Findings of an Audit of Music Therapy Referrals in a Specialist In-patient Setting for 16 Patients with Advancing Huntington’s Disease

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Abstract
This article details the findings of an audit of referrals to a music therapy service in a specialist in-patient setting for 16 patients with advancing Huntington’s Disease. Thirteen out of the sixteen patients were referred to music therapy; three were not referred. The findings indicated that the mean age at diagnosis of those referred was 45.62 years (SD = 10.73), and for those not referred 33.33 years (SD = 7.02). The mean age at time of referral was 60.54 years (SD = 9.35), and for those not referred 51 years (SD = 9). Comparisons between the mean ages of the two groups at time of referral revealed no significant difference (p = 0.13). However, those that were not referred were on average substantially younger than those referred. A strong relationship between age and age at diagnosis (r = 0.85) was highlighted, and when a t-test to assess whether the average age at diagnosis was associated with whether a referral to music therapy was made or not during the time of the audit, the result was approaching significance (p = 0.08). Calculations of percentages resulted in identifying that patients were most likely to be referred due to a need for emotional expression (n = 10; 29%), and maintenance of communication skills and social relationships (n = 9; 26%). Infrequent referrals were made due to occupation (n = 5; 14%), physical presentation (n = 4; 11%), behaviour (n = 4; 11%), and cognitive factors (n = 3; 9%). The findings of the audit are discussed and compared with the literature to assist with understanding the role of music therapy with this population.

Keywords: music therapy, Huntington’s Disease, audit

Introduction

The role of music therapy can be partially understood through examining music therapists’ caseloads, and the profile of those who access, and are referred to music therapy (Horne-Thompson, Daveson, & Hogan, in press). Additionally, once profiles are identified, and the strengths of treating teams have been explored, areas of service development and research foci can be highlighted. This knowledge can be gained through
the use of the audit tool and pre-audit activity. Audit is a quality improvement process that aims to:

...improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change....Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery (The National Institute for Clinical Excellence, NHS, 2002, p. 1).

However, in a profession (such as music therapy) where national or international standards are yet to be set, pre-audit activity is required, meaning that the collected data is not related to clinical standards or criteria but rather it is collected “with the explicit purpose of setting standards of best practice...” (United Bristol Healthcare Trust, 2005, p. 3).

In this paper the findings from an audit that investigated music therapy referrals over an eleven-month period on a specialist-inpatient ward for those with progressing Huntington’s Disease (HD) are presented. Additionally, the findings are compared with practice and research literature to demonstrate how the findings can be used to create new knowledge about areas of practice and to assist with setting standards of practice. To aid with contextualising these findings, an outline of the cause, onset, and clinical features of HD is presented. This will be followed by a review of the music therapy practice and research literature. The presentation of this material will enable a comparison between the findings of the audit and the literature to be made, and for the relevance of the findings of the audit to be considered. The incidence of onset of HD is approximately 1 in 10 000 persons in North America and Europe (Walker & Raymond, 2004) and 7 per 100 000 of the population in Australia (Australian Huntington’s Disease Association, 2006), the sample identified in this audit is therefore representative of a sizeable cohort of those diagnosed and living with HD.

**Huntington’s Disease: Cause, Onset, and Clinical Features**

*Cause and Onset*

HD is a neurogenetic degenerative disease caused by a mutation in the Huntington gene on chromosome four (Kremer et al., 1994 cited in Skirton, 2004). It is a dominantly inherited disorder, which means that it is passed onto offspring by the parent that is carrying the affected gene. There is a 50% risk of inheriting the mutated gene from those carrying the gene and symptoms develop later in life (Skirton & Patch, 2002, cited in Skirton 2005).
Symptoms can present at any age, with approximately seven percent developing symptoms before reaching 21 years of age (Nance & Myers, 2001). The mean age of onset has been reported to be 41.5 years for those living in North America, Australia, and Europe. Earlier age of onset has been associated with particular clinical features, including more dystonia, less chorea, and a faster rate of motor, cognitive, and functional progression. An older onset has been associated with more chorea and less dystonia (Mahant, McCusker, Byth, & Graham, 2003).

