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Professor Denise Grocke's contribution to the establishment of the music therapy profession in Australia: A Historical Research Study.

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Abstract

Since its beginnings in the 1970s, the music therapy profession in Australia continues to grow and change. However, there is little literature about either the history or the continual growth of the profession in Australia. This study was the first historical research project which aimed to reflect on the growth of the music therapy profession in Australia over time. Qualitative data was obtained through interviews with three of Australia's most prominent figures in the field of music therapy. This article focuses on the establishment of the music therapy profession in Australia between 1970 and 1990 and Professor Denise Grocke's influence and contribution to the profession in these early years. The interview narrative provides invaluable insight into the establishment of the music therapy profession in Australia. This study brings to light the importance of developing the historical 'story' of the music therapy profession in Australia.

Key words: historical research, music therapy profession, Australia.

A historical research study in the field of music therapy has not been conducted in Australia to date, although several historical documents have been written. Although the music therapy profession in Australia is now well established, it still continues to grow and change. It was the purpose of this study therefore to explore the evolving history of the music therapy profession in Australia, and collect current data regarding the employment settings and conditions for RMTs in Australia. Qualitative data were collected to address these gaps in the music therapy literature.

Historical interviews were conducted with three of Australia's most prominent figures in the field of music therapy. Each participant answered questions in relation to a period of time in which they were most prominent or active in the profession. The process of 'purposive sampling' (Creswell & Plano Clark, 2007) was used to select interview participants. The

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participants were selected based on their prominent involvement in the profession during 1970-1990, 1990-2005 or 2005-2011. All participants were presidents of the AMTA at some stage during their allocated time spans. Participant one, Professor Denise Grocke was invited to share her knowledge from the years 1970 to 1990. Participant two, Dr. Helen Shoemark was invited to discuss her experiences from the years 1990 to 2005. Participant three, Ms. Louise Miles was invited to share her experiences from 2005 to 2011. In this article, only the interview data from one participant, Professor Denise Grocke will be presented and discussed, in an attempt to reflect on the establishment of the profession from the years 1970 to 1990.

Structure of the Interviews. During the interviews, a series of questions were asked in relation to the participants' personal account of the profession in the years most pertinent to their professional career. The interviews were semi-structured and primarily guided by the researcher. The five open-ended questions sought information on 1) the general growth of the profession, 2) the localised developments in different geographical areas of Australia, 3) developments in clinical settings for employment over time; 4) funding sources for positions; 5) changes in employment conditions, including working hours, job security, and position types over time. The interview was audio recorded and transcribed by the researcher. Minimal risk ethics approval was granted by the University of Melbourne Ethics Committee (HREC # 1135965.1) for this study.

Data analysis. Data from the qualitative interviews were analysed by distilling the responses to interview questions into a combined chronological narrative, with each of the five interview questions as themed headings. Authentication was conducted where possible, by checking with a credible source. Since there was no detailed example outlining the process of 'authenticating' personal historical accounts published in the literature, the historical data was authenticated by asking the interviewee to verify the researcher's interpretation of the distilled themes from the interview. Therefore the trustworthiness of this analysis was mainly addressed by asking the participant to verify the reduction and interpretation of their historical account.

Results are presented in the form of a historical narrative in relation to the five interview questions answered by the participants. The historical

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narrative is biographical and aims to tell a story based on the historical events described. The author has paraphrased Grocke's reflections in an attempt to integrate the interview data into a 'historical story.' Direct quotes from Grocke are identified through quotation marks and verification (edited or added) by Grocke at a later date is identified in square brackets. It is important to note that although the narrative includes true historical events, it portrays the personal view of Denise Grocke and does not necessarily represent historical fact.

