions the CMTS had with the MDT outside of the clinical music therapy work.

Figure 1. illustrates the data sources and analysis procedures that took place.



10. Ethical Considerations:

Hays, Murphy and Sinclair (2003) described the experiences of gaining ethics for research that concerned men with an ID who are at risk of sexual offending. They found that this type of research "...presents a number of ethical, legal and methodological challenges." (p. 182).

The researcher underwent rigorous ethical analysis, and gained ethical approval from two ethical boards; the Massey University Human Ethics Committee and the Central Regional Health and Disability Ethics Committee, Wellington, New Zealand. As the client population for this research study presents with vulnerabilities, this research maintained a high degree of ethical morality in accordance with the standards outlined in the Massey University code of ethical conduct and the Central Regional Health and Disability Ethics Committee guidelines.

10.1 Informed Consent:

Wheeler (1995) states that when the subject exhibits diminished cognitive or emotional capacities, participants rights may be compromised. As stated earlier in

this chapter, an information sheet was customized for client participants and MDT participants.

The researcher ensured full informed consent was obtained from each client.

10.2 Confidentiality

Confidentiality was preserved as much as possible. Demographic information relating to the participants in the study was included to provide a contextual backdrop for the case studies. However, no personal information that could reveal the identity of the participants was included and pseudonyms were used throughout. The specific name of the institution was not mentioned throughout the study to protect the identity of client participants.

10.3 Cultural issues:

As stated earlier the client participants in this study all identify as New Zealand Maori. As a part of the ethical process the researcher consulted the cultural worker at the unit. The cultural worker confirmed that the researcher had been co-facilitating sessions in a culturally sensitive manner.

11. Reliability and Validity

In the case of this research, there was a possible conflict of interest between the researcher and client participants, who were receiving music therapy. The researcher was aware of this fact and ensured that the clinical music therapy work was always client focused. The relationship between the researcher and clients could be jeopardised if clients felt they were being scrutinised. It was also the researcher's responsibility to ensure the research followed the clinical work as closely and as naturally as possible, and that the research process itself was free of coercion, oppression or imposition of interests.

11.1 Interview procedures:

There are many facets that are brought to each interview. These include the personality and life experience of each participant, what is asked, what is responded to, and the type of relationship the participant has with the researcher. All of these factors have a profound impact on the content and style of the interview.

The researcher decided to assume an epistemological position which was "flexible and sensitive to the specific dynamics of each interaction...effectively, tailor-making each on the spot" (Mason, 1999, p. 40). As the researcher possessed in-depth knowledge about the music therapy sessions at the unit, this was the most suitable approach. The researcher also included questions in which participants were invited

to comment on any improvements that could have been made by the researcher concerning the music therapy work. This effectively reduced bias as it was hoped that participants felt comfortable to relay their opinions, both positive and negative, to the researcher.

Both Archer (2004) and Hogan (1997) expressed concerns about the nature of the therapist's relationship in participants being interviewed, when the therapist was also the researcher. However, with relation to client participants in this study, the music therapy process was not interrupted or changed to any degree. In the case of interview participants, the researcher was not specifically asking participants about the content of the music therapy clinical work. If the interview had been specifically about the clinical music therapy work, the researcher may have sub-consciously constructed the interview so as to receive positive feedback. However, the interviews were geared towards the interaction between the MDT and the music therapy program as a whole. Therefore, the researcher concluded that conflict of interest was reduced.

12. Limitations of the study

One of the major limitations of this study is the possible conflict of interest between the researcher and participants and the possibility of this bias affect the validity of results.

Another limitation is the presence of the video camera in the music therapy sessions. This may influence client participant behaviour. It may cause them to feel uncomfortable and disempowered in a music therapy session. The researcher emphasised to client participants that they were free to ask for the video camera to be turned off at any time.

Finally, as a student co-facilitating sessions, the relative inexperience of the researcher may limit the conclusions drawn in this study.

CHAPTER IV

1. Clinical summaries of the sessions

This chapter outlines clinical work during the research period. Throughout the chapter the researcher will be referred to as the music therapy student (MTS) and the co-music therapy student as the CMTS. The chapter is organised in the following way. Brief background information about each client is provided, sourced from the clinical notes available to the researcher at the research location.

A brief overview of the development of the group is given and music therapy methods that were employed with this group are explained. Music therapy sessions are presented as condensed summaries. Any prolonged verbal or musical interaction between the MDT member and clients is highlighted.

A more detailed documentation of Session Three is presented in Appendix E for the reader to refer to as an example of the process of a session from which the more condensed summaries are derived. This particular session was included as the researcher observed several significant interactions between the MDT member and the client, which consequently affected the dynamics of the group. A detailed documentation of these interactions provides the reader with an example of the subtle nuances and dynamics between clients and between the MDT member and clients that can occur in the course of one session.

Background information about clients and their presentation in groups:

To protect the confidentiality of clients, pseudonyms have been used. Furthermore, the researcher refrained from detailing offences that clients had committed to protect their identity.

The OT had recommended three client participants for group music therapy. Reasoning for each client attending the group is provided in the individual background section for each client.

Client participant # 1

Tahi

Background:

Tahi identifies himself as a New Zealand Maori. Legally, Tahi is detained under the Mental Health Act.

Diagnosis:

Tahi has a complex diagnosis. According to the DSM IV criteria he has:

Axis I: Schizoaffective disorder, sexual paraphilia, alcohol/drug abuse

Axis II: Borderline personality disorder, mild ID.

Axis III relates to diagnoses that are physical. These included, obesity, nocturnal enosis and sleep apnoea

Risk management: early warning signs

Blank expressions, appearing angry and muttering.

Important information relayed from OT and other staff:

The OT recommended Tahi for group music therapy sessions in order to help him develop group awareness and further his understanding of group dynamics. It was stressed that Tahi could be potentially very dominating in a group setting and particularly focused on clients and MDT members that presented as being more timid and less assertive. A lot of this was attributed to Tahi's large size.

Client participant # 2

Mark

Background:

Mark identifies himself as a New Zealand Maori. Legally, Mark is detained under the Mental Health Act.

Diagnosis:

Mark's diagnosis is listed as sexual paraphilia, and a mild ID which leads to disorder of cognitive processes. Mark also has a pinned shoulder with an inserted metal plate, which has resulted in this joint being considerably less mobile.

Risk management: early warning signs

Facial grimace, restlessness, sexual pre-occupation with staff, being demanding and making requests.

Important information relayed from the OT and/ or other staff:

The OT emphasised the need to establish firm boundaries with Mark in terms of

personal space and also any personal information. A handshake, but not a 'high-five' was determined an acceptable degree of personal contact. Mark was reported to need skill-based activities. The OT stated that he is highly aware of being patronised and is also aware that he has a slightly higher cognitive functioning than others in the group. The OT anticipated that group music therapy would benefit Mark in increasing his self-expression.

Client participant # 3**David****Background:**

David identifies himself as a New Zealand Maori. Legally, David is detained under the Intellectual Disability Compulsory Care and Rehabilitation Act.

Diagnosis:

Mild to moderate ID.

Risk management: early warning signs

David can become agitated when he misunderstands due to his cognitive ability.

Important information relayed the OT and/or other staff:

David can become anxious and when he is confused, imitates others. He is vulnerable to suggestion from his peers and it was noted that he could feel intimidated by Tahi. David also responds best to structured activities. The OT recommended David for group music therapy to increase his social skills in a structured environment.

Group goals:

Based on the information derived from the OT, and an assessment period, the following group goals were formulated:

- For all clients to engage in collective decisions about activities
- To increase appropriate social interaction between group members
- To increase verbal and musical expression

Brief overview of the group music therapy sessions leading up to the research period:

The music therapy group was co-facilitated by the MTS and CMTS for thirty minutes every Tuesday morning. Music therapy sessions had been conducted for ten months with this group prior to the research period. The research period covered the last five music therapy sessions facilitated with this group.

The music therapy group was included in each clients treatment program. MDT members were responsible for prompting and collecting clients for the session. Attendance was not compulsory, though clients were strongly encouraged to participate in the program. With the exception of the first few sessions, attendance of clients to the music therapy group was very regular.

Music therapy methods employed: ⁸**Opening rap:**

As the year progressed routines were established in the group. The group began with a 'check-in' in the form of a rap. Each member of the group slapped his or her knees and a 'rap' was circulated around the circle. The MTS and CMTS usually determined what the subject was. For example the MTS might have offered: 'It's such a shame it's raining today.' The group then repeated this back, and the next person offered a 'rap' about the weather.

The rap might develop into a body slap improvisation or an instrumental improvisation. Typically however, the rap stopped and the group made a decision about what activity should proceed. This could take the form of a vote about various activities that are described as follows.

Circle wave:

This involved a 'wave' of music characterised by each member of the group choosing their desired instrument and then playing one beat. The beat was then

⁸ These methods have been presented in bold in the chapter for ease of reference

passed around the group and required all members to observe and listen to others in order to play at the right time. The activity was varied when clients were able to determine the direction of the wave by standing up. This indicated that the circle flowed in the opposite direction.

Call and response:

One member chose a partner to have a 'musical conversation' with. The two members then chose their respective instruments. Other members of the group provided a supportive clap and counted eight beats for the two members. One partner then 'calls' for eight beats and the other partner 'responds' for eight beats on his or her instrument.

Improvisation:

Clients chose an instrument of their choice and participated in a group improvisation.

Matching improvisation:

One client is asked to choose an instrument. Other clients are then asked to try and match the sound quality of this instrument.

Group singing

Each session finished with a song. Clients chose between 'Ten guitars' and 'Hoki Mai' or any other song they would like to include in the singing segment.

Clinical Examples:

Session (1) 15 November

Handover with the OT aid:

The OT aid relayed to the researcher that Tahi had not been complying with his program. Other clients in the group were reported to be stable.

Initial presentation of clients:

Tahi:

Stable. Appropriate behaviour. Presented with slight resistance.

Mark:

Mark appeared to be a little preoccupied. His eyes were downcast for the first segment of the session and his involvement was limited

David:

Appeared to be in a stable mood.

Attending staff member: Eileen (MHSW)

Eileen communicated to the group that she was camera shy and moved away from the camera in the first few minutes of the session. She remained in the circle and was an active participant in the session musically only, keeping verbal interactions to a minimum.

Condensed summary of the session:

The session began with an **opening rap** in which all clients and other members of the group participated fully. The rap developed into a twelve-minute **improvisation** with Mark and Tahī on the djembe drums and David on the tuba. Clients then agreed to participate in the circle wave. Tension was evident between Tahī and Mark as Tahī musically interrupted Mark several times. In the **matching improvisation** that followed, Tahī looked at the video camera for extended periods of time. He dominated this section of the session musically. To close the session, clients voted on a song. Tahī and Mark both voted for Ten Guitars. David appeared slightly frustrated. This could have been due to the fact that his song was not chosen.

Reflective Commentary:

I felt that this session was considerably influenced by the presence of the video camera. The clients all arrived early to the session, which was unusual. It is

debatable but I felt that the group was not as talkative as normal, perhaps sensing the video camera's presence. Tahi in particular was acutely aware of its presence, often looking over to the camera during the session. There was a substantial amount of prolonged improvisations, in which clients were mostly engaged throughout. Tahi asserted a dominant presence in this session, both musically and verbally.

Mark became more withdrawn as the session progressed. This may have been a reaction to Tahi dominating his 'voice' during the circle wave activity.

Eileen (attending MDT member) displayed obvious discomfort with the video camera at the onset of the session. However, the group received her reaction humorously. As a regular attendee to music therapy sessions Eileen appeared comfortable with the activities. She maintained a reasonably low profile with minimal verbal interactions with clients. Clients did not specifically try to engage Eileen or direct any specific attention towards her: they appeared very comfortable with her presence in the group. Eileen assisted clients when needed and participated fully in all activities.

Session (2) 22 November**Handover with the OT aid:**

The OT aid reported that there were no problems and all clients were reported to be in a stable state.

Initial presentation of clients:**Tahi:**

Presented in a cheerful and stable mood

Mark:

Mark presented as reactive, but not interactive, as his head remained low and eyes downcast for the first segment of the session.

David:

David presented in a stable mood, slightly anxious and withdrawn.

Attending staff member: Warwick (Registered Nurse)

Warwick had attended music therapy sporadically throughout the year. He instantly expressed pleasure at being a part of the group and immediately picked up the drum and began playing confidently. Warwick interacted both musically and verbally throughout the session, demonstrating humour in certain parts of the session.

Condensed summary of the session:

The session began with an **opening rap**. Tahi and Warwick demonstrated a connection, through humorous verbal exchange with each other. They also both played the drums in a similar, confident manner. Mark and David became withdrawn immediately following the opening rap. Tahi asserted a dominant presence, speaking over David. David responded by withdrawing further, folding his arms and looking down. Clients then voted on the **call and response** activity. Mark explained the activity to Warwick. Tahi played the whistle loudly whilst Mark was doing this.

During the **call and response** activity all clients supported each other well musically. Afterwards they agreed to participate in an **improvisation**. Warwick, Tahi and David all interacted on the drums, while Mark was on the violin.

The MTS and CMTS mentioned that closure was imminent. All clients added appropriate verbal comments, agreeing with each other on several occasions. Mark closed the session with a karakia.

Reflective Commentary:

In this session all the clients eventually interacted in a more egalitarian way.

However, in the first half of the session, the presence of Warwick was strong, as he and Tahi interacted a lot musically and verbally. Warwick was particularly confident

and skilled on the djembe drum, which appeared to elicit more complex, confident playing from Tahi. Mark and David appeared to withdraw, perhaps feeling intimidated by this style of playing. David in particular remained flat and frustrated unless attention was focused on him. Thus, it appeared the group was vying for attention from Warwick.

During the improvisation, which ensued, Tahi and David interacted for a prolonged period on the drums. The client group appeared to be co-operating better. This reached a climax at the end when I talked about closure to the clients. There was a feeling of togetherness as the clients agreed with each other about their reluctance to end the group and expressed intimate feelings with the group.

Session (3) 29 November**Handover with the OT aid:**

All clients were reported to be in a stable condition.

Initial presentation of clients:**Tahi:**

Tahi initially presented as in an apathetic state.

Mark:

Mark presented as stable. He was noticeably more relaxed, as compared to the previous weeks session, and his facial expressions were more genuine.

David:

David presented in a stable mood.

Attending MDT member: Brian (MHSW)

This was Brian's first music therapy session. Brian appeared very shy and unsure.

There is a high possibility this was due to the fact it was Brian's first session and he may have felt apprehensive about what his role was and how to interact with the clients through music therapy.

Condensed summary of the session:

The session again began with an **opening rap**. All clients offered comments about projects they were currently working on in the OT room. When the circle reached Brian he appeared shy and slightly uncomfortable, saying he had ‘nothing to offer.’ Tahī began lightly tapping David on the knee at this stage, but stopped shortly afterwards.

The MTS and CMTS introduced a new version of the **circle wave**, which enabled everyone to play a ‘solo.’ All clients participated. Tahī specifically asked Brian to play. Brian agreed and played, although he appeared shy and nervous.

Mark had asked to do the **call and response** activity. Tahī and David played together, with Tahī playing extremely loudly on the whistle. David expressed obvious discomfort at this. Brian and Mark then formed a partnership, with David supporting by clapping. Tahī began tapping Brian’s head several times. David responded by reprimanding Tahī.

Tahī ceased touching Brian and suggested the MTS and CMTS play together. As they played together Tahī began slapping BOTH Brian and David. He was reprimanded by the MTS.

The MTS and CMTS suggested an improvisation to close the session. Towards the end of the improvisation Brian and Tahi played the cymbal together. The group sang Ten Guitars to close the session.

Reflective Commentary:

The group appeared to be quite fragmented. Tahi behaved in a particularly dominant manner and over-stepped boundaries by hitting Brian lightly with the claves. As Brian was a new support worker, there was a possibility that Tahi was 'testing' him to gauge his reactions.

David appeared very sensitive to Tahi's interactions, especially with Brian. He seemed to become more withdrawn. However, at one stage David responded by interjecting and telling Tahi to 'keep your hands to yourself.'

Mark appeared to be feeling confident and happy. This may have been due to his eminent visit home in January. He confidently instigated playing a couple of instruments, and appeared mostly unaffected by Tahi's dominant behaviour.

There was a significant moment in the last segment of the session where Brian and Tahi shared the cymbal together. This positive interaction, compared with the antagonistic behaviour earlier in the session, was cemented through singing the last song together.

Session (4) 6 December**Handover with OT aid:**

The OT aid reported that all clients in the group were in a stable condition. A greeting 'rap' was included in the session plan as the MTS and CMTS wanted to discuss whanau day. Whanau day was an organised social event for family and friends. It was thus important that the MTS and CMTS ascertain what clients would have family or friends attending, and whether they would have permission to leave the unit. The OTA stated that it would be appropriate to discuss whanau day and family and friends as all clients were able to attend and had family and friends attending.

Initial presentation of clients:**Tahi:**

Presented in a stable and pleasant mood, making good eye contact with MTS

David:

Presented as stable. He was a little anxious at the beginning of the session, often rocking on his chair.

Mark:

Presented as noticeably more animated than the previous session.

Attending MDT members: Jim (MHSW)

Jim had not attended a music therapy session before in the unit. He appeared to know the clients well and appeared confident. Jim appeared to have established firm boundaries with the clients and interacted musically and verbally to an appropriate degree.

Condensed summary of the session:

The **opening rap** was characterised by talk about whanau day and confident exclamations from all clients. The rap developed into a fast **improvisation** on the djembes. At this stage, Tahī began invading personal space. He touched the violin when David was playing and lightly tapped the MTS with a pair of claves. He was reminded to respect others space by the MTS.

All clients participated in the **circle wave**, demonstrating humour and pleasure. Tahī assumed a quieter role. Mark then instigated and led a body slap **improvisation**, which progressed, into a strong instrumental improvisation, with all clients improvising on the djembe drums.

The session closed with the group singing Ten Guitars. Tahī and Mark sung confidently, while David was more withdrawn.

Reflective Commentary:

This session illustrated the rapidly fluctuating dynamics that this group often presented with. In the first half of the session Tahī asserted a prominent role, antagonising David in particular. David defended himself by offering a verbal retaliation towards Tahī. Contrarily, in the second half of the sessions, Tahī assumed a quieter role and appeared to cope with Mark leading the group more. There was a significant shift of power dynamics in the second half of this session. I felt that Mark asserted a more dominant role, by playing the djembes strongly, and instigating the body slaps, as well as instigating the end of an improvisation.

