



## Article

# A voyage of discovery: From fulfilling funding criteria to revealing a clearer vision for music therapy in a special needs school

Claire Cartwright

### ABSTRACT

In the era of the evidence-based practice (EBP) movement, music therapists are increasingly asked to provide evidence for funders. Often this has been the requirement to “evaluate existing services, or to justify the creation of new services with ‘appropriate’ evidence” (Pavlicevic, Ansdell, Procter & Hickey 2009: 3-4). Youth Music Initiative|Creative Scotland (YMI) awarded funds to Nordoff-Robbins Music Therapy in Scotland to support music therapy services for a number of schools in a local council area in Scotland. As part of this funding, they requested a service evaluation of one of these schools. The first part of this paper describes this evaluation (conducted in 2013) of the music therapy service in a school for pupils with complex needs. The evaluation aimed to assess the impact of music therapy on the pupils and the school and to ensure the quality of the service. The second part of the paper discusses the process of meeting an additional request from the funders which came after the completion of the evaluation. This time, all of the schools under the umbrella of this funding block were each asked to provide information to prove eligibility to access this funding to ensure funding renewal. Case studies and the evaluation findings are used to help illustrate how music therapy meets the funder’s goals. This process led to the development of a model for a continuum of music provision in the school. This paper aims to demonstrate how the funding journey not only ensured the continuance of music therapy but actually resulted in a clearer vision of the role of music therapy in the school.

### KEYWORDS

music therapy; funding; vision; service evaluation; music education; complex needs

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## INTRODUCTION

Music therapy in the 21<sup>st</sup> century continues to grow and prosper. However, funding is as ever an integral factor in the establishment and continuation of music therapy services. Funders increasingly require evidence of the quality of the service and confirmation of how their funding criteria are being met (Miller 2014). This is something we, as music therapists, need to engage with so we can continue to provide music therapy to our clients. However, the process of evidence gathering can be time consuming and is often met with apprehension by practitioners. In fact, in 2004 Pavlicevic, Ansdell and Procter published *Presenting the Evidence: A Guide for Music Therapists Responding to the Demands of Clinical Effectiveness and Evidence-Based Practice* in response to the increasing anxiety and pressure felt by our profession to “demonstrate the value of the services they provide, or to justify with appropriate ‘evidence’ the creating of new services” (Pavlicevic et al. 2004: 4). At times it can feel as if we are being asked to categorise, define and present music therapy in ways that do not feel altogether satisfactory. In the evidence-based practice (EBP) movement, one of the most highly regarded methods of measuring effectiveness is randomised control trials (RCTs). Qualitative methods, on the other hand, feature at a lower level in hierarchies of research standards (Pavlicevic, Ansdell & Procter 2004). Yet it is encouraging that qualitative research is beginning to gain more credibility, as discussed in the second edition of *Presenting the Evidence* (Pavlicevic et al. 2009) e.g. the government’s report *Quality in Qualitative Evaluation* report and the recently set-up Campbell Collaboration which “[...] can be seen as the counterpoint to the Cochrane Collaboration, with its framework and protocols for systematic reviews of qualitative research evidence [...]” (Pavlicevic et al. 2009: 16). However, RCTs are still widely considered one of the gold standards but are not easily undertaken in music therapy research for a number of reasons including the large sample size needed and the nature of improvisation in many music therapy models which means difficulty in replicating studies (Pavlicevic, Ansdell & Procter 2004). Some music therapy researchers are exploring RCTs (Erkkilä et al. 2011; Geretsegger & Gold 2012; Gold et al. 2014; Porter et al. 2012; Rolvjord, Gold & Stige 2005). However, such research projects require a lot of time and resources, and they are not generally feasible for those with busy clinical workloads when asked to provide evidence to funders. There is often little

time available outside the actual service provision and we may only have access to a small client base as a sample size. Therefore, evidence out of necessity must occur on a smaller scale.

This article hopes to demonstrate that by undertaking to provide evidence for funders and meet their requirements, music therapists might not only fulfil the needs of the funders but also gain further insight into their own clinical work. This article illustrates how my journey into meeting funding criteria led to a clearer vision of the role of the music therapy service within a school.

This journey began when Youth Music Initiative | Creative Scotland (YMI) awarded funds to Nordoff-Robbins Music Therapy in Scotland to support music therapy services for a number of schools for pupils with additional needs in a local council area in Scotland. As part of this award, YMI requested an evaluation of the service at one of the schools they were funding as an indicator of the quality of work and the impact of music therapy on the pupils. An evaluation study is one of the achievable strategies outlined for practising clinicians to meet the demand for evidence which is “geared explicitly to give a value judgement on the music therapy service” (Pavlicevic et al. 2009: 44). Examples of other evaluation studies in music therapy include Moss (2003), Powell (2006), Rowland and Read (2011), Lawes (2012) and Foster, Wiseman and Pennert (2014).

The evaluation was chosen to take place at a school which caters for pupils with sensory impairments and complex needs, for which YMI were part-funding the music therapy service. The school in question is a co-educational, inter-denominational school catering for children and young people aged 2-19 years old. Most pupils have a visual and/or a hearing impairment. Pupils also have additional learning difficulties and/or complex needs. The school has a vibrant music department and a number of on-site specialists amongst the multi-disciplinary team including nurses, physiotherapists, a speech and language therapist, a visual impairment specialist, a hearing impairment specialist, a mobility specialist and so on. The school also offers a range of therapies including rebound therapy, massage therapy and equine therapy.

The school has had a music therapy service since 2011. Funding has come from a variety of sources and with that, service input has increased from an initial 4 hours to 8 hours. The service is provided over 2 days. I provide a combination of individual music therapy, work in pairs and some small groups. The number of individual and group

sessions varies according to referrals and needs of the pupils. Due to the complex learning, physical and medical needs of many of the pupils, there are often staff members present in sessions. As well as support staff accompanying pupils, teachers or specialists have sometimes sat in to observe and nurses have often been in and out to deal with medical needs. Therefore, a large number of staff have direct experience of music therapy. At the time of the evaluation, there were 19 pupils attending music therapy: 4 individual sessions, 4 groups of two, 1 group of three and 1 group of four pupils.

The first part of this paper details the evaluation process and sets out its findings. This evaluation was carried out as part of the conditions of receiving funding for a number of schools but is specific to the school in question as requested. The evaluation is communicated here as one part of the overall process of meeting funding criteria.