Background and Literature Review

Professor Grocke is an internationally renowned and respected music therapy clinician, researcher and academic. She co-established the Australian Music Therapy Association (AMTA) in 1975 with Dr Ruth Bright and was involved in the running of the AMTA for 33 years. Professor Grocke was president of the World Federation of Music Therapy from 1999 to 2002. She established and directed Australia's first music therapy training course at The University of Melbourne for 35 years; founded the Graduate Diploma in Guided Imagery and Music in 1995; and the National Music Therapy Research Unit in 1999. A prolific author, researcher and supervisor, Professor Grocke has influenced the professional lives of hundreds of music therapists in Australia and internationally for over 40 years.

After studying a music degree at Melbourne University, Denise Erdonmez completed her music therapy training in the US in 1969. She returned to Australia in 1970 and established the first position in music therapy at Larundel Psychiatric Hospital, in Melbourne. During the same year, the Victorian Public Service Board recognised her music therapy position at Larundel and it was formally defined (Bright & Grocke, 2000). The Board created the professional category 'Music Therapist' in its Award structure, which was a milestone for the development of the music therapy profession in Victoria (Erdonmez, Bright, & Allison, 1993). This encouraged the creation of similar music therapy positions across the State. In fact, by the 1980s, 14 positions existed in the Victorian Mental Health Authority, in psychiatric hospitals and centres for the intellectually disabled (Bright & Grocke, 2000).

In 1960, with assistance from a prominent psychiatrist, Ruth Bright created the first music therapy program at the Parkside Psychiatric Hospital

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in Adelaide. Two years later she moved to Sydney and implemented a similar program in Callan Park Hospital's male refractory wards (Bright & Grocke, 2000). Despite a lack of remuneration, Bright was appointed as 'Honorary Music Therapist' and was accepted as part of the hospital team. As a result of Bright's work, in 1972 music therapy was established as a profession in the Public Service of New South Wales (Bright & Grocke, 2000). Following Bright's creation of music therapy programs in psychiatric hospitals during the early 1960s, she wrote extensively in books and articles, of her music therapy work in the fields of psychiatry, dementia and grief (O'Callaghan, 2002).

During these early years, Erdonmez and Bright established a working relationship. In 1972 they began discussions about the creation of the Australian Music Therapy Association (AMTA), and plans for the first music therapy training course in Australia. With the support of other professionals and some overseas trained music therapists, they held the first AMTA conference in 1975 (O'Callaghan, 2002).

The undergraduate training program at the University of Melbourne commenced in 1978 and under Grocke's continuing direction (until 2013), this program now offers Masters and PhD programs, and Guided Imagery and Music training. The Melbourne training course was later followed by other educational programs at the University of Queensland, the University of Technology in Sydney, and the University of Western Sydney (O'Callaghan, 2002). As the music therapy profession grew and became more recognised in Australian society, there were significant changes and developments in the clinical settings for music therapy work.

In the mid-twentieth century various music therapy roles were established in psychiatric hospitals and institutions for the intellectually disabled. In the decades following the 1980s, new deinstitutionalisation policies led to job losses in these areas (O'Callaghan, 2002). By the early nineties, music therapists predominantly worked with older adults in nursing homes, hospitals, rehabilitation hospitals, psychiatric hospitals, hospice centres and day centres. This was due to government and private funding sources being sympathetic to programs for the growing number of older adults in society (Allison, 1992; Erdonmez et al., 1993). During this time, employment in private practice was rare, perhaps due to the lack of funding or reimbursement through the health insurance system in Australia (Erdonmez et al., 1993). Due to the lack of literature written in this area, much of the historical evidence of the profession may only be gleaned from

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the memories that significant people hold of the past.

Historical Narrative of Profession Developments in Australia between 1970-1990 from Denise Grocke's Interview

General growth of the profession 1970-1990. For many years prior to 1970 the Victorian Division of the Australian Red Cross Society pioneered remedial music services in Australia. Despite being untrained in music therapy, a number of musicians from the Red Cross visited large institutions for the psychiatrically ill, and intellectually disabled (including Larundel Hospital, Willsmere, and Kew Cottages). The musicians from the Red Cross sang, played instruments, and "provided what was called an 'annotated record library' [to the hospitals]." Within the annotated record library, 'music appreciation programs' were placed into large black boxes and delivered to hospitals all over Victoria. "Occupational therapists [presented] these annotated music programs [to patient groups] and [played] music" from the vinyl records.

