Towards integrating a holistic rehabilitation system: the implications for music therapy

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Abstract:
The philosophy underpinning rehabilitation services is continually evolving (McGrath and Davis, 1992). Music therapists, like all health professionals, respond and adapt to accommodate these changes to ensure their role in these structures is secure. This process of adaptation is particularly important for the music therapy profession as it is not currently recognised as an essential service in rehabilitation facilities in Australia (Milford, 1993). This paper explores the impact of an altered treatment ideology (from multidisciplinary to interdisciplinary) on music therapy clinical practice in a 63-bed rehabilitation facility specialising in the rehabilitation of clients with an Acquired Brain Injury (ABI), mostly through road trauma.

Research conducted in England by McGrath and Davis (1992) in a rehabilitation facility contemplated the effects of such a change in treatment philosophy. The Interdisciplinary Rehabilitation System (IRS) model was applauded by McGrath and Davis (1992) for its capacity to empower the client and family in the treating process; and in its attempts to provide a consistent and streamlined team focus to treatment. This treatment framework was implemented at the Ivanhoe Manor Private Rehabilitation Hospital (IMPRH) in 1995, to supersede the existing multi-disciplinary model. This paper describes the continual shaping of music therapy practice to operate efficiently within the new model. Emphasis has been placed on the struggles, oppositions and challenges faced, and the consequent impact of these factors on music therapy practice. To date, there have been no written accounts in existing literature of music therapists’ experiences in adapting to a change in treatment ideology within rehabilitation services. The need for continued documentation in this area is paramount, as the effects of this change in treatment philosophy has had far reaching ramifications. Even at this point in time, 3 years post the initial adoption of the IRS, the accommodation and integration process by the entire team continues to progress. The authors emphasise that the issues and experiences discussed are specific to the facility described. It is not intended by the authors to apply generically the information discussed herein to all rehabilitation facilities.

Identifying the need for a change in treatment ideology.
The music therapy department has been in operation at IMPRH since 1993. At that stage, a multidisciplinary treatment model was in operation. Within this model, health care disciplines functioned as separate entities on the treating ‘team’. Each discipline focused on the assessment and treatment of a specific component of the client, often independently of other disciplines on the team. Consequently, programs were directed at impairment and disability minimisation. For example, the speech pathologist generally would focus solely on swallowing and communication issues. An assumption is made within multidisciplinary orientations as to
the correlation between disability and handicap reduction. This is generally not
the case (IRS Manual, 1995). Reducing a client's handicap, for example, may
involve teaching them to put on a pair of socks. By increasing the client's ability
to touch their toes (disability minimisation) does not necessarily result in a reduc-
tion of handicap. Other factors, including motivation to decrease the handicap,
planning skills and upper limb function, all contribute to enable the client to put
socks on their feet. These factors may be ignored in the multidisciplinary approach.

Towards the end of 1993, a group of health professionals providing therapy ser-
vice at IMPRH began to identify and express problems associated with the multi-
disciplinary system. A committee was formed to examine concerns with the former
treatment model, and it identified the following inadequacies:

- within a multidisciplinary framework the client was expected to achieve multiple
goals for each discipline, some of which were in conflict with goals set by other
disciplines;
- inconsistencies in treatment approaches adopted by each discipline often
produced inconsistencies in patient behaviour;
- difficulties were experienced by clients in the transference of skills to different
settings;
- with the treatment focus hinged on disability minimisation, the functional
relevance of programs was not always apparent, and
- there was little concept of the whole client embodied within the treatment
approach, resulting in an emphasis on rehabilitating components of the client.

After almost 12 months of research and review, the Interdisciplinary Rehabilita-
tion System (IRS) was implemented.

A comparison of the multidisciplinary and interdisciplinary rehabilitation
systems (IRS)
The IRS derives its ideology from a handicap-directed approach. Treatment orienta-
tion focuses on the attainment of significant and valued roles as identified by the
patient and family/significant others. On entry into the IRS, the client is assigned
to one of five streams according to his/her clinical presentation and prevailing
needs: high dependency, post-traumatic amnesia, rehabilitation, maintenance and
community. Clients are reassigned to a different stream as changes occur in their
status. In conjunction with this initial process, consultation ensues with the client
and family to identify an appropriate program classified according to 'life role focus
areas'. Two to three focus areas are selected to form the basis of the rehabilitation
program. Interdisciplinary goals are set according to the chosen focus areas and
these guide the general direction of the client's rehabilitation program. Discipline
specific goals are then formulated to address these goals. The basic differences in
treatment service from a multidisciplinary to an interdisciplinary treatment model
will be highlighted using a fictitious case study, "Sylvia".

