



Board of Health Professions Regulatory Research Committee Meeting

July 31, 2019
9:00 a.m. - Board Room 4
9960 Mayland Dr, Henrico, VA 23233

- In Attendance**
 - Martha S. Perry, PhD, Citizen Member
 - John Salay, MSW, LCSW, Board of Social Work
 - James Wells, RPH, Citizen Member
- Absent**
 - Louis R. Jones, Board of Funeral Directors & Embalmers
 - Maribel Ramos, Citizen Member
- DHP Staff**
 - David Brown, DC, Director DHP
 - Barbara Allison-Bryan, Chief Deputy Director DHP
 - Elizabeth A. Carter, PhD, Executive Director BHP
 - Laura Jackson, MSHSA, Operations Manager BHP
 - Yetty Shobo, PhD, Deputy Executive Director BHP
 - Elaine Yeatts, Senior Policy Analyst DHP
- Observers**
 - Becky Bowers-Lanier, VA Assoc. Hospices & Palliative Care
 - Jerry Gentile, DPB
 - Tracy Bowdish, VA Music Therapy State Task Force
- Speakers**
 - No speakers signed in
- Emergency Egress**
 - Dr. Carter

Call to Order

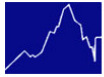
Chair Mr. Wells **Time:** 9:02 a.m.

Quorum Established

Quorum was established with three members in attendance.

Approval of Minutes

The minutes from the June 24, 2019 meeting were approved by Mr. Salay and properly seconded by Dr. Rackets. All members were in favor, none opposed.



Public Comment

No public comment was provided.

Music Therapist Study-Draft 2 Presentation

Presenter Ms. Jackson

Discussion

Ms. Jackson provided an update on the changes made to the first draft of the study. The transcript from the June 24, 2019 public hearing and written comment received were also reviewed. Attachment 1.

Committee Discussion - Music Therapist

Presenter Mr. Wells

Discussion

The Committee reviewed the criteria and their application and discussed at length the options of licensure, statutory certification and registration.

Mr. Salay recommended licensure, pointing to the special vulnerabilities of the client population, including PTSD victims, dementia patients, ICU and hospice patients, and children with autism and other disorders that affect communication. He also cited the inherent invasiveness music on the frontal cortex and verbal centers of the brain that can result in positive and negative consequences. These effects may not be readily apparent to even other healthcare professionals who may not be familiar with music therapists practice.

Dr. Rackets expressed concerns centered on the level of practice autonomy (Criterion 3) and the fact that the profession permits credentialing with bachelor's degree education (in addition to the other requirements).

Motion-Recommendation of Licensure of Music Therapists in the Commonwealth of Virginia

Discussion

A motion was made by Mr. Salay to license music therapists in the Commonwealth of Virginia. Mr. Salay and Mr. Wells were in favor, Dr. Rackets was opposed. The motion was properly seconded by Mr. Wells and approved.

Motion-Recommendation for Music Therapy to be Placed Under the Board of Counseling

Discussion

Upon motion to license music therapists, the Committee discussed if the profession should be placed under the Board of Medicine or the Board of Counseling. The Board of Counseling was recommended for art therapist licensure previously and that board currently regulates rehabilitation providers. A motion was made by Dr. Rackets to place music therapists under the Board of Counseling. Dr. Rackets and Mr.



Wells were in favor, Mr. Salay was opposed. The motion was properly seconded by Mr. Wells and approved.

Next Meeting

Presenter Mr. Wells

Discussion

The originally scheduled August 20, 2019 meeting will be cancelled as the Committee voted at this meeting to recommend licensure for music therapists.

New Business

Presenter Mr. Wells

Discussion

There was no new business.

Adjourned

Adjourned 10:48 a.m.

Chair James Wells, RPh

Signature: _____ Date: ____/____/____

Board Executive Director Elizabeth A. Carter, PhD

Signature: _____ Date: ____/____/____

DRAFT



THE VIRGINIA BOARD OF HEALTH PROFESSIONS

**STUDY INTO THE NEED TO REGULATE MUSIC THERAPISTS
IN THE COMMONWEALTH OF VIRGINIA**

JULY 2019

VIRGINIA BOARD OF HEALTH PROFESSIONS

9960 MAYLAND DR, SUITE 300

HENRICO, VA 23233-1463

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EXECUTIVE SUMMARY

Section 54.1-2510 of the *Code of Virginia* authorizes the Virginia Board of Health Professions (BHP) to advise the Governor, General Assembly, and Director of the Department of Health Professions on matters pertaining to the regulation of health professions and occupations and scope of practice issues. Senate Bill 1547 (Appendix 1) directs the Board of Health Professions to evaluate whether music therapists and the practice of music therapy should be regulated in the Commonwealth and the degree of regulation to be imposed. The BHP is required to report the results of its evaluation to the Chairmen of the Senate Committee on Education and Health and to the House Committee on Health, Welfare and Institutions by November 1, 2019.

The review uses the principles, evaluative criteria, and research methods set forth in the BHP's standard policies and procedures for evaluating the need for regulation of health occupations and professions. It examines music therapist education, training, competency examination and continuing competency requirements, typical duties and functions, regulation in other U.S. jurisdictions, available workforce data, and the potential impact on existing behavioral health professions regulated in Virginia.

AUTHORITY

At its May 14, 2019 meeting, the Board of Health Professions considered a request to review the need to regulate music therapists in the Commonwealth of Virginia. At this meeting, the Regulatory Research Committee (RRC) received approval to move forward with the study. The same day, the RRC adopted the work plan and began work on the study. The study is conducted pursuant to the following authority:

Code of Virginia Section 54.1-2510 assigns certain powers and duties to the Board of Health Professions. Among them are the power and duty:

7. To advise the Governor, the General Assembly and the Director on matters relating to the regulation or deregulation of health care professions and occupations;
12. To examine scope of practice conflicts involving regulated and unregulated professions and advise the health regulatory boards and the General Assembly of the nature and degree of such conflicts;

Pursuant to these powers and duties, the Board of Health Professions and its Regulatory Research Committee conduct a sunrise review evaluating the need to regulate music therapists in the Commonwealth of Virginia.

THE CRITERIA AND THEIR APPLICATION

The Board of Health Professions has adopted the following criteria and guidelines to evaluate the need to regulate health professions. Additional information and background on the criteria are available in the Board of Health Professions Guidance Document 75-2 *Appropriate Criteria in Determining the Need for Regulation of Any Health Care Occupations or Professions*, revised February 2019 available on the Board's website: [Policies and Procedures for the Evaluation of the Need to Regulate Health Occupations and Professions](#)

CRITERION ONE: RISK FOR HARM TO THE CONSUMER

The unregulated practice of the health occupation will harm or endanger the public health, safety or welfare. The harm is recognizable and not remote or dependent on tenuous argument. The harm results from: (a) practices inherent in the occupation, (b) characteristics of the clients served, (c) the setting or supervisory arrangements for the delivery of health services, or (d) from any combination of these factors.

CRITERION TWO: SPECIALIZED SKILLS AND TRAINING

The practice of the health occupation requires specialized education and training, and the public needs to have benefits by assurance of initial and continuing occupational competence.

CRITERION THREE: AUTONOMOUS PRACTICE

The functions and responsibilities of the practitioner require independent judgment and the members of the occupational group practice autonomously.

CRITERION FOUR: SCOPE OF PRACTICE

The scope of practice is distinguishable from other licensed, certified and registered occupations, in spite of possible overlapping of professional duties, methods of examination, instrumentation, or therapeutic modalities.

CRITERION FIVE: ECONOMIC IMPACT

The economic costs to the public of regulating the occupational group are justified. These costs result from restriction of the supply of practitioner, and the cost of operation of regulatory boards and agencies.

CRITERION SIX: ALTERNATIVES TO REGULATION

There are no alternatives to State regulation of the occupation which adequately protect the public. Inspections and injunctions, disclosure requirements, and the strengthening of consumer protection laws and regulations are examples of methods of addressing the risk for public harm that do not require regulation of the occupation or profession.

CRITERION SEVEN: LEAST RESTRICTIVE REGULATION

When it is determined that the State regulation of the occupation or profession is necessary, the least restrictive level of occupational regulation consistent with public protection will be recommended to the Governor, the General Assembly and the Director of the Department of Health Professions.

APPLICATION OF THE CRITERIA

In the process of evaluating the need for regulation, the Board's seven criteria are applied differently, depending upon the level of regulation which appears most appropriate for the occupational group. The following outline delineates the characteristics of licensure, certification, and registration (the three most commonly used methods of regulation) and specifies the criteria applicable to each level.

- **Licensure** - Licensure confers a monopoly upon a specific profession whose practice is well defined. It is the most restrictive level of occupational regulation. It generally involves the delineation in statute of a scope of practice which is reserved to a select group based upon their possession of unique, identifiable, minimal competencies for safe practice. In this sense, state licensure typically endows a particular occupation or profession with a monopoly in a specified scope of practice.
 - Risk: High potential, attributable to the nature of the practice.
 - Skill & Training: Highly specialized accredited post-secondary education required; clinical proficiency is certified by an accredited body.
 - Autonomy: Practices independently with a high degree of autonomy; little or no direct supervision.
 - Scope of Practice: Definable in enforceable legal terms.
 - Cost: High
 - Application of the Criteria: When applying for licensure, the profession must demonstrate that Criteria 1 - 6 are met.

- **Statutory Certification** - Certification by the state is also known as "title protection." No scope of practice is reserved to a particular group, but only those individuals who meet certification standards (defined in terms of education and minimum competencies which can be measured) may title or call themselves by the protected title.
 - Risk: Moderate potential, attributable to the nature of the practice, client vulnerability, or practice setting and level of supervision.
 - Skill & Training: Specialized; can be differentiated from ordinary work. Candidate must complete education or experience requirements that are certified by a recognized accrediting body.
 - Autonomy: Variable; some independent decision-making; majority of practice actions directed or supervised by others.
 - Scope of Practice: Definable, but not stipulated in law.
 - Cost: Variable, depending upon level of restriction of supply of practitioners.
 - Application of Criteria: When applying for statutory certification, a group must satisfy Criterion 1, 2, 4, 5, & 6.

- **Registration** - Registration requires only that an individual file his name, location, and possibly background information with the State. No entry standard is typically established for a registration program.
 - Risk: Low potential, but consumers need to know that redress is possible.
 - Skill & Training: Variable, but can be differentiated for ordinary work and labor.
 - Autonomy: Variable.
 - Application of Criteria: When applying for registration, Criteria 1, 4, 5, & 6 must be met.

OVERVIEW

This preliminary overview of the profession provides background information including recent changes affecting the profession. It highlights some key areas of concern. Its purpose is to inform BHP and RCC members and the public during the public comment period. Interested parties may also review the sunrise proposal submitted by the Virginia State Music Therapy Task Force (Appendix 10). A full report, incorporating public comment and final recommendations, will be issued at the end of the study period.

HISTORY OF THE PROFESSION

The healing influence of music is as old as the writings of Aristotle and Plato. The 20th century profession formally began after World War I and World War II when community musicians of all types, both amateur and professional, went to hospitals around the country to play for the thousands of veterans suffering both physical and emotional trauma from the wars.