David appeared to find emotional content difficult to cope with, when closure was discussed, at the end of the session. He did not offer any verbal comment and dropped his head.

Musically, the session was characterised by two sets of very spontaneous, energetic, rhythmic instrumental playing in which the group appeared to be very united.

Jim maintained a consistent degree of participation throughout the session. He appeared to establish a sense of distance from clients. This consistency was important and appropriate in a session where there were shifts in the power dynamics and some very expressive improvisational playing occurred. I felt that the clients were comfortable with Jim's presence, even though it was the first time he

had attended a music therapy sessions with them. There were no instances were clients instigated interaction with Jim.

Session (5) 13 December (Last music therapy session for this group)**Handover with OT Aid:**

The OT aid reported that all clients were stable. She added that most of them also appeared to be in very good spirits.

Initial presentation of clients:**Tahi:**

Presented in a stable, reactive, pleasant mood

Mark:

Presented as stable, reactive and animated

David:

Presented as slightly anxious

Attending MDT member: John (MHSW)

John had attended a small number of music therapy sessions. John sat on the outside of the group, with his back turned to the group. He did not interact with clients, the MTS, CMTS, or OTA for the duration of the session.

Condensed summary of the session:

The theme of the opening rap was reflecting on whanau day that had occurred the weekend before. After the rap, clients all voted on the **circle wave** in which all were fully engaged. The **circle wave** developed into an improvisation, which included some very quiet, sensitive playing, particularly from Tahī and Mark. David appeared a little anxious to move to the next activity. Ten guitars was sung as the groups closing song.

When the MTS and CMTS offered a closure song to the group, all clients withdrew and made minimal eye contact with other members of the group. Tahī and Mark offered closure speeches. David appeared uncomfortable and tense.

Reflective Commentary:

Overall I felt that clients coped well and behaved very appropriately with the closure session of the group. David, as in previous session demonstrated some difficulty with the emotional content of the session. Mark and Tahī delivered appropriate speeches to the MTS and CMTS.

John's (attending MDT member) limited interaction with the group was suitable for this session. I felt that the clients were able to achieve closure with myself and the CTMS, without the overt presence of an MDT member in the group, where they

would normally sit. As the CMTS, the clients, myself (the researcher) and the OTA had been the stable core members of the group, it was appropriate that the group consisted of the above members only for the last session.

2. Results from interviews:

The first five interviews with MDT member participants have been analysed under the following headings:

- Background
- Attitude towards music therapy
- Gaining understanding about client responses and behaviour through music therapy
- Educating the MDT about music therapy
- Handovers
- MDT roles
- Feedback with the MDT and attending MDT meetings

The interview with the CMTS was analysed under the following headings:

- Background
- Overall experience of co-facilitating with MDT members attending the group music therapy sessions
- Possible positive impact of MDT involvement in the sessions
- Possible negative impact of MDT involvement in the sessions
- Educating the MDT about music therapy
- Relating to the MDT

Interview # 1

Background

Eileen had worked at the unit as a MHSW and had attended music therapy sessions on a regular basis with all clients throughout the year.

Attitude towards music therapy:

Eileen stated that music therapy at the unit was her first experience of it: “.. I did not really have a view before. It was something new and I just went along with an open mind...” (Appendix F, p.190). She understood music therapy as an opportunity to for clients to express emotions. It helps the clients to express “how they’re feeling in any form of the instruments they use” (Appendix F, p.189).

Gaining understanding about client responses and behaviour through music therapy:

Eileen expressed an interest in the development and behavioural patterns of clients. She noted the difference between the beginning of the year and the end in terms of the development of client involvement: “I think initially clients would sit there and be well I don’t want to play that...and now it’s straight in”(Appendix F, p. 190).

This had given her insight into the way clients reacted to the music. Some reactions had surprised her:

E: .. Tahi has got quite a soft side to him and he quite often chooses the little recorder thing

R: Was that surprising?

E: ... it was actually. I think he likes the way he can move it and the way it sounds...but just I would of thought he'd have gone for bigger instruments where every week he's quite regular with that (Appendix F, p. 189-190).

Educating the MDT about music therapy:

Eileen supported guidelines and meetings set up to educate the MDT. However, she suggested education of the MDT should be presented more informally: "...nothing beats the personal touch with staff. You can read all the information you like. You got hundreds of information about everyone in here and sometimes its just another thing to read" (Appendix F, p.193). Face to face contact was stated as being the most beneficial way to educate the MDT.

Handovers:

The handover was understood as determining “...what’s happened over the week and sort of different interactions between the clients...” (Appendix F, p. 192) and to obtain a “...more well rounded sort of view...” (Appendix F, p.191-192).

Eileen commented on whom to obtain a handover from. While stating that Jan (OTA) was sufficient to obtain a handover from she also suggested that “.. it would be good to sit down with people who are actually going to be participating in the group” (Appendix F, p.191).

MDT roles:

Allowing for more contact time with staff on the unit was stressed as a vitally important factor to motivate MDT members to become more actively involved: “... sometimes the staff don’t get the clients here on time and I appreciate that they should, but sometimes if they’d met you, know what your doing and how it relates back to the clients I think they’re more inclined to...push it a bit” (Appendix F, p. 195).

Feedback With The MDT And Attending MDT Meetings:

“ I think they’d (music therapists) be really good in MDT meetings we have weekly”(Appendix F, p.193). This was based on the concept that music therapy had the potential to compliment other programs.

Summation:

Overall, Eileen expressed support for music therapy at the unit. An underlying theme of her interview was the need for increased involvement and personal contact with the MDT. She stressed the need for more informal contact with MDT members. Eileen emphasised that when staff became more involved and knowledgeable about the music therapy sessions, they would be more motivated and feel confident to play a more active role in the sessions as well as collecting clients before the session.

Interview # 2

Background:

Richard is the on-site psychiatrist. Although he did not attend any music therapy sessions, he always expressed an interest in the music therapy sessions, often asking the researcher and CMTS questions about certain responses from clients.

Attitude towards music therapy:

Richard's attitude towards music therapy at the unit was positive and supportive: "I think its marvellous.. the patients here thoroughly enjoy it...it doesn't depend on their IQ ,their age..." (Appendix F, p.197). He saw music therapy as a success-orientated activity "It's something they can DO they can't DO many things apart from manual stuff" (Appendix F, p.197). The active nature of music therapy was perceived as having a direct effect on the self-esteem of clients. " I think that ACTIVE is very good and they appreciate it they get warm fuzzies if they do well and its' nice. It reinforces their self-worth." (Appendix F, p. 197).

Gaining understanding about client responses and behaviour through music therapy:

Even though Richard had not attended music therapy sessions at the unit, he had formed some understanding of the sessions from discussions with the researcher and CMTS. He agreed that the MDT would be interested in responses from clients that differed from their normal presentation.

Educating the MDT about music therapy:

Richard did not discuss this issue with the researcher.

Handovers:

A chat before sessions begun was seen as important: “.. you should have a little chat to the staff when you come in everything is alright and they say yes it is fine (or)... worry about Tahi or someone...” (Appendix F, p.198).

MDT roles:

This was not applicable for Richard as he did not attend sessions.

Feedback With The MDT And Attending MDT Meetings:

What exactly the music therapist should be feeding back to the staff was expressed very clearly: “ I think they’re interested in something DIFFERENT or of

CONCERN not what you're doing. ...UNDERLINE if you're concerned about someone particularly. Otherwise it's just a report by the music therapist." (Appendix F, p.199).

Richard remarked that the information the music therapist relays back to the MDT concerning client behaviour would be valued:

I think the information you provide to the staff is very useful.. How did they behave there, were they surly, were they cheerful any interesting behaviour any lack of enthusiasm...I think feedback to the group would be quite good if you feel there's something to be said about an individual patient (Appendix F, p.198).

Summation:

As Richard had not attended any music therapy sessions the interview revolved around his views of music therapy and communication with the MDT outside of music therapy sessions. He viewed the active component of music therapy as very beneficial for this client population. He stressed the need for the music therapist to be able to disseminate information clearly for the MDT. Clinical notes from music therapy sessions were considered to be an important way of relaying information to the MDT. He stated that in particular the presentation of the client and any significant responses should be reported in the notes.

Interview # 3

Background:

Warwick is a RN working at the research location and had attended a small number of music therapy group sessions. He had had previous experience with music therapy when he worked as a nurse in England.

Attitude towards music therapy:

Warwick stated that music therapy could help this client population communicate more effectively. He emphasised the importance of the active nature of music therapy. Furthermore, he explained that music therapy could educate clients about various aspects of communication and social interaction. He said it can “actually teach people things while they’re doing other things and they’re not aware that they’re actually learning things”(Appendix F, p.202).

“To be honest its’ not a matter of them just going and banging a drum. They actually learn in a kind of subtle way”(Appendix F, p.204). Informality and keeping activities fun was emphasised as a crucial way to engage clients in this population.

Gaining understanding about client responses and behaviour through music therapy:

Warwick explained how the music therapy group was used as an indicator to gauge if clients were able to function in a group when he had worked in England with music therapists: “If they can’t function in a music therapy group then it’s pretty nil chance they’re gonna function in any other group...I used to always think if they can’t handle the music therapy which is pretty sort of fun really it doesn’t bode well”(Appendix F, p. 206).

Warwick reported that he had been surprised by some responses of clients: “Yeah that was pretty interesting... some guys playing softer instruments that you might have thought of them playing louder instruments. I know other people have said that has surprised them” (Appendix F, p.208).

Educating the MDT about music therapy:

Warwick appeared to be very comfortable with the meaning of music therapy and his involvement in the sessions. He did not mention any need for further education of staff about music therapy.

Handovers:

Warwick did not specifically mention handovers.

MDT roles:

Warwick felt that it was his role to merge with the group according to the group facilitators: “ Yeah I think you just come in and sort of go with the flow I mean... that’s what I took our job is not leading the sessions” (Appendix F, p.205).

The relationship that MDT members have with clients was reported to affect client behaviour in a session. When a positive relationship with a client had been established, MDT members could use modelling to encourage participation from clients: “Sometimes if you’ve got a rapport with the guys as well they’ll come in because you’re in and they can see that you’re taking part and they might do something...” (Appendix F, p.206).

Feedback With The MDT And Attending MDT Meetings:

Warwick related his experiences of working with a music therapist in England.

They (music therapists in England) used to contribute to team meetings you know they’d feed back on the session and they’d had a yearly care team meetings what they’d done they’d feed back in ward how they’d done how they were progressing how they presented in group settings because it’s still a group (Appendix F, p. 203).

Summation:

Warwick viewed music therapy as an alternative communication medium where clients could learn social and communication skills in an active, fun, motivating way. His previous experience in England with music therapists meant he possessed a sound understanding of the process and meaning of music therapy. This appeared to result in him feeling comfortable with his role in the music therapy group.

Interview # 4

Background:

Jan is the OTA at the forensic psychiatric unit. However, from September to the time this research was being conducted there was no OT working in the unit. This situation had resulted in Jan overtaking many of the OT's responsibilities. She was the researcher and CMTS's main link to the MDT. They were reliant on her to relay handovers and the general happenings of the unit.

Attitude towards music therapy:

Jan had no experience of music therapy before the placement had begun at the unit. The spontaneous nature of the sessions had initially induced feelings of anxiety in Jan, but as she stated she had relaxed as her understand of the process grew.

Jan understood music therapy as being a fun, active and expressive tool for clients at the unit: "...They can just express themselves and especially..(those)...who don't really you know express themselves very well or whatever or don't do anything spontaneously they just pick it up and do it and they respond to the rhythm" (Appendix F, p 208).

Gaining understanding about client responses and behaviour through music therapy:

As Jan had attended music therapy sessions regularly, she had gained many insights into client responses in the music therapy sessions. She spoke particularly how music therapy meant different things to different clients:

“I think it’s fun but it’s more he (the client) actually manages to show off a bit of skill or something too you know like when he picks up the guitar I think he feels quite empowered...”(Appendix F, p.209).

Educating the MDT about music therapy:

Jan contended that disseminating information in MDT meetings was a good way to educate MDT members who did not attend sessions:

you could say how they do in that music session and it could give a different perspective to that person to that client whereas now I don’t think anybody really knows except for the guys that go in there they don’t KNOW what happens in music therapy and they might just go with one person and never go with anybody else too (Appendix F, p.214).

Handovers:

Handovers were seen as an important way to relay information to the music therapist. Jan stated that meetings, clinical notes and observation of client behaviour should make up material relayed in the handover.

MDT roles:

Overall, Jan was a strong advocate for intense MDT involvement. Involvement was referred to in relation to prompting clients to come to music therapy sessions and active participation in the actual music therapy sessions. "...I think they (MDT members) need to be more involved with making sure they attend the session or making sure they're in a good space for the session" (Appendix F, p.212).

If a music therapist were to work permanently in the unit, the responsibility of prompting clients would shift from staff to the music therapist. Jan gave a hypothetical example:

"..(prime) them ahead. Even say 'Oh tomorrow I'm going to see you tomorrow' because they (the clients) work a lot like that you know like.." (Appendix F, p.213).

The relationship that the MDT member had with clients was understood as having a direct influence on the session. As a result of this influence, Jan emphasised the importance of including MDT members in sessions that are motivated to become involved in sessions

...if whoever was co-ordinator was aware of how the guys how the staff members relate to the different clients because if they send someone in there who is really not interested in doing anything really.. and really not interested in music they're just.. It's' not very good for the rest of the clients... (Appendix F, p.209).

Feedback With The MDT And Attending MDT Meetings:

Jan stated that reporting back on the music therapy sessions was considered to be very important, as some MDT members would be totally unaware of what happens in a music therapy session.

She believed music therapy had the potential to offer new insights for the MDT:

...you could say how they do in that music session and it could give a different perspective to that person, to that client. Whereas now I don't think anybody really knows except for the guys that go in there they don't KNOW what happens in music therapy and they might just go with one person and never go with anybody else too (Appendix F, p.214).

Summation:

Jan alleged that music therapy was beneficial for this client population as it offered them an opportunity to express themselves. She noted that music therapy represents different meanings for different clients.

Jan held that MDT members strongly influenced the music therapy session. She provided evidence, stating that the relationship the MDT member had with an individual client, had an obvious effect on the session. In addition, she advocated that MDT members should be screened and clarified that they should only attend the sessions if they maintained a positive outlook and were actively involved. If the MDT member was not interested in becoming actively involved, Jan stated that it would have a negative effect for the clients.

Jan also focused on the responsibilities of the MDT and the music therapist. MDT responsibilities outlined by Jan included prompting clients to attend sessions and active participation in the session. Music therapist's responsibilities included prompting clients to attend sessions, even a day in advance. She stated that the music therapist should also inform the MDT as to what occurs in the music therapy session and thus educate them as to the processes of music therapy.

Interview # 5**Background:**

Don is a MHSW at the forensic psychiatric institution where this research took place. He had attended music therapy sessions regularly with the same individual client.

Attitude towards music therapy:

Don had had no experiences of music therapy prior to the student music therapy placement at the unit. His overall attitude was positive and encouraging of the researcher and CMTS.

Gaining understanding about client responses and behaviour through music therapy:

Don expressed enjoyment at attending music therapy with his individual client. Although he did not state specifically what particular behaviour his client had displayed in music therapy, he did insinuate that his client expressed obvious enjoyment in the session.

Educating MDT About Music Therapy:

Don did not refer to educating the MDT about music therapy.

Handovers:

Don did not refer to handovers in the interview.

MDT roles:

Don appeared to have a sound understanding about his role in the sessions. When asked if he understood his role he stated that everyone's safety in the room was his first priority. After that was established and his client appeared relaxed, he was also able to relax and enjoy the session.

His expressed an enthusiasm to be actively involved with his client: "I want to be part of everything that's going on..."(Appendix F, p.225).

Feedback With The MDT And Attending MDT Meetings:

The importance of MDT support to ensure the success of a program was emphasised by Don. He compared music therapy to other programs in the unit and concluded that music therapy was received well by the MDT. This was measured by the fact

that MDT attendance was relatively high for music therapy sessions, compared to other programs.

Summation:

Don received music therapy positively at the unit. He believed the client whom he had attended music therapy sessions with enjoyed it immensely. Don placed importance on the support from the MDT. He drew the conclusion that it was more likely for a program to continue successfully if it were well supported by the MDT.

Interview # 6⁹**Background:**

Rachel had co-facilitated group music therapy sessions with the researcher consistently throughout the year.

Overall experience of co-facilitating with MDT members attending the group music therapy sessions:

Rachel emphasised the fact that the attending MDT member had the power to influence the whole group:

“...it (the MDT member’s presence) impacted on us which of course then impacted on the clients and when it impacted on the clients it had counter transference back to us so it was bouncing around the room big time” (Appendix F, p. 227).

Furthermore, she stated how the personality of the carer and the way they interacted greatly affected the dynamics of the group:

⁹ The CMTS has referred to members of the MDT in the sessions as *carers* in this interview.

The actual personality of the carer also how confident a person they were was often picked up... so if you had someone come into the room as we did who had quite a perhaps a poor self esteem...if you've got someone dominant in the group they'll just sort of sap that energy away and then the whole dynamics of the group changes once again and then you're in the protective role as opposed to working with the whole group... so the dynamics were enormously changed each week as those people came in to the group (Appendix F, p.229).

She contended that MDT members should only be a part of the therapeutic space if they felt comfortable participating. Otherwise "they're better to be sitting out of the therapeutic group.." (Appendix F, p.230).

Possible positive impact of MDT involvement in sessions:

1. MDT members could act as good models for clients
2. MDT members' involvement in the session could potentially foster good relations between MDT members and clients:

I think anything that emulates if you like um eh well parent child I suppose where the communication is fun and equal and developmental and productive. I think that

any play together where it's active and positive is good because if you can model what is good and positive (Appendix F, p.231).

Possible negative impact of MDT involvement in sessions:

Rachel implied that the presence of an MDT member, and the way in which they interacted in the group could detract from the music therapy facilitators focusing on client interaction and therapeutic goals for each client. Three different examples were provided.

1. If a MDT member had a close relationship with a client in the group, the group could become split as a dyad was created:

“...that (interaction) immediately... formed a dyad of those two people and then that would mean that our (researcher and CMTS) energy instead of being in a therapeutic situation was actually trying to bolster to make sure that everybody in the room had a group experience and feel to it” (Appendix F, p.228-229).