A few months after the evaluation, when considering funding renewal, the funders requested further information to illustrate how music therapy was eligible for this source of funding. The request was made across the board to all of the council schools receiving funding from this award (including the school where music therapy had been evaluated). This request was separate to the evaluation which was not about funding eligibility but rather about the impact of music therapy. The second part of this paper therefore deals with how this request was met. It outlines the three aims of the funding body and discusses how I, in collaboration with the music specialist, set out to explain how music therapy could meet those aims. Both case studies and the findings of the evaluation are utilised to support the case of music therapy as an appropriate means of achieving these aims. The discussion around the aims also resulted in the creation of a model of a continuum of music provision in the school, enabling the full potential of the music therapy service and of the pupils to be achieved. It is hoped that this proposed continuum of music provision can be of use to others working in settings with a variety of musical inputs, as a means for helping identify the roles of these different provisions.

## **PART 1: SERVICE EVALUATION**

### **Aims of the evaluation**

The purpose of the evaluation was to assess the impact of music therapy on the pupils and the

school as a whole. The evaluation also aimed to ensure the quality of the service and identify areas for improvement.

### **Evaluation design and method**

The evaluation sought to explore the impact of music therapy from the viewpoint of staff and parents. Due to the complex nature of their communication needs, it was not possible to get pupils' feedback. There would have been time constraints associated with meeting staff and parents individually for interviews or through focus groups. Also, as I was in the dual role of music therapist and evaluator, it may have proved difficult for staff and parents to answer questions openly. Therefore, a questionnaire seemed the most appropriate method of data collection in order to reach a wider number of participants, as well as to generate more honest answers and to ensure anonymity. A questionnaire would also have taken less time for participants to undertake and could be filled out at their convenience. Sampling was purposeful due to the necessity of targeting parents whose child had experienced music therapy and staff who were working in the school where music therapy was being provided.

Due to the different kinds of involvement with the music therapy service, two questionnaires were designed: one for staff (Appendix A) and one for parents (Appendix B). The staff questionnaire was based on a previous evaluation project for a different school which was carried out by another member of the Nordoff-Robbins Music Therapy in Scotland team. This previous project included the same type of aims as the one currently being discussed. This also meant that the questionnaire had been trialled before and proved a useful method of collecting data. Some questions needed minor alteration in relation to the context of the school. In the previous evaluation study responses were collected from pupils (not parents), as the communication abilities of the pupils enabled them to give appropriate feedback. However, as this study included parent responses instead, I designed a separate parent questionnaire accordingly.

Questions intended to assess the impact of music therapy on the pupils were the same in both staff and parent questionnaires. Warm-up questions differed (due to context) and questions with the purpose of understanding quality of the music therapy service (particularly in relation to communication with myself as the therapist) were different in the two questionnaires, as the forms of

contact I had with parents and staff were not the same. The language and construct of each question in both questionnaires was carefully assessed to avoid leading the participants towards certain answers and to provide opportunity for both positive and negative comments. I also shared draft versions with my line manager, the regional head music therapist at Nordoff-Robbins Music Therapy in Scotland and the head teacher at the school, to ensure the clarity and structure of the questionnaires.

The questionnaires used a combination of open and closed questions. The closed questions gave the opportunity for numerical data, which could provide concise results for the funders and a broad overview of the impact of music therapy and the quality of the service. The open questions provided room for narrative data in order to better understand the impact of music therapy through the experience of the staff and parents and to allow suggestions for improvement. This resulted in a rich corpus of data.

### Data collection

Staff's and parents' questionnaires were made available electronically via SurveyMonkey. Paper copies of the staff questionnaire were also available from the school reception. Although this meant the questionnaire was available to all staff who had access to the reception, it is unlikely staff without direct knowledge/experience of the music therapy service could have answered the questionnaire. Paper copies of the parents' questionnaires were posted out. One copy was sent per household. However, in hindsight, two copies could have been sent to gain the perspectives of both parents – where applicable. Participants were given information about why the evaluation was taking place and how results might be used. Participation was voluntary and anonymity was ensured. Descriptive statistics and thematic analysis were used to analyse the collected data.

### Limitations

1. The evaluation results are localised to this service and due to the small sample cannot be generalised.
2. Participants' awareness of the evaluation aims may have influenced their views. However, answers appear genuine, stemming from actual events and many (in particular with regard to areas of impact) can be confirmed via clinical notes and video recordings of sessions. Gaining

the view from both staff and parents also acted as triangulation.

3. On SurveyMonkey, questionnaires were set to allow only one response per computer. However, due to paper copies being available too and the paper copies not being individually handed out, there was potential for duplicate responses. Although, this did not seem apparent during analysis as the combination of answers varied.

## Description of respondents

### Staff

There were 30 members of staff who either worked with a pupil who attended music therapy, or had experience of music therapy through observing or attending sessions with pupils. It is unlikely that staff would have completed the questionnaires without direct knowledge or experience of the service; therefore this was taken as the probable number of staff who could have answered the questionnaire. Fifteen members of staff returned questionnaires (Figure 1) giving a response rate of 50% (77% were paper responses and 23% by SurveyMonkey). The majority of the respondents (87%, n=13) had either accompanied pupils to music therapy or observed a session. It is possible that their more direct involvement motivated them to take part in the evaluation project. It also allowed them to give insight based directly on their observation of pupils' responses. The remaining 13% (n=2) worked with a pupil who attended music therapy and had met me in relation to a pupil's progress in music therapy. Almost half of respondents (47%, n=7) had also attended a music therapy presentation for staff.

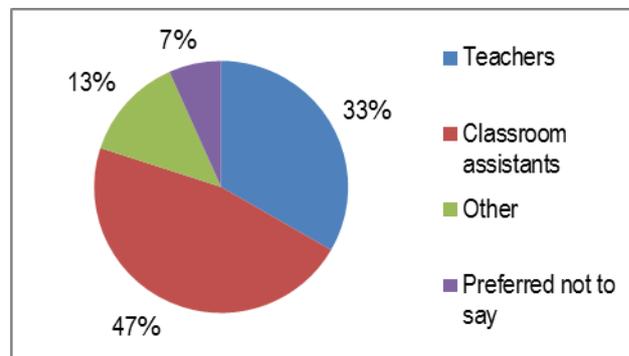


Figure 1: Designation of staff respondents

### Parents /carers

There were 19 pupils who attended music therapy at the time of this evaluation. Of these, 9 parents/carers responded, giving a response rate of 47%. All responses were via paper questionnaire copies.. Of those who responded, 77% (n=9) had previously attended a music therapy feedback meeting (which included video extracts of their child’s sessions), perhaps suggesting that more contact with the service and with me motivated parents to take part in the evaluation project or helped them to feel they could contribute more to the questionnaire.