Concurrently, after previously implementing a music therapy program in a South Australian hospital, Dr Ruth Bright formed a similar program in a Sydney hospital. Bright had "visited various music therapists . . . in England where she observed [the method of] improvisation." Thus, in both Sydney and South Australia, Bright utilised much of her experience in improvisation with her clients. This period is described in the literature as being:

> "The beginning of Bright's interest in music for grief resolution, which arose from seeing how people with dementia and/or psychiatric illness responded to particular items of music...This was innovative work, in individual referrals by psychiatrists and in the planning of music therapy to meet particular needs of individuals...[In Sydney, Bright] was appointed as Honorary Music Therapist...this was vitally important professionally" (Bright & Grocke, 2000, p. 7).

Grocke had originally been "introduced to music therapy through the Journal of Music Therapy" [published in the USA], which she sourced in the music library during her undergraduate studies at Melbourne University. After expressing an interest in studying music therapy, Dr. Percy Jones, the Professor of Music at Melbourne University referred

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Grocke to Professor George Duerksen, who taught music therapy at Michigan State University in the USA. Grocke then moved to the US to study music therapy.

When Grocke returned to Australia after completing her music therapy training she searched for employment in Melbourne. Grocke was referred [again by Dr. Jones] to Dr. Daniel Kahans a consultant psychiatrist at Larundel Hospital (a psychiatric hospital in Bundoora, Melbourne). Kahans was "very interested in music therapy and psychodrama...and did whatever was required to create a music therapy position" for Grocke at Larundel Hospital. This was ideal for Grocke who had gained clinical experience in the area of psychiatry by completing a "six month full-time clinical training internship at Northfield State Hospital in Detroit." While in the US, Grocke had also considered completing her clinical training internship at a facility for disabled children in Boston instead. On reflection, had Grocke chosen a different clinical specialisation (not psychiatry), the beginnings of music therapy in Australia "would have been a different history!"

When Grocke commenced her employment at Larundel Hospital at the end of 1971, a classification for 'music therapy' within the Public Service Board of Victoria did not exist. Grocke was initially employed under a 'tailor, grade two' position, which was then reclassified. Consequently, the Public Service Board of Victoria "set about making a formal classification" for music therapy, which later "fed into the Health Professionals Award." This original classification enabled "music therapists in Victoria [to] have an award." So on the 7th of January 1974, Grocke "was finally classified as a music therapist Class T1, working full-time." Her salary was $5, 376 per annum.

Localised developments in the different States of Australia. In the 1970s, "a number of positions were created in Victoria. . . there were about 14 hospitals in Victoria that had music therapists." Firstly, the Red Cross employed Pauline Waldon who was a "Guildhall trained therapist." Then, Marvin Barg, [a qualified music therapist from the US] came to Melbourne and a "position was created for him at Willsmere" (a psychogeriatric facility in Kew).

During that time, there were many different ways to become a music therapist through the AMTA. There were different categories for an applicant's various levels of training. Category A was for people with music therapy qualifications. Category B was for people who had

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qualifications, like a Bachelor of Music degree and who through years of experience had developed sufficient knowledge and expertise to become a qualified music therapist. Lastly, Category C was for people who had no qualifications. This Category allowed people with little or no training to still practice music therapy [until it was phased out in 1984]. This was because, "in the 1970s it wasn't really common for people to go to university." As such, there "would have been a number of people [across Australia] between 1970 and 1990 who were practicing as music therapists even though they weren't trained [but had met the requirements for Certification with AMTA]." In Queensland, the Red Cross had a similar music therapy program as the one in Victoria. A number of "key people in Queensland, (such as Moya Evans, who was Certificated under Category B) were doing extensive music therapy work" and started to create positions.