2. If an MDT member ‘performed’ on an instrument, this could alter the grounding of the therapy from client-centred to performance based.

“...if they (the MDT member) were wanting to be the star of the drumming for example well then other people (clients); their experiences that they had would not

of been as perhaps as successful in their eyes um if they were comparing themselves with how the carer was doing” (Appendix F, p. 229).

To summarise this issue; if a MDT member was skilled on an instrument, this could cause clients to feel intimidated. This would consequently interfere with a success-orientated therapeutic philosophy that is inherent in music therapy.

3. MDT members can cause confusion when over-facilitation of the group occurs:

...to give you an example the music therapist might be.. either unsure of the song that the client wants or...the client (might not) come forward with the song and the carer might misinterpret that and take over that role facilitating the group and on that occasion ,particularly as students, but for anybody it once again diverts away from the group and splits the group and that makes the client I could imagine feel unsure and. ..destabilises the whole therapeutic environment and dynamics that are going on (Appendix F, p.230).

Educating the MDT about music therapy:

The CMTS stressed that educating the MDT about the workings of music therapy is very important. She gave justification for this: “I think it was very difficult for the carers coming in because they did not know guidelines and they did feel unsure and

of their role and how to react and that was partly a time restraint...” (Appendix F, p. 232).

Observing and experiencing the group was valued as an apt way to educate members of the MDT about music therapy. The CMTS commented that it sometimes takes time for MDT members to understand the process of music therapy. She explained that initially the MDT viewed music therapy as “... a noise around the place that people had to put up with” (Appendix F, p.232). However, as sessions progressed:

...they (members of the MDT) in fact started to move meetings away from us... They said on numerous occasions that they thought the sessions were worthwhile for the guys and the place and they enjoyed having so called noise, music, around the place and to see... the clients actively involved in something that they were obviously motivated tool to use with them because they could be more expressive than they normally could be (Appendix F, p.232).

The CMTS saw the education of the MDT about music therapy as directly affecting the clinical work:

I think they (the clients) immediately pick up if the person (MDT member) doesn't want to be there or if they're feeling unsure in their role so I think that's where

music therapy, therapists or music therapy students, can make that education behind that quite...clear and good (Appendix F, p. 231).

Relating to the MDT:

The CMTS stated that venturing outside of the music therapy space would enable the music therapist to receive more feedback from the MDT members about the music therapy sessions.

“...go to multi-disciplinary team type meetings or MDT members meetings and just go over the principles behind music therapy and also give some vignettes of what’s happening” (Appendix F, p.231).

She also remarked that the researcher and herself “did not have time to be part of the team which I think is a great disadvantage for music therapy and for us in an establishment” (Appendix F, p.233).

The CMTS music therapist maintained the music therapist must have an awareness of the workings of the institution:

“We were probably reasonably accommodating and careful how we did not disturb the whole system because it’s a complex system that’s going on there” (Appendix F, p.232).

By the same token, the CMTS emphasised the importance of the music therapist being assertive with MDT members and keeping the client at the centre of the therapeutic process:

We kept the client at the centre so if for example it meant putting some MDT members out by out I mean just disturbing a little bit so we really wanted a client out of bed and we made it quite clear that that was their therapeutic time and we wanted that person there if they were well enough, and it wasn't that they had just gone to bed because they were bored

Generally this was well received after perhaps some initial little bit of resistance from the carers but generally speaking this started to happen more and more and it was seen as a serious intervention overall (Appendix F, p.232).

If the music therapist forms a good relationship with the MDT the music therapy program could be implemented with other programs. The CTMS described how the music therapist could collaborate sessions with the speech language therapist and the OT.

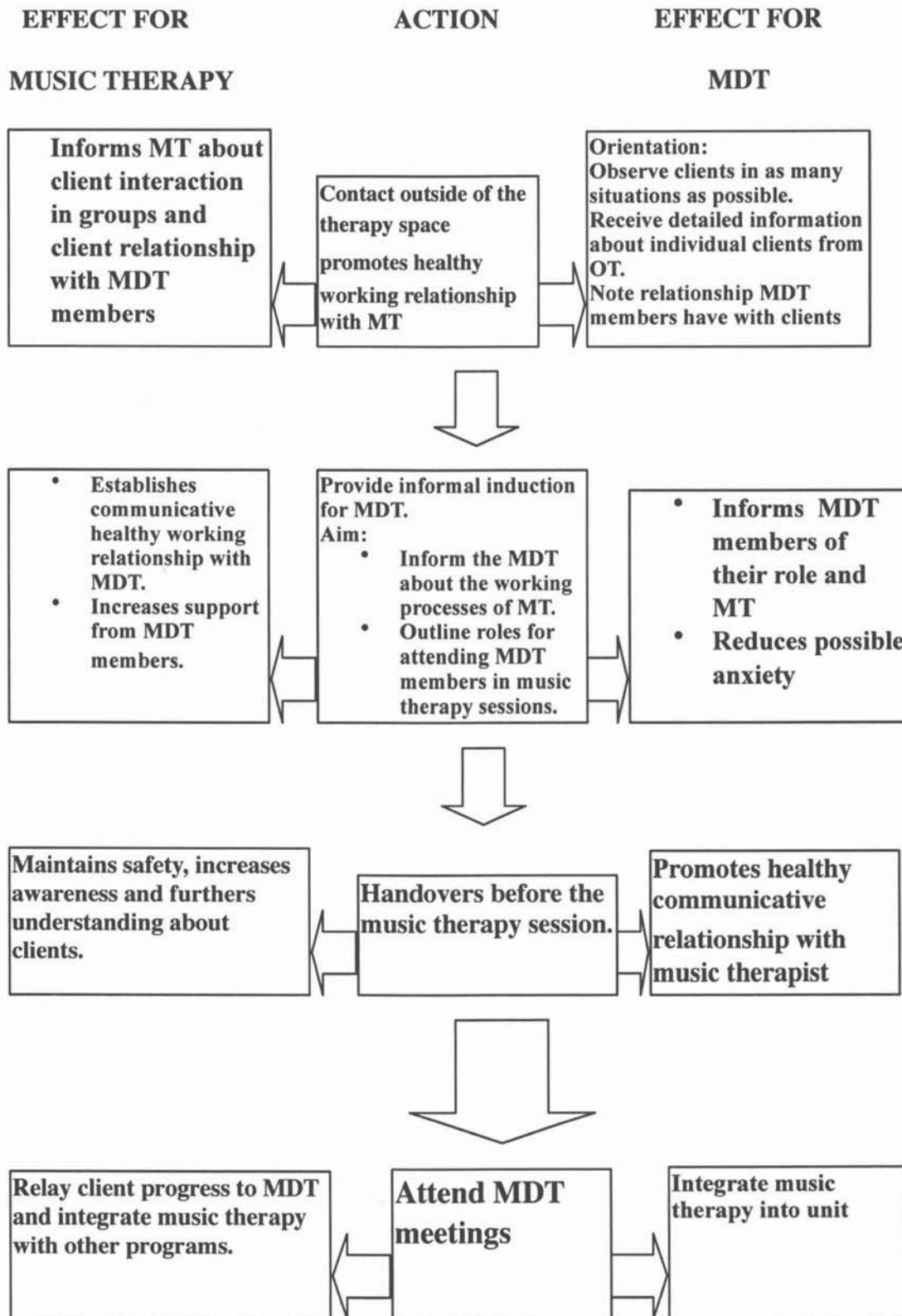
Summation:

Rachel held that the MDT member's personality and style of interaction could contribute or detract from the therapeutic focus. The importance of educating MDT members about their role in the sessions, and music therapy as a whole was stressed as a way to ensure MDT members interacted in a therapeutically appropriate way in the sessions.

Rachel also mentioned the disadvantages of a student placement in forming closer connections with the MDT.

Figure 2. illustrates the interaction between the music therapy program and the MDT from orientation to facilitations to dissemination of clinical work. The figure originated out of the process of comparing and contrasting data from both the interviews and summaries of the music therapy sessions. Further information is available in the discussion section.

Interaction with the MDT



CHAPTER V

Discussion

The research questions will be discussed systematically, with examples from the summaries of the sessions with the interview results supporting claims made.

1. How does MDT involvement in sessions affect the dynamics of the music therapy sessions?

Before discussing the accounts of the sessions in depth, members of the music therapy group need to be revisited. In the case of this research, the music therapy group was not confined to clients only. As MDT members were encouraged actively to participate, the group included MDT members, the researcher, the CMTS and clients. Richards and Davies (2002) share this quote about group processes: “Members of a music therapy group, irrespective of verbal skills or the availability of words, can have an enriched experience, expressive as well as receptive, of themselves and others” (Richards & Davies, 2002, p. 23). This quote reflects the all-inclusive nature of music therapy groups, regardless of whether a member is a client or a MDT member participating.

Summaries of the sessions indicate that interaction between the MDT member and clients was distinctly different between sessions. Out of the five music therapy sessions that were documented, two sessions were characterised by a high degree of client-MDT member interaction, while in the remaining three sessions, there was limited interaction between clients and the MDT member. Results from the interviews were consistent with the researchers conclusions that the attending MDT member's presence strongly influences dynamics. Summaries provide examples of the MDT member's affect on the group, both positive and negative.

1.1 Power hierarchies

This client group presents with volatile power plays. The clinical summaries illustrate fluctuating and changeable dynamics of this group and in particular, the power struggles between Tahi and David. This reflects claims made in the literature that secure environments tend to encourage the development of an intense culture, particularly in group situations (Thaut, 1987, Coddling, 2002, Glynn, 2002, Davis et al., 1999).

It follows that when inherent power hierarchies are established in a group, that group would be very sensitive to the presence of a different MDT member each session.

1.2 Complexities of client-MDT interaction in the music therapy session:

Clients are sensitive to their relationship with MDT members in the music therapy session. Jan commented:

“ I think definitely the guys relate to different staff members like that time when Bill wanted to go out and have a smoke cos he did not want (MDT member) to be there in the session” (Appendix F, p.199).

The literature refers to the dichotomy for therapists and other professionals working in forensic psychiatry between maintaining firm boundaries and facilitating a degree of freedom and permissiveness (Glynn, 2002, Davis et al.,1999). As Glynn (2002) states “patients are constantly reminded that their freedom has been placed in the hands of doctors, MDT members, the wider social service...” (Glynn,2002, p. 45).

In the interview with the CMTS, she referred to the relationship with the MDT member and client as based on rules and authority. She remarked that the music therapy session

could “be strange for both the clients and the carer to feel...that those usual roles and balances of power...move around and shift around” (Appendix F, p.220).

It is highly probably that clients and MDT members are unfamiliar with interacting together through improvisational music. Richards & Davies (2002) explore improvisational music in the music therapy group. They explain “that interactions of

improvised music allow something of the group process, conscious and unconscious to be made audible” (Richards & Davies, 2002, p. 19). In session three, Tahi and Brian played the cymbal together for a sustained period in the last improvisation. Previous to that event there had been no co-operative playing between the pair. In fact, there had been obvious displays of tension in their discourse with each other. Their co-operation through music appeared to be a way of releasing tension that had developed and re-connecting through non-verbal means.

A detailed examination of the interactions between MDT members and clients during improvised sections is outside the scope of this study. This observation does however highlight the intensity of the MDT member-client interaction that can occur during the music therapy sessions.

1.3 Personality and style of interaction:

Personality and style of interaction of the MDT member naturally dictates how the MDT member interacts with the group. In the OTA interview and the CMTS interview, it was suggested that MDT members be carefully selected for each music therapy group, based on their degree of active, positive participation with clients. While this could create more stability for the client group, it may also create the potential for tension and division between MDT members. The ramifications within the wider institution must be taken into account.

Furthermore, sometimes it is not appropriate for MDT members to become fully involved in a session. For example, in session five, the MDT member remained on the periphery of the group for the duration of the session. This was very appropriate as clients were able to process closure with the researcher and CMTS without the immediate presence of a MDT member in the group.

1.4 Regular verses irregular attendance of the MDT member: effect on group dynamics

The presence of an MDT member in the group who has not attended regularly can result in clients focusing on this individual. Session one and session three highlight this point. Eileen, who had regularly attended the music therapy group throughout the year, attended session one. By contrast, in session three, the attending MDT member was Brian, who had never attended a music therapy group prior to that session. The degree of interaction between the MDT member and clients was decidedly different.

In session one, clients appeared very comfortable with Eileen's presence. Eileen, also (as stated in her interview) was comfortable with her role in the group. In session three, Tahi quickly ascertained that Brian was unsure about his role in the group, as it was his first session. He reacted by testing the boundaries. In this case he

physically touched Brian several times. This consequently affected other clients in the group. David in particular responded by becoming agitated. He then reprimanded Tahi. As well as highlighting the differences between attendance levels of MDT members, this behaviour is also consistent with claims made earlier about the power dynamics and complexities of the MDT member-client relationship.

1.5 Effect of the MDT relationship with clients:

If a MDT member has developed rapport with a particular client this can lead to more intense interaction with that client compared to other clients in the group. Thus, the relationship the MDT member has with a client has an impact on interactional dynamics.

The CMTS agreed that concentrated interaction between a particular client and a MDT member could fragment the group dynamic. To a certain extent, the music therapist must expect heightened interaction between MDT members and individual clients. This is because MDT members are allocated an individual client for each session. It is therefore understandable that they would interact more with that particular client. To provide an example; in session two Tahi and Warwick in particular interacted closely. Their verbal and musical interaction had the effect of alienating other clients in the group. David and Mark responded by becoming

increasingly withdrawn. The splitting of the group that occurred strongly impacted the dynamics of the group.

1.6 Role modelling:

However, a high level of participation of the MDT member in the group, as in session two with Warwick, can result in positive results. In session two, Warwick's enthusiastic involvement motivated Tahi to engage more intensely. Warwick and the CMTS agreed in the interviews that active participation of an MDT member can act as a role model for clients.

2. What features have been observed in the interaction between the MDT and the music therapy program in the setting of a one-year student practicum in forensic psychiatry?

2.1 Attitudes towards music therapy and the role of music therapy in the MDT

Overall, interview participants viewed music therapy positively. There were varying understandings of the meaning and therapeutic aims of music therapy. There was a general consensus amongst interview participants that music therapy has the potential to elicit unexpected responses from clients. Glynn (2002) claimed that forensic psychiatric clients could form very different relationships in music therapy compared to other treatments. He adds that the MDT must be aware of this. All

interview participants agreed that the MDT would be highly interested in any unexpected responses and that these reports would be valued in MDT meetings. Thus, the interaction between music therapy and the MDT outside of the music therapy space is a vital way to ensure clinical work is disseminated effectively, and the music therapy clinical work finds relevance within the institution as a whole.

This is consistent with claims made in the literature relating to the MDT in forensic psychiatry that professionals need to relate their practice to the wider forensic psychiatric institution in which they work. With support of the MDT, the music therapist can then meet the needs of this challenging, complex client population. Session summaries and interview results reveal the points of interaction outside of the music therapy space between the music therapy program and the MDT.

2.2 Handovers:

Session summaries highlight that the handovers that occurred before the session informed the researcher and CMTS of the presentation of clients. This is an essential gauge of the overall mood and presentation of clients.

In her interview, Eileen raised some questions about who the music therapist should approach to obtain a handover before a music therapy session. However, the majority of interview participants agreed that a summation of client's presentation

could be relayed from any member of the MDT. All interview participants agreed that the handover was an important aspect of the clinical work.

2.3 Understanding of the MDT member role in the session:

Interview results show that Eileen and Jan had both experienced anxiety when they first attended music therapy sessions. This anxiety was related to uncertainty about their role, and unfamiliarity with playing instruments in improvisation. The anxiety had alleviated as the sessions had progressed and their understanding of the processes of music therapy had increased. Wigram (2004) notes that clients need to build familiarity and confidence, particularly in regard to improvisational music making. He explains “even if they (the clients) have had a musical education, they may feel uncomfortable to be required to create music spontaneously through improvisation...” (Wigram, 2004, p.183). It is highly likely that MDT members experienced similar feelings of anxiety based on many of them exhibiting a lack of familiarity with music therapy.

Educating MDT members about the process of music therapy could reduce anxiety concerning their role in the sessions, which could consequently affect their degree of participation. Members of the MDT require an understanding of the workings of music therapy and an outline of their expected roles when attending music therapy sessions. In the interview with Eileen, she emphasised the need for MDT education.

Specifically she recommended the music therapist conduct an informal meeting to educate MDT members, rather than providing handouts.

Additionally, active involvement in the sessions can educate the MDT about the workings of music therapy. In the literature, Choi (1997) found that MDT members who attended music therapy sessions often, valued it more than those who did not attend often. The CMTS agreed. She explained how the MDT had understood and valued music therapy more as they had attended sessions, or received feedback about client progress from those who had attended. Also, several participants in the interviews commented on developments they had witnessed throughout the year in relation to client behaviour and responses.

Educating the MDT about music therapy can also encourage more support of the music therapy program. The literature reports that when MDT members possess a sound understanding of the workings of music therapy, levels of support for the music therapist and the music therapy program increase (Brooks and O'Rourke, 2002, Brooks and O'Rourke, 1999, Choi, 1997). This generalization is consistent with comments from interview participant Don. He reported that programs which MDT members valued and understood were more likely to receive support from the MDT.

Finally, educating MDT members about music therapy and their role in the session ensures that members are interacting in a way that complements the therapeutic goals and aims of the session. The CMTS referred to negative effects that MDT member could have on the session. These included over-facilitating, or changing the focus from client centred therapy to performance based. She stated this could intimidate clients, and cause the therapeutic environment to become destabilised and confused. Fulford (2002) concurs. She emphasises the influence the MDT member can have on client responses stating that inappropriate verbal or musical interaction with an MDT member and client could interfere with therapeutic aims.

2.4 Music therapy complementing other programs in the MDT:

In Rachel's interview she mentioned that, if clients were engaged in some art activity " then it could be tied into the music therapy process" (Appendix F, p. 219).

Additionally, Warwick, who had previous experience with music therapy, stated that the music therapy group was used as a benchmark to monitor whether clients could function well in a group. This is another example how music therapy can be integrated into the overall approach to treatment for clients.

3. What clinical responsibilities does the music therapist need to undertake, in order to work effectively with the MDT, in a forensic psychiatric setting?

Assimilating conclusions drawn from the first two research questions, has informed the third question. This relates to the clinical responsibilities the music therapist may need to be aware of in a forensic psychiatric setting, in order to practice successfully and effectively with the MDT.