### Findings

#### Music therapy’s impact on pupils

Figure 2 outlines the perceived general impact of music therapy on the pupils according to staff and parents.

In addition to this, 100% (n=9) of parents wanted the music therapy service in the school to continue. (This question was not included in the staff questionnaire due to limitations of number of questions and restrictions of free version of SurveyMonkey).

Table 1 outlines the key areas of impact identified and provides examples of quotes pertaining to each area.

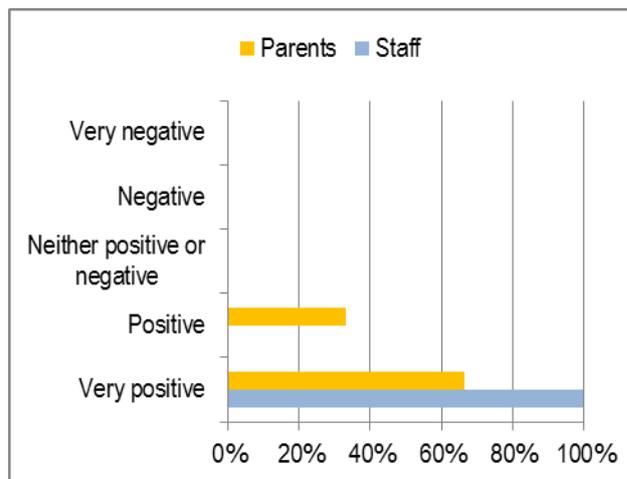


Figure 2: Impact of music therapy on pupils

Key areas of impact	Examples of quotes
<b>Confidence</b>	“The children I accompanied to a session have got more confident and respond a lot more to music” (Staff).
<b>Focus</b>	“Definitely more focussed” (Staff).
<b>Responsiveness</b>	“Both children who attend respond really well to the music session. There are times when sometimes they are sleeping and as soon as the therapist starts playing the hello song both children smile. Children become quite vocal when the therapist asks them to sing.” (Staff). “See children reacting differently during music therapy sessions” (Staff).
<b>Developmental skills</b>	“Some of our most physically challenged pupils [show] reactions and make movements outwith their normal range to gain the musical reward” (Staff). “If the children are happy, content, and reaching developmental milestones like touching to explore, grasping and holding and turn-taking then an activity like this is worth its weight in gold” (Staff).
<b>Emotional impact i.e. relaxed, peaceful, happy, enjoyment</b>	“I know my daughter enjoys music therapy from the feedback I have received from teachers and looking at videos, she seems to get pleasure and enjoy her time there” (Parent). “...the chance to experience something innately pleasurable and relaxing” (Parent). “Children whom appear a little distracted generally within their school day tend to relax and appear peaceful” (Staff).

<b>Motivation/ anticipation</b>	<p>“This pupil can be very reluctant to go to certain activities but he is always keen to go to music therapy which is a very good indicator that he enjoys it” (Staff).</p> <p>“Music therapy plays a huge part in the children’s life within my class, they all enjoy it very much and look forward to it each week” (Staff).</p>
<b>Self-expression/ communication</b>	<p>“Music therapy allows my child to express themselves. As they are non-verbal this is hugely important” (Parent).</p> <p>“It provides the pupils freedom to express themselves with no restrictions” (Staff).</p> <p>“Music therapy provides my son with <i>so much fun</i>. He is able to communicate non-verbally for more or stop by using facial or body expressions. Music is such a big part of our family life and ... it has taught us how to cope with many of my son’s highs and lows” (Parent).</p>
<b>Turn-taking</b>	<p>“Pupil has become more aware of turn-taking. He patiently listens to other children play and reaches out when his name is said to find the instrument” (Staff).</p> <p>“A pupil who came to the school who was unwilling to take turns has learned to wait and anticipate when the therapist is working with him” (Staff).</p>
<b>Self-belief and self-esteem</b>	<p>“It makes them feel good about themselves” (Parent).</p> <p>“Music therapy is invaluable to children with sensory needs and the experience is life enriching, providing the child with self-belief” (Parent).</p>
<b>Experience of new sounds and instruments</b>	<p>“It provides an environment where fantastic musical instruments are accessible to my daughter that she wouldn’t normally have access to” (Parent).</p>
<b>Vocalisations/use of voice</b>	<p>“A number of the children have been very vocal during sessions” (Staff).</p> <p>“With two children they have learned to use their voices. Another child also often makes sounds in the key and intonation which the therapist has used” (Staff).</p>
<b>Choice-making</b>	<p>“Helps with their everyday skills, i.e. choosing” (Staff).</p> <p>“Pupils confidence in self-expression when choosing and playing instruments” (Staff).</p>
<b>Motivation for exploration of instruments and moving out of comfort zone</b>	<p>“One pupil never liked leaving the piano, but as the weeks progressed more and more time was spent with other instruments which is a huge achievement” (Staff).</p>
<b>Listening skills</b>	<p>“One pupil is putting her hand up more and more regular when she hears her favourite instrument. She is bringing it back and doing it in class too” (Staff).</p> <p>“He patiently listens to other children play and reaches out when his name is said to find the instrument” (Staff).</p>
<b>Transference of skills from music therapy to other situations</b>	<p>“[We have] a pupil who would not touch or explore items [and has now] begun to play a tambourine independently. This skill has transferred [out of sessions] to him willingly exploring and tapping/touching other media like the iPad, switch-it work, and sensory exploring of other materials” (Staff).</p> <p>“This pupil would not hold onto items for a few months but has begun to hold onto a shaker in music therapy which has transferred to other areas” (Staff).</p> <p>“I have witnessed pupils previously reluctant to any involvement in a ‘normal’ music lesson become and develop their confidence to use instruments of their choice – this in turn has transferred to class music sessions” (Staff).</p>

**Table 1: Key areas of impact and supporting quotes**

### *Music therapy's impact on the school as a whole*

Staff and parents highlighted what they felt music therapy provided that was unique within the school including how it engages pupils, how it provided children with the opportunity to express themselves, how it gives them more choice and provides them with enjoyable experiences. They also mentioned that "The one-to-one specialist input is very valuable and beneficial for certain pupils" (Staff) and highlighted the person-centred nature of music therapy: "The therapist's approach to the children is all very individualised to the child's needs" (Staff).

