Integrating clients with an intellectual disability to the community through music therapy

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Abstract:
This paper describes one of the music therapy programmes at Perkin Arts Centre (PAC), Kew Cottages and the process undertaken in integrating the clients to the community by firstly relocating the programme to an Adult Training Support Service (ATSS) and secondly to a community facility. A description of Kew Cottages and an ATSS is given.

Introduction & Rationale

Integration is defined as: "to denote development of personality by the conscious attempt to weld into a harmonious whole its diverse aspects and abilities" (Irvine 1972 p.524).

Ely & McMahon (1990) define some of these 'diverse aspects' of integration in relation to people with an intellectual disability who live in an institution. They state that integration has three areas: "personal integration, social integration and physical integration. Personal integration is the development of relationships between staff, clients and family. Social integration is the development of attitude, confidence, respect, esteem and dignity between both parties of the relationship. Physical integration is the transition from the residential institution to the community, i.e. unit (where the clients live) to centre (day programme centre) to access and/or integration into the community" (Ely & McMahon 1990 p.36).

Ely & McMahon also state 'the enhancement of clients' potential as part of the process of integration can occur in three stages:

(i) "creatively exploring interest areas,
(ii) developing skills and
(iii) providing the opportunity for the client to access community based programmes" (Ely & McMahon 1990 p.37).

Due to the varying needs of clients and areas of integration this sequential and planned process of integration can take months or years.

The notion of integration is in accordance with the 14 Principles stated in the Intellectually Disabled Persons' Services Act (IDPS Act) 1986. The pertinent Principles are as follows:

"(b) Every intellectually disabled person has a capacity for physical, social, emotional and intellectual development and a right to individualised educational and developmental opportunities and is entitled to exercise maximum control over every aspect of his/her life;
(d) The needs of intellectually disabled persons are best met when the conditions of their everyday life are the same as, or as close as possible to, norms and patterns which are valued in the general community;

(e) Services should promote maximum physical and social integration through the participation of intellectually disabled persons in the life of the community; and

(h) Services to intellectually disabled persons should be sufficiently flexible in structure and organisation to meet the varying needs of intellectually disabled persons in developing towards independence and to maximise the choices open to them" (p.4-5).

These principles are reflected in the Victorian Health & Community Services Departmental primary aim and objectives which states:

"(1) The primary aim of the Department under this Act is to advance the dignity, worth, human rights and full potential of intellectually disabled persons" (p.6).

The relevant objectives include:

"(2f) to promote the integration of intellectually disabled persons into the community.

(2g) to promote the use of general community services by intellectually disabled persons" (p.6).

Description of Facility

Kew Cottages is a large residential institution for people with an intellectual disability. There are approximately 660 people who reside at Kew, 425 of whom receive Day Programmes from the two Disability Day Programme Centres. Kew Cottages and Disability Day Programmes, Eastern Region are both under the auspices of the Department of Health & Community Services, Victoria.

The two multi-disciplinary teams provide services with different focuses. The Sport & Recreation team provides programmes which are mainly outdoor leisure and recreation. The music therapists involved in the programme discussed, are located at PAC. The PAC team uses the arts as its medium for the provision of service. This includes music, dance, art, crafts, ceramics, cooking and sensory exploration programmes.

The programme originated in January 1993. Clients were referred to PAC to be involved in a communication and music programme. The referral came from the Unit Manager as a result of the client's General Service Plan. This Plan covers 10 different areas of client need (e.g. communication, living situation, health, advocacy, etc.). It is reviewed every 12 months and areas of priority are established according to client need. As the clients referred had communication highlighted as a need and enjoyed and responded to the medium of music, they were selected for a music/communication programme.

Clients involved had varying degrees of communication. Some communicated through speech, in single words or sentences, others communicated with vocalisations, gestures and used Compic* symbols, photos and/or Australasian hand signs (referred to as 'hand signs' in remainder of paper). (*Dictionary of Australasian Handsigns* 2nd Ed.).