The positive motor features have been described as the most obvious features of HD, however these cannot necessarily be used to predict the level of disability experienced, or activity able to be completed by the patient.¹ Mahant and colleagues (2003) reported that disability best correlates with negative motor symptoms and cognitive impairment. Also, some of the motor symptoms fluctuate rapidly due to a range of factors including emotional stress, medication, and motor activity.² Scales to rate the ability of those with HD have been developed (e.g., the Unified Huntington’s Disease Rating Scale authored by Seisling, Vugt, Zwinderman, Kieburitz, & Roos, 1998).

**Clinical Features**

Some patients remain un-symptomatic, even though carrying the affected gene, while others present with a varying range (severity and scope) of motor, cognitive, and behavioural symptoms (Leng, Woodward, Stokes, Swan, & Baker, 2003; Skirton, 2005), or otherwise described by Skirton (2005) as physical, cognitive, and psychiatric areas. Physical symptoms include ataxia, chorea, dysphagia or difficulty swallowing, dysphasia, incontinence, bruxism, dystonia, bradykinesia, and oculomotor deficits. Cognitive symptoms can include dementia, memory deficits, and difficulties with executive functioning. Psychiatric symptoms may include depression, personality change, mood swings, obsessive-compulsive disorder, anxiety, agitation, irritability, apathy and inflexibility (Leng et al., 2003; Hamilton et al., 2003; Skirton, 2005).

The scope of symptoms requires the conjoint work of various healthcare professionals. At the Hospital where this audit was completed, the input, for example, may include speech and language therapy to address communicative and swallowing needs; dietician focusing on nutrition; nursing activity to assist with daily care needs; occupational therapy to assess the impact of the disease on activities of daily living; social work to enable family support; psychology to complete periodic

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¹ A positive symptom means the presence of a feature, for example, chorea.
² A negative symptom means an absence or decline of features, for example, a lack of motor activity.
cognitive assessments; bio-medical engineering to design wheelchairs; dental input to address oral health-care; medical officer involvement to manage symptomatology; and physiotherapy for maintenance of physical functioning. While this list is not exhaustive or comprehensive, it is clear that the onset of HD requires the input of many professions.

Notably, Leng and colleagues (2003) highlighted that while there continues to be no cure for HD, interventions most frequently comprise management of symptoms, genetic counselling and palliative care. Furthermore, as deterioration occurs, patient’s access to and benefits from, what Leng and colleagues (2003) described as “standard” (p. 31) forms of therapy, are limited. Plus, the emergence of various combinations of symptoms means that patients may experience profound functional loss, which results in a decline in independence as measured by activity in daily living tasks (Hamilton et al., 2003). Music therapy has a role to play throughout the course of disease progression and aspects of this role are described within the literature outlined in the subsequent section of this paper.

Music Therapy Literature Review

It is acknowledged that there is much allied literature that is useful to informing music therapy work with the HD population, including (a) research into the use of music therapy with those living with chronic neuro-degenerative disease such as Multiple Sclerosis (Magee, 1999), (b) research that has examined the experiences of music therapy with those living with chronic oncological disease (O’Callaghan, 2001), (c) research that has measured the effects of music therapy on improving quality of life (Hilliard, 2003), and (d) research into music therapy palliative care (Hogan, 1997). Additionally, there is a long history of the development of music therapy practice with the HD population with one of the first documented accounts of such work circulated in Australia in 1976 (Groke, 1976).

Since this time, the body of literature authored or co-authored by music therapists has evolved, and includes conference proceedings publications or professional bulletins (Brandt, 1996, 1999; Curtis, 1987; Dawes, 1985a; Grocke, 1976; Hoskyns, 1981, 1982; Magee, 1995b; Rainey-Perry, 1983; Wright, 1976), chapters published in books about HD or related topics (Dawes, 1985b; Magee, 1995b, 1999, 2002), and articles within peer-reviewed journals (Davis & Magee, 2001; Magee, 1995a; Thaut et al., 1999). The review used in this article is purposefully limited to publications that (a) focussed specifically on HD music therapy work, (b) were authored or co-authored by registered music therapists, and (c) were published in national or international peer-reviewed journals, and
when reviewing the literature using these parameters it was found that only three articles fulfilled the criteria. Two of these articles are described as practice literature and comprises descriptions and evaluations of clinical work with patients with HD (Davis & Magee, 2001; Magee, 1999), while the third is a research article based within the positivist paradigm (Thaut, McIntosh, Miltner, Lange, Hurt, & Hoemberg, 1999). The details of these three publications are subsequently reviewed.