"Sylvia" is a thirty-three year old woman who was involved in a head-on motor
vehicle accident in which she sustained a severe closed head injury (C.H.I.). Result-
ing injuries included a left hemi-paresis, lacerations to her face and legs, multiple
fractures, and poor vocal control. Prior to her accident she was an avid gardener.
and florist, who enjoyed outdoor activities and co-owned a busy florist in Melbourne. Some of Sylvia’s sustained impairments included:

• a decreased sense of balance;
• deficits in right hand functioning; and
• poor motor planning skills.

A multi-disciplinary directed program provided a structure for each discipline to work towards the minimisation of Sylvia’s impairments, as separate entities. Typical disciplinary goals would focus on rehabilitating various “parts” of the patient.

• to increase range of movement (physiotherapy [PT], occupatational therapy [OT]);
• to increase muscle tone (PT); and
• to increase voice volume (speech pathology [SP]).

However, in an interdisciplinary directed program, the primary focus is to enable Sylvia to assume various roles in the community. Sylvia’s role as a florist/gardener was identified as being important and presently unfulfilled. Interdisciplinary goals were established by the team and directed to the chosen focus area:

• Sylvia will be able to independently ambulate and maintain her balance on a number of different outdoor surfaces (PT, OT, recreation [Rec], nursing, music therapy [MT]);
• Sylvia will be able to plan, organise and arrive promptly for all appointments (SP, neuropsychology [NP], MT, PT, OT, nursing and Rec); and
• Sylvia will achieve and maintain a grasp when utilising gardening tools of differing diameter, shape and weight (NP, Rec, MT, OT, nursing and PT).

Through regular sharing, communication and a consistent team approach, it is envisaged that on conclusion of the interdisciplinary directed program, Sylvia will be able to fulfill to some degree her life role focus, including her role as a gardener. In contrast, the multidisciplinary approach was not functionally based, merely enabling Sylvia to reduce her impairments and disabilities.

Identifying the challenges in adapting the music therapy program.
The adoption of the IRS into each discipline’s clinical practice is an ongoing process. As part of a quality management project at the end of 1996, the music therapy department assessed the change in service effectiveness prior to and following the inception of the IRS. Staff perceptions of the music therapy department were examined. This information was collated in 1996 from two questionnaires, which were distributed throughout the hospital to nursing, allied health and medical staff. The first questionnaire was completed by all staff; the second, completed by staff who were employed at IMRH prior to the introduction of the IRS. The results collated from both questionnaires were compared with the insights acquired from a Quality Assurance project investigating the “Staff Knowledge of Music Therapy” conducted by the department in 1994.
In 1994, 40% of staff understood the benefits of music therapy, and 30% of staff asked the music therapist to address related goals in the music therapy sessions. These results highlighted the initial challenge for the music therapy department to cement its role on the treating team. Compared with the statistics collated in 1996, (60% understood the benefits of music therapy, 77.7% had communicated their goals to the music therapist), it appeared that the other team members were aware of the music therapist’s role regarding clinical matters and indicated that this initial goal had been achieved.

Further challenges in aligning the music therapy service within the IRS format were highlighted by the study and included: addressing the adjective — conjunctive label; consultation with the Music Therapy department by other team members; addressing psychosocial oriented goals; the development of functional based programs; the impact of multi-skilling; and fusing medical and music therapy knowledge bases.

Meeting the challenges in adapting the music therapy program.

a) The development of functional based programs

Attempts to supersede music therapy programs (formerly focused on impairment/disability minimisation) with a handicapped based functional approach proved to be an enormous task. A reconstruction of existing approaches to clinical practice was needed to view programs according to ‘life role’ outcomes. Initially it was an overwhelming task to imagine designing programs to assist the redevelopment of tasks such as how to operate a washing machine; put on a pair of shoes or catch a bus to a local shopping centre. After considerable time and revision, our service delivery evolved to see beyond the final product. Programs were constructed to focus on improving various components of a target skill and then integrated to correlate with functional improvement. These targeted components are identified by the team, common strategies formulated and music therapy programs are devised to redevelop these skills and strategies.