3.1 Student music therapist vs employed music therapist.

On this particular student placement, the music therapy sessions were conducted for one morning a week. The interviews reveal the pitfalls of a tight time frame in which to conduct music therapy sessions *and* interact with members of the MDT. However, these pitfalls served as a means of comparison between a student placement and what is expected from a music therapist as an employed member of the MDT.

3.2 Responsibilities for the music therapist:

The music therapist must carry out responsibilities within the MDT in order to practice effectively in the forensic psychiatric setting. Results from the interviews reveal that expectations for the music therapist working in this setting revolve around the following:

1. Educate the MDT about music therapy and their role in the group.

2. Provide opportunities for MDT members to observe sessions initially if anxiety evident in clients.
3. Attend MDT meetings in order to disseminate the clinical work, gain support from the MDT and compliment the music therapy program with the overall treatment plan for clients.
4. Facilitate interactions with the MDT and clients outside of the music therapy room
5. Maintain a high degree of awareness about the specific workings of the institution.

3.3 Responsibilities for the MDT:

Through the research process the researcher also discovered that the MDT, as well as the music therapist, had certain responsibilities to fulfil in supporting the music therapy program. Langan et al. (1999) expressed the negative outcomes that can occur when the MDT does not support the music therapy program in the forensic psychiatric setting.

From a purely logistical point of view, safety requirements demand that MDT members attend sessions. MDT members have the power not to attend sessions, or collect clients. Thus at the most minimal level, the music therapist requires the MDT members to attend the music therapy program to ensure it can proceed. The CMTS and the OTA described in their interviews the expectations that they placed on the MDT for support:

1. Provide the music therapist with a handover before the music therapy session. This should include information about client presentation and the type or relationship the attending MDT member has with the clients. The music therapist should also be informed as to which MDT member will be attending the session.
2. Prompt clients to attend music therapy sessions
3. Collect clients for music therapy sessions
4. Engage in discussion and feedback with the music therapist after the music therapy session.

Based on the above information that was dissected and collated in this research process, the researcher formed a template of clinical responsibilities for future

music therapists working with the MDT in a forensic psychiatric setting. The template was formed out of the learning process that the researcher underwent during this research study. This research has allowed the researcher to appreciate the many facets that constitute music therapy clinical work in the forensic psychiatric setting.

Template for future music therapy clinical work within the MDT in forensic psychiatry:

Client Orientation

Consult the OT or any other member of the MDT about each clients history, risk management plan and any other important information.

Observe clients in other groups. This will inform the music therapist about client behaviour. Even though other groups will always differ from a music therapy group, any power hierarchies and general group dynamics will be detected.

Also, observe MDT members interacting with clients. Note any particular rapport between MDT members and clients that could influence music therapy session.

MDT Orientation:

- Conduct an informal meeting before you begin facilitating sessions
- Give a brief definition of the working practices of music therapy
- If possible give examples of music therapy work in the forensic psychiatric setting, or setting you are working in.
- Explain what role MDT members fulfil in the sessions.

Encourage staff to ask questions about their role in the sessions.

Be proactive and ask staff for their reflection on the work. Where possible ask staff if they are available after sessions for a de-brief.

Before facilitating sessions:

Ensure there is an OT, OTA or another member of the MDT available for handover before you commence sessions.

Determine what MDT member will be attending your sessions. If possible find out what relationship each staff member has with clients in your group, or individual client.

Arrange setting or set out of instruments in the music therapy room to correspond to staffing and dynamics of the client group.

Facilitating sessions:

Encourage the MDT member attending to be actively involved in sessions.

Establish that that music therapist is the main facilitator of the group.

Make sure the MDT member has a clear understanding of their roles in the session.

They are there to preserve safety and model for clients.

If a MDT member has never attended a music therapy session before, be sure not to raise anxiety by focusing attention on them. For example it would not be appropriate to ask them to play an instrument by themselves to the group.

Outside of sessions:

Pursue extra contact with staff and clients on the unit outside of the music therapy space. Make sure you circulate the unit, in between and after sessions so clients and MDT members can interact with you outside of the music therapy room.

Write in the clinical notes. Keep notes brief and succinct, underlining significant aspects of the session for other members of the MDT.

Attend MDT meetings. Emphasis any behaviour or responses that were particular to the music therapy session (s).

De-brief with the MDT members attending the session.

Encourage feedback from MDT members. Ask where they think there could be improvements.

4. Discussion of methodology

4.1 Qualitative paradigm:

The qualitative paradigm utilised in this study was appropriate as it enabled the researcher to be actively involved in the research process: in this study the researcher directly co-facilitated music therapy sessions and conducted interviews with MDT members.

By contrast, in quantitative research, the researcher is limited from becoming directly involved in the research process. This would be considered a “liability to the research process” (Bruscia, 1995, p. 390). Therefore, the methodological procedures utilised in this study best suited the qualitative paradigm.

4.2 Naturalistic inquiry:

The naturalistic inquiry appeared to best suit this study for several reasons. Firstly, it was the researcher’s aim to preserve the natural flow of the music therapy session as much as possible. Aside from the presence of the video camera, the researcher continued to co-facilitate sessions with minimal interruption. The foundations of naturalistic inquiry, state that “the natural setting is the source of the study because the context it provides is necessary to establish the meaning and significance of its findings” (Aigen, 2005, p.357).

Secondly, the semi-structured format for the interviewing was appropriate for this research study. Depending on the type of relationship that had been established, it is likely that MDT participants were aware of their relationship with the researcher. It is inevitable that during the interviews participants talked at ease about some subjects, while they found others more difficult. Using semi-structured interviewing techniques, the researcher was not confined to continue questioning participants when they expressed obvious discomfort or disinterest in a subject. This method also

allowed participants to feel at ease and empowered to direct the interview if they felt the desire to do so. Mason (1998) agrees and states that the "... fluidity and flexibility of methods such as semi-structured interviewing.. (enhance) validity, and criticise the rigidity and standardisation of structured questionnaires by contrast for lack of sensitivity to validity..." (Mason, 1998, p. 148).

5. Relationship of participants to researcher:

The researcher had formed a relationship with each of the participants in the interview and with the clients in the music therapy sessions. The researcher was in this case a student fulfilling requirements for a Masters degree in Music Therapy. As the researcher was the student music therapist and researcher, another layer of complexity was added to the dynamics of the interactions with research participants.

5.1 MDT participants:

Clients and MDT participants were aware of the researchers social positioning. It is possible that this knowledge might of affected the interactions of both client and MDT participants. MDT participants had been involved in music therapy sessions or had generally conversed with the researcher, while client participants had been receiving music therapy from the researcher and CMTS.

Furthermore, the fact the researcher was a student might have increased the validity of the interviews with MDT participants. MDT members might have felt more comfortable in giving the researcher advice about the clinical work. Hypothetically, if the researcher was a professional music therapist, the MDT participants may not have felt comfortable offering negative comments.

5.2 Client participants:

As mentioned in the methodology chapter, the client-therapist-researcher relationship can become complicated. There is the potential that clients can become compromised through the research process, especially as the client participants in this study presented with vulnerabilities.

However, credibility and trustworthiness of the researcher was established on a number of levels. The researcher was always clear and honest with client-participants. Information sheets and consent forms were explained and filled in by the clients key worker to eliminate any possible coercion or obligation felt by the client to participate.

Credibility was also preserved because the researcher had interacted with the client participants in what is described in the paradigm of naturalistic inquiry as

“prolonged engagement.” Prolonged engagement means the researcher “stays engaged with the research study and milieu long enough to establish trust with participants, learn the milieu of study well enough to grasp the context of the culture in which the meaning of events and experiences is found...” (Aigen, p.359).

For client participants, authority and power are often the basis for the client-staff interaction. Glynn (2002) states that clients are inherently aware of the fact that MDT represent part of the institution which is “...harshly authoritarian, invasive and restrictive, to which the patient responds rebelliously or fearfully” (Glynn, 2002, p. 61). The clients involved in this research may have perceived their relationship with the researcher and CMTS as more equal, as they were aware of their student status. In the music therapy session results, there are a number of instances where clients tried to push boundaries. There is the prospect that the interaction between MDT, researcher and the CMTS was exaggerated as clients might have felt they had permission to test already established boundaries with MDT members, the researcher, or the CMTS.

6. Validity of interpretation:

The researcher endeavoured to provide sound and solid methodological procedures that maintain a high degree of integrity and validity. The two corresponding sections of data that comprised of data from music therapy sessions and transcriptions from

interviews were interpreted using non-cross sectional data organisation analysis. The two data sources were then woven together and themes drawn between the two. The data gathered from the music therapy sessions offered a narrative, from which the researcher was able to highlight examples of MDT involvement. This type of data analysis is consistent with characteristics of naturalistic inquiry: “Because knowledge is a human construction, not a reflection of a single, objective reality, researchers can use inductive and interpretative forms of data analysis” (Aigen, 2005, p.355).

A large proportion of the accounts of the music therapy sessions document the interaction between clients in a music therapy session. This may have appeared irrelevant, considering the focus was on the MDT member who attended the session. However, isolated interactions between the MDT member and clients could only be understood in the context of the whole group.

Therefore, as the researcher was also the music therapy student, the clinical examples of music therapy sessions were imbued with bias. The researcher undertook data interpretation of the music therapy sessions with a high degree of awareness of her position. In order to reduce bias, the researcher summarised the sessions in a simple fashion, as over-analysis or over-interpretation could have caused role conflict, and therefore reduce the validity of the interpretation. The researcher adopted a similar approach to the analysis of the interviews. The results

contained large excerpts of primary data from the interview transcripts. This was done in order to reduce the possibility of transferring either negative or positive emotions from the researcher, during the transformation of data.

Reliability and validation of the data collected from music therapy sessions was also achieved through constant reflective practice and discussions with CMTS and the OTA after sessions were facilitated. In addition, the inclusion of the commentary at the end of each summary of the music therapy session meant that the researcher was able to vent any personal experiences and feelings about the session. This was included to eliminate any possible counter transference that might have surfaced because of the researcher-student therapist relationship with participants. Therefore, the commentary served as a tool to enable the researcher to continue with reflective practice. These factors all contributed to an increase in the validity of the chosen method for data analysis.

6.1 Peer supervision:

Peer supervision is mentioned as part of the criteria for maintaining trustworthiness in naturalistic inquiry. Regular meetings with other post graduate students and supervision with the researcher's supervisor enabled the researcher to be able to fully disseminate the research process. It should be noted that the researcher did not engage with peer supervision with the CMTS as she was directly involved in the

research process. Clinical work that was co-facilitated with the CMTS was discussed without reference to the research. Discussions concerning ethical and methodological issues also heightened the researcher's self-awareness, and insight into the research process.

7. Limitations of the study:

7.1 Time restraints:

One of the major limitations of this study was the time restraint placed on data collection. Obtaining ethical approval was a lengthy process and the researcher began the research four months later than the proposed date.

Delays in obtaining ethical approval also affected the number of music therapy sessions, which the researcher was able to document. If there had been the opportunity to document more music therapy sessions, the researcher would have been able to arrive at more conclusive findings. As is, generalization of a limited number of sessions was difficult. However, the small number of sessions did succeed in illustrating a variety of MDT members and interaction styles.

Finally, time restraints meant that the researcher was only able to interview six MDT participants (five of whom attended sessions at various times). The aim was to

elicit rich and varied experiences from participants about their views of music therapy, understanding of their role in the session, and the function of the music therapists from the MDT members. The researcher contends that this was achieved. However, in retrospect a larger participant population for the interviews may have been beneficial to increase the validity of the data.

7.2 Researcher-MDT participant relationship

The researcher also had a relationship with each of the participants interviewed. In interviews participants may have not disclosed some information for fear of offending the researcher. The researcher was aware of this dynamic and attempted to offer participants a chance to reflect on any improvements that could be made. Results reflected that participants appeared to feel comfortable communicating negative comments to the researcher. However, perhaps if a research assistant had conducted the interviews, this conflict of interest could have been reduced further.

It should be noted that this study was pioneering. The researcher, who was also a student, was engaged in the research process for the first time. It was also the first time the research location had facilitated a clinical music therapy placement, and in fact, the first time music therapy had been conducted at the unit. Interviews therefore might have been influenced by a lack of comparison to other experiences of music therapy.

7.3 Data collection techniques: use of a video camera.

Another limitation to the validity of the results was the presence of the video camera. The researcher required a video camera to analyse the music therapy sessions in a detailed fashion. As shown in the summaries of the music therapy sessions, the presence of the video camera affected client and the attending MDT members' behaviour. This was particularly noticeable in the first two sessions recorded. In the sessions that followed there was no behaviour that could be directly correlated to the presence of the video camera.

Had the researcher had time she may have been able to introduce the video camera into the music therapy sessions earlier. If this scenario eventuated, participants may have been more comfortable with the presence of the video camera from the outset of the research.

It should also be noted that the music therapy sessions documented were the final sessions of this group. This added another dimension to the dynamics of the sessions, as closure was imminent, particularly in the last three sessions. Thus, session summaries might not have represented a typical period of clinical work with this group.

7.4 Data interpretation:

The subtle nuances and dynamics are very difficult to transfer from the video to the written word. The researcher did engage in reflective discussions with the CMTS and the OTA. However, final interpretations of the videoed sessions were the researcher's own conclusions. These two factors may have reduced the overall validity of the clinical summaries.

CHAPTER VI

Conclusion

This research explored five group music therapy sessions. Sessions were co-facilitated by the researcher and a CMTS. These sessions were summarised in order to uncover particular group dynamics that could be attributed to the presence of the attending MDT member. Six interviews were conducted with members of the MDT, five of whom attended sessions at various times. The aim was to ascertain participant's attitudes towards music therapy, and what role they saw music therapy assuming in the MDT.

This study had three aims. The first aim was to examine the impact attending MDT members have on the dynamics of the music therapy session. The researcher concludes that the attending MDT member can have a strong influence on the dynamics of the music therapy group. For both MDT members and clients, participation in the music therapy group can be challenging and new situation. Summaries of the clinical work and interview results indicate that the interaction with the music therapist, clients and the MDT members in the music therapy space is characterised by the following: knowledge of music therapy and their role in the group, degree of attendance, style of interaction and relationship with clients in the group. The combination of these factors affects the type of influence each MDT member has on the group. Negative ramifications can surface if the MDT member is unaware of their role in the session, the therapeutic aims or group process. This

can lead to fragmentation of the group, through interacting exclusively with one client, or facilitating over the music therapist, and therefore causing a confusion of roles. However, positive effects were also noted. When the MDT possesses an understanding of the therapeutic process and their role in the group, they can act as behavioural models for clients. The MDT member adds another layer of complexity to the already complex group of clients. It is the music therapist's responsibility to ensure the MDT member assists with, not detracts from, the therapeutic process.

The second aim was to explore the features of the interaction between the MDT and the music therapy program. Specific themes emerged. The main theme was based on the maintenance of a high degree of communication between the MDT and music therapist, from orientation to facilitation of sessions, to dissemination of client progress.

A link was made between understanding music therapy processes and support of the music therapy program. Interaction both in the music therapy space and outside of the music therapy space between the music therapist and MDT is highly valued.

Finally, the third aim was to clarify clinical responsibilities for the music therapist when working with the MDT in a forensic psychiatric setting. The demands of the forensic psychiatric setting mean it is imperative that the MDT is very high functioning. The implementation and maintenance of effective risk assessment, and risk management is reliant on the MDT. Because of complex legal, mental health and ID needs the clients present with, the MDT must be able to form a collaborative,

co-ordinated approach that integrates the various professional affiliations. This is in order to provide the highest possible level of care for clients.

The results of the interviews and accounts of the music therapy sessions indicate that the discourse between the music therapist and the MDT is reliant on support and effective communication. To ensure a healthy working relationship between the music therapist and MDT in the forensic psychiatric setting, both parties must undertake certain responsibilities. The interviews highlighted areas where the music therapist could improve the working relationship with the MDT.

Future research in music therapy:

There are many potential directions for future research in this field. This research hinted at the possibility of members of the MDT and clients finding the egalitarian nature of music therapy a new, and sometimes anxiety-inducing concept. This may be because authority, distance and barriers often prevail in everyday life on the unit. Results from the music therapy sessions indicate that MDT members and clients can find it difficult to interact in the music therapy sessions. As discussed, this may be due to the fact that different power dynamics exist within the music therapy space, compared to the existing dynamics in the institution.

However, while MDT members and clients might have found this aspect of music therapy challenging, results also show that MDT members found it interesting to observe and participate with clients in a new situation. Summaries of the sessions show that conflict between MDT members and clients in the session could be resolved through playing an instrument together. On the basis of these suggestions, the researcher proposes that longitudinal studies could examine the interaction of MDT members and clients in music therapy sessions and what impact this has on the MDT member-client relationship.

Clinical implications:

The introduction of this paper commented that MDT members accompany clients to music therapy sessions in other settings. The template the researcher created (page 132) is anticipated to be of use to music therapists working in the forensic psychiatric setting. It is also anticipated to have clinical application for other settings to inform music therapists how to practice effectively within the MDT.

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Appendix A

List of Abbreviations:

- CMTS = Co-music therapy student
- ID = Intellectual disability
- MDT = Multi-disciplinary team
- MHSW= Mental Health Support Worker
- MT = Music Therapist
- MTS = Music therapy student
- OT = Occupational Therapist
- OTA = Occupational Therapist's Aid
- RN = Registered Nurse

Appendix B

Glossary of terms

Borderline personality disorder:

This disorder is marked by instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood (American Psychiatric Association, 2000).

Diagnostic criteria under the DSM-IV (American Psychiatric Association, 2000) is listed as:

- 1) Desperate efforts to avoid real or imagined abandonment.
- 2) A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation
- 3) Identity disturbance: marked and persistent unstable self-image or sense of self
- 4) Impulsiveness in two areas that could be potentially self-damaging. For example spending, sex, substance abuse, reckless driving, binge eating
- 5) Recurrent suicidal behaviour, gestures or threats or self-mutilating behaviour
- 6) Affective instability as a result of a marked reactivity of mood.
- 7) Chronic feelings of emptiness
- 8) Inappropriate, intense anger or difficulty controlling anger.
- 9) Transient, stress-related paranoid ideation or severe dissociative symptoms

Forensic Psychiatry:

Relates to the training and experiences in the assessment, treatment and care of persons who have offended, are alleged to have offended or appear likely to offend because of their psychiatric condition (Brunton, 1996).