In the 1940s, three persons emerged as innovators and key players in the development of music therapy as an organized clinical profession. Psychiatrist Ira Altshuler promoted music therapy in Michigan for three decades. Willem van de Wall pioneered the use of music therapy in state-funded facilities and wrote the first "how to" music therapy text, *Music in Institutions* in 1936. E. Thayer Gaston, known as the "father of music therapy," was instrumental in moving the profession forward from organizational and educational standpoints. Michigan State University established the first academic program in music therapy in 1944 and other universities followed, including the University of Kansas, Chicago Musical College, College of the Pacific, and Alverno College. (AMTA, 2019)

MUSIC THERAPY DEFINED

According to the American Music Therapy Association (AMTA), music therapy is the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. Music therapy is an evidence-based health profession with a strong research foundation. Music therapy degrees require knowledge in psychology, medicine, and music. (AMTA, 2019)

A music therapist assesses emotional well-being, physical health, social functioning, communication abilities, and cognitive skills thru musical responses and designs music sessions for individuals and groups based on client needs. The therapist may use music improvisation, receptive music listening, song writing, lyric discussion, music and imagery, music performance, and learning thru music. The music therapist also participates in interdisciplinary treatment planning, ongoing evaluation, and follow up. (AMTA, 2019)

A music therapist has a genuine interest in people and a desire to help others empower themselves. The essence of music therapy practice involves establishing caring and professional relationships with people of all ages and abilities. Empathy, patience, creativity, imagination, an openness to new ideas, and understanding of oneself are also important attributes. Because music therapists are accomplished musicians as well as therapists, a background and love of music are also essential. A music therapist must be versatile and able to adjust to changing circumstances. Music therapists must express themselves well in speech and in writing. In addition, they must be able to work well with other health care providers. (AMTA, 2019)

A music therapist is versatile and able to adjust to changing circumstances. Many different instruments may be used within a therapeutic context. Music therapy students generally choose one instrument to be their instrument of focus during their educational course of study and are given basic training on a variety of instruments (guitar, piano percussion, voice). The choice of instrument or musical intervention used in a music therapy session is dependent upon goals and objectives, the client's preferences, and the music therapist's professional judgement. (AMTA, 2019)

Credentialed music therapists work with brain-injured patients to help them regain speech. They may work with older adults to lessen the effects of dementia or with children to reduce asthma episodes. Music therapists work with hospitalized patients to reduce pain. They work with children who have autism to improve communication capabilities. In addition, music therapy may be beneficial to help improve premature infants sleep patterns and music therapy intervention may stimulate infant weight. (AMTA, 2019)

Not all music in a healthcare setting is music therapy. Music therapy does not include a patient suffering from dementia listening to favorite songs, nurses playing background music for patients, or a choir singing on the pediatric floor of a hospital. (AMTA, 2019)

Clinical music therapy is the only professional, research-based discipline that actively applies supportive science to the creative, emotional, and energizing experiences of music for health treatment and educational goals. Music therapy and the credentialed music therapists who practice it have a bachelor's degree in music therapy from one of AMTA's 80 approved colleges and universities. They have completed 1,200 hours of clinical training and hold the MT-BC credential, issued through the Certification Board for Music Therapists (CBMT). This certification is a way to protect the public by ensuring competent practice and requiring continuing education. Some states also require licensure for board-certified music therapists.

ASSOCIATIONS

AMERICAN MUSIC THERAPY ASSOCIATION

The American Music Therapy Association (AMTA) serves 5000 member music therapists, students, graduate students and other supporters. AMTA's mission is to advance public knowledge of the benefits of music therapy and to increase access to quality music therapy services. AMTA also serves as an advocate for music therapy on state and federal levels

VIRGINIA MUSIC THERAPY ASSOCIATION

The Virginia Music Therapy Association's (VMTA) mission is to advance music therapy as a professional discipline in the state of Virginia. The association seeks to engage and involve music therapy professionals and students who are committed to advocating, educating and legislating for the profession of music therapy.

The VMTA State Task Force works collaboratively with AMTA and CBMT to implement the State Recognition Operational Plan and works to fulfill the AMTA mission of increasing awareness of the benefits of music therapy and increasing access to quality music therapy services within the state. The Virginia State Task Force consists of five music therapists and one student member.

DISCUSSION OF THE CRITERIA

CRITERION ONE: RISK OF HARM

Due to the small number of states that license or utilize title protection for music therapists, and the CBMT requirement that all MT-BC credential holders self-report any violations of the CBMT Code of Professional Practice, the level of reported cases is very low. There has been a yearly increase in the number of cases since 2015.

The following information regarding disciplinary action against music therapists is provided by CBMT. The data represents the last 20 years since the current Code of Professional Practice and new disciplinary procedures were adopted in 1998. (See Table 1)

Table 1. CBMT-Violations 1998-June 2019

State	Falsification of Records	Misuse of Credential	Negligence and Malpractice	Inappropriate Boundaries/ Dual Relationships	Sexual Offenders or Sexual Harassment	Financial Exploitation
Alabama			1			
Arkansas			1	1		
Arizona		1			1	
California	1	3				1
Connecticut*		1				
Florida					1	
Illinois				1		
Indiana	1	2	1			
Maryland					1	
Massachusetts		2	1			
Michigan		3				
Missouri	1	2				
New Mexico		1				
New York	1	1	1			
North Carolina		1				
Ohio		1	1	1		
Oklahoma*	1	1				
Oregon*		1				
Pennsylvania	2	4	1			
Texas	1	2		2		
Virginia					1	
Wisconsin		1				1
Total	8	27	7	5	4	2

*States with existing licensure

Since 1998, Pennsylvania has had the highest number of reported disciplinary actions with seven cases reported. (Table 2) The greatest number of incidents reported (13) was reported in 2018. (Table 3) Overall, Misuse of Credentials was the most frequently disciplined violation with 27 actions over 20 years. (Table 1) In 2009 Virginia had it's first and only reported case falling under the Sexual Offenders or Sexual Harassment category.

Table 2. CBMT-Disciplinary Action by State

State	
Alabama	1
Arkansas	2
Arizona	2
California	5
Connecticut*	1
Florida	1
Illinois	1
Indiana	4
Maryland	1
Massachusetts	3
Michigan	3
Missouri	3
New Mexico	1
New York	3
North Carolina	1
Ohio	3
Oklahoma*	2
Oregon*	1
Pennsylvania	7
Texas	5
Virginia	1
Wisconsin	2
Total	53

*States with existing licensure

Source: CBMT

Table 3. CBMT-Disciplinary Action by Year

Year	Incidents Reported
Prior to 2010	5
2010	2
2011	0
2012	1
2013	1
2014	0
2015	9
2016	11
2017	7
2018	13
2019	4
Total	53

Source: CBMT

Virginia does not delineate disciplinary actions or complaints against practitioners with music therapy credentials and there have been no cases reported to the Department of Health Professions. Virginia does not have a peer review mechanism for music therapists; however, credentialed music therapists are subject to review according to the CBMT code of Professional Practice. (Appendix 9) Both AMTA and CBMT have mechanisms by which music therapists who are in violation of safe and ethical practice are investigated.

Music therapists do not utilize dangerous equipment while performing within their practice guidelines. They do however work with vulnerable populations, individuals with intellectual or emotional disabilities, or persons coping with physical, mental or terminal health diagnosis. The potential for harm exists if a nonqualified individual provides inappropriate applications of music therapy interventions that could cause emotional harm.

The Virginia Department of Education does not formally recognize the profession or its national board certification credential. VMTA purports that a lack of recognition has led to the disruption of student progress, school staff being asked to provide services they are not qualified to offer, and significant frustration for families affected by the interpretation of the federal special education law. (VMTA, 2019)

To protect the public from threats of harm in clinical practice, music therapists comply with safety standards and with transport protocols for clients. A therapist is trained to recognize the potential harm of music experiences and use them with care. The therapist knows the potential harm of verbal and physical interventions during music experiences and uses them with care. A music therapist practices infection control protocols (e.g., universal precautions, disinfecting instruments) and recognizes client populations and health conditions for which music experiences are contraindicated. (VMTA, 2019)

The potential for fraud does exist, as there are no existing laws or regulations regarding this profession. Virginia does not acknowledge the profession of music therapy, does not codify a scope of practice, nor does it provide any form of title protection for individuals practicing as music therapists. Consumers are not able to determine actual credentialed music therapists with academic and clinical training from those that claim to be music therapists but have no training.

Music therapists in Virginia may qualify for direct third party payments. Third party payers could be paying for services provided by untrained individuals.

CRITERION TWO: SPECIALIZED SKILLS AND TRAINING

EDUCATION

A music therapist must earn a bachelor's degree or higher in music therapy from one of over 80 American Music Therapy Association (AMTA) approved programs and have at minimum the entry level credential, MT-BC to ethically practice as a music therapist.

The curriculum includes coursework in music, music therapy, biology, psychology, social and behavioral sciences, disabilities and general studies as outlined below.

Musical Foundations (45%)

Music Theory, Composition and Arranging, Music History and Literature, Applied Music Major, Ensembles, Conducting, Functional Piano, Guitar, and Voice

Clinical Foundations (15%)

Exceptionality and Psychopathology, Normal Human Development, Principles of Therapy, The Therapeutic Relationship

Music Therapy (15%)

Foundations and Principles, Assessment and Evaluation, Methods and Techniques, Pre-Internship and Internship Courses, Psychology of Music, Music Therapy Research, Influence of Music on Behavior, Music Therapy with Various Populations

General Education (20-25%)

English, Math, Social Sciences, Arts, Humanities, Physical Sciences, etc.

Electives (5%)

Clinical skills are developed through 1,200 hours of required fieldwork, including an extended internship requirement in an approved mental health, special education, education or health care facility. Clinical supervisors must meet minimum requirements outlined by the AMTA Standards for Education and Clinical Training (Appendix 4) and abide by the AMTA Professional Competencies (Appendix 5), CBMT Board Certification Domains (Appendix 6) and AMTA Code of Ethics (Appendix 7). (AMTA, 2019)

Upon successful completion of the music therapy bachelor's degree an individual is eligible to sit for the national certification exam to obtain the credential Music Therapist-Board Certified (MT-BC) which is necessary for professional practice. The Certification Board administers the national exam for Music Therapists. The exam consists of a 150 question multiple-choice test administered by computer at over 200 Assessment Centers geographically. To maintain this credential, 100 hours of continued competence in music therapy education is required every five years. (AMTA, 2019)

All board certified music therapists receive education and training in compliance procedures for state, federal and facility regulations and accreditation. They are trained and skilled to conduct music therapy assessments, draft and incorporate goals and objectives into treatment plans, specify procedures and define expected treatment outcomes, evaluate and make appropriate modifications and accommodations and document the process utilizing standard tools. (AMTA, 2019)

There are two universities in Virginia, Radford University and Shenandoah University, that offer bachelor's level and master's level music therapy training. Both are accredited and approved by the AMTA. Radford University is also approved by the National Association of Schools of Music (NASM). (Appendix 8)

MASTER'S DEGREE

A music therapist with a bachelor's degree in music therapy may obtain a master's degree in music therapy to expand the depth and breadth of their clinical skills in advanced and specialized fields of study such as supervision, college teaching, administration, a particular method, orientation, or population.