In addition, staff noted that music therapy provides a "contrasting experience to that of a music lesson". For pupils who found it difficult to partake in other musical inputs, the specialised approach appeared to help them to access music and give them confidence in doing this:

"These sessions are different from other music activities because they give the children the time to take the lead. The musical tasks that are asked of them are simple and at their own level, which gives them more opportunity of succeeding" (Staff).

"I have witnessed pupils previously reluctant to any involvement in a 'normal' music lesson become [sic] and develop their confidence to use instruments of their choice – this in turn has transferred to class music sessions" (Staff).

A couple of staff felt that in some ways it was difficult to class music therapy as unique, with one staff member saying:

"the school offers a range of therapies which address communication, confidence and self-esteem. Music therapy is part of a suite of interventions evaluated and selected to support teaching and learning" (Staff).

Another staff member also told how music therapy provides:

"[...] enhanced opportunities for our pupils to lead their own learning and experience a greater variety of instruments".

These quotes show that music therapy supports and fits with the overall values of the school and can work alongside the various learning opportunities and therapies that the school provides.

"The music therapy service fits effortlessly into our educational ethos" (Staff).

Both staff and parents demonstrated the value they placed on music therapy being a part of school life:

"Music therapy plays a huge part in the children's life within my class, they all enjoy it very much and look forward to it each week" (Staff).

"Nordoff-Robbins [Music Therapy in Scotland] is a fantastic organisation that does wonderful work that makes a huge difference to the people it teaches. Thank you." (Parent).

"We are proud to say that Nordoff-Robbins [Music Therapy in Scotland] plays a weekly part in our son's schooling and are so grateful for that. The therapist is fantastic with all the children and so many happy times will be had, by singing and by having fun. Thank you" (Parent).

Two thirds of the staff (67% n=13) felt that they had learned something that could be applied in their own work. As mentioned previously, staff often sat in on sessions and these are therefore learned experiences as opposed to information provided to them. Four main learning areas seemed to be apparent as illustrated in Table 2.

The data in Table 2 shows a positive impact on the school as a whole in what music therapy provides, how it fits within the school's other inputs and how observation of music therapy has influenced the awareness of certain things for staff that can be transferred to other aspects of school life.

### *Quality of the music therapy service*

In relation to the provision of the service, staff felt that the "approach is all very individual to the child's needs. She [the music therapist] has a very calm approach" and that sessions were provided "in a relaxed but professional manner". They also stated that sessions have been "great" and that "the therapist is a wonderful music therapist and all the pupils love attending her music therapy sessions". Figure 3 shows the levels of satisfaction amongst staff relating to different indicators of the quality of the service.

Key learning areas for staff	Example of quotes
Give pupil more time to respond	“I have been reminded to give the pupil more time to focus at his/her speed” (Staff). “To give children more time and leave them to choose themselves” (Staff). “By giving a child longer to process your request and using your imagination to position instruments, they are more likely to play independently” (Staff).
Awareness of environment	“How important it is to have a quiet environment with no distractions” (Staff). “Not to be afraid to be hands-off for a long period of time with the pupils to let them process the environment and respond to it” (Staff).
Use of voice	“Singing more to children can get good responses” (Staff). “One child made use of his voice when trying to play a kazoo. This encouraged staff to look at other ways of encouraging his voice production” (Staff).
Learning what children respond to	“It has provided us with examples of different sounds which our pupils responded to in a positive manner which can be transferred to other learning experiences” (Staff).

Table 2: Key learning areas for staff

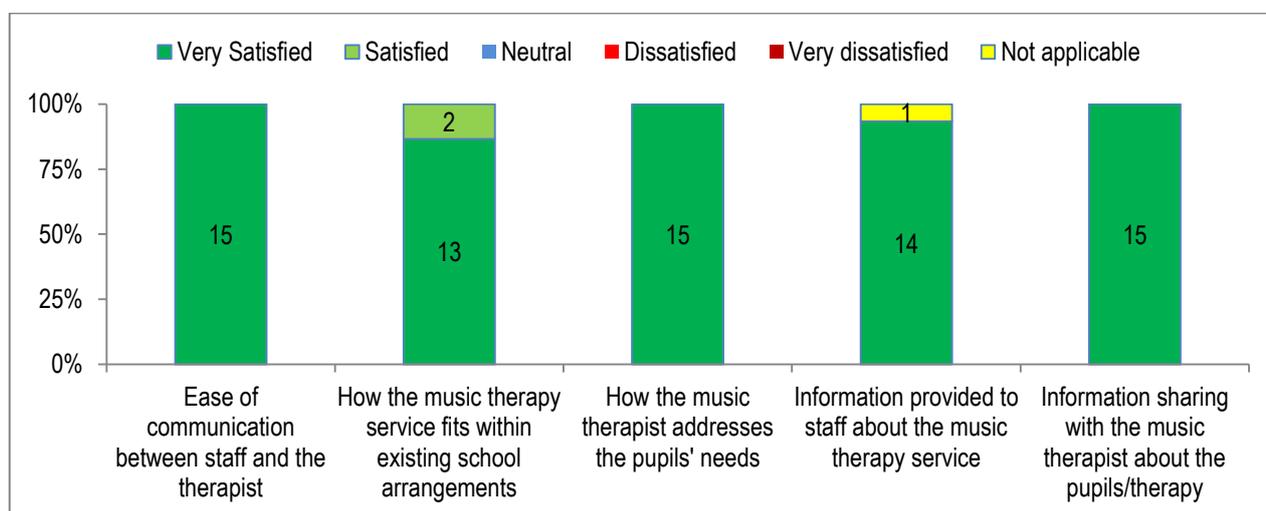


Figure 3: Staff satisfaction with the quality of the music therapy service

Parents were either “very satisfied” (67%, n=6) or “satisfied” (33%, n=3) with the written reports they received about their child’s music therapy and 100% (n=15) were happy with the frequency of these reports. Of the 6 parents who had met with me at a parents’ evening, 83% (n= 5) found this meeting very beneficial and 17% (n=1) found it to be of some benefit. Those parents who had not had a meeting expressed interest in doing so at a future opportunity.

Although opportunity was given in staff and parent questionnaires to provide both positive and negative answers, questions were designed not to lead one way or the other and participation was anonymous. There were no criticisms of the music therapy service. It is possible that participants were biased or reluctant to provide negative feedback as they were aware the evaluation would provide

information to funders. However, all of the information above demonstrates that both staff and parents were satisfied with the quality of the service.