Intellectual disability:

The DSM-IV (American Psychiatric Association, 2000) lists four degrees of severity of mental retardation:

Mild mental retardation: IQ level 50-55 to approximately 70

Moderate retardation IQ level 35-40 to 50-55

Severe mental retardation IQ level 20-25 to 25-40

Profound mental retardation IQ level below 20 or 25

Diagnostic criteria for mental retardation is listed under the DSM-IV as:

Significantly lower than average intellectual functioning: an IQ of approximately 70 or below. Concurrent deficits or impairments in adaptive functioning in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety.

Intellectual Disability Compulsory Care and Rehabilitation Act (2003):

This act authorises compulsory care and rehabilitation of individuals with an intellectual

disability who have been charged with, or convicted or an imprisonable offence

(Ministry of Health, 2004).

Mental Health Act:

This refers to the ordering imprisonment with treatment. Treatment can be undertaken in a secure hospital and the person can be transferred to prison once their mental health issues have been addressed. When the prison sentence expires, a person could be reclassified as a patient under the Mental Health (Compulsory Assessment and Treatment) Act 1992. Tahi and Mark are both held under the Mental Health Act.

Multi-disciplinary team (MDT):

A group of professionals, each of whom is responsible for individual decisions; who together hold a common purpose; who meet together to communicate, collaborate and consolidate knowledge, from which plans are made, actions determined and future decisions influenced (Twyford et al., 2005).

Schizoaffective Disorder:

Diagnostic criteria for schizoaffective disorder according to the DSM-IV (American Psychiatric Association, 2000) is:

- A. An uninterrupted period of illness during which there is a major depressive episode, a manic episode or a mixed episode with symptoms concurrent with schizophrenia
- B. During that same period there have been delusions or hallucinations for a least two weeks in the absence of prominent mood symptoms
- C. Mood episode symptoms are present for a substantial part of the total length of the active and residual part of the illness
- D. The disturbance is not due to direct physiological effects of a substance or general medical condition.

Sexual paraphilia:

Diagnostic criteria for sexual paraphilia according to the DSM-IV (American Psychiatric Association, 2000) is:

Sexually arousing fantasies, sexual urges, or behaviours generally involving:

- 1) non-human objects
- 2) the suffering or humiliation of oneself or ones partner
- 3) children of other nonconsenting persons that occur over a period of six months.

Appendix C

Consent Form for a Research Project for staff participants:

REQUEST FOR INTERPRETER

English	I wish to have an interpreter.	Yes	No
Maori	E hiahia ana ahau ki tetahi kaiwhakamaori/kaiwhakapakeha korero.	Ae	Kao
Cook Island	Ka inangaro au i tetai tangata uri reo.	Ae	Kare
Fijian	Au gadreva me dua e vakadewa vosa vei au	Io	Sega
Niuean	Fia manako au ke fakaaoga e taha tagata fakahokohoko kupu.	E	Nakai
Samoaan	Ou te mana'o ia i ai se fa'amatala upu.	Ioe	Leai
Tokelaun	Ko au e fofou ki he tino ke fakaliliu te gagana Peletania ki na gagana o na motu o te Pahefika	Ioe	Leai
Tongan	Oku ou fiema'u ha fakatonulea.	Io	Ikai
	Other languages to be added following consultation with relevant communities.		

Title of the research project: Documenting a music therapy program in a forensic psychiatric setting

I have read the information sheet dated _____ and understand what the research project is about.

I have had the chance to discuss this study. I am satisfied with the answers given.

I have had time to think about whether I want to take part in this research project.

I understand that taking part in this study is voluntary and that I may withdraw from the study at any time

I have had been told I can use whanau support or a friend to help me ask questions and understand the study.

I understand I can ask any questions at any time. I know who to contact if I want to ask questions.

I understand that I have the right to not take part in the study at any time and don't have to answer any questions

I understand it is my right to have privacy respected.

I understand that information about myself can be shared with the researchers supervisor, the supporting music therapist, the co-music therapist, occupational therapists and staff members present at music therapy sessions and other music therapy students during seminars.

I understand that in no point in this research will my name or location of the institution be written down.

I agree/do not agree to the music therapy sessions/interviews being audio taped
I agree/ do not agree to the music therapy sessions/interviews being video taped.

I understand that I have the right to ask for the recording device to be turned off at any time.

If consent is agreed to:

The original of the above will be stored at _____ and

OR

___ copies of the above will be stored at _____ and:

(tick boxes)

___ must remain on-site at all times

___ may be taken off-site to be used by Anna Hill for:

___ writing up case studies for the proposed research project

___ sharing with Massey University Music Therapy Students

___ sharing in a professional conference

This consent expires on _____ (date) and may be withdrawn at any time.

I understand that this research will be given to Massey University and will be read and marked by examiners of Massey University.

I _____ (full name) agree to take part in this study.

Date _____

Signed _____

Full name of researcher: Anna Marie Hill

Project role: To document setting up a music therapy program in a forensic psychiatric setting.

Signature: _____

Consent Form for clients at xxxx:

REQUEST FOR INTERPRETER

English	I wish to have an interpreter.	Yes	No
Maori	E hiahia ana ahau ki tetahi kaiwhakamaori/kaiwhakapakeha korero.	Ae	Kao
C o o k Island	Ka inangaro au i tetai tangata uri reo.	Ae	Kare
Fijian	Au gadreva me dua e vakadewa vosa vei au	Io	Sega
Niuean	Fia manako au ke fakaaoga e taha tagata fakahokohoko kupu.	E	Nakai
Samoaan	Ou te mana' o ia i ai se fa'amatala upu.	Ioe	Leai
Tokelaun	Ko au e fofou ki he tino ke fakaliliu te gagana Peletania ki na gagana o na motu o te Pahefika	Ioe	Leai
Tongan	Oku ou fiema'u ha fakatonulea.	Io	Ikai
	Other languages to be added following consultation with relevant communities.		

Title of the research project: Documenting a music therapy program in a forensic psychiatric setting

I have read the information sheet dated _____ and understand what the research project is about.

I have had the chance to talk about the study. I feel ok about the answers given.

I have had time to think about if I want to take part in this research project.

I understand that me being in this study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect my music therapy treatment.

I have had been told I can use whanau support or a friend to help me ask questions and understand the study.

I understand I can ask any questions at any time. I know who to see if I want to ask questions.

I understand that I have the right to not take part in the study at any time and don't have to answer any questions

I understand it is my right to have privacy respected.

I understand that information about myself can be shared with the researchers supervisor, the supporting music therapist, the co-music therapist, occupational therapists and staff members present at music therapy sessions and other music therapy students during seminars.

I understand that in no point in this research will my name or location of the institution be written down.

I agree/do not agree to the music therapy sessions/interviews being audio taped
I agree/ do not agree to the music therapy sessions/interviews being video taped.

I understand that I have the right to ask for the recording device to be turned off at any time.

If consent is agreed to:

The original of the above will be stored at _____ and

OR

___ copies of the above will be stored at _____ and:

(tick boxes)

___ must remain on-site at all times

___ may be taken off-site to be used by Anna Hill for:

___ writing up case studies for the proposed research project

___ sharing with Massey University Music Therapy Students

___ sharing in a professional conference

This consent expires on _____ (date) and may be withdrawn at any time.

I understand that this research will be given to Massey University and will be read and marked by examiners of Massey University.

I _____ (full name) agree to take part in this study.

Date _____

Signed _____

Full name of researcher: Anna Marie Hill

Project explained by: (if applicable) _____

Project role: To document setting up a music therapy program in a forensic psychiatric setting.

Signature: _____

Information Sheet for a research project for client participants

Title of Research Project: Documenting a music therapy program in a forensic psychiatric setting.

Principle Investigator: Anna Hill

I am a second year Masters of Music Therapy Student. This research is a part of my clinical music therapy studies in order to become a registered music therapist.

Supervisor: Sarah Hoskyns.
 Director of Masters of Music Therapy Program
 College of Creative Arts
 Massey University
 Wellington

Activities participants will be asked to participate in:

Attending music therapy sessions

Participating in discussion with the researcher concerning the music therapy sessions.

Interview

You are invited to take part in a research project that will document music therapy sessions.

This research project is therapeutic.

If you do agree to take part you are free to withdraw from the study at any time, without having to give a reason.

You will have 2 weeks to decide whether you want to take part in this research project.

The aim of this study is: to document the music therapy sessions that take place at a forensic psychiatric unit.

The researcher would like to know about

- 1) The special features of this setting
- 2) How the music therapists fits into the therapeutic team
- 3) What music therapy methods can best meet your needs

The research project will be written up as 2 case studies.

Where will the study be held?

(this information has been deleted to protect confidentiality)

Why have I been selected?

You have been selected because you are involved in music therapy sessions in this unit.

How many participants will be involved?

The researcher will ask all staff involved in music therapy sessions to take part in an interview.

How long will the research project take?

The time span for the study is 4 months, starting in August 2005 and ending in November 2005.

What will the researcher do?

Staff will be asked to attend music therapy sessions and where possible contribute to discussions after music therapy sessions have finished.

Interviews will only be conducted with staff members on the unit involved in music therapy sessions. They will be 15 minutes long. The researcher will transcribe interviews from a Dictaphone. You can stop the interview at any time.

Interviews will be necessary with staff to obtain information about staff's attitudes towards music therapy and the music therapist's role in the therapeutic team

The researcher promises not to judge you. The researcher will act in the most sensitive matter in relation to your age, gender, religion, culture, and physical, mental, personal and social well-being.

What are the benefits of being involved in this research project?

It is anticipated that staff will benefit from observing clients interact in a different environment and thus further their understanding of clients. Furthermore, music therapy could facilitate positive relations between staff and clients.

What are the risks of being involved in this research project?

Possible physical risks for you in this study include injuries to yourself or others in the room, falling over instruments, or receiving injuries from the instruments themselves. Equipment in the room will be minimized and arranged so the room is not over crowded.

As music can bring up powerful emotions and memories, the researcher will always try to contain this musically to reduce this risk.

If the researcher suspects any negative outcomes she will discuss the project with you to determine whether the intervention should continue, change or cease.

What happens when the research ends?

When the study is finished, all data will be stored in a locked cupboard in the music therapy department, at Massey University for a period of 10 years. This will include consents in written or audio form, transcriptions and any audio or visual material,

The research project will be given to Massey University and will be read and marked by examiners of Massey University.

The researcher will provide you with a copy of this research project when it is completed.

You will have access to music therapy after the project ends. Music therapy sessions will continue until the music therapy students' placement finishes in February 2006.

How will my privacy be protected?

The researcher promises where possible, to protect your confidentiality. When the research is completed it will be published and stored in the music therapy room at Massey University, Wellington for a period of 10 years.

Pseudonyms (fake names) will be used in the write up of the research project.

There may be a delay between collecting data and the publication of this project.

This study has been reviewed by a Sub-Committee of the Massey University Human Ethics Committee, Palmerston North Application 05-61. If you have any concerns about the ethics of this research, please contact Dr John G O'Neill, Chair, Massey University Campus Human Ethics Committee
Palmerston North Telephone: 06 350 5799 x 8635
Email: humanethicssp@massey.ac.nz

Thank you for taking the time to read this information sheet.

Information Sheet for a research project for staff participants

Title of Research Project: Documenting a music therapy program in a forensic psychiatric setting.

Principle Investigator: Anna Hill

I am a second year Masters of Music Therapy Student. This research is a part of my clinical music therapy studies in order to become a registered music therapist.

Supervisor: Sarah Hoskyns.
 Director of Masters of Music Therapy Program
 College of Creative Arts
 Massey University
 Wellington

Activities participants will be asked to participate in:

Music therapy sessions

You are invited to take part in a research project that will document music therapy sessions.

This research project is therapeutic.

If you do agree to take part you are free to not be in the study at any time, without having to give a reason and this will in no way affect your music therapy sessions.

You will have 2 weeks to decide if you want to take part in this research project.

You may have a friend, family or whanau support to help you understand the risks and/or good things about this study and any other things.

The aim of this study is: to write about the music therapy sessions that take place at a forensic psychiatric unit.

The researcher would like to know about

- 4) The special things of this setting
- 5) How the music therapists fits into the therapeutic team
- 6) What music therapy methods can best meet your needs

The research project will be written up as 2 case studies.

Where will the study be held?

(This information has been deleted for confidentiality issues)

Why have I been chosen?

You have been picked because music therapy sessions are already happening at this unit. The researcher thought that the research would then closely follow normal music therapy sessions.

How many participants will be involved?

5 participants will be involved. 4 will be involved in the group case study and 1 for the individual case study. Around 10 staff at the unit will also be part of the project. In total around 15 people will take part.

How long will the research project take?

The time span for the study is 4 months, starting in August 2005 and ending in November 2005.

What will the researcher do?

The researcher will write a story about the music therapy sessions. Sessions will be held for half an hour weekly. Total music therapy sessions will be 16. Total time involved will be 8 hours.

The researcher hopes to take a group session, as well as an individual session. These sessions could involve a range of music therapy techniques from you listening to music, improvising with instruments and singing.

The researcher promises not to judge you. The researcher will act in the most sensitive matter in relation to your age, gender, religion, culture, and physical, mental, personal and social well-being.

What are the benefits of being involved in this research project?

There are several possible benefits of this study for you. Music therapy is thought to be good at increasing self-esteem, self-expression and can help you have good communication with others.

What are the risks of being involved in this research project?

Possible physical risks for you in this study include injuries to yourself or others in the room, falling over instruments, or receiving injuries from the instruments themselves. There won't be too much equipment in the room and it will be set out so the room is not over crowded.

As music can bring up powerful emotions and memories, the researcher will always try to support this musically to stop this risk.

If the researcher thinks something bad will happen, she will talk about the project with your primary health team to see if the music therapy sessions should continue, change or stop.

What happens when the research ends?

When the study is finished, all data will be stored in a locked cupboard in the music therapy department, at Massey University for 10 years. This will include consents in written or audio form, transcriptions and any audio or visual material,

The research project will be given to Massey University and will be read and marked by examiners of Massey University.

The researcher will provide you with a copy of this research project when it is completed.

You will have access to music therapy after the project ends. Music therapy sessions will continue until the music therapy students placement finishes in approximately January 2006.

How will my privacy be protected?

The researcher promises where possible, to protect your confidentiality. When the research is completed it will be published and stored in the music therapy room at Massey University, Wellington for a period of 10 years.

Pseudonyms (fake names) will be used in the write up of the research project.

There may be some time between collecting data and the publication of this project.

This study has been reviewed by a Sub-Committee of the Massey University Human Ethics Committee, Palmerston North Application 05-61. If you have any concerns about the ethics of this research, please contact Dr John G O'Neill, Chair, Massey University Campus Human Ethics Committee

Palmerston North Telephone: 06 350 5799 x 8635

Email: humanethicssp@massey.ac.nz

Thank you for taking the time to read this information sheet.

Appendix D

Guideline Questions for Interviews:

What are your thoughts about music therapy?

What role do you think the music therapy program would have in the MDT?

Did you understand your role as a MDT member in the sessions?

What improvements could be made to the music therapy program?

Appendix E

Session (3) 29 November

Summary of the session:

Opening rap:

The session began with an opening rap. The MTS and CMTS asked clients what they had been making in the occupational therapy room. David offered information about his motel he was making in the occupational therapy room and appeared proud and pleased to relay this information to the group. Mark stated that he was 'drawing pictures and it looked good.' Tahi participated with minimum involvement; then after other members had offered 'rap' engaged and said ' And he made a monkey and it looks like me!' He then began beating his chest in imitation of a monkey. **Brian** appeared shy and declined to participate saying he had 'nothing to offer.'

Mark changed the subject to food and Tahi added some humorous interjections about work and food. When the MTS and CMTS asked if there was any other news Mark added that he was going home in January. David became more withdrawn and anxious as Tahi became more involved. He put down the tuba and folded his arms, biting his nails occasionally. Tahi at this stage made eye contact with David and playfully tapped his hand.

Circle wave:

After the rap David instantly wanted to 'go round in a circle'. However, rules were instigated by the MTS and CMTS and all clients offered a rule each. The circle wave was voted for. The CMTS and MTS asked if clients would like to try a variation on this activity. In this variation 2 chords would be played on the guitar and a melody sung to the song 'Get up stand up' by Bob Marley. The tune was then adapted for each client. For example if Mark was playing the guitar the tune would sing 'Mark's guitar, Listen to Mark play' and Mark would play a 'solo'.

David played for an extended amount of time during his 'solo' but his body appeared tense when others were playing. Mark showed confidence and initiative and asked to play the guitar and learn another chord. Tahi began playing on his whistle in soft manner, which became increasingly louder and higher pitched. He then asked **Brian** to play the guitar and sung 'Listen to **Brian**.' **Brian's** body language however, communicated that he was uncomfortable. His head was down and his posture appeared slightly tense.

A brief discussion occurred after this activity. MTS and CMTS mentioned 'If I had a hammer' as a reference point as this was similar activity.

Call and response:

The clients did not express much interest in the singing of 'If I had a hammer.' Instead, the MTS and CMTS suggested the call and response activity. Mark immediately said he would like to do this activity. His participation had begun to wane at this stage, and he appeared a little drowsy. The first partnership was between Tahī and David. David played the Fijian drum. However, his legs began to shake and he was obviously finding the loud noise of Tahī's whistle difficult to handle. David did not make eye contact with Tahī during the call and response but looked towards his direction often. He told the MTS afterwards that it was too noisy for him.

The next partnership was between **Brian** and Mark, which was suggested by Tahī. Mark played a simple rhythm, changing half way through. David supported well by clapping throughout. During this call and response Tahī began lightly tapping **Brian's** head several times, making prolonged eye contact with the MTS. David responded by saying 'keep your hands to yourself.' He was reprimanded by the MTS and his hands remained stationary. Tahī then suggested the MTS and CMTS play together. While they were playing Tahī began slapping both David and **Brian** on the thigh, and was laughing and smiling as he did this. David and **Brian** appeared to become more frustrated, making more eye contact with Tahī. Tahī was reprimanded again by the MTS and responded by remaining in his personal space.

The MTS and CMTS then suggested a general improvisation to unite the group as friction had grown between members. David still appeared tense and anxious and was unsure what instrument to pick. Mark again demonstrated confidence and asked to play the flute. He was assisted by the CMTS. Tahi played the cymbal in the improvisation, and then changed to the whistle. **Brian** and Tahi shared the cymbal and played simultaneously with each other, in a gentle fashion.