DOCTORAL DEGREES

Although there is no AMTA-approved doctoral degree in music therapy, selected universities do offer coursework in music therapy in combination with doctoral study in related disciplines, which imparts advanced competence in research, theory, development, clinical practice, supervision, college teaching, and/or clinical administration, depending on the title and purpose of the degree program. (AMTA, 2019)

CREDENTIALING

Nationally, the CBMT is the only organization to certify a music therapist to practice music therapy. Since 1986, the CBMT MT-BC program has been fully accredited by the National Commission for Certifying Agencies (NCCA). Some music therapists hold older designations as a registered music therapist (RMT), certified music therapist (CMT) or advanced certified music therapist (ACMT) which were issued by the American Music Association of Music Therapy (AMTA) or the National Association of Music Therapy (NAMT). The ACMT and NAMT merged into the American Music Therapy Association (AMTA). The AMTA has phased out the AMT, CMT and ACMT designations as well as the national registry. Currently music therapists seeking national certification must obtain the MT-BC credential.

Table 4. Virginia Music Therapists with CBMT Certification

Year	Number Certified Each Year
1985-2008	88
2009	11
2010	11
2011	5
2012	8
2013	10
2014	18
2015	17
2016	20
2017	16
2018	16
2019	7
Total	227

Source: CBMT-Virginia Certified Music Therapist

The CBMT administers the examination, which is based on a nationwide music therapy practice analysis that is reviewed and updated every five years to reflect current clinical practice. Both the practice analysis and the examination are psychometrically sound and developed using guidelines issued by the Equal Employment Opportunity Commission, and the American Psychological Association’s standards for test validation.

To maintain this credential, music therapists must demonstrate continued competence by completing 100 recertification credits or retaking and passing the CBMT examination within each five-year recertification cycle. The CBMT recertification program provides music therapists with guidelines for remaining current with safe and competent practice and enhancing their knowledge in the profession of music therapy.

CBMT credentialing allows for easy recognition of individuals who have successfully completed an academic and clinical training program approved by the AMTA and successfully completed a written objective examination demonstrating current competency in the profession of music therapy. Today, over 8,200 music therapists hold the credential, Music Therapist-Board Certified (MT-BC). There are over 200 MT-BC therapists in Virginia. (Table 4)

The purpose of board certification in music therapy is to provide an objective national standard that can be used as a measure of professionalism and competence by interested agencies, groups, and individuals. The MT-BC credential may also be required to meet state laws and regulations. Any person representing him or herself as a board certified music therapist must hold the MT-BC credential awarded by CBMT.

CRITERION THREE: AUTONOMOUS PRACTICE

Whether practice is autonomous or not depends on the music therapist’s clinical practice setting. Should the music therapist have a private practice all treatment would likely be unsupervised, holding the music therapist accountable for the job they perform. However, when treating patients in a clinical environment or school setting, there would be some level of being both supervised and unsupervised, holding both parties accountable for the job being performed. Virginia currently cannot hold music therapists legally liable for improper conduct or unethical practice as no standards have been established for this unlicensed profession. Music therapist currently follow the Standards of Clinical Practice (Appendix 3) established by the AMTA.

According to the AMTA Standards of Clinical Practice, music therapists in private practice are responsible for seeking and participating in supervision on a regular basis. Types of supervision may include but are not limited to direct observation, peer review, verbal feedback, group supervision, individual supervision, and music based supervision. A music therapist may seek supervision from another music therapist as well as other

professionals including but not limited to psychologists, psychiatrists, social workers, art therapists, dance/movement therapists, drama therapists, physical therapists, occupational therapists, speech language pathologists, physicians, and nurses. Supervision is only mandatory for selected advanced practice certifications.

Music therapists design music therapy treatment plans, collaborate with other health care providers, direct the music therapy portion of treatment but do not typically direct an overall patient care program. In general, a music therapist works as a member of the treatment team, alongside nurses, physicians and allied health providers. Clients have direct access to music therapy. Other occupational groups may also refer them. Music therapists do not diagnose or use dangerous equipment or substances. (AMTA, 2019)

CRITERION FOUR: SCOPE OF PRACTICE AND OVERLAP

The practice of music therapy is specific in its scope of practice (Appendix 2). Music therapists provide health care and educational support services to individuals of all ages and ability levels. Client groups include individuals with developmental disabilities, mental illnesses, acute or chronic illnesses or pain, impairments or injuries due to accidents or aging, hearing, visual or speech impairments, terminal illnesses, the learning disabled, and others with health and wellness issues. (AMTA, 2019)

Typical work settings for music therapists include medical facilities, mental health settings, geriatric facilities, developmental centers, educational facilities and private practice settings. Music therapists often work in conjunction with an interdisciplinary treatment team. (AMTA, 2019)

There are several professions (licensed and unlicensed) that use or may use music as a modality for treatment. Licensed professions that may employ musical modalities include psychologists, occupational therapists, speech-language pathologists, marriage and family therapists, professional counselors, social workers and massage therapists. These professions are licensed by the Department of Health Professions. Unlicensed professions who may use music include hypnotherapists, therapeutic musicians, music practitioners and healing musicians.

Music therapy differs from the professions listed above in that its practice uses music interventions to accomplish individualized goals. This form of therapy involves the development of music therapy treatment plans specific to the needs and strengths of the individual client.

The regulation of music therapists could negatively affect other licensed professionals who use music during treatment. Regulation would also negatively affect individuals utilizing the term “music therapy” when they do not hold the necessary credentials to do so. (AMTA, 2019)

CRITERION FIVE: ECONOMIC IMPACT

WAGES & SALARIES

Available compensation data on the profession is subsumed within broader behavioral health providers' categories, specifically Recreational Therapists. The U.S. Department of Labor Bureau of Labor Statistics in May 2018 showed that the national median salary per year for recreational therapists is \$47,860 with a salary range of \$29,590 up to \$77,050. (BLS, 2019)

The Virginia Labor Market Information (LMI) occupation profile does not provide information specifically for music therapists, but rather groups them under recreational therapists. Recreational therapists in Virginia have a median annual wage of \$43,180.00.

Table 5. Salary of Music Therapists by State

State	Salary
Connecticut	\$48,730
Georgia	\$43,270
Nevada	\$53,580
North Dakota	\$44,510
Oklahoma	\$36,980
Oregon	\$56,970
Rhode Island	\$43,610
Utah	\$42,030
Wisconsin	\$41,010

Source: Career Explorer-Music Therapist Salary

According to the AMTA, music therapists' salaries vary based on location, setting, population, experience, training, full time or part time employment, as well as a number of other factors. Many music therapists work in private practice and charge an hourly rate for services. In 2014, the overall average salary reported by all music therapists surveyed was \$50,808. The overall median salary reported in 2014 was \$46,000 and the overall most commonly reported salary was \$40,000. (Table 5)

The average hourly individual rate for a music therapist in the Mid-Atlantic region is \$83.31 with the average hourly group rate per person at \$78.04. The national average hourly individual rate is \$68.93 with the average hourly group rate per person is \$77.67. (VMTA, 2019)

WORKFORCE ADEQUACY

According to CBMT, there are 227 music therapists in Virginia with the MT-BC credential. Whether there is a shortage or an oversupply of these practitioners in Virginia is unknown. The profession-distinct supply and demand data are not available to make such assessment. It may be said that as mental health providers in Virginia, that music therapists do provide care to individuals in need of this unique type of mental health care.

Many facilities that would employ music therapists often require providers to have state recognized credentials. The Virginia Department of Education does not recognize music therapists or the MT-BC credential as the profession is not licensed in Virginia.

REIMBURSEMENT

The American Music Therapy Association now estimates that approximately 20% of music therapists receive third party reimbursement for the services they provide.

Music therapy is comparable to other allied health professions such as occupational therapy and physical therapy in that individual assessments are provided for each client, service must be found reasonable and necessary for the individual's illness or injury, and interventions must include a goal-directed documented treatment plan.

MEDICARE

Since 1994, music therapy has been identified as a reimbursable service under benefits for Partial Hospitalization Programs (PHP). Falling under the heading of Activity Therapy, the interventions cannot be purely recreational or diversionary in nature and must be individualized and based on goals specified in the treatment plan. The current HCPCS Code for PHP is G0176.

Music therapy must be considered an active treatment by meeting the following criteria:

1. Be prescribed by a physician;
2. Be reasonable and necessary for the treatment of the individual's illness or injury;
3. Be goal directed and based on a documented treatment plan;
4. The goal of treatment cannot be to merely maintain current level of functioning; the individual must exhibit some level of improvement.

MEDICAID

There are currently a few states that allow payment for music therapy services through use of Medicaid Home and Community Based Care waivers with certain client groups. In some situations, although music therapy may not be specifically listed within regulatory language, due to functional outcomes achieved, music therapy interventions qualify for coverage under existing treatment categories such as community support, rehabilitation, or habilitation services. Approximately 23 states provide funding for music therapy services through Medicaid Waiver programs or state agency funds.

PRIVATE INSURANCE

At this time, private insurance companies in Virginia are not directly reimbursing for music therapy service.

Nationally, AMTA reports that approximately 20% of music therapy services receive third-party reimbursement. Companies like Blue Cross Blue Shield, United Healthcare, Cigna, and Aetna have all paid for music therapy services at some time. Like other therapies, music therapy is reimbursable when services are pre-approved and deemed medically or behaviorally necessary to reach the individual patient's treatment goals.

OTHER SOURCES

Additional sources for reimbursement and financing of music therapy services include many state departments of mental health, state departments of developmental disabilities, state adoption subsidy programs, private auto insurance, employee worker's compensation, county boards of developmental disabilities, IDEA Part B related services funds, foundations, grants, and private pay. (AMTA, 2019)

IMPACT OF LICENSURE ON THE DEPARTMENT OF HEALTH PROFESSIONS

Some regulated professions lack a sufficient number of individuals to cover their regulatory costs. This places a strain on a board's cash resources.

CRITERIA SIX AND SEVEN: ALTERNATIVES TO REGULATION/ LEAST RESTRICTIVE REGULATION

Currently, nine states regulate music therapists. Five states license music therapists, one state provides title protection only, one state provides title certification, and two states require registration. (Table 6) Currently there are 11 states seeking some form of legislation. (Table 7)

Table 6. Current State Licensure Recognition

State	Licensure	Title Certification	Title Protection	Registry
Connecticut			Must hold MT-BC	
Georgia (LPMT)	X - 140			
Nevada (LPMT)	X - 23			
North Dakota (MT-BC/L)	X - 18			
Oklahoma (LPMT)	X - 23			
Oregon (LPMT)	X - 76			
Rhode Island (LPMT)	X - 8			X***
Utah (SCMT)		X - 54**		
Wisconsin (WMTR)				X - 38*
Total	288	54		38

*Applicants must be certified, registered or accredited as Music Therapists by one of the following organizations:

The Certification Board for Music Therapists, National Music Therapy Registry, American Music Therapy Association, or another national organization that certifies, registers, or accredits Music Therapists.