*Suggestions for improvements to the music therapy service*

There were no areas of difficulty or concern identified by either parents or staff. The improvements mentioned by staff seemed to re-affirm the positive feelings towards music therapy with 5 staff wanting more music therapy input throughout the week:

“No improvements, just more sessions during the week as all the children benefit from music” (Staff).

“Have more sessions during the week as they [pupils] really respond to it” (Staff).

One staff member also asked for videos to be shared with class staff. As mentioned above, parents did not feel the need for any improvements with communication. One parent commented on what would be beneficial if the service continued:

“If therapy continues over an extended period, my child will benefit from consistency of staff and approach as this will maximise his ability to access his sessions” (Parent).

One parent who had experience of a music therapy open day wrote:

“I enjoyed the open day and I’m sure a lot of parents or carers would learn a lot. Maybe a parents’ support group led by Nordoff-Robbins [Music Therapy in Scotland] would be useful, but seeing the children first hand works best”.

### Summary of evaluation findings

The results demonstrate the highly positive impact that music therapy has on the pupils, both in sessions and outside sessions. They show that music therapy helps pupils to access music who have difficulty accessing other musical input and that the one-to-one specialist approach is very beneficial for some pupils. Music therapy was deemed to have a positive impact on the school as a whole in what it provides, how it fits within the school’s other inputs and how observation of music therapy has influenced staff’s awareness of techniques that can be transferred to other aspects of school life.

## PART 2: MAKING A CASE FOR ELIGIBILITY TO ACCESS FUNDING SOURCE

A few months after the evaluation, all of the music therapists working in the schools funded by YMI were asked to provide information to demonstrate the relevance of music therapy in relation to the intentions of the YMI programme. Whereas the evaluation was requested to discover the impact of music therapy when they provided the initial funding, now YMI were wanting further information across the board in order to prove the appropriateness of this funding source so as to justify the continued funding of the services the following year.

This part depicts how I endeavoured to meet

this requirement in relation to the school discussed in this article. In seeking to address this I started with their three main aims as outlined on the YMI website (2014):

- Aim 1: Create access to high quality music making opportunities for young people aged 0-25, particularly for those that would not normally have the chance to participate.
- Aim 2: Enable young people to achieve their potential in and through music making.
- Aim 3: Support the development of the youth music sector for the benefit of young people.

While the evaluation provided an excellent source of data (and I return to this later), it was necessary to examine the music provision already existing in the school and to assess why music therapy was needed to achieve the above aims in this school. In order to do this I met with the music specialist. We already kept in close contact for feedback purposes and the music specialist had previously observed some music therapy sessions. This had led to the increased awareness of the music specialist of the potential of musical improvisation after observing the responses and engagement of a pupil during improvised music in music therapy. This had resulted in the music specialist creating an improvisation group. Other performance groups the music specialist ran included a pop/rock band and a samba band. The music specialist was also involved in the delivery of music classes to the pupils (as were other members of the staff).

As part of a funding allocation to training, I provided further information on music therapy to the music specialist. We shared our approaches with each other in order to understand where the differences and similarities between our work lay. We discussed how music is often the goal in education/performance situations, whereas music is part of the process in music therapy as opposed to being the goal. In music therapy, music is the tool through which to achieve non-musical goals and outcomes. Robertson (2000: 41) deliberated upon the following notion that

“[...] *the notes between* (the expression, the experience, the essence) are particularly relevant to the music therapy process, and *the notes themselves* (the theoretical, the tangible, the taught) are the *raison d’être* of music education” (Robertson 2000: 41).

However, Robertson argued that this distinction,

although clear, could also be viewed as “too simple”. We also felt that the difference was only part of the picture. We discussed some overlapping areas e.g. that some aims of music therapy (e.g. increasing confidence, developing social skills, etc.) can also be a by-product of music education/performance experiences. In some ways our discussion helped to clarify our respective roles in terms of music input within the school. Yet in other ways it raised more need to explore our professional roles further and if there were any links to be made. Robertson (2000: 42) raised the question “Is the music therapist working in special education in danger of being sidelined?”. Indeed, Pethybridge (2013) discussed how allied health professionals in educational settings are being encouraged to find ways of meeting therapeutic needs with less actual contact time with pupils. In evaluating partnership working by involving nursery staff in a music therapy group, she found “[...] the flexibility of the music therapist in direct work is highly specialised and cannot be easily replicated in other classroom music activities” and also that partnership working can “[...] offer some level of transferable learning for teaching and support staff and potential for developing more indirect approaches [...]” (Pethybridge 2013: 24). This also seemed evident in the school we were working in, as discussed earlier under what staff had learnt from sitting in on music therapy sessions.

As the discussion of our roles continued, we examined the various music-making opportunities in the school (the groups mentioned above) and how some pupils were not able to access them due to their difficulties. It was also recognised that for some pupils, class music-making sessions were not able to offer the individualised and specialised attention needed to realise the pupil’s full potential. It was felt that for these pupils accessing music needed to be approached with more than just the music in mind. It was here we felt music therapy came in.

After this discussion with the music specialist, I decided to look at each aim of the funder in turn to provide information pertaining to the relevance of music therapy to that aim. I was then able to use case vignettes in conjunction with data from the evaluation to provide support for the fulfilment of each aim.

### **Aim 1:**

“Create access to high quality music making opportunities for young people aged 0-25, particularly for those that would not normally have the chance to participate” (Creative Scotland 2014).

As the school catered for pupils aged 2-19, the pupils were within the correct age bracket. In terms of the high quality music making opportunities I was able to draw on my training as a music therapist to meet this aspect. All professional music therapists hold a postgraduate qualification, with the entry requirements to the training courses requiring a high quality of musicianship (Nordoff-Robbins Music Therapy in Scotland 2014). I was trained to create and improvise music with clients in an interactive and therapeutic way as outlined under the Introduction to MSc Music Therapy (Nordoff-Robbins) (Queen Margaret University 2014) where I qualified.