In about 1986, Jeanette Milford "set up" music therapy in Adelaide after completing the music therapy course in Melbourne at what was then called Frankston State College, a teachers college (later part of Deakin University). This course had been established "to help people who were training to be teachers . . . provide music therapy in the schools where they were employed". Additionally in Adelaide, Marie Reynolds (certificated under Category B) who was "head of music for the Education Department in Adelaide . . . began music therapy programs", due to her additional interest in music and special education. Then, others such as Margaret Donald and Cheryl Trimper (also both Certificated under Category B) commenced music therapy work in South Australia.

In the early 1990s Susan Hadley and Anja Tait opened the doors for music therapy in Perth and Renate Marek, a graduate from Melbourne University, established the first program in the Northern Territory in the mid 1980s. In Tasmania, Stephanie Thompson was the first to start a program.

Bright and Grocke worked "from about 1974 to create the [music therapy] course" at Melbourne University. After much persistence from the pair, and with the help of other important figures at the University, the course was available for students in 1978. There were six people in the first group of students who graduated in 1981. Since Grocke had trained under Bob Unkefer (at Michigan State University) who adhered to a humanist perspective (as opposed to a behavioural orientation mostly favoured in the US), the Melbourne course took a similar slant. Grocke believes that her

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teaching of the course was based around "this humanist model." Subsequently, graduates of the Melbourne course (Alison Short, Jane Edwards and Alan Lem) who later worked to establish the other music therapy courses in Brisbane and Sydney also taught from a humanistic model, which is why, Grocke states, "the really strict behaviouralism, we just don't have in Australia."

Development of AMTA. Additionally, the period from 1970 to 1980 saw significant development of the AMTA. Bright and Grocke established the AMTA in 1975 and held the first conference in Sydney the same year. Bright developed the Constitution for the association, which created the structure: a national organisation with State branches. The first branches were Victoria, New South Wales (NSW) and Queensland. The other States of Australia were initially "interest groups", in Tasmania, South Australia, and Western Australia (WA). Over time, as they got bigger, they developed their own branch. Waldon, Barg and Grocke established "the ground rules for Certification as a music therapist" and then in 1977, established the guidelines for educational programs and clinical training. Each year since 1975, the AMTA has held a national conference. Conference proceedings were published, and then after "about the 14th conference proceeding" (in about 1980) the Australian Journal of Music Therapy (AJMT) was established.

The initial members of the AMTA "were very active in the 1970s." They facilitated many "workshops" in hospitals informing the public about music therapy as a profession. Grocke recalls "100 to 120 people" attending workshops and in- services. Subsequently, by the end of 1979 there was something "like [25] certificated music therapists and 300 [general] members" of the AMTA. There were many people who were interested in music therapy, "not so much to become [a] qualified music therapist but... interested in the notion, the concept of music therapy." Grocke describes these years as "good years to live through [but] it was hard, it was...very difficult."

Developments and fluctuations in clinical settings for employment. The 14 music therapy positions established in Victoria in the 1970s were mainly in institutions for psychiatric patients and children with disabilities. Then, in the 1980s a Canadian model called 'normalisation' was

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implemented in Australia, which focused on allowing those people living in institutions "the right to...a normal pattern of a day, a normal pattern of a week, [and] a normal pattern of living." Bengt Nirje who developed the principle describes this as:

> "Making available to all people with disabilities people patterns of life and conditions of everyday living which are as close as possible to the regular circumstances and ways of life or society"(Nirje, 1985, p. 67).

The implementation of the 'normalisation model' resulted in the decommissioning of large institutions around Australia. This "was done gradually over a ten year period." Patients were moved from the institutions "into either existing homes or...'cluster housing'" which were built in the community.