**Currently seeking licensure

***Rhode Island-registration functions as a license

Source: AMTA

Table 7. 2018 Legislative Activity by State

State	Licensure	Title Certification	Title Protection	Registry
Illinois	X			
Iowa		X		
Michigan	X			
Minnesota	X			
Missouri			X	
New Jersey	X			
New York	X			
North Carolina	X			
Ohio	X			
Pennsylvania	X			
Utah	X			
Total	9	1	1	

Source: AMTA

MUSIC THERAPY LICENSURE IN OTHER STATES

CONNECTICUT (2016)

Music therapists in Connecticut are not strictly regulated and are provided title protection only. Individuals who are not board certified by the CBMT and have not graduated with a bachelor’s degree from an AMTA accredited program cannot call themselves “music therapists” or “certified music therapists”. An individual that wrongly uses either title is guilty of a class D felony. (Connecticut, 2019)

GEORGIA (2012)

In Georgia, music therapists are licensed, pursuant to statute, by the Secretary of State. Music therapists who wish to be licensed must obtain a bachelor’s degree from an accredited AMTA school, complete a minimum of 1,200 hours of clinical training, have passed the CBMT exam, have passed a criminal background check, and must be at least 18 years of age. Licensure renewal requires maintaining the MT-BC credential, and 40 hours of continuing education approved by the CBMT. (Georgia, 2019)

NEVADA (2011)

Music therapists are licensed in Nevada by the Bureau of Health Care Quality and Compliance. Licensure protects the public health, safety and welfare from unqualified or unlicensed individuals. Qualifications for licensure include at least a bachelor’s degree from an accredited AMTA school, submission of a licensing fee, completion of a minimum of 1,200 hours of clinical training, a passing grade on the CBMT exam, a criminal background check, and must be at least 18 years of age. Licensure renewal requires completion of 100 hours of continuing education every three years from a CBMT approved program. (Nevada, 2019)

NORTH DAKOTA (2011)

Music therapists in North Dakota are regulated by the Board of Integrative Health Care. Qualifications for licensure include graduation from a board-approved program, completion of a board-approved exam, good standing with the CBMT, have the physical, mental, and professional competencies to practice and have not committed any acts that would warrant discipline. Licenses expire biannually and 40 hours of approved continuing education must be completed biannually. (North Dakota, 2019)

OKLAHOMA (2011)

Music therapists in Oklahoma are licensed by the State Board of Medical Licensure and Supervision. Music therapists must hold at least a bachelor's degree in music therapy by an AMTA approved program, completed at least 1,200 hours of clinical training in an approved program, have a passing grade on the CBMT exam, be at least 18 years old, and be in good moral character. Licenses expire every two years and music therapists must remain in good standing with the CBMT. (Oklahoma, 2019)

OREGON (2015)

In Oregon the Health Licensing Office regulates music therapists. To obtain licensure, a music therapist must pass the CBMT certification exam within two years preceding application submission, maintaining CBMT certification as well as a professional designation and must be at least 18 years of age. To maintain licensure music therapists must complete a minimum of ten continuing education credits each year. (Oregon, 2019)

RHODE ISLAND (2014)

Music therapists in Rhode Island are regulated by the Department of Health and are termed "registered," with registration functioning as a license. To qualify for registration as a music therapist an applicant must hold a bachelor's degree from an AMTA approved school, complete a minimum of 1,200 hours of clinical training provided by an AMTA approved program, pass the CBMT certification board exam, currently be a board certified music therapist, and be at least 18 years of age. Registrations expire biannually and renewal requirement is that the music therapist remain board certified. (Rhode Island, 2019)

UTAH (2014)

Utah music therapists are regulated by the Division of Occupational and Professional Licensing. To qualify for certification as a music therapist an applicant must be in good standing with the CBMT, be of good moral character, and pay an application fee. Certificates expire biannually and to renew a music therapist must prove good standing with the CBMT. This certification system functions closer to a title protection act than a practice act, but it does allow for more disciplinary measures than traditional title protection. (Utah, 2019)

WISCONSIN (2011)

The Department of Safety and Professional Services regulates Wisconsin music therapists. Music therapists fall under a subset of creative arts therapists, which itself is a subset of psychotherapists. Music therapists must be CBMT board certified, disclose criminal convictions or pending criminal charges and pay an application fee. Registration expires biannually and to renew a registration a music therapist must maintain CBMT certification.

To register as a psychotherapist, which is optional for music therapists, the individual must pass an exam on the Wisconsin statutes and rules that apply specifically to the profession, hold a master's or doctoral level degree in music therapy from an approved AMTA school, submit completion of at least 3,000 hours of clinical training in the form of signed and sworn affidavits, pass the CBMT certification exam, disclose any criminal convictions or pending criminal charges and pay an application fee. Psychotherapy registrations expire biannually and music therapists must remain in good standing with the CBMT to renew. (Wisconsin, 2019)

Summary of the Public Hearing

A public hearing was conducted on June 24, 2019 in Board Room 4 at 9:00 AM at the Department of Health Professions, 9960 Mayland Drive, Henrico, Virginia. The purpose of the hearing was to receive public comment on the need to regulate music therapists in the Commonwealth of Virginia.

Approximately 13 persons attended the hearing representing related professional organizations, hospital organizations, universities, as well as individuals previously and currently employed in these and related professions. Comment on the need for regulation closed July 31, 2019 with 64 comments received in writing at the offices of the Board of Health Professions. All of the comments received were in support of regulation. A transcript of the comments from the public hearing (Appendix 11) and copies of comments received via correspondence are included in this report (Appendix 12).

The RRC requested at the June 24, 2019 public hearing additional information from the VMTA regarding their request to be licensed under the Virginia Board of Medicine rather than the Board of Social Work. The VMTA responded with the following statement, "Music therapy is first and foremost an allied health profession. Although some music therapists work in mental health (approx. 20%), the majority work in other areas of practice, including rehabilitation, medical, special education, early intervention, and aging, and target non-mental health goals, such as physical, cognitive, communicative, and academic ones. Similar to Occupational Therapists, who address a wide range of health goals and are overseen by the Board of Medicine, our preference is to be included under this Board should the Board of Health Professions determine a need for licensure. However, we certainly defer to the expertise of your committee/Board in determining the best placement for our profession."

Board of Medicine:

Currently, the Virginia Board of Medicine has 10 advisory boards: acupuncture (547), athletic trainers (1,699), behavior analysis (1,174), genetic counseling (230), midwifery (87), occupational therapy (5,814), physician assistants (4,143), polysomnographic technology (496), radiological technology (4,491) and respiratory therapists (4,016). Each of these professions is licensed.

The Board of Medicine also has two professions that are registration only: surgical assistant (251) and surgical technologist (285).

Behavioral Sciences Boards

The Behavioral Sciences boards include the Board of Counseling, the Board of Psychology and the Board of Social Work.

The Board of Counseling licenses: marriage and family therapists (923), professional counselors (5,894) and substance abuse treatment practitioners (257); provides certification of: substance abuse counselors (1,944), substance abuse counseling assistants (261) and rehabilitation providers (226); provides registration of: qualified mental health professional-adult (7,500), qualified mental health professional-child (6,804), qualified mental health professional-trainee (2,008) and peer recovery specialists (239).

The Board of Psychology licenses: applied psychologists (29), clinical psychologists (3,715), school psychologists (100) and school psychologists-limited (601); provides certification of sex offender treatment providers (437); and registration of residents in psychology (865).

The Board of Social Work licenses: associate social workers (1), clinical social workers (7,246) and social workers (859); and registration of supervisees in social work (2,200).

SOURCES

American Music Therapy Association (AMTA). <https://www.musictherapy.org/about/>

Bureau of Labor Statistics (BLS): <https://www.bls.gov/ooh/healthcare/recreational-therapists.htm#tab-5>

Career Explorer: <https://www.careerexplorer.com/careers/music-therapist/salary/west-virginia/>

Certification Board for Music Therapists (CBMT). <https://www.cbmt.org/>

Connecticut Music Therapy Regulations: <https://portal.ct.gov/DPH/Practitioner-Licensing--Investigations/Music-Therapit/Music-Therapist>

Georgia Music Therapy Regulations: <https://sos.ga.gov/index.php/licensing/plb/59/faq>

Labor Market Information-Virginia (LMI: <https://virginiawlmi.com/occupational-employment-statistics-oes?page83019=1&size83019=12>

Nevada Music Therapy Regulations: <http://dph.nv.gov/Reg/MusicTherapist/MusicTherapists - Home/>

North Dakota Music Therapy Regulations: <https://www.legis.nd.gov/cencode/t43c59.pdf>

Oklahoma Music Therapy Regulations: http://www.okmedicalboard.org/music_therapists

Oregon Music Therapy Regulations: <https://www.oregon.gov/OHA/PH/HLO/Pages/Board-Music-Therapy-Program-License.aspx>

Rhode Island Music Therapy Regulations: <http://health.ri.gov/licenses/detail.php?id=287>

Utah Music Therapy Regulations: <https://dopl.utah.gov/music/index.html>

Virginia Music Therapy Association (VMTA). <https://www.musictherapy.org/about/>

Wisconsin Music Therapy Regulations: <https://dsps.wi.gov/Pages/Professions/MusicTherapist/Default.aspx>

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CHAPTER 680

An Act to direct the Board of Health Professions to evaluate whether music therapists and the practice of music therapy should be regulated and the degree of regulation to be imposed.

[S 1547]

Approved March 21, 2019

Be it enacted by the General Assembly of Virginia:

1. § 1. *That the Board of Health Professions shall, pursuant to subdivision 2 of § 54.1-2510 of the Code of Virginia, evaluate whether music therapists and the practice of music therapy should be regulated and the degree of regulation to be imposed. The Board of Health Professions shall report the results of its evaluation to the Chairmen of the Senate Committee on Education and Health and the House Committee on Health, Welfare and Institutions by November 1, 2019.*



CERTIFICATION
BOARD FOR
MUSIC
THERAPISTS

SCOPE OF MUSIC THERAPY PRACTICE

Preamble

The scope of music therapy practice defines the range of responsibilities of a fully qualified music therapy professional with requisite education, clinical training, and board certification. Such practice also is governed by requirements for continuing education, professional responsibility and accountability. This document is designed for music therapists, clients, families, health and education professionals and facilities, state and federal legislators and agency officials, private and public payers, and the general public.

Statement of Purpose

The purpose of this document is to define the scope of music therapy practice by:

1. Outlining the knowledge, skills, abilities, and experience for qualified clinicians to practice safely, effectively and ethically, applying established standards of clinical practice and performing functions without risk of harm to the public;
2. Defining the potential for harm by individuals without formalized music therapy training and credentials; and
3. Describing the education, clinical training, board certification, and continuing education requirements for music therapists.

Definition of Music Therapy and Music Therapist

Music therapy is defined as the clinical and evidence-based use of music interventions to accomplish individualized goals for people of all ages and ability levels within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. A music therapist is an individual who has completed the education and clinical training requirements established by the American Music Therapy Association (AMTA) and who holds current board certification from The Certification Board for Music Therapists (CBMT).

Assumptions

The scope of music therapy practice is based on the values of non-maleficence, beneficence, ethical practice; professional integrity, respect, excellence; and diversity. The following assumptions are the foundation for this document:

- **Public Protection.** The public is entitled to have access to qualified music therapists who practice competently, safely, and ethically.
- **Requisite Training and Skill Sets.** The scope of music therapy

practice includes professional and advanced competencies. The music therapist only provides services within the scope of practice that reflect his/her level of competence. The music therapy profession is not defined by a single music intervention or experience, but rather a continuum of skills sets (simple to complex) that make the profession unique.