**Practice Literature**

Two refereed-journal articles that described music therapy practice with patients with HD were located. This work detailed clinical work completed at the Royal Hospital for Neuro-disability and was published within a six-year period. The first article focussed on the presentation of the stages of HD and how practice could be shaped to meet the changing needs of those living with HD (Magee, 1995a). The second article explored the use of particular music therapy methods or techniques with this population (Davis & Magee, 2001).

In the first article, Magee (1995a) delineated the role of different music therapy methods and method variations, including the use of improvisation, familiar songs, and receptive experiences, throughout the course of the progression of their disease. This detailed work resulted in an approach to service delivery.

In the early stages of the disease it was suggested that the need for active participation in music therapy was paramount. Magee (1995a) wrote that this need could best be facilitated within individual programmes, and that patients would benefit from opportunities to demonstrate and maintain their strengths. The use of less structured activities was highlighted along with the creative and expressive qualities of the music to assist with increasing active participation of the patient. The role of the therapist in assisting with ongoing assessment of information-organising, memory function, musical interaction, initiation, and creative abilities of the patients was highlighted, as was the risk of adverse reactions from patients being placed in therapeutic groups with others living with progressing HD.

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3 The Positivist Paradigm is based on the belief that there is one absolute truth and that a cause and effect relationship can be determined through research procedures (Edwards, 1999).
4 The term “stages” as used in this article is a relative one and is used generally to refer to points along disease progression where changes in care needs prompt significant changes to service provision in order for needs to be met.
5 It is noted that Magee did not present in detail what was meant by “adverse reactions” however this was referenced and is accordingly highlighted in this paper.
In the mid-stages of the disease, group participation was recommended (Magee, 1995a) due to two reasons. First, the patient’s abilities may have declined to the point where time between active engagement opportunities was required and this need could be addressed within group work. Second, responses from the other patients could be used as a model for other group members. The use of highly organised musical tasks was recommended due to loss of information-organising capabilities. The author also highlighted how the structure of songs could be used to assist with (a) the recall of information despite memory function deterioration, and (b) the preservation of vocal abilities through the singing of well-known and rehearsed songs.

And finally, in the late-stages, or the time when the patient was unable to demonstrate functional ability, the use of passive or receptive methods was recommended in group-settings (with attendance of those from the patient’s support network recommended). However, opportunities for active instrumental participation were also encouraged when the patient was still able to engage actively in tasks. Notably, the provision of choice and control opportunities was emphasised as being important in both the middle and late stages, as was the selection of the use of methods around the patient’s existing or remaining skills (Magee, 1995a).

In the second practice article, the use of improvisation with those living with neurological disease, with a focus on the use of structure within improvisation with one HD patient, was reported (Davis & Magee, 2001). In contrast to the first article, wherein a rationale for music therapy from a needs-based perspective was volunteered, the rationale for music therapy in this article was supported by the proposal that music has certain properties that can be used to enable specific responses.

When outlining the reasons why music can be used therapeutically with HD patients, it was highlighted that music can offer opportunities for interaction and communication as it (a) is a nonverbal medium that involves expressive parameters, (b) can increase arousal, leading to increased responsivity, and (c) can assist with organising patients’ responses.⁶ In this article, the responses of one patient were described, and in doing so, the use of intra-musical structure to support interaction was illustrated. The influence of musical parameters to assist with increasing communicative contact and relationship development was also described (Davis & Magee, 2001).