**Compic is an abbreviation for Computer Pictographs For Communication. They are a standardised set of pictographs (line drawings) used with adults and children with severe communication difficulties.*

The area of communication was developed in the music therapy programme through the use of a communication board. This included photos and Compic symbols for singing, playing, listening and dancing. The communication board involved clients using the board to select an activity by pointing to a photo and then other clients matching the activity to the corresponding photo. Aims of using this method were for clients to:

(i) choose the activity of their choice
(ii) match a photo with the corresponding activity
(iii) determine the order of the activities for the session
(iv) extend means of communication for those clients without speech
(v) extend the repertoire of Compics/photos that clients recognise
(vi) transfer this skill of communication to other areas of life.

The notion of community integration for the clients in this particular music therapy programme was initiated by the music therapists at PAC after it had been running in its original format for a period of four months. It became apparent that clients had developed skills over this time that would enable them to take the next step of the integration process. These skills were:

Personal & Social Integration. Clients had increased their social network and developed a relationship of trust and respect with group members. They were able to acknowledge and recognise each other and had the confidence to make decisions regarding their own involvement.

Physical Integration. The clients had made the transition from the unit setting and were attending the programme at PAC, a centre within Kew Cottages institution.

Area of Potential. Clients had all shown an interest and enjoyment with the medium of music. They had developed the skills necessary to make the move to accessing community venues and integrating with other members of the community. These skills included appropriate social skills, e.g. turn taking, tolerating touch and participating in a group dance, sitting quietly during a listening activity, greeting each other and communication skills such as recognition of hand signs, photos and pictures, initiating choice through use of communication board, initiating a greeting.

As the clients had developed these skills their needs had changed. The music therapists perceived the reviewed needs of the group as follows:

Physical Integration: for the clients to access the program in a community based facility.

Personal and Social Integration: for clients to extend further their social network.

Development of Skills: for clients to continue to extend their means of communication through the learning and recognition of hand signs, Compics and photos.

Initiating the Idea

Staff from PAC were encouraged to visit ATSSs within the Eastern Region to investigate Day Programmes run for people with an intellectual disability at non-residential services. ATSSs are funded by the State Government of Victoria and are required to adhere to the principles and objectives of the IDPS Act (1986).

Onemda is one ATSS visited which provides day programmes with approximately 50 full-time places, for clients with moderate to severe intellectual and physical disabilities. Training and developmental programmes are offered in a variety of areas by instructors and allied health professionals.

Discussion was held with the Programme Director of Onemda regarding the feasibility of a music therapy programme combining clients from Kew Cottages and Onemda ATSS with the long term goal to run the programme at a community facility. The Programme Director and Management from Disability Day Programmes were enthusiastic and in support of the idea. They suggested that a proposal be written.

The Proposal

The proposal consisted of the following information:

Purposes Of The Proposed Integration Programme:

1. To provide opportunities for physical and social integration for clients from Onemda and Kew Cottages.
2. To increase social network and opportunities for social interaction for clients.
3. To extend opportunities for clients to access a community based facility.
4. To provide music therapy expertise and programme to clients and staff from Onemda.
5. To extend Disability Day Programme staffs' knowledge of Support Services for clients within Eastern Region.

Objectives Of The Existing Music Therapy Programme.
Description Of Clients Involved In The Existing Programme.
Description Of Existing Music Therapy Programme.

Outline Of Programme and Integration proposal:

- The Programme Director from Onemda to observe the music programme at Kew Cottages to determine the suitability of clients from Onemda to combine with clients from Kew Cottages.
- The music therapists from Kew Cottages to spend one morning at Onemda to assess the needs of clients from Onemda.

The assessment included the music therapists observing the clients in their regular morning session and then conducting some musical activities with them. This was to determine their skill level and interest in music and to begin to establish a rapport with clients. Activities included a greeting song where clients were encouraged to respond into a microphone. Songs were sung that were requests from clients or suggested by the music therapists. An instrumental activity was carried out allowing clients an individual turn with their own choice of instrument, followed by a group improvisation.

It was concluded by the music therapists that the clients from Onemda had similar needs, abilities and potential as the clients from Kew. They were able to give a greeting to the group, some were able to recognise other group members from photos, some initiated songs and all were able to choose the instrument of their choice. Staff from Onemda believed that the music therapy programme could meet the needs of the Onemda clients and were therefore keen for it to begin as soon as possible. The process to be undertaken was:

- to take the Kew clients out to Onemda to orient them to the new environment. This would include Kew clients meeting the Onemda clients, having morning tea together and then joining in a singalong;
- for the music therapists to plan and adapt the programme accordingly;
- for the programme to run for 12 weeks and then be reviewed;
- to explore the possibilities of alternate venues to hold the programme in a community based facility;
- to offsite the programme to a new facility.