- **Evidence-Based Practice.** A music therapist's clinical practice is guided by the integration of the best available research evidence, the client's needs, values, and preferences, and the expertise of the clinician.
- **Overlap in Services.** Music therapists recognize that in order for clients to benefit from an integrated, holistic treatment approach, there will be some overlap in services provided by multiple professions. We acknowledge that other professionals may use music, as appropriate, as long as they are working within their scope.
- **Professional Collaboration.** A competent music therapist will make referrals to other providers (music therapists and non-music therapists) when faced with issues or situations beyond the original clinician's own practice competence, or where greater competence or specialty care is determined as necessary or helpful to the client's condition.
- **Client-Centered Care.** A music therapist is respectful of, and responsive to the needs, values, and preferences of the client and the family. The music therapist involves the client in the treatment planning process, when appropriate.

Music Therapy Practice

Music therapy means the clinical and evidence-based use of music interventions to accomplish individualized goals for people of all ages and ability levels within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. Music therapists develop music therapy treatment plans specific to the needs and strengths of the client who may be seen individually or in groups. Music therapy treatment plans are individualized for each client. The

goals, objectives, and potential strategies of the music therapy services are appropriate for the client and setting. The music therapy interventions may include music improvisation, receptive music listening, song writing, lyric discussion, music and imagery, singing, music performance, learning through music, music combined with other arts, music-assisted relaxation, music-based patient education, electronic music technology, adapted music intervention, and movement to music. Music therapy clinical practice may be in developmental, rehabilitative, habilitative, medical, mental health, preventive, wellness care, or educational areas. Standards of practice in music therapy include:

- Accepting referrals for music therapy services from medical, developmental, mental health, and education professionals; family members; clients; caregivers; or others involved and authorized with provision of client services. Before providing music therapy services to a client for an identified clinical or developmental need, the music therapist collaborates, as applicable, with the primary care provider(s) to review the client's diagnosis, treatment needs, and treatment plan. During the provision of music therapy services to a client, the music therapist collaborates, as applicable, with the client's treatment team;
- Conducting a music therapy assessment of a client to determine if treatment is indicated. If treatment is indicated, the music therapist collects systematic, comprehensive, and accurate information to determine the appropriateness and type of music therapy services to provide for the client;
- Developing an individualized music therapy treatment plan for the client that is based upon the results of the music therapy assessment. The music therapy treatment plan includes individualized goals and objectives that focus on the assessed needs and strengths of the client and specify music therapy approaches and interventions to be used to address these goals and objectives;
- Implementing an individualized music therapy treatment plan that is consistent with any other developmental, rehabilitative, habilitative, medical, mental health, preventive, wellness care, or educational services being provided to the client;
- Evaluating the client's response to music therapy and the music therapy treatment plan, documenting change and progress, and suggesting modifications, as appropriate;
- Developing a plan for determining when the provision of music therapy services is no longer needed in collaboration with the client, physician, or other provider of health care or education of the client, family members of the client, and any other appropriate person upon whom the client relies for support;
- Minimizing any barriers to ensure that the client receives music therapy services in the least restrictive environment;
- Collaborating with and educating the client and the family, caregiver of the client, or any other appropriate person regarding the needs of the client that are being addressed in music therapy and the manner in which the music therapy treatment addresses those needs; and
- Utilizing appropriate knowledge and skills to inform practice including use of research, reasoning, and problem solving skills to determine appropriate actions in the context of each specific clinical setting.

Music therapists are members of an interdisciplinary team of healthcare, education, and other professionals who work collaboratively to address the needs of clients while protecting client confidentiality and privacy. Music therapists function as independent clinicians within the context

of the interdisciplinary team, supporting the treatment goals and co-treating with physicians, nurses, rehabilitative specialists, neurologists, psychologists, psychiatrists, social workers, counselors, behavioral health specialists, physical therapists, occupational therapists, speech-language pathologists, audiologists, educators, clinical case managers, patients, caregivers, and more.

Music therapy-specific assessment, treatment planning, and implementation consider diagnosis and history, are performed in a manner congruent with the client's level of functioning, and address client needs across multiple domains.

Potential for Harm

Music therapists are trained to independently analyze client non-verbal, verbal, psychological, and physiological responses to music and non-music stimuli in order to be clinically effective and refrain from contra-indicated practices. The music therapist implements ongoing evaluation of client responses and adapts the intervention accordingly to protect the client from negative outcomes.

Music therapists use their knowledge, skills, training and experience to facilitate therapeutic, goal oriented music-based interactions that are meaningful and supportive to the function and health of their clients. These components of clinical practice continue to evolve with advances in basic science, translational research, and therapeutic implementation. Music therapists, therefore, participate in continued education to remain competent, know their limitations in professional practice, and recognize when it is appropriate to seek assistance, advice, or consultation, or refer the client to another therapist or professional. In addition, music therapists practice safely and ethically as defined by the AMTA Code of Ethics, AMTA Standards of Clinical Practice, CBMT Code of Professional Practice, CBMT Board Certification Domains, and other applicable state and federal laws. Both AMTA and CBMT have mechanisms by which music therapists who are in violation of safe and ethical practice are investigated.

The use of live music interventions demands that the therapist not only possess the knowledge and skills of a trained therapist, but also the unique skill set of a trained musician in order to manipulate the music therapy intervention to fit clients' needs. Given the diversity of diagnoses with which music therapists work and the practice settings in which they work independently, clinical training and experience are necessary. Individuals attempting to provide music therapy treatment interventions without formalized music therapy training and credentials may pose risks to clients.

To protect the public from threats of harm in clinical practice, music therapists comply with safety standards and competencies such as, but not limited to:

- Recognize and respond to situations in which there are clear and present dangers to a client and/or others.
- Recognize the potential harm of music experiences and use them with care.
- Recognize the potential harm of verbal and physical interventions during music experiences and use them with care.
- Observe infection control protocols (e.g., universal precautions, disinfecting instruments).

- Recognize the client populations and health conditions for which music experiences are contraindicated.
- Comply with safety protocols with regard to transport and physical support of clients.

Definition of Governing Bodies

AMTA's mission is to advance public awareness of the benefits of music therapy and increase access to quality music therapy services in a rapidly changing world. AMTA strives to improve and advance the use of music, in both its breadth and quality, in clinical, educational, and community settings for the betterment of the public health and welfare. The Association serves as the primary organization for the advancement of education, clinical practice, research, and ethical standards in the music therapy profession.

AMTA is committed to:

- Promoting quality clinical treatment and ethical practices regarding the use of music to restore, maintain, and improve the health of all persons.
- Establishing and maintaining education and clinical training standards for persons seeking to be credentialed music therapists.
- Educating the public about music therapy.
- Supporting music therapy research.

The mission of the CBMT is to ensure a standard of excellence in the development, implementation, and promotion of an accredited certification program for safe and competent music therapy practice. CBMT is an independent, non-profit, certifying agency fully accredited by the National Commission for Certifying Agencies (NCCA). This accreditation serves as the means by which CBMT strives to maintain the highest standards possible in the construction and administration of its national examination and recertification programs, ultimately designed to reflect current music therapy practice for the benefit of the consumer.

CBMT is committed to:

- Maintaining the highest possible standards, as established by the Institute for Credentialing Excellence (ICE) and NCCA, for its national certification and recertification programs.
- Maintaining standards for eligibility to sit for the National Examination: Candidates must have completed academic and clinical training requirements established by AMTA.
- Defining and assessing the body of knowledge that represents safe and competent practice in the profession of music therapy and issuing the credential of Music Therapist-Board Certified (MT-BC) to individuals that demonstrate the required level of competence.
- Advocating for recognition of the MT-BC credential and for access to safe and competent practice.
- Maintaining certification and recertification requirements that reflect current practice in the profession of music therapy.
- Providing leadership in music therapy credentialing.

The unique roles of AMTA (education and clinical training) and CBMT (credentialing and continuing education) ensure that the distinct, but related, components of the profession are maintained. This scope of music therapy practice document acknowledges the

separate but complementary contributions of AMTA and CBMT in developing and maintaining professional music therapists and evidence-based practices in the profession.

Education and Clinical Training Requirements

A qualified music therapist:

- Must have graduated with a bachelor's degree (or its equivalent) or higher from a music therapy degree program approved by the American Music Therapy Association (AMTA); and
- Must have successfully completed a minimum of 1,200 hours of supervised clinical work through pre-internship training at the AMTA-approved degree program, and internship training through AMTA-approved National Roster or University Affiliated internship programs, or an equivalent.

Upon successful completion of the AMTA academic and clinical training requirements or its international equivalent, an individual is eligible to sit for the national board certification exam administered by the Certification Board for Music Therapists (CBMT).

Board Certification Requirements

The Music Therapist – Board Certified (MT-BC) credential is granted by the Certification Board for Music Therapists (CBMT) to music therapists who have demonstrated the knowledge, skills, and abilities for competence in the current practice of music therapy. The purpose of board certification in music therapy is to provide an objective national standard that can be used as a measure of professionalism and competence by interested agencies, groups, and individuals. The MT-BC credential may also be required to meet state laws and regulations. Any person representing him or herself as a board certified music therapist must hold the MT-BC credential awarded by CBMT, an independent, nonprofit corporation fully accredited by the National Commission for Certifying Agencies (NCCA).

The board certified music therapist credential, MT-BC, is awarded by the CBMT to an individual upon successful completion of an academic and clinical training program approved by the American Music Therapy Association (or an international equivalent) and successful completion of an objective written examination demonstrating current competency in the profession of music therapy. The CBMT administers this examination, which is based on a nationwide music therapy practice analysis that is reviewed and updated every five years to reflect current clinical practice. Both the practice analysis and the examination are psychometrically sound and developed using guidelines issued by the Equal Employment Opportunity Commission, and the American Psychological Association's standards for test validation.

Once board certified, a music therapist must adhere to the CBMT Code of Professional Practice and recertify every five years through either a program of continuing education or re-examination.

By establishing and maintaining the certification program, CBMT is in compliance with NCCA guidelines and standards that require certifying agencies to: 1) have a plan for periodic recertification, and 2) provide evidence that the recertification program is designed to measure or enhance the continuing competence of the individual.²⁶

The CBMT recertification program provides music therapists with guidelines for remaining current with safe and competent practice and enhancing their knowledge in the profession of music therapy.

The recertification program contributes to the professional development of the board certified music therapist through a program of continuing education, professional development, and professional service opportunities. All three recertification categories are reflective of the Practice Analysis Study and relevant to the knowledge, skills and abilities required of the board certified music therapist. Documentation guidelines in the three categories require applying learning outcomes to music therapy practice and relating them to the CBMT Board Certification Domains. Integrating and applying new knowledge with current practice, developing enhanced skills in delivery of services to clients, and enhancing a board certified music therapist's overall abilities are direct outcomes of the recertification program. To support CBMT's commitment of ensuring the competence of the board certified music therapist and protecting the public, certification must be renewed every five years with the accrual of 100 recertification credits.

NCCA accreditation demonstrates that CBMT and its credentialing program undergo review to demonstrate compliance with certification standards set by an impartial, objective commission whose primary focus is competency assurance and protection of the consumer. The program provides valuable information for music therapists, employers, government agencies, payers, courts and professional organizations. By participating in the CBMT Recertification Program, board certified music therapists promote continuing competence and the safe and effective clinical practice of music therapy.

AMTA and CBMT created this document as a resource pertinent to the practice of music therapy. However, CBMT and AMTA are not offering legal advice, and this material is not a substitute for the services of an attorney in a particular jurisdiction. Both AMTA and CBMT encourage users of this reference who need legal advice on legal matters involving statutes to consult with a competent attorney. Music therapists may also check with their state governments for information on issues like licensure and for other relevant occupational regulation information. Additionally, since laws are subject to change, users of this guide should refer to state governments and case law for current or additional applicable materials.