The case study of “Jane” illustrates the provision of functional oriented music therapy programs within the interdisciplinary team approach. Jane sustained a severe closed head injury following a collision with a motor vehicle. She sustained severe physical, communication and cognitive deficits including difficulties in self-monitoring, impulsive behaviour, lack of insight, problem-solving and motor and balance coordination. An issue raised in Jane’s team meetings related to her ongoing unsafe behaviour during wheelchair transfers, and when independently travelling in her wheelchair. This behaviour included a tendency to forget to engage her brakes, not using her seatbelt correctly, and attempting unsafe transport routes while travelling in her wheelchair. Strategies to promote safer wheelchair behaviour were devised by the PT and conveyed to the team. The music therapist incorporated these strategies into a safety song, which functioned as a memory and learning tool. Team members were informed and given a copy of the song to facilitate consistent carry over in a variety of hospital settings. Utilising a team focus to achieve functional tasks, for example, “Jane’s” wheelchair safety issues, worked with great success. The case study of “Jane” clearly illustrates the focus placed on functional outcomes employed by the treating team. Through invocation of...
the IRS, Jane improved in her foresight of potential risks contained within different situations; and was able to safely and independently utilise her brakes and seatbelt.

b) Addressing psychosocial oriented goals

The challenge of addressing psychosocially oriented goals, unlike the other challenges discussed has not stemmed from the implementation of the IRS. This area of concern has manifested within the behavioural treatment philosophy employed by the facility, and has been intensified by the adoption of the IRS. While the IRS provides for a positive emphasis on functional outcomes, psychosocial aims are sometimes neglected within this framework, and it is not always appropriate to focus on psychosocial issues with the client. Clients may not have the cognitive prequisites needed to process the issue(s) as a result of the deficits sustained in areas of reasoning, problem solving, insight and short-term memory. Without this processing ability, resolution of psychosocial issues is near impossible and impractical.

Sometimes psychosocial elements of treatment can be incorporated within the IRS framework however. Liz sustained a severe closed head injury resulting in deficits in verbal reasoning and problem solving; expressive language initiation; and insight, in particular her changed role within the family, post accident. Liz was unable to initiate logical expressive language and tended to catastrophise unexpected events. The cumulative effect of these deficits distorted Liz’s perceptions of the severity of unexpected situations. A music therapy song folio containing original songs composed by Liz (during music therapy sessions) was initiated within the music therapy program. The folio recorded significant weekly events experienced by Liz and became an external record and memory cue of Liz’s treatment process. Subsequent to discharge from music therapy, a concurrent emphasis on psychosocial and ‘functional’ related goals within the treatment program revealed the dual achievements attained. Improvements were observed in Liz’s ability to logically debate her point of view and to listen to others (worked on in conjunction with the SP); tolerance of others when in conflict situations (targeted in conjunction with the social worker and SP); and the ability to utilise practical strategies (relaxation exercises, or verbal problem solving) when faced with a potential conflict situation. The improvements noted demonstrate the functional relevance of psychosocial oriented treatment in attending to the patient as a ‘whole’. It may be argued that input from a single discipline, for example social work, music therapy or speech pathology facilitated this change for Liz. However, within the IRS framework, this is irrelevant as all disciplines work together as members of the same team, not merely as affiliated clubs. Other team members were presented with copies of songs written by Liz in music therapy. These were used, for example in social work sessions as a starting point for discussion. This example of liaison between team members, for example the social worker and music therapist, enables consistent follow through of treatment objectives and allows each team member to draw on the specialised skills brought to the team by each discipline.

Educating the team and funding body as to the importance of psychosocially directed therapy in combination with the present treatment program represents an ongoing challenge. The music therapy service continues to provide psychosocially oriented goals when appropriate, aiming to highlight to the team the obvious functional relevance.
c) Fusing the medical model and music therapy knowledge bases
Defining and communicating music therapy’s function within the treatment process in a form valued by the team continues to challenge us. Problems arose when trying to fuse music therapy knowledge bases with the prevailing medical model in which the hospital operates.

Staff comments arising from the questionnaire distributed in 1996 were indicative of a prevailing perception of music therapists as inexperienced and unqualified to assign functional improvement measures in assessment and treatment evaluation. This perception deterred other disciplines from seeking the clinical opinions of the music therapist. Being unable to provide complementary insights into client status in clinically specific or quantifiable terms worked to exclude the music therapy department from clinical discussions. This predicament was addressed through a number of initiatives.

Firstly through the development of a concise music therapy referral form. This revised referral form aided the fusion process by increasing staff knowledge bases regarding music therapy’s ability to address various handicap areas within rehabilitation programs. Subsequent to the introduction of the new referral form, there was an increase in client numbers referred to the service implying increased staff confidence in referring patients to the service.

Secondly, ongoing formal and informal education was provided to hospital staff regarding areas that music therapy can offer, from a therapy based in creative arts. Songs written in therapy, insights gained, and goals achieved were shared with team members to inform them of music therapy programs provided. From our perspective it was important to not devalue the musical knowledge and terminology that we brought to the team. Continuous engagement in hospital based and external professional development increased our clinical knowledge bases to aid our alignment within the prevailing medical model. Describing functional skills attained within a musical framework infuses these knowledge bases. For example the music therapist demonstrated how improving a client’s ability to tap his feet to the music might relate to skills being redeveloped in the physiotherapy program.