However, this resulted in a change of many positions that had originally been established in the institutions. "A lot of the therapies just went by the board, even occupational therapy positions were lost." Community therapy programs were created instead, but were not mandatory for patients, "which meant that people would only go if they wanted to." In the past in institutional care, attendance at music therapy was compulsory. Grocke states that since "one of the main symptoms of schizophrenia is lack of motivation [it was] not surprising that [it] didn't work so well" in the community setting! Therapists who obtained positions in the community found "it was very difficult work because there was no consistency." Also, therapy skills that were gained through working on a "really deep level" in long term "reconstructive therapy" (Wheeler, 1983) in the institutions were lost, since music therapy in the community setting was short-term and provided little opportunity for closed groups. More recently, hospitals and institutions have started to employ art and music therapists on a sessional basis. Although "a session is sometimes three hours, [there is no opportunity to] really do any long term work at all." Music therapy on a contractual basis is only now beginning to be developed in acute psychiatric care. In community psychiatric care, the problem of low attendance still remains a challenge for music therapists conducting open groups.

Developments in palliative care. When Clare O'Callaghan completed the Melbourne University course in 1982 she took a tour overseas, worked

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alongside Lucanne Magill in New York and she "also went to the McGill hospital in Canada." O'Callaghan observed how music therapy in palliative care was situated overseas, and on returning to Melbourne, created a music therapy position at Bethlehem Hospital. The program "blossomed really quickly." Later Bethlehem created an initiative which aimed to "outsource services from the hospital" and music therapy was given a grant to implement this. This "echoed out" into the other palliative care facilities in Melbourne. "Palliative care...took over [from] psychiatry in a way." Grocke believes music therapy was very strong in palliative care during this time, "mainly because of Clare and everything she did to promote music therapy" in this area.

Changes in funding sources. During 1970-1990, the classifications for music therapists included grade one, two and three. However, when "positions for specific therapies disappeared" (due to the deinstitutionalisation process), generic advertisements for 'therapist' appeared for community work instead. These generic positions incorporated all therapists in the Allied Health sector, which often meant music therapists "lost out." These therapy positions were "designed to support people in the community" and involved more case management, than therapy work.

Changes in employment conditions. Fortunately in Victoria, when many positions were lost due to the deinstitutionalisation process, the "public service board's definition of music therapy was transferred into the health professionals award", so music therapists still obtained an award. During this period, a number of positions were established in aged care settings, and for a while music therapy appeared to Grocke to be the "flavour of the month" in aged care facilities. However, there was a change in the assessment of aged care services in Australia, which included 20 categories that "defined the services in aged care." Category 19 included "specialist services that could be taught to nursing staff", which meant that the nursing staff could implement the service instead of a trained professional.

At the time, Grocke and her colleagues "argued for music therapy to be in category 20, where [the facilities] couldn't train nursing staff to do music therapy work." In retrospect, Grocke now perceives that decision as "a mistake, because all of the funding went into category 19" which meant

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that because music therapists were seen as a 'specialist service' they lost out on funding and therefore positions. Aged care facilities, "particularly small centres" perceived that it "was far too costly to employ music therapists." As a result, the facilities began to employ entertainers to provide music to residents. Grocke states, "in the last decade [we have] lost a lot of positions in aged care because they can't afford us." In conclusion, Grocke states that, although "it took a long time", she now perceives music therapy to be "very secure as a profession in Victoria."

Conclusion

The historical narrative of the development of music therapy from 1970-1990 sheds light on the early years of the music therapy profession in Australia. Recommendations for future historical music therapy studies include conducting more interviews of RMTs from within different time spans, and from each State of Australia in order to obtain a more in-depth historical account of the profession.

Professor Grocke's interview provides invaluable insight into the establishment of the music therapy profession in Australia. The excerpt offers an interesting narrative into the successes and challenges for Australian music therapists during the profession's early beginnings. Professor Grocke's influence on the profession through its establishment in the 1970s, has truly 'paved the way' for music therapy in Australia.

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