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AMTA Standards of Clinical Practice

PREAMBLE

Definition Music Therapy is the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program.

Further Clarification:

- "Clinical & evidence-based": There is an integral relationship between music therapy research and clinical practice.
- "Music interventions": The process is "purpose-driven" within a productive use of musical experience based on the AMTA Standards of Clinical Practice.
- "Individualized goals within a therapeutic relationship": This process includes assessment, treatment planning, therapeutic intervention, and evaluation of each client.
- "Credentialed professional": Each credential or professional designation (i.e., MT-BC, RMT, CMT) requires a set of professional competencies to be fulfilled and maintained according to established professional standards.
- "Approved music therapy program": A degreed program with AMTA approval and NASM accreditation.

Music therapy services are rendered by credentialed Music Therapistsⁱ, clinicians who are professional members of the American Music Therapy Association Inc. (AMTA). Although music therapy services exist in diversified settings, there is a core of common procedures and considerations stated formally as standards of general practice for all Music Therapists. Additional standards that are germane for particular clientele are delineated herein for ten areas of music therapy service: 1) addictive disorders, 2) consultant, 3) intellectual and developmental disabilitiesⁱⁱ, 4) educational settings, 5) older adults, 6) medical settings, 7) mental health, 8) physical disabilities, 9) private practice, and 10) wellness practice. These ten areas reflect current music therapy services, but should not be interpreted as strict limits that would prevent development of new areas for music therapy.

Concomitant with the AMTA Code of Ethics, these Standards of Clinical Practice are designed to assist practicing Music Therapists and their employers in their endeavor to provide quality services. The Music Therapist will utilize best professional judgment¹ in the execution of these standards. The AMTA's Standards of Clinical Practice Committee is charged with periodic revision to keep these standards current with advances in the field.

INTRODUCTION

Standards of Clinical Practice for music therapy are defined as rules for measuring the quality of services. These standards are established through the authority of the American Music Therapy Association, Inc. This document first outlines general standards which should apply to all music therapy practice. Following these General Standards are specific standards for each of the ten areas of music therapy service. These serve as further delineations of the General Standards and are linked closely to them. This close relationship is reflected in the numbering system used throughout this document. For example, section 4.0 regarding implementation in the General Standards ends with standard 4.7. The standards on implementation in Mental Health begin with 4.8 and supplement the General Standards with others which are specific to mental health settings. **Thus, the reader should read the General Standards first, and have them in hand when reading the specific standards.**

GENERAL STANDARDS

In delivery of music therapy services, Music Therapists follow a general procedure that includes 1. referral and acceptance, 2. assessmentⁱⁱⁱ, 3. treatment^{iv} planning, 4. implementation, 5. documentation, and 6. termination. Standards for each of these procedural steps are outlined herein and all Music Therapists should adhere to them in their delivery of services. Exceptions must be approved in writing by the Standards of Clinical Practice Committee. Decisions affecting the quality of services should be based on the best professional judgment^v of the Music Therapist with regard to client ratio and caseload, as well as the frequency, length, and duration of sessions. The Music Therapist will allocate time needed to execute responsibilities such as administration, in-service, and services relating to client care in order to provide quality, direct client service.

The recipient of music therapy services may be called by a variety of terms, depending on the setting in which therapy is rendered--e.g., client, consumer, patient, resident, or student. Such diversity of terminology is reflected in this document.

***Note: General Standards are provided in this section as a whole, but are also reprinted in sequence under each setting/population/area of focus to aid in clarity.*

1.0 Standard I - Referral and Acceptance

A client will be accepted for music therapy in accordance with specific criteria.

1.1 A client may be a candidate for music therapy when a cognitive, communication, psychological, educational, social, or physiological need might be ameliorated or prevented by such services.

1.2 A client may be referred for an initial music therapy assessment by:

1.2.1 a Music Therapist

1.2.2 members of other disciplines or agencies

1.2.3 self

1.2.4 parents, guardians, advocates or designated representatives

1.3 The final decision to accept a client for music therapy assessment will be made by a Music Therapist.

2.0 Standard II - Assessment

A client will be assessed by a Music Therapist for music therapy services.

2.1 The music therapy assessment will include the general categories of psychological, cognitive, communicative, social, and physiological functioning focused on the client's needs and strengths. The assessment will also determine the client's responses to music, music skills and musical preferences.

2.2 The music therapy assessment will explore the client's culture. This can include but is not limited to race, ethnicity, language, religion/spirituality, socioeconomic status, family experiences, sexual orientation, gender identity or expression, and social organizations.

2.3 All music therapy assessment methods will be appropriate for the client's chronological age, diagnoses, functioning level, and culture(s). The methods may include, but need not be limited to, observation during music or other situations, interview, verbal and nonverbal interventions, and testing. Information may also be obtained from different disciplines or sources such as the past and present medical and social history in accordance with HIPAA permission regulation.

2.4 All interpretations of test results will be based on appropriate norms or criterion referenced data ^{vii}.

2.5 The music therapy assessment procedures and results will become a part of the client's file.

2.6 The final decision to accept a client for music therapy services, either direct or consultative, will be made by a Music Therapist and, when applicable, will be in conjunction with the interdisciplinary team. Screening ^{vi} may be used as part of this process.

2.7 The results, conclusions, and implications of the music therapy assessment will become the basis for the client's music therapy program and will be communicated to others involved with provision of services to the client. When appropriate, the results will be communicated to the client.

2.8 When assessment indicates the client's need for other services, the Music Therapist will make an appropriate referral.

3.0 Standard III - Treatment Planning

The Music Therapist will develop an individualized treatment plan based upon the music therapy assessment, the client's prognosis, and applicable information from other disciplines and sources. The client will participate in program plan development when appropriate. The music therapy program plan will be designed to:

3.1 Help the client attain and maintain the maximum level of functioning.

3.2 Comply with federal, state, and facility regulations.

3.3 Delineate the type, frequency, and duration of music therapy involvement.

3.4 Contain goals ^{viii} that focus on assessed needs and strengths of the client.

3.5 Contain objectives ^{ix} which are operationally defined for achieving the stated goals within estimated time frames.

3.6 Specify procedures, including music and music materials, for attaining the objectives.

3.6.1 The Music Therapist will include music, instruments, and musical elements, from the client's culture as appropriate.

3.7 Provide for periodic evaluation ^x and appropriate modifications as needed.

3.8 Optimize, according to the best professional judgment ^{xi} of the Music Therapist:

3.8.1 The program plans of other disciplines.

3.8.2 Established principles of normal growth and development.

3.9 Change to meet the priority needs of the client during crisis intervention.

4.0 Standard IV - Implementation

The Music Therapist will deliver services according to the written program plan and will:

4.1 Strive for the highest level and quality of music involvement consistent with the functioning level of the client.

4.1.1 The Music Therapist's provision of music will reflect his or her best abilities as a musician.

4.1.2 Appropriate musical instruments and materials, as well as the best possible sound reproduction equipment should be used in music therapy services.

- 4.1.3 The Music Therapist will make every effort to ensure safe and quality client care.
- 4.2 Use methodology that is consistent with recent advances in health, safety^{xii} and infection control practices.
- 4.3 Maintain close communication with other individuals involved with the client.
- 4.4 Record the schedule and procedures used in music therapy treatment.
- 4.5 Evaluate the client's responses periodically to determine progress toward the goals and objectives.
- 4.6 Incorporate the results of such evaluations in subsequent treatment.
- 4.7 Consider the psychological effects of therapeutic separation as termination of services approaches.

5.0 Standard V - Documentation

The Music Therapist will document the client's referral to music therapy, assessment, placement, treatment plan, and ongoing progress in music therapy in a manner consistent with federal, state, and other regulations and policies.

- 5.1 The Music Therapist will periodically document the client's level of functioning with regard to the goals and objectives.
- 5.2 The documentation of progress will describe significant intervention techniques and the client's responses to them.
- 5.3 In all documentation relating to music therapy services, the Music Therapist will:
 - 5.3.1 Write in an objective, professional style based on observable client responses.
 - 5.3.2 Include the date, signature, and professional status of the therapist.
 - 5.3.3 Place such documentation in the client's file and maintain its confidentiality unless proper authorization for release is obtained.
- 5.4 Upon obtaining written client permission, the Music Therapist will document and disseminate information to key service providers to ensure consistency of services.
- 5.5 The Music Therapist will document referrals made to other sources and will include plans for music therapy services as appropriate.
- 5.6 The documentation of all referrals will include date of referral, source of referral, and services requested.

6.0 Standard VI - Termination of Services

The Music Therapist will terminate music therapy services when the client has attained stated goals and objectives, fails to benefit from services, can no longer be scheduled, or is discharged. At the time of termination, consideration will be given for scheduling periodic reevaluation to determine the need for follow-up services. The Music Therapist will prepare the music therapy termination plan in accordance with federal, state, and facility regulations. The termination plan will:

- 6.1 Further optimize the goals of the individualized music therapy treatment plan.
- 6.2 Coordinate with the individualized treatment plans of other services received by the client.
- 6.3 Allow sufficient time for approval, coordination, and effective implementation whenever possible.

6.4 Summarize the client's progress and functioning level at the time of termination.

7.0 Standard VII - Continuing Education

7.1 It is the responsibility of the Music Therapist to maintain knowledge of current developments in research, theory, and techniques in music therapy related areas specific to the populations and therapeutic settings.

7.2 The Music Therapist will be familiar with current federal, state, and local laws pertaining to issues of client rights and confidentiality.

7.3 The Music Therapist will contribute to the education of others regarding the use and benefits of music therapy.

8.0 Standard VIII - Supervision

8.1 It is the responsibility of the Music Therapist to seek and participate in supervision on a regular basis.

8.1.1 Types of supervision may include but are not limited to direct observation, peer review, verbal feedback, group supervision, individual supervision, and music based supervision.

8.1.2 The Music Therapist may seek supervision from music therapists as well as other professionals including but not limited to psychologists, psychiatrists, social workers, art therapists, dance/movement therapists, drama therapists, physical therapists, occupational therapists, speech language pathologists, physicians, and nurses.

8.2 It is the responsibility of the Music Therapist providing supervision to maintain knowledge of current developments in research, theory, and techniques in music therapy supervision and supervision in general.

8.2.1 The Music Therapist providing supervision will be familiar with current federal, state, and local laws as well as the AMTA Code of Ethics as they pertain to supervision and confidentiality within supervision.

8.2.2 The Music Therapist providing supervision is required to will adhere to all AMTA Standards of Clinical Practice and will assure that the Music Therapist supervisee has read and agrees to adhere to the AMTA Standards of Clinical Practice. The Music Therapist providing supervision shall hold the supervisee accountable for adhering to the AMTA Standards of Clinical Practice.

8.2.3 The Music Therapist providing supervision will complete any necessary documentation pertaining to supervision accurately, completely, and in a timely manner.

8.2.4 The Music Therapist providing supervision will keep all supervision content confidential. All records will be kept for at least five years after the final supervision session.

ADDICTIVE DISORDERS

These Standards of Clinical Practice are designed specifically for the Music Therapist working with clientele who have addictive disorders. The Music Therapist will adhere to the General Standards of Clinical Practice (which are reprinted in sequence in this section), as well as the specific standards for clients with addictive disorders described herein (in dark blue text). The Music Therapist will also adhere to the standards of other applicable music therapy service areas.