Other information included the venue, time, cost, materials and equipment, transport and staff commitment.

The proposal as submitted was accepted by management of both facilities. It commenced as outlined using the proposed format.

The Music Therapy Programme at Onemda

Description of Clients

There was a total of thirteen clients involved in the programme.

- There were six clients from Kew Cottages, 5 males and 1 female. The average age was mid-30s. The clients had moderate to severe intellectual disability. All clients were ambulant, one male had a hemiplegia which resulted in an unsteady gait.
- There were seven females from Onemda. The average age was mid to late 20s. These clients had moderate disabilities. All clients were ambulant, although one female had an unsteady gait and required assistance with walking.

All clients were relatively independent. They required little or no assistance to find their way to the programme room and clients from the Cottages could easily take themselves back to the bus. They were able to toilet themselves, make themselves morning tea with minimal assistance and were also able to assist setting up the room.

The expressive communication skill varied between clients. Eight clients had speech ranging from simple sentences to single words. The other clients were nonverbal and communicated using gestures, vocalisations, basic communication boards with photos and some handsigns. All clients were encouraged to use communication boards and learn hand signs.

Clients' receptive communication skills also varied. All clients could choose the activity of their choice and then relocate the same photo when it had been placed in a different position on the communication board. Some clients were able to respond to more complex tasks, e.g. 'Go and say good morning to V.' Other clients required tasks to be broken down into simple, single tasks, e.g. 'D. Stand up'; 'Walk to N'; 'Shake hands with N' etc. All prompts and cues were accompanied by hand signs.

Clients' social skills and interaction with others also varied. Some of the clients were extremely social and initiated interaction with other clients and staff. Other clients were generally rather reserved and at times withdrawn, requiring encouragement from staff to be involved in activities. One male demonstrated ritualistic behaviours, e.g. touching every pole with the heel of his foot on the way to the

centre and smelling every instrument before passing it to another. Three females in the group had mood swings. These were often unpredictable. One female could be extremely extroverted and involved in activities and within a minute be showing no affect or response.

Client Objectives:

1. To extend means of communication (words, vocalisations, recognition of photos, Compic symbols, learn handsigns, gestures).
2. To develop social skills and group interaction between clients.
   - Initiate a greeting.
   - Recognise other clients either by name or photo.
   - Learn to take turns and to respect others' turns.
   - Develop listening skills to others during turn taking activities and to various selections of pre-recorded music.
3. To develop self confidence and self expression.
   - Extend length and volume of vocalisations, singing.
   - Explore the use and potential of different instruments, individually and within a group.
4. To develop their own independence.
   - Choose activities, instruments, songs and pre-recorded music.

Description of Programme

Clients were encouraged to prepare the room for the programme, i.e. setting up chairs and musical equipment that was required and then packing up equipment at the end of the session.

The group commenced with a "greeting" song (K. Scott 1992) to establish the beginning of the programme and also to facilitate responses. Each client initiated their own greeting as the music therapist sang 'G, What are you going to say/do?' After their individual response clients were given a photo of a client or staff and then encouraged to go and greet that person.

The order of the following activities was chosen by clients through a use of a communication board. As mentioned these included singing, playing instruments, dancing and listening to a selection of music. Clients were encouraged to initiate responses and were given opportunities for individual turns and to work together as a group throughout the activities.

Singing

Song cards with photos or pictures depicting a variety of song themes were introduced and placed on the floor within the circle. Clients took turns to choose a song card of their choice and the corresponding song was sung, e.g. Sun – 'Here Comes The Sun' (Lennon & McCartney); Train – 'Morningtown Ride' (Malvina Reynolds). Photos were initially used because they provided a two dimensional representation of an object and this was seen as the next step for clients who were able to match objects that were the same. Once this was mastered, Compics would be used. This would provide a symbolic representation of an object rather than a two dimensional photo representation and would mean another step in increasing client communication. Songs were chosen that were familiar to the clients, e.g. they had requested before or were from a similar era. Client requests were also sung.