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⁶ This rationale was supported by the work of other music therapists. A list of references of work that supports this rationale is included in the article written by Davis and Magee (2001).
Research Literature

In the research article, the rhythmic synchronisation ability of 27 patients diagnosed with HD (13 males, 14 females) to a metronomic sound, music, and to no sound was investigated (Thaut et al., 1999). The mean age of the sample was 47 years, and the mean duration of disease was 7.3 years. One patient in the group had no signs of choreic movement, three had soft neurologic signs, and 23 had mild to more severe forms of chorea. There was no or slight forms of disability noted in six of the patients, while 10 were described as mild to moderately disabled. The other 11 patients had moderate to more pronounced degrees of disability, with three of these patients requiring full assistance in all activities of daily living. The majority of the patients were receiving medication (n = 19) however eight were not.

In this study, data for gait analysis was collected when the patients walked along a 26-metre line during the following four conditions (a) at a normal speed to form a pre-test baseline, (b) at a slower speed than baseline, (c) at a faster pace than baseline, and (d) at a normal speed first post-test (Thaut et al., 1999). Following this, patients were asked to synchronise their step pattern to the sounds of rhythmic auditory stimulation (RAS) that was sounded by a metronome. They were requested to do this under four conditions. First, the RAS metronome was set 10% slower than baseline, and then when the metronome was set about 20% faster than the baseline. After this, music was used as the RAS and this was set faster than baseline. The music that was used in the study involved pre-recorded instrumental versions of folksongs that comprised accentuated on-beats in duple meter with the beats subdivided into either two or four rhythms. This condition was followed by the patients being requested to walk at a normal speed without the use of a RAS. Statistical analysis used repeated measures analysis of variance (ANOVA) procedures, with planned comparisons on the change scores between all walking conditions, as compared with the baseline condition (Thaut et al., 1999).

The results showed that most patients could change their gait speed in the direction of the RAS cue and that precise timing synchronisation was negatively impacted upon at the early stages of disease progression. The results of the study highlighted the role of the assessment of sensorimotor synchronisation tasks to assist with the prediction of disease progression, as the ability to process complex auditory stimuli (music) for the purposes of motor timing may decrease as the disease progresses (Thaut et al., 1999).

One of the strengths of the study was the sample size. However, there was variance in the sample, as some patients were experiencing no
symptoms while others were presenting with marked symptoms. Additionally, one could question why other types of music, such as fanfare or marching music, or music that is highly structured, comprises instrumentation that is clearly marked, and used in social contexts to walk to, was not used in the study. The questioning of the type of music used is supported by the rationale provided in the Davis and Magee (2001) article wherein the role of music to assist patients in organising their responses was highlighted. The use of different music in this study may have assisted with producing other results.

In summary, the three reviewed articles varied in content, yet from reviewing these articles, it can be concluded that the scope of practice includes the use of music therapy to address physical functioning, communicative, relationship, and cognitive domains throughout the course of the disease.

Audit of Referrals to Music Therapy Service

Background to Audit Development

This audit was undertaken at the Royal Hospital for Neurodisability; a hospital wherein music therapy is part of the multidisciplinary (MDT) package offered to patients. However at the time of this audit, music therapy was not available to patients residing on this particular ward. This lack of service led to requests from staff for the service for several patients who had received music therapy while residing on another ward and had benefited from it. These requests led to the audit as a way of measuring the perceived need for the service as indicated by music therapy referrals and assessment findings on this ward. As per clinical and research governance procedures in place at the Hospital at the time of the audit, audit procedures were followed and the audit was registered with the Hospital’s audit committee.