After the improvisation the clients voted for Ten Guitars for their closure song. Tahi sung loudly and confidently. Mark played the guitar, but looked around the group more, showing more group awareness. David sung through parts of the song, sometimes playing the drumsticks on his leg. Towards the end he became more withdrawn, as he folded his arms and stopped singing.

Appendix F

Interview transcripts:

Interview # 1

Interviewer = R

Participant = E

Date: Tuesday 22 November 2005

Time: 10:30am

Venue: Whanau room

Transcription of interview:

(Initial problems with Dictaphone for first 2 minutes)

R: So this is just basically um, because I'm doing my research project on how music therapists work in the setting and 'cos you guys come into the sessions it's kind of important to know what's going on that day, if there is any upsets. It's how the music therapists could potentially work with the staff and how it can relate into the setting. Yeah, so I was interested to know what you think about it, like what do you think about music therapy. What's your idea of what it is?

E: Umm I think its' umm it it gives the clients like an opportunity to to express how they're feeling in any form of the instruments they use and calmly if they want to play or softly um. It's been quite interesting sitting in on some sessions, what people have chosen to play

R: Yep. So it's sort of given you a little bit on insight "- " Um yeah that's quite interesting eh. Have you sort of seen things like ooo you did not expect to see that or...

E: Um yeah I mean it's sort of like um with xxx he's quite.. I knew once I saw the big drum he'd go for that um and that's the sort of person he is, he likes the bigger types of things

R: Yeah

E: Whereas um xxx has got quite a soft side to him and he quite often chooses the little recorder thing

R: Yeah

E: Um

R: Was that surprising?

E: Umm it was actually it was sort of um. I think he likes the way he can move it and the way it sounds um but just I would of thought he'd have gone for bigger, bigger instruments where every week sort of he's quite regular with that

R: Yeah, its' interesting eh

E: Yeah

R: So when you come into sessions, like at the beginning of the year and compared to now.. is this your sort of first experience of music therapy here?

E: Yeah no one's done it before

R: Yup

R: And um yeah what do you sort of was your view of it before you started and of it now?

E: Well um I did not really have a view before. It was sort of um something new and I just sort of went along with an open mind and I did not.. cos I did not know anything about music therapy before this

R: Yup

E: So I had not preconceived ideas about what it involved um. Yeah, it's a lot different I think from the beginning of the year

R: Mm yeah that's interesting to be documenting it at this time everything is coming towards closure

E: I think initially the clients would sit there and be well I don't want to play that you know and now it's like straight in

R: Yup

E: um and sort of a lot of the time new instruments with like xxx and that

R: Yeeeah

E: They are alternating

R: Yup

E: with the instruments

R: Getting more sort of exploratory

E: Yeah

R: Yup, So yeah how do you reckon that those sort of things about the clients like how Bill wants the big instrument of xxx got this sort of wee soft side to him .. or just any sort of information about the clients. How do you reckon that the music therapist could be part of the team and...?

E: um like for further sessions?

R: Yeah just how do you think the music therapy sessions could be integrated into..

E: Aw I think you know you guys arrive and coming in and sitting with the staff and having like a week's worth of handover about what's gone on in the unit in the last week and

R: Yup

E: um you mean like in that way?

R: Yeah, we do that with Jan

E: Get a feel for what's actually going on and what's still happening you know umm

R: and that's yup I've found that really important um in that way I've found this very different from other placements because the clients are residential and sometimes things can just change in the morning and so it's having Jan or just OT's here is really important

E: Yeah but it would be I mean its', Jan's good but I think it would be good to sit down with people who are actually going to be participating in the group.

R: Yup

E: You know because what Jan sees and what we see is different because she's only here 2 days a week um

R: So that would be a good thing in future to kind of set up just coming in earlier and

E: Just just you know like you know half an hour earlier just to get a summary of what's happened over the and sort of different interactions between the clients.. who's not getting with who and

R: So basically

E: An what the issues have been and

R: Yeah.

E: Yeah

R: Yeah so getting more of a cos we just get our handover from one person so getting a more well rounded sort of view

E: yeah

E: yeah and not not all the staff on the shift but maybe just a couple, you know, one or two you know particularly who are going to be involved that day with the music group and

You know just bringing them into the dynamics a bit more..

R: Yeah that would that would be excellent I think that's yeah

E: Yeah

R: I think that's a really good point. I mean that's one of the things that I think um could be improved if there is a position for a music therapist

E: Yeah I mean I'm not saying what Jan was doing is wrong that's good. I sometimes think a bit more staff involvement and also gives the staff a bit more about what who you guys are. I mean a lot of the staff see you come in never met you rah de rah de rah and it actually gives them a chance to relate to students

R: Yup yup and um do you think kind of overall the feeling is of what we're doing here like music therapy and staff and like do you think people sort of thinks it's beneficial for clients

E: um I've had some good you know good things you know people saying good things about it. I mean I don't think a lot of people have a lot to do with it um I haven't heard anything negative about it

R: Yup

E: Um but very little is said but what I have heard is good and I think that's mainly because a lot of staff aren't involved in it and just a select few. But it's also hard like a lot of the afternoon staff aren't here

R: Do you think if um, cos one of the problems doing placements, is that we only have a certain amount of time to come in.. I mean if there was a part-time music therapist if they went to team meetings and that sort of thing and do you think their sessions could relate to like speech and language therapy and that quite easily...?

E: I think they'd be really good in that MDT meetings that we have weekly

R: Yup

E: If it's part time one week the other part time next week and and um you know have some involvement there

R: Yup and relating in to kind of other stuff that is going on

E: yeah and work it into the program and

R: Cool. Yeah that's exactly what I think should be happening as well and yeah its just all these ideas that you sort of have about what would be the most ideal kind of..

E: Yeah I mean I think once the staff know what your about and how it fits into the running of the ward and that I think you'd have a lot more you know encouragement and on staff wanting to you know.

R: mmm

E: I think staff they don't wanna do it. I'm not saying they don't want to do it they just don't KNOW what to do really and don't' know what its about

R: Right

E: I mean I know because I've been but someone new coming in you think mm

R: Right 'cos we have sort of thought about um this is one of the things we have learnt as students about how to educate staff and we did we put out some guidelines for support workers coming in or anyone coming into sessions but yeah what is a good way of educating staff do you think so they feel confident?

E: Um again just having a quick chat with staff.. you know nothing beats the personal touch with staff you can read all the information you like you got hundreds of information about everyone in here and sort of sometimes aw its just another thing to read. Actual face to face contact you know just a quick hi I'm so and so I do

music therapy how are you rah rah rah something like informal you know and staff think aaw you know \

R: I think that would work well. We have probably been linked to occupational therapists and occupational therapists aids and we haven't been introduced to other staff in a way and it was our prerogative to do that in a way but I think,.. I've forgotten what I was going to say . oh yeah I was going to say if they had if there was another student of a music therapist here just to make that time in the morning and have that time to check in with staff

E: Yeah makes us a bit more personal for everyone oh yeah you make an effort to get clients

R: Right

E: We know what you're about what you're doing and how it sorts of um yeah it's like that

R: Ok

E: Don't get me wrong the information sheet was good but we've got copious amounts to read here

R: mmm yeah

E: And sometimes you read and you don't take it in

R: Mmm

E: Face to face does a lot

R: Definitely. Ok that's a really good point eh. We should have done this earlier on in the year.. (laughing)Cool just thinking of other things I need to ask you.. yeah. Thinking about the safety issues. Cos one of the things that's been helpful to us with the occupational therapists was we got a really long orientation and risk-management plan and what's

E: Yeah

R: and with xxx for example what was his you know connection you know connecting with his Scottish background and its kind of a way to kind of use music as a safety container

E: that was awesome eh cos he just loves that kind of music so much

R: yeah so that's been a good way to have communication before we came in so we could plan something

E: Yeah

R: But um more of that is good as well like keeping up to date with things like him having lots of changes. We've done a song. We've kind of kept up to date but I think what your saying is our relationship with the staff and hypothetically if we had more time to come in in the morning (laughing) and we're just here more that would be better and better for you guys to come in feeling more confident and

E: Yeah I mean it's sort of um... I'm not. Its sort of like sometimes the staff don't get the clients here on time and I appreciate that they should but sometimes if they of they met you, you know what your doing how it relates back to the client I think they're more inclined to

R: Right

E: ..push it a bit

R: Yup they're motivated yup yup Cool well that's really

E: Its' sort of like the unknown if you don't know who you are all they see is you coming in every week and playing music and you go and its like well what do they do you know. I think a little bit of information goes a long way

R: So maybe if a students comes in next year a student or a music therapist to um part of that orientation with the staff cos that's what we did not have this year

E: yeah even just to come in and meet the staff

R: I mean it's really important to know a lot about the clients but I did feel that was missing in the orientation. These are all things you learn and that's what I'm trying to do here

E: yeah cos staff here are more than willing to get on board with people but its sort of like we need to know the loop as well

R: anything else you would like to add

E: Ah no (laughing

E: I have enjoyed music therapy I mean its good you know I've done my best to do music

R: Its been really good having your support and its good to sort of its really good to get feedback and um yeah

E: yeah no its good cos like on Tuesday morning oo got music therapy today

R: Yeah

E: xxxx xxxxx

R: Its' good you can see the benefits for clients as well Shall we call it a day then?
Thanks for you time.

(End of interview)

Interview # 2

Interviewer = R

Participant = D

Date: Tuesday 22 November 2005

Time: 11:00am

Venue: Staff base

Transcription of interview:

R: Ok so I just wanted to talk to you Dr about what you thought about music therapy and your experiences of it here and

D: I think it's marvellous xxxxxxx the patients here thoroughly enjoy it it doesn't depend on their IQ the age and ah.. Even when they have a psychosis. I think it's marvellous...

(Interruption from outside)

(In relation to interruption) Of course he enjoys it he always says this

No I think it's marvellous. I think it's a very good job you're doing and it's really quite important. It's something that they can DO they can't DO many things apart from manual stuff. They sit passively watching TV, which is ah not xxx educational. It's entertaining but it's very passive

R: Mmm so it's a good active thing for them to be doing

D: Yes I think that ACTIVE is very good and they appreciate it they get warm fuzzies if they do well and it's nice it reinforces their self-worth

R: Yup

D: I think it's very good

R: Aw thank you. Um I'm sort of yeah I'm wondering also how if there is a music therapist employed here or another student, because this is a really new setting for a music therapist to work in um I'm interested in how the music therapist can relate to the team and how it (music therapy)can be integrated into other therapies..

D: It is difficult labour here. I mean music therapy second chance, school you know what I mean they do their own thing, which is quite alright. They all have their areas of expertise. I don't know if there's much xxxx in the activities

I don't think it's necessary really, you do your thing. It is how it is. And they themselves want it limited, music is music

R: Ok um what about with, because we have to have a handover in the morning with Jan or when there was an OT here um just yeah the information kind of

D: I think the information you provide to the staff is very useful,. How did they behave there were they surly were they cheerful any interesting behaviour any lack of enthusiasm ah you know were they depressed, so psychotic they can't concentrate. I think feedback to the group would be quite good if you feel there's something to be said about an individual patient

R: So if there was a music therapist working here to have them come to the team meetings and give verbal feedback about that as well as the notes and that sort of thing?

D: Yeah I'm not sure about full time of course but certainly sometime

R: Yeah cos that was factor being here one morning so it's difficult to link in with staff.

D: No I don't think you should worry about the staff. It just happens when you do see the patients and you note anything and ah similarly the staff should advise you if someone's' on the war path and they should advise you this chap is stroppy he watch him you know

R: Mmm

D: In fact you should have a little chat to the staff when you come in everything is alright and they say yes it is fine oh well worry about xxx or someone you know I think he's been a bit surly or whatever so you're more aware you

R: Yeah we have been we usually when the OT was here we got that from the OT or the OT aid but do you think it would be good to get that from a wider section of staff

D: O I think you find most staff know pretty well if someone is playing up because it reverberates throughout all the other staff if so and sos being stroppy or difficult. I don't think you can go around asking all staff you know what are you views what's happening. Someone like xx (head nurse) takes 5 minutes not even that everything alright yeah fine

Stuart might be playing up say I wouldn't go near him....that that sort of thing

R: OK cos we found it was also quite good with clients getting a long orientation about someone like xxx um discovering he had a Scottish background so we could use that Scottish music in the sessions um yeah that sort of thing has been really useful but I've kind of realised the need for on-going communication with staff

D: Well I think it's nice I mean they want to know if you worried about someone because they may let their hair down with you you see maybe they keep it under

their hats when they're talking to staff. Their irritability if they drum too hard or getting angry when they get a bum note

R: Mmmm

R: So that's the sort of thing. I mean I think we write quite detailed notes. I mean do you think staff are interested to know what happens in the actual music and

D: I think they're interested in it if there is something DIFFERENT or of CONCERN not what you're doing. You see xxxx played the drum. Now that is fine. And maybe enthusiastically. Really what they will go through they will skip through it is maybe you should UNDERLINE if you're concerned about someone particularly> you underline it and it will attract them in some way. Otherwise it's just a report by the music therapist. But if you underline something they will read it

R: Right OK so that's a good point. Was there anything else you'd like to say Dr?

D: Not really. I think that ah you're doing a good job. It depends on whether the patients enjoy it or not. You may say we are not here to entertain but I mean you are here to model function and that's one thing and they may see differently also its how they see it, which is important. And staff obviously accept your input and they think you're doing a good job so that's really important

R: Mmmm and there's sort of room for a part-time music therapist here you thin

D: This is to do with kind of management you see you've only got 10 people here. I don't know its something you got to decide you can ask the patients if they would like more sessions or just once a week and then you record what they say and they may say we like 2 a week 3 a week

R: Mmm

D: And then you bring it to the management and they decide whether they think it's a good idea or not a good idea

R: Mmmm

D: xxxx xx to do this with individual patients ask them what they think

R: So getting feedback from patients is a

D: well I think well they'll probably do it if you're here. I don't know how useful it is. It will show that your research is got depth and if you've taken consideration for the patients

R: ah yeah absolutely yup

D: and also what the nurses want do they want more input or less input or are they happy with just once a week ah. You know what I mean. So its' more not your point of view it's their point of view

R: ah absolutely yeah

D: OK

R: Ok thank you very much

End of interview

Interview # 3

Interviewer = R
Participant = W

Date: Monday 28 November 2005
Time: 10:50 am
Venue: Interview room

Transcription of the interview

R: So thanks for your time W and for doing this. So I'm basically just wanting to know.. you probably read this on the information sheet.. Basically I'm just writing about music therapy in this setting cos there hasn't really been any music therapy done in this setting in New Zealand and not a lot world-wide so um kind of just setting up a template for future music therapists but I'm focusing mostly on how um the music therapist can communicate with the team and how they can relate back to the team. Yeah so probably just ask you now what you think music therapy is.. like what's your thoughts on it and...

W: Well I've had we've actually done it before in a forensic setting cos we used music back in England.. so people got so limited intellect it's a way to sort of form bonds sometimes cos they've not got very good communication skills, they're very poor as a group of people

R: Mmm yeah. Oh wow that's interesting. So what was your experiences of it..

W: Ahhh well it.. used to be quite good really. A few of the guys used to misuse it just bang drums and disruption you know

R: Yeah right so it was a chance for them to sort of.. was that kind of a way for them to express some aggression or what it sort of more..

W: I think it was that they did not really wanna do it

R: Right yeah. It was protest. OK so what's it been like. What's your experiences of it like here us as students?

W: I I quite enjoy it cos I mean I sort of I'm a xxxxx. I'm a I don't believe in sitting and doing nothing with em.

R: Mmm

W: And that's the worst thing you can do

R: Yup so it's the active part of it that you like?

W: Well YEAH cos you can actually teach people things while they're doing other things and they're not aware that they're actually ... they're actually learning anything

R: Yeah while they're having fun?

W: mmm

R: Yeah I agree. Cool um so the thing that I've sort of found different about this is how I sort of constructed my thesis and what to write about was that this placement has been really different from other placements in that it's been really important for us to get handovers and having you guys come into the sessions and how you feel you fit into the sessions and how you think music therapy, how we can be part of the team potentially in the future. Yeah how do you how do you think music therapist could be potentially part of the team if there was a job here?

W: I think it's about sort of using it as a means of sort of communication medium

R: mm

W: Because guys with intellectual disabilities are not like mental health individuals and people mistakenly come into this field and believe that its very very similar and in fact it's not.

R: Mmm

W: Hence I think that's why we draw a lot of us over from England cos we actually trained in this area as a specialist field

R: Right yeah

W: When you've got intellectual disability you've got it for life. That's not always the case with a mental illness. A mental illness can be transient and it can ebb and flow but an intellectual disability is permanent.

R: Mmm. And a lot of these guys also have a mental illness

W: Yup

R: Yeah

W: You've then got a sort of dual diagnosis guy who doesn't learn very well and they often learn better when they're amused.

R: Mmm

W: And it has to be on a level that 's quite basic because if you ask them questions and they don't understand they'll do one of two things they'll either get upset or they'll pretend they understand because that's what they think you want them to say

R: So it's important to kind of relax and do something fun and then lower anxiety?

W: That that you could use as a medium as well in quite serious discussions in times in between so you you you get a lower it. A lot of work you do with these guys is done quite informally. You don't take them in a say 'Right we're going to have a discussion' You sort of just sit down and have a talk to them and a cup of tea and they don't actually realise that they're..

R: Mmm yup

W: So that's the way with this particular group

R: Ok yeah it's quite interesting.

W: That's just my experience of it. It's not everybody

R: Yeah no no it's really interesting. It's good having these interview cos I did not even know that you'd had you know these experiences with music therapy..

W: Well I worked in Hampton and Brompton the maximum secure centre in the UK. And when we got guys there was nowhere else

R: Yup

W: They'd been everywhere else and we had to deal with what they presented

R: Yeah

W: So we had to try a lot of different approaches. We did use music therapy

R: So was there a music therapist there working with the the team?

W: Yeah. They were sort of part-time. They went from ward to ward but we did have music therapists, art therapists

R: Yup and how did the music therapist in that setting how did they fit in with the multi-disciplinary team?