Listening
Pieces of music were chosen by the music therapists or requests by clients were played. The length of the piece was between 3-5 minutes. Selections that were chosen by the clients included Abba, John Farnham, Country & Western, The Beatles and Buddy Holly.

Dancing
A prepared and structured dance was performed by willing participants. New steps were included as the previous ones had been mastered. It was rehearsed without music and then performed two or three times with music. Steps included standing in a circle, holding hands, swinging arms, walking in and out, clapping hands, slapping knees, walking around the circle and the final addition was walking through a human arch and reforming the circle. Bush dancing music was used. It was predictable, repetitive and stimulating.

Instruments
Clients were shown numerous hand-held instruments. The song 'We're gonna make some music' (Herbert & Gail Levin) was sung and at the appropriate time during the song each client was asked individually to select the instrument of their choice from a selection of three. Each client had an individual turn and the activity concluded with a group improvisation.

Evaluation notes were recorded at the end of each session regarding each client's responses and involvement for the session. The session plan for the following week was written with changes and adaptations as necessary.

Outcomes and Responses

The outcomes and responses were recorded as descriptive notes and were based on the authors' observations of client responses during sessions.

The programme had been running for 7 to 12 weeks when this paper was written. Since the combined programme began, clients from Kew Cottages showed an enthusiasm and excitement at attending the programme when collected from their unit.

Clients adapted well to the new environment. They were able to find their way to the room without assistance after a couple of weeks and remembered the layout of the room. Inappropriate behaviours that were sometimes demonstrated at Kew had not been observed, such as, constantly demanding staff's attention when they were working with another client, going to the toilet several times in a matter of minutes, stacking chairs in numerous piles.

The music therapists noted that since the beginning of the combined programme there had been some notable changes in clients' responses. They had demonstrated an increase in their concentration, for instance, staying in the session for the entire time. There had also been an extension of their communication skills, i.e. pointing to photos on the communication board had become more specific (using one finger instead of the whole hand) and choice of activity had become more consistent. Those clients who had speech were using more language to indicate their preferred activity, choice of pre-recorded music and naming of picture song cards.

Over the seven weeks the group had developed a trusting and working relationship with each other. They worked co-actively with each other (greetings) and tolerated extended periods of physical interaction (group dance) with each other.

Feedback from the Onemda staff regarding clients involvement in the programme was positive and supportive of the music therapy programme. They expressed surprise at several clients' musical skills and song repertoire. They also showed surprise at the interest, concentration and enjoyment of clients. Three clients stayed in the room for the majority or all of the programme.

Staff had told the music therapists that this did not occur in many other programmes at the centre. Staff were very keen for the programme to continue as they were delighted with the responses of clients. At that particular time no other staff at Onemda had the skills to run a music therapy programme.

Significant changes in several clients' responses has been observed and will be discussed in detail. A discussion of each client will highlight the development of their involvement from the programme's early stages to the present.

J.: J. had no physical disability, he was independent and agile. J. demonstrated ritualistic behaviour, he touched every pole on the way to the bus. J. would talk to himself and vocalisations rose in pitch when he was distressed. J. communicated using single words, e.g. bus, shopping, Abba.

Kew: J. was reluctant to stay at PAC for the duration of the session. He would take himself to the toilet two or three times or take himself home to the unit when distressed or nervous. This happened nearly every session for a couple of months.

His participation was limited and needed several prompts from the music therapists to join in. Initially J. did not sing. After approximately a couple of months he began to hum a melody of a song for a few seconds after it had been sung. At the time of the dance J. would stack chairs against the wall and would take several prompts to join in, if at all. If he was participating in the dance, at times he would drop hands and leave the circle. J. would hesitate before taking an instrument. He was reluctant to play it and would often hold it for a few seconds. During listening J. would sit for a few seconds and then be up and moving around the room or would go home.

Initially the music therapists were unsure about J.'s ability to cope with the transition from Kew to Onemda. With his tendency to leave the session they were concerned about what he might do in an unfamiliar environment.

Onemda: Since the transition J. sat in the circle and stayed with the group for the entire session. He would say 'hello' after the prompt 'J. What are you going to say?' He recognised clients by looking at a photo and needed a verbal prompt from staff to stand up and go and greet them. He would hum a melody during and after a song was sung. He could name picture cards that represented songs.