Method

Accordingly, throughout an eleven-month period the need for music therapy was assessed through a three-step process:
1) All patients deemed suitable for a music therapy assessment were referred by the MDT team to music therapy;
2) The referral (which highlighted the areas that were in need of assessment) was considered upon receipt, and this led to an assessment being completed if evaluated as warranted by the music therapist. Criteria were established to determine whether assessment was warranted or not. Assessment was not warranted, for example, if (a) the patient was experiencing rapid deterioration and discharge from the ward environment
was imminent, (b) the patient was assessed as being unable to make gains from the therapy that could assist in compensating for functional loss associated with the disease, or (c) music therapy was evaluated as being unable to be used to address quality of life needs in a way that was different from a social and recreational programme that involved music; 3) The findings from the assessment determined whether or not a treatment package was offered to the patient. If music therapy (MT) was indicated, then a finite time-limited package, with identified treatment goals, was provided. To ensure that the duty of care responsibilities to the patient could be fulfilled prior to discharge from the service, only goals that were S.M.A.R.T., that is goals that were specific, measurable, attainable, relevant, and time-related (Maidment & Merry, 2002) were set for, and whenever possible with the patient. The music therapy approach offered comprised a compensatory approach or one that aimed to develop strategies that assisted with accommodating for the neurological impairments that inhibited their function. The aim of the therapy was therefore not to restore or regain function but rather to maintain function and provide opportunities for compensatory behaviours to be supported, developed, and rehearsed (Baker & Roth, 2004). Therapy that focussed on psycho-socio-emotional work was also provided throughout the duration of the project. If, after assessment, music therapy was not warranted, then the patient was discharged from the service and leisure guidelines were compiled.

Findings

At the time of the audit, 16 patients (seven males, nine females) diagnosed with HD were residing on the ward. The findings presented in this paper involve these patients.\(^7\)

Referral and Demographic Information

Eighty one percent of patients (n=13) were identified as warranting assessment; three males (19%) were identified as not being suitable for assessment. The MDT and music therapist conjoinly identified that the levels of disease progression and profound loss of activity meant that these three patients would not benefit from treatment and this is why an assessment was not warranted. Of the thirteen referred, 62% (n=8) had previously received music therapy while residing elsewhere in the hospital,

\(^7\) A music therapist was employed for one day a week to complete the clinical work. The therapist was supervised and managed by the Head of the Music Therapy Department for the duration of the project.
however the service had ceased when transferred to the ward where the audit was occurring.

The average age at time of diagnosis of those that were referred was 45.62 years (SD = 10.73), and for those not referred 33.33 years (SD = 7.02). The average age at time of music therapy referral for those referred was 60.54 years (SD = 9.35), and for those not referred 51 years (SD = 9). Although those that were not referred were substantially younger than those referred, the difference in average age at time of referral (or time of not referring) was not significant ($p = 0.13$). A strong relationship between age at diagnosis versus year of birth for those referred and those not referred was highlighted ($r = 0.85$), and when the average ages at diagnosis were compared, using a two group t-test between those referred to music therapy and those not referred during the time of the audit, the result was approaching significance ($p = 0.08$). However, the small sample size does not support a finding of significance as related to this correlation.

Patients were referred due to one or many areas. Calculations of percentages showed that patients were most likely to be referred due to a need related to the preservation of expressive skill and/or a need for emotional expression ($n = 10$; 29%), or communication skills and social relationships ($n = 9$; 26%). These reasons for referral constituted 54% of all referrals. Infrequent referrals were made for needs related to physical presentation ($n = 4$; 11%), behaviour ($n = 4$; 11%), or that which is derived from a combination of cognition and activity – occupation ($n = 5$; 14%). The most infrequent reason for referral was cognition ($n = 3$; 9%).

As per usual music therapy clinical practice, all referrals were prioritised in terms of need for service when the referral was received. This information reflects the evaluation of the need for the assessment as assessed by the music therapist prior to assessment activity. The majority of the referrals ($n = 10$; 77%) were rated as requiring assessment; 23% ($n = 3$) while able to be assessed, were assessed as essentially not requiring assessment.

**Music Therapy Assessment Findings**

After assessment it was found that six (46%) of the 13 patients would benefit from ongoing music therapy, and seven (54%) were assessed as not requiring active input. When examining the background of the six patients that were assessed as benefiting from ongoing input, it was found that the majority of these patients ($n = 5$; 83%) had previously received music therapy. When examining the background of those that were assessed as no longer requiring active input, it was found that three (17%) of these patients had previously benefited from MT but no longer required this service.
Music Therapy Intervention

Treatment goals were established for all of those who were assessed as requiring ongoing intervention. Emotional expression (n = 6), communication skills and social relationships (n = 4) were the most frequent areas focussed on, with emotional expression and communication work often simultaneously addressed. Physical presentation (n = 2) constituted a small part of the work, and this primarily involved maintenance of physical skills through the use of active music-making methods. Behaviour (n = 2) was also infrequently focussed upon.