W: They used to contribute to team meetings you know they'd feed back on the sessions and they had a yearly care team meeting what they'd done they'd feed back in ward how they'd done how they were progressing how they presented in group settings because its' still a group

R: Yup

W: Sometimes you could try and see how somebody's gonna function in a group and if they can do well in a music therapy group maybe they'll do well in another group

R: mm

W: It makes it more a more formal setting so sometimes a good indicator as to whether someone was going to function in a group

R: Mmm

W: And it can be quite apparent some people won't function . If they can't function in a music therapy group then it's pretty nil chance they're gonna function in any other group

R: Right so that was a music therapy was a really good sort of baseline

W: Well I ran groups so I used to think of it like that . Everybody did. I used to always think if they can't handle the music therapy which is pretty sort of fun really it doesn't bode well.

R: M

W: They can always follow but not very ..

R: Ok that's really interesting. So do you think it could in this unit for example that a music therapist could fit in here in the same sort of way or?

W: I think there's a place for it um within this setting because these guys as I say they don't have an awful lot to do um and it's something that they could sort of gain insight from

R: Mmm

W: To be honest it's not a it's not a matter of them just going and banging a drum. They actually learn in a kind of subtle way

R: Mmmm by using rhythm to um like what we were doing last week with the rap just to get the words out with having a back up rhythm there. Give a bit of momentum to it and.. its makes it more fun too?

W: Most of these guys have got no coping strategies, very few communication skills and very little social skills. Cos the only thing they've often had is a disability but they've probably had quite a deprived life as well so you've got an environmental factor tagged on to all the other problems

R: So it's complicated

W: Yeah they're quite complicated individuals

R: Ok that's really interesting. So how have you found like coming into the sessions?

W: I've found it quite fun to be honest

R: Yeah so you've kind of.. did you feel like you wanted more um understanding about what your role was or you were quite kind of ok with that?

W: Yeah I think you just come in and sort of go with the flow I mean that's I took our job is not leading the sessions.

R: Yeah

W: We were sort of there really just to sort of jolly them along. Obviously if any I would imagine if if we had any problems but

R: Yeah

W: As far as I was concerned we were just jollying them along and take part and like the rest of the guys

R: Yeah exactly umm Do you think maybe if you hadn't had experience with music therapy that um its kind of difficult to say but hypothetically would it have been difficult for you to go in for the first time and

W: I don't know really. I think I would of just picked a drum up and banged along . I've always just thought of joining in and see what happens

R: Yeah. Cos we did set up we had a education meeting sort of thing for all the staff earlier in the year and we set out like guidelines for support workers so yeah it was fairly clearly set up but I can still understand people feeling

W: It's quite widely used with people with intellectual disabilities in England. Music therapy is quite widely used

R: Oh ok yeah

W: Within the settings within day care settings in the UK they do perhaps say 9 out of 10 of them have music therapy as part of their activities

R: COS there has been really limited stuff written about music therapy in this setting with guys with intellectual disabilities who have..

W: It's used quite a lot

R: Yeah. That's really interesting. Um is there anything else you'd like to

W: not really no

R: So you've have pretty much good experiences of it basically he?

W: Yeah I've found it quite sort of therapeutic I mean they obviously enjoy it

R: Yeah . Is there anything you think that could be improved like if there was a music therapist here or?

W: I don't really know enough about it at this stage I mean it's not xxxx I've been part of it but not from a sort of therapy point of view. I'm' always just sort of sent in and we've always thought well that's what we'll do we'll sit in and

R: Yup

W: Sometimes if you've got a rapport with the guys as well they'll come in because you're in and they can see that you're taking part and they might do something..

R: Yeah well that's one thing that we've because we're having actually more contact with you guys compared to other placements because we have to have um nurse or support workers or whoever with us um one thing I've really noticed is that if the guys has a really good relationship with you for example then it's makes quite a different sort of session or if one of the guys doesn't get on with someone and that actually closes them down in a session and that's... so it's quite important who actually comes to a session and they kind of interact and some staff find it more difficult to get involved and.. yeah it's quite subtle all those group dynamics. Mmm it must be quite good for you in a way to if you have a good relationship of even if you don't have a good relationship with a client to be able to um interact with them in that way like having fun and doing music.. Have you seen stuff that has surprised you with clients in the sessions?

W: I think xxxx blowing a tuba

R: (Laughter) and absolutely loving it yeah. He wants the trombone as well. Yeah that was pretty interesting. Yeah some guys playing softer instruments that you might have thought of them playing louder instruments. I know other people have said that has surprised them.. yeah. I think that's all pretty good I reckon Thanks

W: Thanks
(End of interview)

Interview # 4

Date: Monday 29 November

Time: 11:05 am

Venue: Staffroom

Interviewer = R

Participant = J

Transcription of the interview:

R: Yeah so I'm just wanting to provide a template for future music therapists, The main focus is not so much what happens in session although that's important but more about how we can relate to the team and that sort of communication and you've been a central part to that as the OT aid. So have you had experience with music therapy before this?

J: Nothing at all

R: Nothing

J: I'm not a very musical person at all. The first time was a bit of a shock to the system (laughter).

R: The first session you came to. Yup

R: What was your sort of thoughts about it?

J: Well, not so much not so much even if I was comfortable but it was MY reaction to it because I'd never done anything musical. As a staff member going in I mean you know I'm not a very spontaneous type of person in that respect so it was almost a shock to me and then to try and join in to try and not make the clients um be aware of the fact that I was probably more nervous than them. But as things have gone on I've mellowed into it and I can really see how the guys respond to it

R: Mmm Ooo ok. So when you sort of heard that music therapy was coming in before hand what was what did you think it might encompass?

J: I did not know because I basically arrived on the one day cos I had only been here like for that first week and music therapy was on that day so it was a case of xxxx just took me in. I did not know it was coming in or or how to put it in I mean I hadn't been working here very long either so it was all a bit you know...

R: So it was quite sort of shocking you were feeling a bit anxious

J: Possibly I was because I mean I was new to the environment working here so I was probably like I was new to working in mental health AND new to working you know with um music therapy and all that but I could I mean having had kids and gone through kindergartens and all that I can see how music has been a big part in their lives and in fact both my daughters have done music right up til the seventh form.

R: Ooo wow

J:.. which is I think Grade 8 or something in piano and all the rest so she picked it up and I've always taken an interest but I've never been a musical person myself you know to play music or anything. So you know I've appreciated other peoples then but I've never actually um seen it working with disabled people or mentally you impaired people or whatever so

R: Mmmm

J: Just in your normal sense

R: How do you think that it's benefited the guys here?

J: I think it's been really good because it's something that they can they can just be spontaneous can't they and a lot of things here they can't be spontaneous or whatever

R: Mmmm

J:...or whatever they want to do they can just express themselves and especially someone like John you know or xxxx who don't really you now express themselves very well or whatever or don't do anything spontaneously they just pick it up and do it and they respond to the rhythm. I think there's a lot of there's rhythm in it isn't it which they don't get anywhere else. xxxx obviously relates to music quite well like you see him watching Grease and all that and he just responds. It gives him an opportunity to respond in a and it's like a positive environment you know and he

gets positive feedback and all that . Yeah I think it's good for them because they can just do it you know

R: They can do it

J: Yeah

R: Yeah so it's accessible for them?

J: Absolutely. Yeah yeah and it's a fun thing too you know especially for the group I mean especially xxxx for instance I think he does it and gets the real fun side of it

R: Mmm yup

J: Yeah

R: And that's motivating for them?

J: Yeah yeah . Like xxxx he gets.. I think its fun but it's more he actually manages to show off a bit of skill or something too you know like when he picks up the guitar I think he feels quite empowered you know because he can do something that not everyone else can do

R: So even within the group it (music therapy) means different things?

J: I think it means different things to different clients yeah. I think probably xxx is a bit like me. He's probably never done it before cos he gets quite embarrassed every now and again you know and he sits back and you know and then xxx and he gets that kind of reaction and you know he gets you know and ...I think yeah for everybody it means different things

R: Mmm and have you I mean because you're in every session that we have so do you find the different staff coming in nurses and support workers and their relationship with the clients and how we kind of interact with them ... how do you find that in the sessions?

J: I think definitely the guys relate to different staff members like that time when xxx wanted to go out and have a smoke cos he did not want (Staff member) to be there in the session

R: Yup

J: You know so.. I think it's actually quite important it would be really if whoever was the co-ordinator was aware of how the guys how the staff members relate to the different clients because if they send someone in there who is really not interested in

doing anything really xx and really not interested in music they're just .. it's not very good for the rest of the clients to

R: Right yeah

J: I think it's got to be somebody who feels they enjoy it you know or really responds to the guys quite well

R: So they can model sort of participating and ..that sort of thing?

J: Absolutely. Because I think like somebody like xxx who also um participates quite well too they enjoy it more whereas if they see someone else like the guy I've just mentioned they look at his face and he sits there with that kind of smug look and it just detracts from the atmosphere

R: Yup

J: You know

R: Yup so it's quite important to.. I mean that's one of the things that I noticed here was because there's more need to have handovers and that sort of thing but also because staff are always going to be there in the session that it's important to have that communication and

J: Absolutely

R: That working relationship'

J: Yes not to just put anybody in there, which wouldn't be good, which I think they do sometimes

R: And that's I suppose just the nature of different shifts that people are on

J: Yeah but I think it could be it could be sorted maybe a little bit more . Maybe they could say to the staff on the day on the Tuesday who's interested in going to music therapy ?

R: mm

J: Instead of just appointing so and so or so and so

R: Yup

J: Some of them definitely want to be there more than the others want to be there

R: Ok yeah well that's a really good point

J: I think that would be could be quite good. Yeah

R: Yeah

J: And I see what lately they have been doing is they've been putting two peoples names down for music therapy whereas before it used to be whoever staff member was with that person. Now they put two people's names down

R: So they have a choice. Yeah.

J: But I think sometimes they've got to realise that some of the staff don't get on with clients like that time with xxxx

R: Mmm

J: And that's not beneficial for the client and if it's only one day a week

R: Yeah

J: It's a short half an hour session so to to jeopardise that

R: And that's very upsetting for clients like having different people coming in..

J: Yeah

R: Yeah

J: Yeah yeah

R: So do you think an idea situation would be to have the same person that gets on well with the client coming in every week.. or?

J: Not necessarily the same on because I think they quite enjoy having different people see their skills and that you know

R: Yeah

J And

R: True

J: But I DO feel in particular with with xxxx maybe xxxx and xxx they really they also respond to who's with them

R: mmmm

J: And who's their even if their keyworker keyworker, CAREWORKER not going to be with them in the music session I think it's really I important that we've seen how they just allow them to go to sleep or whatever

R: MM

J: Or just to decide they don't feel up to it or whatever when sometimes they are

R: mmm

J: So to maybe to earlier on in the day to start prompting them about the fact that music's coming you know and

R: Ok so the careworker to have responsibility for that and

J: Yeah for getting them to make sure they stay up for the session

R: mm

J: Because I don't think they really need to go to sleep at a particular time unless they've had a particularly bad day

R: Mmm

J: So I think they need I think they need to have be more involved with making sure they attend the session or making sure they're in a good space for the session

R: Mmmm yup

J: You know um um like if if xxxxx for instance says 'Ah it's music today' and he doesn't say anything else and maybe did not say some positive things about it or whatever to get him into into the mood of it

R: Yup

J: You know cos otherwise depending on whoever's with that person it could go the negative way you know

R: Yup

J: xxxxx and they don't say the right kind of thing

R: Yup and they end up being....

J: A a no show

R: Yup

J: Yeah

R: Yeah I think that's...

J: You see you guys make a big effort to GET there and to and to set up you know and to make yourself available. I think the least that can happen is that a client is available but to get the client available for staff too

R: Right yeah

J: You know?

R: How do you think um like if there was a music therapist working here we weren't students an it was a full time or whatever part time job.. how do you think the music therapist could fit in with the team?

J: Aw I think that could be quite good because they would know more on a day to day basis how everyone is

R: mmm

J: And they wouldn't probably do what you do like have a few in a row after each other you know which makes it hard to maybe get somebody primed for that fact that they come into music like if they could just do one every now and again and they could say 'Stuart it's your day today' or whatever you know and they could be more on board to actually go and invite the person along

R: Right so the music therapist could have more actual contact with the guys?

J: Yes not just in the room there

R: Yeah

J: you know priming them ahead of . even say 'Oh tomorrow I'm going to see you tomorrow' sort of thing because they work a lot like that you know like..

R: Mmmm oh yeah definitely

J: yeah but for them to all of a sudden nobody says anything about it's that and they forget that today is Tuesday then yesterday it's that you know is the day before come

to think all of a sudden to say ' Oh you've got music now' "Aww' well you know they might not be in the mood you know so I think they need some some prompts along the way

R: Yup and and at the moment it works that the staff do that but if there was a music therapist employed it could be their job to go out and yeah

J: Yeah yeah

R: Ok what about with meetings and and that sort of thing like how

J: With the music therapist?

R: Yeah what they can add to the team?

J: Oh gosh I think they could add quite a lot because depending on um who the xx staff is in the in the music therapy session with the guys nobody else knows what the guys do there .So you feedback like the OT normally feed backs about other things

R: Mm

J: Or whatever you know or how the person is doing that day or that week you could say how they do in that music session and it could give a different perspective to that person to that client whereas now I don't think anybody really knows except for the guys that go in there they don't KNOW what happens in music therapy and they might just go with one person and never go with anybody else too

R: Mmmm

J: So they don't know that that that client has a different how they respond you know that there are different person in the session and that

R: Mmm

J: So I think the music therapist could bring could take that to the meeting

R: Yup

J: And share that quite a lot how they react

R: Mmmm

J: And those kind of things and if they're maybe having a bad week maybe do a extra session or whatever

R: Yup

J: Like with with um John or Stuart or somebody like that if they're having a bad time or Bill

R: Mmm

J: Spending a bit more time writing his song etc if they're during the week you know

R: Yup definitely

J: Yeah. Its about expression isn't it for some of them isn't it yeah

R: yeah definitely

J: Yeah

R: Yup um I was also thinking about cos there hasn't been an OT here for the last how long?

J: Two months

R: Two months yeah um and how that's kind of affected you coming into the sessions?

J: Mmm

R: And and the music therapy sessions?

J: Yeah

R: Yeah

J: Umm I mean that's been ok I don't mind it but um it sometimes I don't even know how the guys have reacted them selves to the past couple of days or or if anything's happened overnight or whatever you know because it's just kind of bang bang bang you know I don't seem to get any handovers

R: Right

J: Whereas I think the OT's do they well they can demand a handover cos they are here permanently you know

R: Mmm

J: I couldn't go up to them to the co-ordinator and say look right now tell me what's going on who's a problem etcera etcetera

R: Mmm

J: but I'm just can't seem to do that because they don't I don't think they take me that seriously you know I mean so

R: Mm

J: You know so I think that's quite hard

R: Yeah

J: So I do a quick read through some of the files sometimes just to find out what's going on.. yeah

R: Yeah cos you're our sort of main link with the handover..

J: Yeah and also I the OT normally goes to the MDT meetings and all the other meetings and all that and finds out what's going on in the unit as a whole. I never go to any of those meetings so I actually don't know what's going on in the unit apart from the clients

R: Yup so getting that sort of whole

J: Yeah the whole picture

R: Yup

J: Yeah you know

R: Yeah it's important for a.. so do you think the music therapist would be kind of linked with if there was an OT here?

J: I think it would be quite good I think it would be quite a good support for each other

R: Yeah

J: Yeah

R: But kind of separate but sort of..

J: Separate but together kind of thing because they're all they both have the same kind of um they're working towards the same thing with the clients you know

occupation you know daily living kind of thing how they respond and keeping them occupied and that so

R: Mmmm

J: Yeah I think it could be great I think it would be good if they could work together

R: Yup

J: Mmm

R: So do you think the OT should be coming into sessions and or?

J: Mmmm (pause) I don't think they'd have to go to all sessions

R: Yup

J: I think it would be good but I don't think they have to go to all sessions

R: Yeah

J: It's not as important as.. the music therapist is the is the trained person and I don't think it's essential but I think it could be good every now and again

R: Yup

J: Yeah

R: Just to get that kind of overview of what's happening?

J: Yeah because I think if there's if there's a music therapist here they could be reporting back xxx instead of reporting to the OT,, the OT reporting or the OT being there to see what's going on cos the the music therapist could just report back

R: Mmm

J: The same as like the OT doesn't go in with psychologist's etc etera etcetera you know

R: Yup

J: Cos they just report back too soo

R: I think yeah one of the things I've kind of realised doing these interviews as well is that if there's another student placement to allow more time for us to actually go to those meetings

J: Yes!

R: And sort of be

J: Absolutely

R: as if we were part of the team

J: Absolutely

R: Because I think that's I mean in all settings but particularly in this setting it's really important to have good working relationship with the staff

J: Oh definitely

R: And that's

J: Cos even as I said for me I sometimes don't feel part of it because I'm temporary here

R: Yeah

J: And because I'm supposed to be under and OT and the OT's supposed to tell me what's going on

R: Mmmm

J: So I don't even feel part of it all the time. So I can imagine you know you guys just coming in

R: Mm

J: Well you don't really know what's going on all the time tooo

R: No.. yeah

J: Yeah

R: And I

J: I think yeah it would be really good instead of getting it like you getting it from the OT etc if you can get to the meetings you're getting it direct from you know from the

R: Yeah

J: person who works with that..

R: and it's difficult within that one morning to sort of set up meetings with everyone

J: Yeah God yes and do everybody's music in the morning and then and then disappear .. yeah

R: Yeah

J: I think it I think it could be good you know it could be a part time position like mornings of something like that or afternoons but yeah you know people like um xxxxx or xxx who wanna come but they don't wanna come you know if you if there was someone here almost everyday it would be easier with those kind of people to

R: Right

J: Or you like if it was spur of the moment just say well just come and try a little bit I've got a bit of time you know

R: Yup

J: Whereas yeah now there's no time is there

R: Exactly that's the the tricky situation

J: Yeah

R: But I mean all the sort of whole idea of this research

J: Mmm

R: is to getting sort of overview of what staff think of what could happen if there was a music therapist here and how they can fit into the team and

J: Have you had positive feedback about that like having a ..

R: Yup

J: I can definitely see it maybe you couldn't employ somebody full time between a couple of units

R: Yup exactly

J: That would be quite good you know yeah yeah cos you'd also get a feeling for the other units and you could compare situations mmm

R: Absolutely xxx um so that's pretty much is there anything else you'd like to add

J: Not really but I have enjoyed it and I've um and you know just seeing the guys responding and that especially in that period of time I think it's wonderful

R: Yeah

J: Seeing them communicate when they can't even normally you know

R: Yeah

J: Yeah no I think you guys are tremendous

R: Thank you

J: Pleasure! (End of interview)

Interview # 5

Interviewer = R

Participant = D

Date: 16 December 2005

Time: 4:00pm

Venue: Whanau room

Transcription of the interview:

R: So have you had music therapy apart from here?