In terms of creating access for those that would not normally have the chance to participate, as identified earlier, some pupils were having difficulty accessing the other music provisions in the school. These pupils were often referred to music therapy. I highlighted the fact that as a music therapist, I work in a way that is person-centred and led by the pupil, working in an interactive, response-led style. The music is used as a tool to help remove the barriers that prevent the pupils from participating (e.g. confidence, interaction skills, communication skills, physical limitations, developmental limitations, listening skills, awareness of self and others, and ability to focus). By using the music to develop these skills and areas, the pupils in turn were then more able to access music. Looking at the key areas of impact for pupils that were highlighted in the evaluation it can be seen that music therapy is making progress in these areas (Table 1).

There are also environmental aspects to consider: music activities/classes tended to be in bigger groups, often proving too overwhelming with too many distractions for pupils. Music therapy takes place in a quieter environment that gives more space for the pupils to respond free from distractions where I respond to what the pupil is doing, therefore encouraging meaningful and purposeful engagement with the music. This was also backed up by comments from the evaluation (Table 2). The following case study is an example of how music therapy fulfills aim 1.

### *Case vignette example of how music therapy allows a young person to access and participate in music*

Pupil A (age 13) has a visual impairment and complex needs. When she began music therapy at age 10 she had very little awareness of her environment, herself or others and there was very little that she responded to. I worked on developing awareness of self and self and other, for example through playing with the tempo of her breathing (which elicited a response of awe) and introduced her to different sounds, initially through co-active playing. Over time the pupil's listening skills improved and she became more aware of my music and responses. She began to show interest in a variety of sounds and instruments. Gradually she began to understand that she could have an effect on her environment and that she could produce sounds from the instruments through her own movements (e.g. when using bells on her wrist she became aware of her arm as part of herself and that by moving it the bells elicited a sound). She will now reach out to independently play some instruments as her understanding of cause and effect has improved (e.g. windchimes, cabasa, nutshaker). Music therapy has worked at removing some of the barriers to her participation in music and she is now accessing music in a way she was unable to before.

As illustrated above, music therapy gives the pupils who have difficulty accessing music under the other music provisions the opportunity to access high quality music making opportunities in a setting that is more conducive to their needs. As one staff member mentioned:

"I have witnessed pupils previously reluctant to any involvement in a 'normal' music lesson become [more confident] and develop their confidence to use instruments of their choice – this in turn has transferred to class music sessions".

#### **Aim 2:**

"Enable young people to achieve their potential in and through music making" (Creative Scotland, 2014)

I felt that there were two parts to this aim that I needed to address – how music therapy enables young people to achieve their potential *in or through* music making. It seemed that case studies of pupils were the most appropriate means of showing how music therapy was achieving this. It

can help them to achieve their potential *in* music making by increasing the accessibility of music and enabling them to make progress musically which the following case study demonstrates.

### *Case vignette example of achieving potential in music making*

Pupil B (age 10) has a visual and hearing impairment and complex needs. She had difficulty focusing or engaging with her environment. Her hearing impairment amongst other issues made it difficult for her to access music. In music therapy, we have been able to learn more about her hearing skills, develop focus, awareness and encourage her to access instruments. Musically, she now explores rhythm, patterns and pulse and is also developing melodic and harmonic awareness. She is also beginning to participate more in class music sessions.

### *Case vignette example of achieving potential through music making*

Pupil C (age 7) has complex physical and learning needs and is registered blind. As mentioned in the evaluation he:

"[We have] a pupil who would not touch or explore items [and has now] begun to play a tambourine independently. This skill has transferred [out of sessions] to him willingly exploring and tapping/touching other media like the iPad, switch-it work, and sensory exploring of other materials" (Staff).

The therapeutic work in sessions through the medium of music is enabling him to more fully reach his potential both in music therapy and in other situations.

#### **Aim 3:**

"Support the development of the youth music sector for the benefit of young people" (Creative Scotland, 2014).

This was the aim that required the most discussion as it is not an aim often associated with music therapy. I spoke with the music specialist to look at whether music therapy was contributing to this aim. In the end this was the aim which proved most beneficial in furthering both my own and the music specialist's insight into the roles of the different school music provisions and how they linked together. It ultimately culminated in the

development of a model of a continuum for music provision in the school which could offer guidance and information as to what type of music input was most appropriate and why. Our thinking and foundations for this idea developed from the following case example.

### *Case vignette example of a pupil who progressed from music therapy to a performance group*

Pupil C (age 15) is registered blind, has autism and is non-verbal. He could not cope with class music sessions and struggled to participate in them at all. Through individual music therapy sessions he gained confidence in interacting musically, gradually increased the number of instruments he explored and played, and developed his listening skills. He was able to follow the rhythm or pulse of a piece of music, play simple and more complex rhythms, explore a range of dynamics, tempi, different time signatures (4/4, 3/4 and 6/8) and follow and initiate changes in the music. He loved to improvise and seemed to gain great joy from it. He went on to join the school's samba group and coped very well with this. At first he continued to attend both therapy sessions and the samba group. He then moved to finishing music therapy and just attending the samba group. He has performed at a number of occasions with the group, contributing to the youth music sector.

In music therapy both the therapeutic need and musical need can be worked on and indeed they are often interlinked. However, the pupil may reach a stage where the goals of music therapy have been achieved and where music therapy is no longer required. However, the pupil may still have a love of music and would benefit from an avenue through which to explore his/her continuing musical needs. This encouraged us to look at how music therapy outcomes could help enable pupils to access the school's performance groups. The groups perform for various events at school and in the community and have performed in a national youth music festival, thereby contributing to the youth music sector.

Already existing within the school was the school's rock band. The band consists of pupils with additional support needs, mainstream music students, volunteer musicians and experienced and professional musicians. The band rehearses and performs regularly to a very high standard. In addition, there was a samba group created for younger pupils who showed musical potential. As mentioned earlier, in response to the observed

impact of improvised music in music therapy, the music specialist also established an improvisation group. We looked at this as a possible natural progression for some pupils from music therapy and a starting point for other pupils in the school who did not attend music therapy. As we discussed the potential of pupils to perhaps move on from music therapy to one of the school's music groups, another group was formed – a pre-samba group, with the purpose of being a transition group to build on skills from music therapy to allow the pupils to access the samba group.

### **Continuum of music provision: An emerging model**

As the music specialist and I discussed these possibilities, we realised we wanted to create a model that took into account all of the musical inputs in the school as part of a continuum of music provision. The aim was to demonstrate potential avenues of progression where appropriate, while acknowledging that for some, one area would remain the most suitable musical input for that pupil and to value their contributions without the need to say they must access other inputs to achieve their potential. It was also necessary to acknowledge that a particular therapeutic need may exist or continue in spite of musical skills and that a pupil could access more than one input simultaneously for different reasons. After our discussion, I created the model below (Figure 4) to provide a visual representation of the discussed continuum and to provide clear guidelines as to why a pupil would access one input over another (or indeed multiple inputs).