To exclude or under utilize this creative art knowledge would undermine music therapist’s professional integrity.

(d) Addressing the adjunctive — conjunctive label
Alter ing staff’s perceptions of the music therapy service to combat the ‘adjunctive’ label was a difficult challenge. Arising from data analyzed in the questionnaires (1996), this label was understood to imply music therapy’s inability to ‘stand alone’ on the treating team. Questionnaire data indicated the assumptions that other disciplines generally directed the music therapy programs. Initially this was perceived as disheartening by the music therapists. However in an IRS oriented approach, the team aims to combine skills and resources to ensure a holistic rehabilitation treatment. The emphasis of the ‘stand alone’ status is a concept entrenched in multi disciplinary philosophy, and is one that needs to be dissolved to provide a balanced rehabilitation program. By constantly demonstrating the value of the music therapist as an equal team member, it is anticipated that music therapy will transcend beyond this role.
The case study of "Margaret" highlights the potential conjunctive status for music therapy on the team. Margaret received a CHI resulting in severe dyspraxia. A joint music therapy and speech pathology program was implemented utilizing a modified melodic intonation therapy approach (Sparks and Holland, 1976). Trigger phrases constructed by the speech pathologist were set to music by the music therapist, and rehearsed by Margaret. On one occasion during the music therapist's absence, the speech pathologist introduced three melodic trigger phrases. The words of each phrase were similar in rhythmic structure and motivic nature, not aiding retention. Margaret consistently confused the new trigger phrases. This incident reinforced to the team the music therapist's specialized knowledge and practical skills about musical structure and its relationships to learning.

(e) **The impact of multi-skilling:**

Sharing insights and client specific information with other team members was not a difficult task for the music therapists to accommodate. The method-based title of the profession, with no specific 'part' of the client to treat, led the music therapists to practice in an interdisciplinary influenced mode prior to the implementation of the new system.

The practical application of an interdisciplinary model of treatment is exemplified in the concept of multi-skilling. As was highlighted in the previous case studies, within the IRS ideology, music therapy often crosses areas of specialty addressed by other disciplines. Conflicts have arisen where team members perceived music therapy to over-step professional boundaries, a perception substantiated by comments made in the 1996 questionnaires. This is indicative of a difficulty in accepting the teamwork concept. When several disciplines converge as an interrelated team, as opposed to being affiliated clubs, comes the delicate scenario of skewed professional boundaries. It demands each discipline's heightened awareness of the role and value of each discipline's contribution to the team. For effective client treatment within the IRS approach, each discipline shares information freely with other team members. To reach this stage demands each discipline to be secure within their professional boundaries and ideally they do not concede any professional status by sharing discipline specific information.

Tenets must be formulated and maintained, to secure professional boundaries between, and suitable to each discipline: (1) each discipline defining their role and "areas" of treatment provided on the team; (2) team member's heightened awareness of boundary issues and discipline protectiveness ultimately leading to comfortable and willing sharing of information; and (3) policy(ies) safeguarding dangers of multi-skilling. Fuelling this scenario, particular to music therapy is its lack of specialty. Redefining and securing boundaries for the music therapy department is a comprehensive and complicated process. Until this has been established, conflict may prevail. This future challenge awaits attention.

**Conclusion**

The IRS has and continues to provide a structure for client centered treatment in which the team provides programs with an emphasis on increasing functional skills. This treatment structure continues to be improved by an increase in communication between the various team members and the gradual accommodation
and integration of this new treatment philosophy by all staff. This change had and continues to have major implications for the music therapy department. As the IRS continues to be accommodated into active treatment by the entire team, refining the music therapist's skills in the provision of functionally based programs continues. Measures employed to address the many challenges in adapting to the IRS philosophy and practice include: the development of functional based programs; promoting the importance of psychosocial aims; integrating our music therapy knowledge bases within a medical model; combating the adjucative label; and recognizing and addressing issues associated with multi-skilling. These areas continue to require ongoing monitoring and review to ensure that music therapy remains an essential and valued service to IMPRH. Postulated future challenges for music therapy lie in addressing the adjunctive therapy label, perhaps coming to a decision of where the music therapist's skills can be best utilized on the team within the interdisciplinary orientation. These challenges aid in our efforts made to continue to facilitate the fusion process and to further sculpt the role of music therapy on an interdisciplinary rehabilitation treating team.

References