Treatment periods ranged from four to 28 sessions in length. The mean treatment length for all patients was 18 weeks. Two treatment programmes were not continued due to the pilot finishing. These programmes were brought to a close and the timeline for this was negotiated between the therapist and patient. As shown in Table 1, sessions were offered either individually, within a group context, or within both individual and group contexts. One patient received group services only. Three patients received a mixture of group and individual services, and two patients received music therapy only via individual work. Every patient participated in four assessment sessions.

Table 1
Sessions offered to patients diagnosed with Huntington’s Disease over an eleven month period.

<table>
<thead>
<tr>
<th>Service offered to patients</th>
<th>Number of patients seen in individual/group work</th>
<th>Number of sessions offered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual work only</td>
<td>2</td>
<td>92</td>
</tr>
<tr>
<td>Group and individual work only</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Group work only</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Assessment sessions</td>
<td>13</td>
<td>52</td>
</tr>
</tbody>
</table>

Discussion of Findings and Recommendations

Referral and Demographic Information

The findings indicated that those who have a later than average age of onset (i.e., greater than 41.5 years of age) may be likely to be referred to music therapy when in the mid-stage of disease progression. This trend is understandable if an earlier age of onset, as highlighted by Mahant and colleagues (2003), means a faster rate of disease progression and therefore possibly less ability to actively engage in therapy and develop
compensatory behaviours to assist with continued function. This finding warrants further investigation and may assist with understanding the role of music therapy in relation to timing of referral. That being said, this finding could also be described as being an artefact, as for example, it may be possible that those who were born before 1950 would have been diagnosed by now, whilst those with HD who were born more recently may not be diagnosed yet. Either way only three patients were referred for music therapy so the interpretation of the results as related to age needs to be approached cautiously.

When considering the three areas of symptomatology highlighted in the literature for those diagnosed with HD, namely physical, cognition, and psychiatric symptoms (Hamilton et al., 2003; Leng et al., 2003; Skirton, 2005), referrals were received in relation to all of these areas. More specifically, 22% of referrals were related to physical or observable reasons (physical presentation and behaviour), 9% were due to cognitive function, and when this percentage was coupled with reasons related to occupation, the percentage of referrals totalled 23%. However, the majority of referrals (55%) were related to communication skills, social relationships, and emotional expression. This finding highlights the wide scope of the role for music therapy with this population.

Additionally, when comparing these findings with the literature it was found that these referral reasons are in line with the role that has been highlighted within the practice literature (i.e., that music therapy can be used to provide a means of self-expression, social interaction, and communication [Davis & Magee, 2001; Magee, 1995a]). This suggests some agreement between the music therapists’ understanding of the role of music therapy with this group with that of the MDT’s. The lack of referrals due to a cognitive need is supported by the literature wherein it has been identified that therapeutic intervention cannot assist with regaining cognitive abilities throughout HD progression (Leng et al., 2003).

When the referrals from the audit are compared with the research literature, similarities between the reasons for referral with the research foci (modulation of gait) are less clear (see Thaut et al., 1999). It is acknowledged that nearly a fifth of all referrals were related to physical presentation or behaviour, however, this work primarily involved maintenance of physical skills through the use of active music making rather than measuring or testing gait. It is suggested that further investigation into the role of music therapy to meet physical functioning needs of this population is required.

Music Therapy Assessment Findings and Intervention

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Assessment indicated that six of the 13 patients (46%) would benefit from ongoing music therapy and seven (54%) were assessed as not requiring input. When the age and time of symptom onset of those that were referred was compared with those that were not referred, it was identified that the group that was not referred were, on average, younger with an earlier time of onset of symptoms. These findings are interesting when considering Magee’s (1995a) rationale for the need of music therapy throughout all of the stages of disease progression. There may be many reasons for the difference between this recommendation and these findings. For example, the medical advances regarding treatment for those diagnosed with HD may mean that those living with HD can now reside in the community for longer periods of time before entering into residential care placements. This may have meant that the population in the hospital at the time of this audit comprised those with more advanced symptomatology than when compared to those from previous times, thus leading to a change in the role for music therapy with this population and the highlighting of differences in practice between contexts.