This model begins at the level of all pupils receiving music education in class. If this is deemed sufficient, then no additional input is offered. However, if in class the pupil is having difficulty accessing music and staff feel a more individualised approach would be beneficial, then they are referred to music therapy. Other reasons for referral to music therapy come under the more traditional areas of communication/interaction, emotional exploration, developmental work and personal growth. The music therapy input they require (e.g. individual/group work) would be determined through assessment of need and the aims of the work. A pupil also may subsequently in time move from individual sessions to paired sessions/small group.

Returning to the level of music in class, if it was felt a pupil was showing musical potential and could benefit from being challenged more in a

performance-orientated outlet, they would then access one of the school's performance groups. Which group they would access would depend on individual skill and need, and be determined by the music specialist. Pupils would have room to subsequently progress through the groups if and when appropriate. Similarly if a pupil in music therapy had achieved their therapeutic goals but would now benefit from continuing to explore their musical potential, they would then have the option of accessing the school's performance groups. The model also gives the option that a pupil may need to access both types of input. For example, a pupil might be very musically-skilled and able to access the performance groups to pursue their musical potential. However, the same pupil may be in need of some emotional support in a therapeutic environment.

It was hoped that this model would make the roles of the different musical inputs in the school clearer for everyone involved and offer guidance to staff for putting pupils forward for one input or another. Perhaps the continuum may prove useful for other music therapists working alongside other musical inputs in special education settings, as a means of demonstrating the need for different musical inputs and how they can support one another. It is recognised that different schools have varying levels of input and may work in different ways, in which case it could provide a starting point for discussion.

It is not the first time that the area of fulfilling musical need after therapy has arisen. Wood (2006) outlined a matrix model for linking conventional music therapy sessions (individual / group music therapy) and non-conventional examples like workshops and concert trips. He based this on

“an understanding that the essence of any form of music-making is the way in which music works within and between people. All formats of music-making can therefore become formats for music therapy, since all formats of music therapy are connected by this common operation of music” (Wood 2006).

Previously, Wood, Verney and Atkinson (2004: 49) spoke of how they:

“[...] regretted the lack of opportunity for music therapy clients to pursue their new interest and ability in music once they had left their treatment institution. Often the outcome of music therapy is as much in musical and social skills as it is in a personal process. We considered it both arbitrary and wasteful for the beneficial effects of music to

decline after a conventional course of music therapy”.

There is also precedence in the very foundations of music therapy as outlined by Nordoff and Robbins (1977: 187-188):

“The child has outgrown the need for, or scope of the particular kind of musical interactivity that individual therapy provides; occasionally he may use a musical situation which lends itself to individual creative expression. When appropriate, formal individual musical instruction can take over [...]. Any personal dependence upon the therapists an individual child might still have diminishes under these conditions. He becomes an independently contributing member of a working group, sharing pleasure and interest with others and feeling pride in his own accomplishments”.

These examples help give meaning and weight to the proposed music continuum model for working in schools. It is hoped it will also add to the argument for the presence of both music specialists and music therapists in special education settings.