When asked which activity he wished to do he verbalised his choice, such as, 'Don't want to' or singing his choice of song. When asked what he wanted to listen to he stated his preferred selection, often Abba. When asked if he wanted to join in the dance J. got out of his chair, took people's hands and held them for the

duration of the dance. J. remained seated during listening and rocked and smiled when he was enjoying the music.

S.: S. was fully ambulant. He was able to follow simple, single directions, such as, 'Stand up, go and shake hands with N.' S. had a form of echolalic speech so he frequently repeated phrases that were out of context, e.g. 'hands down', 'shut up', 'be quiet'. His other means of expressive communication was through gestures and body language. He was learning to use Compics and photos to convey his needs and choices. S. sat quietly, requiring prompts to interact with others.

Kew: S. required many prompts to complete a task. When using the communication board he would use both hands and cover more than one photo at a time, or else he would look elsewhere. This made it difficult to determine S.'s choice of activity and whether in fact he was fully understanding what was asked of him. S. would participate in activities when asked and showed no particular like or dislike for any activity.

Onemda: S. anticipated his role as a group member. At the beginning of the programme the clients were involved in setting up the room and carrying instruments. S. waited at the bus until given something to carry. He then made his way to the room. When using the communication board S. pointed with one finger to one photo. In the majority of cases S. was able to point to the corresponding photo of the chosen activity.

S. still complied with instructions and joined in with all activities, however, for activities that he preferred, he initiated his own involvement, e.g. he would get out of his chair when asked if he would like to dance. He understood the concept of turn taking and would wait until he heard his name in the song and then stood up immediately to select an instrument. He swayed, rocked and smiled to music that he enjoyed, e.g. 'Daisy' (Trad.).

F.: F. was capable and independent. At times she could be very slow to complete a task or give a response. This was often dependent on her fluctuating mood. If F. was bored or had a dislike for a particular activity, she would often take her self out of the room, talk to a staff member across the room or ask for coffee.

F. communicated using speech. She used sentences and had a wide vocabulary of language. She knew the names of staff and clients from Onemda and used these to initiate interaction with them.

Onemda: After a few weeks of the combined programme F. began to show an increase in her involvement. She would leave the room only once or twice a session. She would choose an activity but would not always participate, communicating this choice through speech. F. would initiate her preferences for listening, e.g. John Farnham.

Musically F. had a steady sense of rhythm and was able to vary her playing to keep in time. F. had a wide repertoire of songs. She either initiated a song, joined in during singing or continued to sing a song after the group had finished. F. was one of the few clients who was beginning to associate songs with specific pictures and words, e.g. she would begin singing 'Morningtown ride' at the mention of the word 'train'.

M.: M. was amenable and very social with other participants. Physically she was limited as she required some assistance with walking and dancing. Her receptive and expressive communication were such that she could understand complex sentences and initiated her own ideas which included choice of activity, song and selections of pre-recorded music.

Onemda: M. was present for the assessment but was absent for the first few combined sessions. In the greeting activity, M. was very clear in giving her greeting to the group, e.g. "I would like to say, Hello". She was able to recognise all clients and staff by their photo and indicate where they were sitting. She sang during all songs and initiated her choice of music which included Buddy Holly, The Beatles and Country and Western music. On a couple of occasions she chose the dance activity. This surprised staff as her physical limitations meant that she required assistance and found it awkward to participate.

Discussion and Future Directions

The integration process as described in this report was carried out in a planned and sequential format. It incorporates the stages of physical, social and personal integration outlined by Ely and McMahon (1990), as well as allowing for the development of individual client potential. Each additional step was not taken until it had been assessed by the music therapists that clients would be able to progress and emotionally cope with the new challenges they would face.

Physical Integration:
The clients came from their unit or home to PAC at Kew Cottages. The next step was the move for the clients to Onemda, a community based ATSS.

The clients attending Onemda came from their family home or a Community Residential Unit to Onemda ATSS.

Finally all clients and the programme will move to a generic community facility.

Social and Personal Integration:
The clients were introduced to new people at PAC through the music therapy programme. The clients continued this aspect of integration when they met more people at Onemda.

Clients attending Onemda met people at the ATSS and this was extended with the introduction of the clients and staff from Kew Cottages.