Regardless of the reasons why patients are or are not referred, these findings highlight a difference between incidences of referral during mid-stage disease progression as related to timing of onset of symptomatology. More specifically, the findings in this audit indicated that those in the mid-stages of disease progression with an early age of onset were less likely to be referred for music therapy by the MDT staff. Whether or not this finding is related to staff perception or the need of this particular patient group remains unclear and requires further investigation.

Another notable finding from the audit related to service provision for those in mid-stage disease progression. Namely, the finding indicated that music therapy can be provided as a group or individual service with patients in the mid-stages of HD. In the audit the majority of patients received individual input, or a mixture of group and individual work, and only one patient received group intervention only. This finding is different to what has been recommended in the practice literature (Magee, 1999) and requires further exploration.

Regardless of differences between treatment approaches, foci, and therapeutic contexts, the findings support a role for music therapy intervention with those in mid-stage disease regarding physical presentation, communication skills, social relationships, emotional expressive needs, and behaviour. These foci are similar to areas highlighted within the music therapy practice (Davis & Magee, 2001; Magee, 1999) and research literature (Thaut et al., 1999), and therefore generally support the overall foci highlighted within those publications.

Additionally, while comparisons of the findings with the literature has been possible, it is recommended that the use of a rating scale in future
audits, practice articles, and research work would assist with a homogenous approach to the description of disease progression within the field of music therapy. Through the use of the Unified Huntington’s Disease Rating Scale (Siesling et al., 1998), for example, a consistent way of describing the stages ("early", "mid", or "late") could be adopted amongst music therapists, and this would assist with comparative work across sites. This consistent approach would assist with benchmarking activity and the setting of standards of practice. An example of how this could be done is illustrated in a project that investigated referral patterns in a number of Australian palliative care sites. In that project the Eastern Cooperative Oncology Group Performance Scale (Oken et al., 1982) was used to assist with consistency in description of patients across several sites (Horne, Daveson, & Hogan, in press).

New information regarding music therapy work with patients with HD has been highlighted through this audit. In particular, information related to incidences of music therapy referral and onset of symptomatology has been identified, as has the use of individual or group work to address compensatory, psycho-social-emotional and maintenance needs. The findings along with the literature review can also be used to highlight gaps within the practice and research literature. For example, material regarding the role of music therapy in the terminal or palliative phase of HD (or the time of service provision within which death can be expected within a timeframe of days or months [Social Care Institute for Excellence, 2006]) was not able to be located within the review. And while it is acknowledged that service provision with this patient group, as with many other groups, requires the integration of palliative care principles, it is argued that specialist palliative care skills are required for work in the final stages of life. In closing, ongoing service evaluation of the scope and range of practice with HD patients is indicated to ensure that music therapy can be accessed by patients as related to need throughout the disease trajectory.

Author’s Note

Barbara Daveson is the Head of the Music Therapy Department at the Royal Hospital for Neuro-Disability, London, UK. She is currently completing a research doctorate at the University of Melbourne in Australia as supervised by Dr. O’Callaghan and Dr. Grocke.

The author would like to acknowledge (a) the work of the Music Therapy Department at the Royal Hospital for Neuro-disability and the

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8 It is acknowledged that Thaut and colleagues (1999) described the subjects in their research via the severity of disability however the rating scale that was used to determine these stages was not cited in the article.
contribution of multidisciplinary teams on Wolfson and Andrew Reed Wards as their work is referenced in this article, (b) the support of Dr. Magee and Professor Andrews, and (c) Dr. Swan who assisted with the calculation of the results. A special acknowledgement is made to Gemma Lenton-Smith (Music Therapist) and Thana Yogendran (Ward Sister) for their work in relation to this audit.

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