D: No I did not know that music therapy existed

R: So us coming in was your first experience?

D: Yeah it was yeah

R: So what's been your thoughts on it here?

D: Well I think it's been great to be honest with you. Yeah I think it's been really good. Ah I think that um the boys appear to really enjoy it and get a heck of a lot out of it

R: Yup

D: And ah um you know I think it's really good for them

R: What sort of ways do you think they benefit from it?

D: I just ah I think a lot of the guys here probably are quite musical.

R: Yeah

D: Are interested in music. I mean for example the guy that I work with a lot xxxxx is. He spends his whole day listening to to music basically

R: mm

D: I mean its really good for him to experience um the instruments and you know what goes into actually making those sounds

R: Mmm so it's experiencing the live stuff yeah. Makes more sense too when you hear the recorded music.

D: Yeah

R: You have something that's tactile and real and?

D: Yeah

R: Yeah. What other ways xx can you see with other clients or with that client?

D: I can't think that I've actually been in here with any other clients. Have I been? Mostly it would be with xxxxx. I can't recall coming to music therapy with anybody else.

R: Yup ok yeah that could be right

D: SO you know I know that although with him he hasn't always attended

R: Yup

D: It's not necessarily that the well it's not at all a reflection on what you guys are doing or or even the fact that he doesn't enjoy it. It's more other issues that are going on with him whether you know the reason he's in here I guess the fears and that sort of thing.

R: Yup but that's..

D: SO um in terms of once he gets here I know he enjoys it although you may also notice that sometimes he presents in different moods. You know one day you'll look at him and think you know he's doesn't look that that happy and so its but its nothing to do with the actual therapy.

R: mm

D: You know it's just what's happening with him.

R: Yup

D: and what thoughts are going on with him

R: Totally yup. It's an unpredictable group of..

D: But I mean I've been really impressed with the um effort and enthusiasm that you and Jud have displayed.

R: Thank you

D: I mean I mean it's a real credit to you. Yeah it it really shows and you know I think I need to congratulate you for that.

R: Thank you very much

D: Yeah yeah. I can't imagine anybody that could of tried harder you know and shown more enthusiasm and also I think the way that you two have um approached the guys has been you know has been you know very well professional but also um you know you've had a really good feel for for them you know

R: Thank you

D: SO yeah yeah. I think its been great

R: Cool thanks. The sort of thing I was wanting to know as well about my research is how if there was a job here for a music therapist how you could fit into the whole sort of setting and fit in with other programs and just fit in with the team how do you think that could work ?

D: Well yeah I think I think so. I mean I think that you've you've been doing that and I think it's been working

R: In what ways do you reckon?

D: Well its' seems to me to be one of these programs that has idunno I mean you

could tell me but mate it feels like it's been quite well attended or and I feel it's it's quite ... I think staff view it as as important whereas I know of a lot of other programs that we do where we almost sometimes and I'm sure the poor old OT's pull their hair out at times but they almost aren't supported very well but I think the music therapy almost feels as though people feel it's worthwhile

R: Mmm

D: And and so I think there would be a place. I think if you know the idea is put up to have it permanently here I think it would be quite strongly supported.

R: Yup

D: I think it would be and certainly I would strongly support it yeah yeah

R: Do you think um the staff have a understanding generally about what it's what it's about?

D: I don't know. To be honest with you I'm not sure. I haven't really discussed that with others. But I mean I've never heard anyone say anything bad about music therapy

R: Yup

D: And that is pretty darn good to be honest with you because we do hear some bad things about some programs but I've never heard anything from anybody about music therapy anything negative at all. So

R: That's good. What about when you come in with xxxxx do you feel like when you first came in did you feel like you kind of knew what to do or.. what your role was a support worker?

D: Umm I think with xxxxx I always pretty much know my role.

R: Yeah

D: And that is that my role is to be ah to be is that I'm I keep watching him very closely. I know all the signs in him and I do not want him ah attacking ah anybody like yourselves. So my first thing always is everybody in room's safety and then when I see things that are looking good he's ah relaxed and enjoying himself then I guess I probably relax a little bit more

R: Mmm

D: Yeah but yeah

R: so that's that's the first thing so with the music you felt quite comfortable as in should I play an instrument

D: Ah absolutely or no you you guys were great you involved me and ah you give me an instrument to play and I loved it you know

R: Cool

D: I'm not at all musical but no I just from a personal I just want to be involved with my job and I want to be part of everything that's going on so um I think it's great I enjoy it yeah you know. Im pretty shy as you probably know so I yeah I might not get involved

R: No yeah its its one of those things I think that some workers have found it quite good to do music therapy with clients because you can it's a different things a different activity that you do and you can see different things that you might not have seen before?

D: Yes yeah well you know as I said I've only really been in here with xxxxx but im not sure do the other clients have they um have the caregivers always come in?

R: Mm yup

D: Theres always a caregiver that comes in?

R: Yup

D: See that's something that hasn't happened that's been a complaint in some of our other programs that they haven't been supported b y staff

R: Oh ok

D: Umm and its sounds from what your saying that the fact that staff are supporting your program quite well

R: Yup

D: So that that must be very encouraging

R:Yup y up well we've made sure that there's been staff here so

D: Yeah have you well that's good work on you

R: Yeah and that's sort of what one of the reasons I wanted to do this research cos I noticed at this placement that there was just more staff involvement with finding out

what's going on with the guys and then everyone's in the session with you. There's just more overlap with the staff I think than

D: Ok cool yup

R: So yeah I just wanted to know if there was a music therapist working here how you could fit into the team long term and yeah but I think that...

D: Have you have you come up with the answer yet? (Laughter) Do you want me to come up with the answer for you? (Laughter)

R: Well you could help me with your insights (more laughter)

D: Yeah I don't know how much insight I've got

R: You've given me great insight

D: Um yeah yeah I I can't Im' I'm quite sure that it can be done

R: Yeah

D: Yes. DO you do you think that if they had a music therapy here that that would probably just be one person?

R: I imagine so yeah

D: Yeah I would have thought so too. Yeah if they're going to agree to that I imagine it would be

R: Yup

D: One person.

R: Yeah.

D: Umm I hope it happens quite sincerely because it and um and I certainly hope that it is yourself or xxx because that's going on the recording and I cant' separate ya (laughter) Um yeah because I think you've been great and I think you'd fit in really well here.

R: So theres nothing no improvements you think?

D: Could point to?

R: Yeah improvements as a result of the guys having done music therapy?

D: or things we could do with the staff or

R: Ok things YOU could improve?

D: Yea

D: I can't think of anything to be honest with you Anna. I mean from what I've seen you appear to have been doing a really good job um you bring in heaps of instruments um yeah I mean maybe I mean there's been the odd time when we've had problems knowing the words to some of the songs these guys want to sing

R: Oh yeah

D: But I'm not sure how you'd quite get round that.

R: Yeah

D: But if ya had something that had the words for every song that ever been written you could suddenly sing it you know I'm not sure

R: NO but that's a good point it's practical thing sometimes I think that

D: Yeah yeah but ah that's a pretty minor thing I think no overall I think it's been great.

R: Thank you very much you're very complimentary

D: Oh am I!

R: There's nothing else you'd like to say?

D: No well I would like to say that I enjoyed meeting and knowing you two cos I've found you to be very happy and out going people and you know it's nice being around people like that and I do think you need you need that here those sort of people you know people who are really positive outlook yup

R: Thank you.

End of interview.

Interview # 6

Interviewer = R

Participant = C

Date: 25 January 2006

Time: 3:45 pm

Venue: Practice room, Massey University

Transcription of interview:

(Initial problems with Dictaphone for first 2 minutes)

R: So thanks for coming along to the interview today xx. I wanted to ask you about how you found um co-facilitating a music therapy group in this settings and how you how you found.. how did you think that the staff attending each session impacted on the session or if you thought it impacted the session at all?

C: I thought it impacted hugely. And we're talking about the group as opposed to individual are we.

R: Just the group yup

C: So this is from memory from a sort of 6 to 8 last sessions. Um so where it differed of course depending on who came in but it impacted on us which of course then impacted on the clients and when it impacted on the clients it had counter transference back to us so it was bouncing around the room big time. And um not only the personality of the carer working came in but their relationship with particularly the group. So um

(Participant asked for tape to be turned off)

R: So if the carer came in and they did not understand the therapy goals within the group in music therapy, what could, some of the things that could happen which could happen but particularly did happen was they might have been very much conscious of THEIR mana if you like within the group if they joined the group. This is pre-supposing they joined the group. So then they might have wanted to be musically be lets just say for example the star. And then that of course had a um possibly it could have had an energizing or negative affect on the others in the group depending on how they were feeling that day so without being too specific, um so if they were wanting to be the star of the drumming for example well then other people

their experiences that they had would not of been as perhaps as successful in their eyes um if they were comparing themselves with how the carer was doing. Um that's one reaction that I do remember. The other thing was if they had a good relationship with one group member. Um or even a negative. We'll talk first all about a good relationship. Then that immediately um formed a dyiad of those two people and then that would mean that our energy instead of being in a therapeutic situation was actually trying to bolster of make sure that everybody in the room had a group experience and feel to it. So that then if um that person that came in had a negative reaction to the group that also split the group and we were working hard on those sort of dynamics as opposed to the practical sort of perhaps um well it was all part of the process I guess. Um but those sort of things were happening. And the actual personality shall I keep going? The actual personality of the carer also how confident a person they were or was often picked up and um so if you had someone come into the room as we did who had quite a perhaps a a poor self esteem or a weak sort of personality if you've got someone dominant in the group they'll just sort of sap that energy away and then the whole dynamics of the group changes once again and then you're in the protective role as opposed to working with the whole group so the dynamics were enormously changed each week as those people came in to the group. Does that make sense?

R: Mmm Absolutely. How do you think they could be, when you're talking about some of the negative impacts, how do you think that maybe could be improved in the future in this sort of setting?

C: Well probably the two things that come to mind straight away would be to have as far as possible have carers that have um well they understood the music therapy um process they understood therapeutic processes in general and um wanted to be there and there was some training provided for them and as far as possible keep those people as stable as possible within the whole um music therapy happening session over time. Obviously that would depend on timetabling and that sort of thing but um generally speaking if you have the same um people coming in to work with and that they had um a good understanding of music therapy and a good relationship with um the guys that would make things all the more xx. Um if that wasn't the case in some ways it's better to have them removed and sitting by the door and not part of the group um and particularly if they did not face the group so their whole impact is taken out of the equation and we weren't working if you like um on that whole dimension and counter transference and things that were going on in music or personally in the group it just made it far more complex at times

R: So it sort of makes if a staff member comes in and their behaviour is impacting negatively on the group what your talking about before its splitting the group it means that for the facilitators, or therapy facilitator that your job um becom a lot harder so youre not able to focus completely on the client group is that what you

mean?

C: Mmm mm and um your whole energies um are taken away from the music and the therapeutic elements that we're using because you're doing a sort of psychological adjustment or caring for those that are in a vulnerable situation which I know is all part of the process but it just makes it much more complex

R: How do you think staff attending the sessions could impact positively on the clients group in the music therapy group?

C: Well um the first thing to do I think they immediately pick up if the person doesn't want to be there or if they're feeling unsure in their role so I think that's where music therapy, therapists or music therapy students, can make that education behind that quite um clear and good. I think that otherwise um they want to be there, they're happy and comfortable participating because as I say if they're not they're better to be sitting out of the therapeutic group, but that would make it more positive if those two things were in place and that outside of music therapy room that there was a good relationship between them and the guys in the room so those three things probably?

R: Yup

C: Obviously as well that they got on well with the music therapist or understood professionally um what was happening and they were enthusiastic about using music in this way

R: So when you are talking about outside the music therapy session who do you think that if there were a hypothetically a music therapist employed in this position in this setting how would they relate to the other staff members or the multi-disciplinary team?

C: Mmm that's a good question. Um its quite hypothetical in that the situation at the moment um but I just think that the whole of the therapeutic type of activities or the activities um that go on in the unit should be an integral part um say for example if they (clients) are doing art then it could be tied in to the music therapy process and vice versa rather than letting things be relatively separate so as far as possible have everything integrated so that um for example if someone is doing Christmas decorations you know that then that is somehow brought in to the music therapy and vice versa um and um lets say some other art maybe if there's a um the whole idea of drama within the group that the music therapy is also part of it so it becomes part of their lives and song writing and the various experiential um elements of the whole unit and integrate it more

R: What about music therapist hypothetically going to meetings and that sort of thing how for someone that did not attend music therapy sessions what would be the best way to relay what happens in the session and how to communicate that?

C: Right um I guess um well there's two ways. Either it could be by them coming in sometimes um because until you've been to a session you probably have no idea um no matter how much you talk about it um theres nothing like experiencing it. Um the other way of course is to go to multi-disciplinary team type meetings or staff meetings and just go over the principles behind music therapy and also give some vignettes of what's happening with permission of course. Some of that was sort of gradually happening um because ah we were going out of the therapeutic space a little bit um and so just by hearing that and discussing it and sometimes it makes people grumpy you know its' just noise to them or they don't' see the principles behind it but um even those discussions xxx because it just highlights the various aspects because it s new discipline it's as far I know the first in the unit

(Participant asked for tape to be turned off)

R: Ok so you wanted to talk a bit more about the actual inside the music therapy session?

C: There were a couple of things that have occurred to me that the if the person carer coming in has not had an understanding of what um music therapy is about what has happened is one occasion at least is that that carer actually takes over the role of the music therapists and to give you an example the music therapist might be um either unsure of the song that the client wants or um perhaps there is um not intending to be but not for the client to come forward with the song and the carer might misinterpret that and take over that role facilitating the group and um on that occasion um particularly as students but for anybody it once again diverts away from the group and splits the group and that makes the client um I could imagine feel unsure and unstabilises , destabilises the whole therapeutic environment and dynamics that are going on. Um the other issue of course is that usually like a carer um has to be in a um different type of role than we have in the music therapy environment because normally they would be um I don't' know how to say this exactly but there would be definite role where they would be superior but they would have definite rules that they had to adhere to um of the establishment and that could be seen by the clients as being um on a different hierarchical system if you like. Um in music therapy group with the playing in particular which might be facilitated by the music therapy students but the roles are equal well we went to a lot of um effort to do that to um be inclusive and um not to include instruments were we were particularly skilled on um so that we were playing if you like together music together on that basis and um I can I can see that would be strange for both the clients and the carer to feel um that those usual roles and balances of power if you like move around and shift around

and also I mean the same thing if someone came in and they were skilled for example on the drums and how that effects I think the group ah which in turn has a therapeutic um imbalance possibly because we were um a lot of the time um aiming for successful um experiences for the clients who were quite fragile; their self esteem and self awareness

R: Do you think this is just an aside really but clients and staff members that aren't the music therapists participating in um group music therapy sessions. Do you think that can be beneficial for their relationship.. client and staff relationships?

C: Well I do. I think anything that emulates if you like um eh well parent child I suppose where the communication is fun and equal and and developmental and productive um. I think that any play together where it's active and positive is good because if you can model what is good and positive

R: So staff have a role of modelling do you think?

C: Mmm absolutely. I mean we do it ourselves um as far as possible but for the carer to model um a healthy way um of playing and being and and um talking> I think that all comes out of creating within the session as an equal.

R: Well I don't think there's anything else I'd like to ask. If theres anything else you'd like to add?

C: No

R: If there's anything else about co-facilitation that you wanted to talk about or our status as students um

C: With the carers or in the whole establishment?

R: Umm yeah maybe in the whole establishment.

C: Well I would say we um we very fortunate I think um and we were treated exceedingly well. We unfortunately did not have time to be part of the team which I think is a great disadvantage for music therapy and for us in an establishment um but I feel the clients and the carers and um the administration staff and so on treated us very well and it was a positive experience for everyone as far as I could ascertain. I think it was very difficult for the carers coming in because they did not know guidelines and they did feel unsure and of their role and how to react um and that was partly a time restraint um sometimes they would just appear at the door and we haven't done a lot of stuff educational stuff around music therapy and so that was inevitable I guess um there were certain people who hadn't been in the organisation

very long. Have I got off track a little bit?

R: No its great

C: Um and so um but overall I would say that the client staff viewed music therapy as a positive intervention um which is what we were aiming at but I do think when they came into the room there was a definite feeling of oo what are they going to do with us?!

R: For the staff members?

C: Yeah the staff the carers. Um how will I fit into this and will I be there just to watch When they realised what was going on which often was quite quickly you could almost see their body language relax and the guys would then view it differently. Particularly as they participated and realised that it was a good and fun intervention and group dynamics and if we had problems and so on could be worked out in the music. Problems? Challenges would be a better word.

R: Thank you

(Tape turned off. Participant asked for interview to re-commence as she had wanted to divulge further)

C: Yes so just thinking about the way we were received and how I thought it was a positive experience for all um I'd like to just say we were always greeted each week really favourably people helped us carry instruments around into the building and what started to be in the early sessions perhaps if I may just say that um a noise around the place that people had to put up with um they in fact started to move meetings away from us that was true but they felt it was worthwhile. They said on numerous occasions that they thought the sessions were worthwhile for the guys and the place and they enjoyed having so called noise, music around the place and to see um the clients actively involved in something that they were obviously motivated and um people who were in on the sessions consistently felt that um for people it was a motivating tool to use with them because they could be more expressive than they normally could be because they tend to have quite limited verbal skills and so with music that they could do all sorts of things with the music and the elements that they couldn't do verbally um particularly in the expressive area but also to build memories that were positive um and so also I think that we were probably reasonably accommodating and careful how we did not disturb the whole system because it's a complex system that's going on there. Um on the other hand we kept the client at the centre so if for example it meant putting some staff out by out I mean just disturbing a little bit so we really wanted a client out of bed and we made it quite clear that that was their therapeutic time and we wanted that person there if

they were well enough, and it wasn't that they had just gone to bed because they were bored Um generally this was well received after perhaps some initial little bit of resistance from the carers but generally speaking this started to happen more and more and um it was seen as a serious intervention overall and the psychologist as well supported what we were doing and the psychiatrist as well who felt that it was a good intervention um so I think the team as a whole thought it was a very positive way of working with people at this forensic unit.

R: Thank you.

(End of Interview)