This aspect of integration involved the development of trust, rapport and allowed for clients to extend their social network by meeting and interacting with other people, males and females. (Clients from Kew Cottages lived in single sex units.)

It is envisaged that when the programme moves to the new location clients' social network will expand further with members from the general community.

Development of Client Skills and Potential:
Like the above mentioned areas this is also ongoing. Challenges were presented to each individual client and extended as the previous ones were mastered. For example, if a client could successfully and consistently match a photo given a choice of two photos, then the choice would be extended to three or four photos, or

the number of cues given to assist a client to complete an activity would be gradually reduced.

The step-by-step approach of integration for these clients has so far proved successful. In the 7 out of the 12 weeks of the combined programme clients from both centres have progressed in all the stated objectives. Clients have been able to achieve by working at their own pace and to their own level of ability.

The relocation of the programme to a community facility is by no means the final step in the process of integration. It is a constant ongoing process.

It was, however, difficult for the authors to determine if achievements in the area of communication skills for the clients from Kew would have or would not have occurred if the programme had remained at Kew Cottages. There was no control group and even if there had been, the number of variables, such as the levels of the intellectual disability, the differing learning capacity of each client and the rate at which each client would assimilate new information, would be nearly impossible to control or determine. The authors wonder if J. and S. would have made the same achievements in the area of communication if the programme had remained on-site at Kew.

In the area of social skills, evaluation is not easily undertaken either. However, the new location, the meeting of new people and working in a group twice its original size created no apparent difficulties or concerns for clients from either facility.

All clients showed a development in the area of social skills. The relocation of the programme for the clients from Kew Cottages and the introduction of this particular method of music therapy for the clients from Onemda may have assisted in accelerating the development of their social skills, or turn taking, concentration and interaction with others.

What is it about music that encourages such changes and responses? Is it the fact that music is motivating, always moving and changing in its delivery and application? Or is it that music is a non-verbal and non-threatening language and does not distinguish or discriminate?

It would seem that music as a therapeutic tool was successful in this programme because of the quality and quantity of responses observed during the course of the combined programme. These included musical and non-musical responses, e.g. choosing an activity and participating in it, initiating songs, singing individually and as a group, choosing an instrument and playing it. For the clients from Onemda many of these skills had not been noticed in other programmes. The clients from Onemda had not previously been involved in a music therapy programme and perhaps the introduction to a new medium of programme meant that they were interested, curious and motivated to be involved.

For the clients from Kew Cottages, although they had been involved in the music therapy programme for the four months prior to the combined programme, their involvement, motivation and interest continued and increased from session to session. The clients had originally been referred for a communication program by the Unit Manager who had indicated that music was enjoyed by these clients and

may be successful in meeting their needs. The authors would agree, that in this instance, music had been a powerful and inviting means to achieve.

It was envisaged that the programme would continue in its present format for a further five weeks. After this, a review would be carried out by Kew Cottages and Onemda staff. As previously stated, staff were keen for the programme to continue for the clients' enjoyment, interest, and development of skills which showed much potential.

As outlined in the proposal the next step in integrating clients into the community was for the programme to move to a community setting, possibly a Neighbourhood House or Community Centre. This was yet to be researched and funding would be a contributing factor in negotiating the venue.

There are some issues for the authors to consider as they plan this next step. When the program is relocated to a community facility, the clients will be taking the next step as outlined in the planned and sequenced format of integration. Will this mean physical and social integration with members of the general public or access only to a community facility? Will members of the general public access or participate in a programme with people with an intellectual disability? It is not to say that they would not, but if they did, the focus of this particular music therapy programme would need to change to incorporate interests, skill level and needs of the general public.

Other questions that arise for the authors as they continue this programme of integrating intellectually disabled people with the general public are, 'What role will the general public have in an integrated group?' and 'What are the educative strategies, if any, that need to be put into place for the public, so that an understanding, supportive relationship is there for people with disabilities and not necessarily a sympathetic one?'

These questions are at present unable to be fully and comprehensibly answered by the authors. They are left for the reader to ponder and hopefully resolve as the process of integration continues. The authors do believe that one way in which integration can be more fully and wholistically achieved is if we, the general public, accept people with disabilities for the persons they are and not for their disability. This is a big undertaking and one that is not easily or quickly achieved.

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