Music therapy with clientele who have addictive disorders is the specialized use of music to restore, maintain, and improve mental, physical, and social-emotional functioning.

1.0 Standard I - Referral and Acceptance

A client will be accepted for music therapy in accordance with specific criteria.

1.1 A client may be a candidate for music therapy when a cognitive, communication, psychological, educational, social, or physiological need might be ameliorated or prevented by such services.

1.2 A client may be referred for an initial music therapy assessment by:

1.2.1 a Music Therapist

1.2.2 members of other disciplines or agencies

1.2.3 self

1.2.4 parents, guardians, advocates or designated representatives

1.2.5 Members of a treatment team

1.3 The final decision to accept a client for music therapy assessment will be made by a Music Therapist.

2.0 Standard II - Assessment

A client will be assessed by a Music Therapist for music therapy services.

2.1 The music therapy assessment will include the general categories of psychological, cognitive, communicative, social, and physiological functioning focused on the client's needs and strengths. The assessment will also determine the client's responses to music, music skills and musical preferences.

2.2 The music therapy assessment will explore the client's culture. This can include but is not limited to race, ethnicity, language, religion/spirituality, socioeconomic status, family experiences, sexual orientation, gender identity or expression, and social organizations.

2.3 All music therapy assessment methods will be appropriate for the client's chronological age, diagnoses, functioning level, and culture(s). The methods may include, but need not be limited to, observation during music or other situations, interview, verbal and nonverbal interventions, and testing. Information may also be obtained from different disciplines or sources such as the past and present medical and social history in accordance with HIPAA permission regulation.

2.4 All interpretations of test results will be based on appropriate norms or criterion referenced data ^{vii}.

2.5 The music therapy assessment procedures and results will become a part of the client's file.

2.6 The final decision to accept a client for music therapy services, either direct or consultative, will be made by a Music Therapist and, when applicable, will be in conjunction with the interdisciplinary team. Screening ^{vi} may be used as part of this process.

2.7 The results, conclusions, and implications of the music therapy assessment will become the basis for the client's music therapy program and will be communicated to others involved with provision of services to the client. When appropriate, the results will be communicated to the client.

2.8 When assessment indicates the client's need for other services, the Music Therapist will make an appropriate referral.

2.9 The music therapy assessment will include current diagnosis and history will be performed in a manner congruent with the patient's level of functioning to address the following areas:

2.9.1 Emotional status

- 2.9.2 Motor development (fine, gross, perceptual-motor)
- 2.9.3 Developmental level
- 2.9.4 Independent functioning and adaptive needs
- 2.9.5 Sensory acuity and perception
- 2.9.6 Attending behaviors
- 2.9.7 Sensory processing, planning, and task execution
- 2.9.8 Substance use or abuse
- 2.9.9 Vocational status
- 2.9.10 Reality orientation
- 2.9.11 Educational background
- 2.9.12 Coping skills
- 2.9.13 Infection control precautions
- 2.9.14 Medical regime and possible side effects.
- 2.9.15 Mental status
- 2.9.16 Pain tolerance and threshold level
- 2.9.17 Spatial and body concepts
- 2.9.18 Long and short term memory
- 2.9.19 Client's use of music

3.0 Standard III - Treatment Planning

The Music Therapist will prepare a written individualized program plan based upon the music therapy assessment, the client's prognosis, and applicable information from other disciplines and sources. The client will participate in program plan development when appropriate. The music therapy program plan will be designed to:

- 3.1 Help the client attain and maintain the maximum level of functioning.
- 3.2 Comply with federal, state, and facility regulations.
- 3.3 Delineate the type, frequency, and duration of music therapy involvement.
- 3.4 Contain goals ^{viii} that focus on assessed needs and strengths of the client.
- 3.5 Contain objectives ^{ix} which are operationally defined for achieving the stated goals within estimated time frames.
- 3.6 Specify procedures, including music and music materials, for attaining the objectives.
 - 3.6.1 The Music Therapist will include music, instruments, and musical elements, from the client's culture as appropriate.

- 3.7 Provide for periodic evaluation^x and appropriate modifications as needed.
- 3.8 Optimize, according to the best professional judgment^{xi} of the Music Therapist:
 - 3.8.1 The program plans of other disciplines.
 - 3.8.2 Established principles of normal growth and development.
- 3.9 Change to meet the priority needs of the client during crisis intervention.
- 3.10 Comply with infection control procedures.
- 3.11 Incorporate medical precautions as necessary.

4.0 Standard IV - Implementation

The Music Therapist will deliver services according to the written program plan and will:

- 4.1 Strive for the highest level and quality of music involvement consistent with the functioning level of the client.
 - 4.1.1 The Music Therapist's provision of music will reflect his or her best abilities as a musician.
 - 4.1.2 Appropriate musical instruments and materials, as well as the best possible sound reproduction equipment should be used in music therapy services.
 - 4.1.3 The Music Therapist will make every effort to ensure safe and quality client care.
- 4.2 Use methodology that is consistent with recent advances in health, safety^{xii} and infection control practices.
- 4.3 Maintain close communication with other individuals involved with the client.
- 4.4 Record the schedule and procedures used in music therapy treatment.
- 4.5 Evaluate the client's responses periodically to determine progress toward the goals and objectives.
- 4.6 Incorporate the results of such evaluations in subsequent treatment.
- 4.7 Consider the psychological effects of therapeutic separation as termination of services approaches.
- 4.8 Include family member participation in the treatment plan when appropriate.
- 4.9 Disclose information to the patient and the patient's family consistent with the physician's judgment and discretion in accordance with regulations when appropriate.
- 4.10 Disclose information consistent with the treatment team's recommendations in accordance with federal, state, and local confidentiality regulations.

5.0 Standard V - Documentation

The Music Therapist will document the client's referral to music therapy, assessment, placement, treatment plan, and ongoing progress in music therapy in a manner consistent with federal, state, and other regulations and policies.

- 5.1 The Music Therapist will periodically document the client's level of functioning with regard to the goals and objectives.

5.2 The documentation of progress will describe significant intervention techniques and the client's responses to them.

5.3 In all documentation relating to music therapy services, the Music Therapist will:

5.3.1 Write in an objective, professional style based on observable client responses.

5.3.2 Include the date, signature, and professional status of the therapist.

5.3.3 Place such documentation in the client's file and maintain its confidentiality unless proper authorization for release is obtained.

5.4 Upon obtaining written client permission, the Music Therapist will document and disseminate information to key service providers to ensure consistency of services.

5.5 The Music Therapist will document referrals made to other sources and will include plans for music therapy services as appropriate.

5.6 The documentation of all referrals will include date of referral, source of referral, and services requested.

6.0 Standard VI - Termination of Services

The Music Therapist will terminate music therapy services when the client has attained stated goals and objectives, fails to benefit from services, can no longer be scheduled, or is discharged. At the time of termination, consideration will be given for scheduling periodic reevaluation to determine the need for follow-up services. The Music Therapist will prepare the music therapy termination plan in accordance with federal, state, and facility regulations. The termination plan will:

6.1 Further optimize the goals of the individualized music therapy treatment plan.

6.2 Coordinate with the individualized treatment plans of other services received by the client.

6.3 Allow sufficient time for approval, coordination, and effective implementation whenever possible.

6.4 Summarize the client's progress and functioning level at the time of termination.

6.5 At the time of termination of services, document an evaluation of the client's functional abilities in the following areas: physiological, affective, sensory, communicative, social-emotional, and cognitive functioning.

7.0 Standard VII - Continuing Education

7.1 It is the responsibility of the Music Therapist to maintain knowledge of current developments in research, theory, and techniques in music therapy related areas specific to the populations and therapeutic settings.

7.1.1 The Music Therapist will maintain knowledge of current developments in research, theory, and techniques concerning addictive disorders and related areas.

7.1.2 Related areas may include, but need not be limited to, family systems theory and 12 step programs, such as Alcoholics Anonymous, Narcotics Anonymous and Adult Children of Alcoholics.

7.2 The Music Therapist will be familiar with current federal, state, and local laws pertaining to issues of client rights and confidentiality.

7.3 The Music Therapist will contribute to the education of others regarding the use and benefits of music therapy.

8.0 Standard VIII - Supervision

8.1 It is the responsibility of the Music Therapist to seek and participate in supervision on a regular basis.

8.1.1 Types of supervision may include but are not limited to direct observation, peer review, verbal feedback, group supervision, individual supervision, and music based supervision.

8.1.2 The Music Therapist may seek supervision from music therapists as well as other professionals including but not limited to psychologists, psychiatrists, social workers, art therapists, dance/movement therapists, drama therapists, physical therapists, occupational therapists, speech language pathologists, physicians, and nurses.

8.2 It is the responsibility of the Music Therapist providing supervision to maintain knowledge of current developments in research, theory, and techniques in music therapy supervision and supervision in general.

8.2.1 The Music Therapist providing supervision will be familiar with current federal, state, and local laws as well as the AMTA Code of Ethics as they pertain to supervision and confidentiality within supervision.

8.2.2 The Music Therapist providing supervision is required to will adhere to all AMTA Standards of Clinical Practice and will assure that the Music Therapist supervisee has read and agrees to adhere to the AMTA Standards of Clinical Practice. The Music Therapist providing supervision shall hold the supervisee accountable for adhering to the AMTA Standards of Clinical Practice.

8.2.3 The Music Therapist providing supervision will complete any necessary documentation pertaining to supervision accurately, completely, and in a timely manner.

8.2.4 The Music Therapist providing supervision will keep all supervision content confidential. All records will be kept for at least five years after the final supervision session.

CONSULTANT

These Standards of Clinical Practice are designed specifically for the Music Therapist working as a consultant in various settings such as educational, psychiatric, medical, and rehabilitation facilities and with professionals of other disciplines. The Music Therapist consultant will adhere to the General Standards of Clinical Practice (which are reprinted in sequence in this section), as well as the specific standards for consultative music therapy services described herein (in dark blue text). The Music Therapist will also adhere to the standards of other applicable music therapy service areas.

The music therapy consultant may provide services to other professionals in music therapy and related disciplines and to others directly involved with the client. The consultant may also provide resource information regarding music therapy techniques and materials or may design music therapy programs for clientele in various settings.

1.0 Standard I - Referral and Acceptance

A client will be accepted for music therapy in accordance with specific criteria.

1.1 A client may be a candidate for music therapy when a cognitive, communication, psychological, educational, social, or physiological need might be ameliorated or prevented by such services.

1.2 A client may be referred for an initial music therapy assessment by:

1.2.1 a Music Therapist

1.2.2 members of other disciplines or agencies

1.2.3 self

1.2.4 parents, guardians, advocates or designated representatives

1.3 The final decision to accept a client for music therapy assessment will be made by a Music Therapist.

1.4 The Music Therapist consultant will establish a written contract which details the services and responsibilities of both the consultee and the consultant.

1.5 The Music Therapist consultant will adopt a fee schedule which is fair and appropriate for professional services rendered.

2.0 Standard II - Assessment

A client will be assessed by a Music Therapist for music therapy services.

2.1 The music therapy assessment will include the general categories of psychological, cognitive, communicative, social, and physiological functioning focused on the client's needs and strengths. The assessment will also determine the client's responses to music, music skills and musical preferences.

2.2 The music therapy assessment will explore the client's culture. This can include but is not limited to race, ethnicity, language, religion/spirituality, socioeconomic status, family experiences, sexual orientation, gender identity or expression, and social organizations.