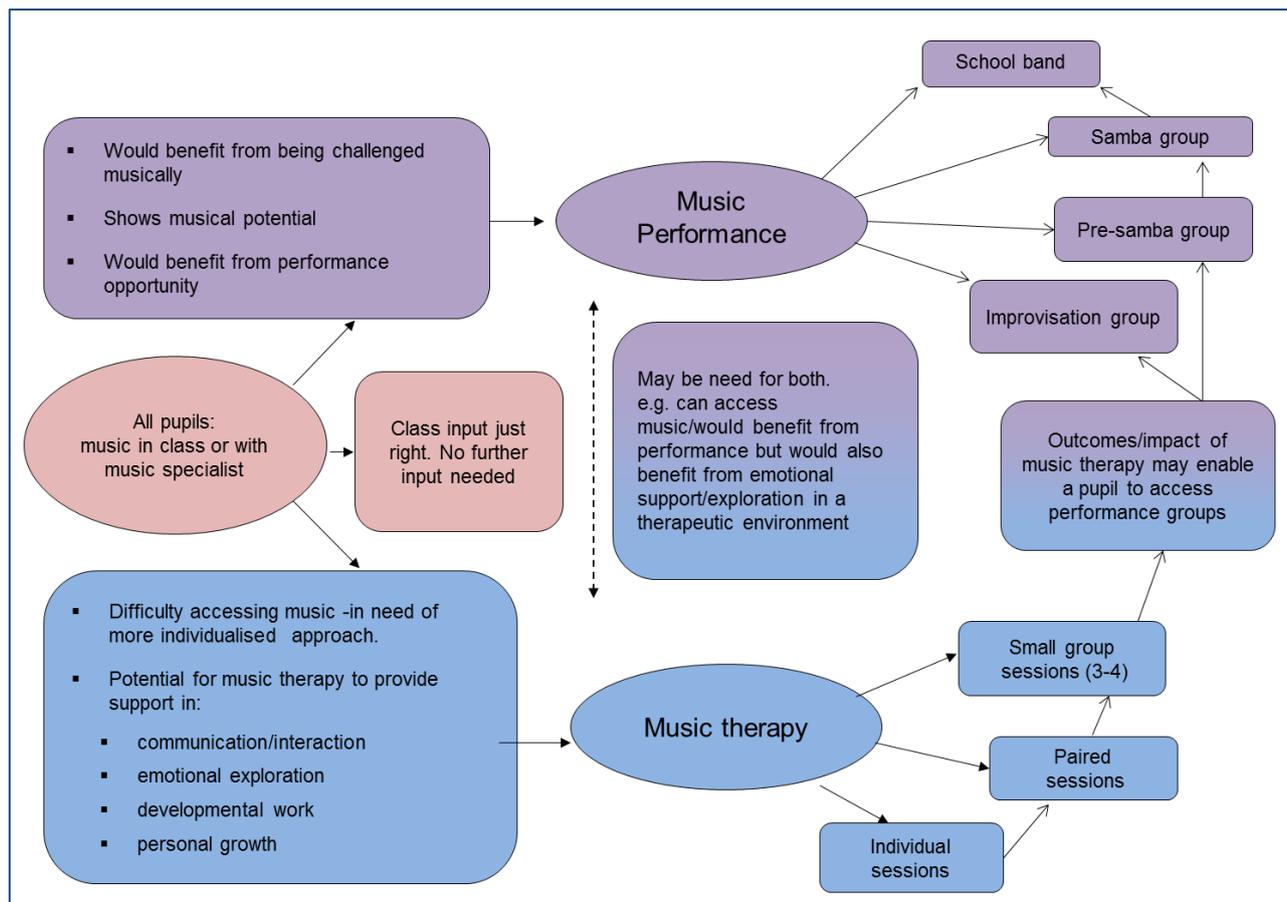


Figure 4: Model of continuum of music provision in the school

## CONCLUSION

There are many benefits in rising to the challenge of providing evidence for funders in order to ensure continued funding of services. The evaluation project brought forth a wealth of information in relation to the aims of discovering the impact of music therapy on the pupils and the school, as well as ascertaining the quality of the service and if there were any improvements to be made. The findings demonstrated the highly positive impact that music therapy had on the pupils, both during sessions and outside of sessions. Music therapy was shown to have had a positive impact on the school as a whole, with staff having become aware of things like giving the pupil more time to respond, awareness of environment and use of voice which subsequently influenced their approach in other situations. The results also gave clear information that both parents and staff were satisfied with the quality of the service.

Subsequently the examination and exploration of music therapy's relevance to the funder's aims (with the aid of the evaluation and case studies) proved a worthwhile and valuable exercise. The process ultimately led to the formulation of a

proposed model for a continuum of music therapy in the school. The discussion of where a music therapist's role lies when present alongside a music specialist can be illustrated via the continuum, giving significance to both roles. This vision of a music continuum has begun to materialise, with five pupils who have had music therapy input now attending one of the performance groups in the school (as at the end of the academic year 2013/14). By being able to access high-quality music making opportunities through music therapy and developing their potential in and through music, some pupils have had/will have the opportunity to take part in school music groups and potentially other groups in the future that are part of the youth music sector. For other pupils, music therapy remains the most appropriate way for them to access high-quality music making and to meet their needs. This all contributed to a case for the relevance of music therapy to the funder's aims. The funders continued contributing towards music therapy in the school and their commitment to the funding is currently confirmed up until the end of the academic year 2014/15. The school hopes to secure additional funding to continue exploring the potential of this music continuum of which music

therapy plays an integral part.

It is hoped that this paper can encourage other music therapists to embrace the calls to provide evidence to funders. In a simplistic yet important way, it helps us to ensure funding to undertake/continue the music therapy provision. However, it is also a process through which we may learn and develop our practice and gain clarity of our position and contribution. Let it inspire us to be creative, allowing the full potential of our music therapy services and of our clients to be achieved.

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## APPENDIX 1: STAFF QUESTIONNAIRE

### 1. What has been your involvement with the music therapy service? (Tick all applicable)

- I attended the music therapy presentation on [date]
- I have accompanied a pupil to music therapy sessions
- I have observed a music therapy session
- I have been part of a music therapy group session
- I work in another context with a pupil who attends music therapy
- I have had a meeting with the music therapist
- Feedback from other staff
- Other (please specify)

### 2. In general, please rate the experience of music therapy for your pupil(s): (Tick one)

- Very positive
- Positive
- Neither positive or negative
- Negative
- Very negative
- Don't know / Not applicable

### 3. Have you noticed anything interesting, unexpected or different (positive or negative) about a pupil in relation to their music therapy experience? Tell us about it:

### 4. Please indicate how satisfied you are with the following: (Please tick one for each row)

	<i>Very Satisfied</i>	<i>Satisfied</i>	<i>Neutral</i>	<i>Dissatisfied</i>	<i>Very Dissatisfied</i>	<i>Not applicable</i>
a. Ease of communication between yourself and the therapist.	<input type="checkbox"/>					
b. How the music therapy service fits within existing practical arrangements.	<input type="checkbox"/>					
c. How the music therapist addresses the pupils' needs.	<input type="checkbox"/>					
d. Information provided to you about the music therapy service.	<input type="checkbox"/>					
e. Information sharing with the music therapist about the pupil(s)/therapy.	<input type="checkbox"/>					

### Any additional comments:

### 5. In your opinion what does music therapy provide, if anything, that is unique within the school?

**6. What improvements could be made to the music therapy service?**

**7. Have you learned anything from the music therapist that can be applied within your own work? (Tick one)**

- Yes
- No
- Not sure

**Please give any examples:**

**8. Any further comments?**

**9. What is your designation? (please tick all applicable)**

- Teacher
- Classroom assistant
- Specialist
- Member of management team
- I would prefer not to say
- Other (please specify)

*Thank you very much for completing this questionnaire.  
Your responses will help to ensure the quality of the music therapy service.  
Your participation will remain anonymous.*

*Please return this questionnaire to reception by:  
[date]*

## APPENDIX 2: PARENT QUESTIONNAIRE

### 1. Which of the following input does your child receive?

- My child attends individual music therapy sessions
- My child attends group music therapy sessions
- My child has attended both individual and group sessions at different times
- I'm not sure

### 2. Please rate the experience of music therapy for your child? (Tick one)

- Very positive
- Positive
- Neither Positive or Negative
- Negative
- Very negative
- Don't know/ Not applicable

### 3. How satisfied are you with the written reports about your child's music therapy?

- Very satisfied
- Satisfied
- Neutral
- Dissatisfied
- Very dissatisfied

### 4. Music therapy reports will be sent at Christmas and Summer. Is this frequent enough? (Please tick one)

- Yes
- No
- Not sure

Suggestions:

### 5. Did you meet the music therapist at parents evening on [date]?

- Yes (go to a)
- No (go to b)

#### a) If yes, how beneficial was this meeting?

- Very beneficial
- Of some benefit
- Neutral
- Not much benefit
- Of no benefit

#### b) If not would you like to meet the therapist at the next parents evening?

- Yes
- No
- Maybe

**6. Do you have any suggestions for improving communication about your child's music therapy?**

**7. In your opinion, what does music therapy provide, if anything, that is unique for your child?**

**8. Would you like the music therapy service at this school to continue? (Tick one)**

- Yes
- No
- Maybe

**9. Any further comments?**

*Thank you very much for completing this questionnaire.  
Your responses will help to ensure the quality of the music therapy service.  
Your participation will remain anonymous.*

*Please return this questionnaire to reception by:  
[date]*

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