2.3 All music therapy assessment methods will be appropriate for the client's chronological age, diagnoses, functioning level, and culture(s). The methods may include, but need not be limited to, observation during music or other situations, interview, verbal and nonverbal interventions, and testing. Information may also be obtained from different disciplines or sources such as the past and present medical and social history in accordance with HIPAA permission regulation.

2.4 All interpretations of test results will be based on appropriate norms or criterion referenced data ^{vii}.

2.5 The music therapy assessment procedures and results will become a part of the client's file.

2.6 The final decision to accept a client for music therapy services, either direct or consultative, will be made by a Music Therapist and, when applicable, will be in conjunction with the interdisciplinary team. Screening ^{vi} may be used as part of this process.

2.7 The results, conclusions, and implications of the music therapy assessment will become the basis for the client's music therapy program and will be communicated to others involved with provision of services to the client. When appropriate, the results will be communicated to the client.

2.8 When assessment indicates the client's need for other services, the Music Therapist will make an appropriate referral.

3.0 Standard III - Treatment Planning

The Music Therapist will prepare a written individualized program plan based upon the music therapy assessment, the client's prognosis, and applicable information from other disciplines and sources. The client will participate in program plan development when appropriate. The music therapy program plan will be designed to:

3.1 Help the client attain and maintain the maximum level of functioning.

3.2 Comply with federal, state, and facility regulations.

3.3 Delineate the type, frequency, and duration of music therapy involvement.

3.4 Contain goals ^{viii} that focus on assessed needs and strengths of the client.

3.5 Contain objectives^{ix} which are operationally defined for achieving the stated goals within estimated time frames.

3.6 Specify procedures, including music and music materials, for attaining the objectives.

3.6.1 The Music Therapist will include music, instruments, and musical elements, from the client's culture as appropriate.

3.7 Provide for periodic evaluation^x and appropriate modifications as needed.

3.8 Optimize, according to the best professional judgment^{xi} of the Music Therapist:

3.8.1 The program plans of other disciplines.

3.8.2 Established principles of normal growth and development.

3.9 Change to meet the priority needs of the client during crisis intervention.

3.10 Comply with infection control procedures.

3.11 Incorporate medical precautions as necessary.

4.0 Standard IV - Implementation

The Music Therapist will deliver services according to the written program plan and will:

4.1 Strive for the highest level and quality of music involvement consistent with the functioning level of the client.

4.1.1 The Music Therapist's provision of music will reflect his or her best abilities as a musician.

4.1.2 Appropriate musical instruments and materials, as well as the best possible sound reproduction equipment should be used in music therapy services.

4.1.3 The Music Therapist will make every effort to ensure safe and quality client care.

4.2 Use methodology that is consistent with recent advances in health, safety^{xii} and infection control practices.

4.3 Maintain close communication with other individuals involved with the client.

4.4 Record the schedule and procedures used in music therapy treatment.

4.5 Evaluate the client's responses periodically to determine progress toward the goals and objectives.

4.6 Incorporate the results of such evaluations in subsequent treatment.

4.7 Consider the psychological effects of therapeutic separation as termination of services approaches.

5.0 Standard V - Documentation

The Music Therapist will document the client's referral to music therapy, assessment, placement, treatment plan, and ongoing progress in music therapy in a manner consistent with federal, state, and other regulations and policies.

5.1 The Music Therapist will periodically document the client's level of functioning with regard to the goals and objectives.

5.2 The documentation of progress will describe significant intervention techniques and the client's responses to them.

5.3 In all documentation relating to music therapy services, the Music Therapist will:

5.3.1 Write in an objective, professional style based on observable client responses.

5.3.2 Include the date, signature, and professional status of the therapist.

5.3.3 Place such documentation in the client's file and maintain its confidentiality unless proper authorization for release is obtained.

5.4 Upon obtaining written client permission, the Music Therapist will document and disseminate information to key service providers to ensure consistency of services.

5.5 The Music Therapist will document referrals made to other sources and will include plans for music therapy services as appropriate.

5.6 The documentation of all referrals will include date of referral, source of referral, and services requested.

6.0 Standard VI - Termination of Services

The Music Therapist will terminate music therapy services when the client has attained stated goals and objectives, fails to benefit from services, can no longer be scheduled, or is discharged. At the time of termination, consideration will be given for scheduling periodic reevaluation to determine the need for follow-up services. The Music Therapist will prepare the music therapy termination plan in accordance with federal, state, and facility regulations. The termination plan will:

6.1 Further optimize the goals of the individualized music therapy treatment plan.

6.2 Coordinate with the individualized treatment plans of other services received by the client.

6.3 Allow sufficient time for approval, coordination, and effective implementation whenever possible.

6.4 Summarize the client's progress and functioning level at the time of termination.

7.0 Standard VII - Continuing Education

7.1 It is the responsibility of the Music Therapist to maintain knowledge of current developments in research, theory, and techniques in music therapy related areas specific to the populations and therapeutic settings.

7.2 The Music Therapist will be familiar with current federal, state, and local laws pertaining to issues of client rights and confidentiality.

7.3 The Music Therapist will contribute to the education of others regarding the use and benefits of music therapy.

8.0 Standard VIII - Supervision

8.1 It is the responsibility of the Music Therapist to seek and participate in supervision on a regular basis.

8.1.1 Types of supervision may include but are not limited to direct observation, peer review, verbal feedback, group supervision, individual supervision, and music based supervision.

8.1.2 The Music Therapist may seek supervision from music therapists as well as other professionals including but not limited to psychologists, psychiatrists, social workers, art therapists, dance/movement

therapists, drama therapists, physical therapists, occupational therapists, speech language pathologists, physicians, and nurses.

8.2 It is the responsibility of the Music Therapist providing supervision to maintain knowledge of current developments in research, theory, and techniques in music therapy supervision and supervision in general.

8.2.1 The Music Therapist providing supervision will be familiar with current federal, state, and local laws as well as the AMTA Code of Ethics as they pertain to supervision and confidentiality within supervision.

8.2.2 The Music Therapist providing supervision is required to will adhere to all AMTA Standards of Clinical Practice and will assure that the Music Therapist supervisee has read and agrees to adhere to the AMTA Standards of Clinical Practice. The Music Therapist providing supervision shall hold the supervisee accountable for adhering to the AMTA Standards of Clinical Practice.

8.2.3 The Music Therapist providing supervision will complete any necessary documentation pertaining to supervision accurately, completely, and in a timely manner.

8.2.4 The Music Therapist providing supervision will keep all supervision content confidential. All records will be kept for at least five years after the final supervision session.

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

These Standards of Clinical Practice are designed specifically for the Music Therapist working with clientele who have or are at risk for *developmental disabilities. The Music Therapist will adhere to the General Standards of Clinical Practice (which are reprinted in sequence in this section), as well as the specific standards for clients with developmental disabilities described herein (in dark blue text). The Music Therapist will also adhere to the standards of other applicable music therapy service areas.

Music Therapy with clientele who have or are at risk for developmental disabilities is the specialized use of music to improve or maintain functioning in one or more of the following areas: motor, physiological, social/emotional, sensory, communicative, or cognitive functioning.

1.0 Standard I - Referral and Acceptance

A client will be accepted for music therapy in accordance with specific criteria.

1.1 A client may be a candidate for music therapy when a cognitive, communication, psychological, educational, social, or physiological need might be ameliorated or prevented by such services.

1.2 A client may be referred for an initial music therapy assessment by:

1.2.1 a Music Therapist

1.2.2 members of other disciplines or agencies

1.2.3 self

1.2.4 parents, guardians, advocates or designated representatives

1.3 The final decision to accept a client for music therapy assessment will be made by a Music Therapist.

2.0 Standard II - Assessment

A client will be assessed by a Music Therapist for music therapy services.

2.1 The music therapy assessment will include the general categories of psychological, cognitive, communicative, social, and physiological functioning focused on the client's needs and strengths. The assessment will also determine the client's responses to music, music skills and musical preferences.

2.2 The music therapy assessment will explore the client's culture. This can include but is not limited to race, ethnicity, language, religion/spirituality, socioeconomic status, family experiences, sexual orientation, gender identity or expression, and social organizations.

2.3 All music therapy assessment methods will be appropriate for the client's chronological age, diagnoses, functioning level, and culture(s). The methods may include, but need not be limited to, observation during music or other situations, interview, verbal and nonverbal interventions, and testing. Information may also be obtained from different disciplines or sources such as the past and present medical and social history in accordance with HIPAA permission regulation.

2.4 All interpretations of test results will be based on appropriate norms or criterion referenced data^{vii}.

2.5 The music therapy assessment procedures and results will become a part of the client's file.

2.6 The final decision to accept a client for music therapy services, either direct or consultative, will be made by a Music Therapist and, when applicable, will be in conjunction with the interdisciplinary team. Screening^{vi} may be used as part of this process.

2.7 The results, conclusions, and implications of the music therapy assessment will become the basis for the client's music therapy program and will be communicated to others involved with provision of services to the client. When appropriate, the results will be communicated to the client.

2.8 When assessment indicates the client's need for other services, the Music Therapist will make an appropriate referral.

2.9 The music therapy assessment will include current diagnosis and history will be performed in a manner congruent with the client's adaptive functioning and developmental levels to address the following areas:

2.9.1 Motor functioning

2.9.2 Sensory processing, planning and task execution

2.9.3 Emotional status

2.9.4 Coping skills

2.9.5 Infection control procedures

2.9.6 Attending behaviors

2.9.7 Interpersonal relationships

3.0 Standard III - Treatment Planning

The Music Therapist will prepare a written individualized program plan based upon the music therapy assessment, the client's prognosis, and applicable information from other disciplines and sources. The client will participate in program plan development when appropriate. The music therapy program plan will be designed to:

3.1 Help the client attain and maintain the maximum level of functioning.

3.2 Comply with federal, state, and facility regulations.

- 3.3 Delineate the type, frequency, and duration of music therapy involvement.
- 3.4 Contain goals ^{viii} that focus on assessed needs and strengths of the client.
- 3.5 Contain objectives ^{ix} which are operationally defined for achieving the stated goals within estimated time frames.
- 3.6 Specify procedures, including music and music materials, for attaining the objectives.
 - 3.6.1 The Music Therapist will include music, instruments, and musical elements, from the client's culture as appropriate.
- 3.7 Provide for periodic evaluation ^x and appropriate modifications as needed.
- 3.8 Optimize, according to the best professional judgment ^{xi} of the Music Therapist:
 - 3.8.1 The program plans of other disciplines.
 - 3.8.2 Established principles of normal growth and development.
- 3.9 Change to meet the priority needs of the client during crisis intervention.
- 3.10 Comply with infection control procedures.
- 3.11 Incorporate medical precautions as necessary.

4.0 Standard IV - Implementation

The Music Therapist will deliver services according to the written program plan and will:

- 4.1 Strive for the highest level and quality of music involvement consistent with the functioning level of the client.
 - 4.1.1 The Music Therapist's provision of music will reflect his or her best abilities as a musician.
 - 4.1.2 Appropriate musical instruments and materials, as well as the best possible sound reproduction equipment should be used in music therapy services.
 - 4.1.3 The Music Therapist will make every effort to ensure safe and quality client care.
- 4.2 Use methodology that is consistent with recent advances in health, safety ^{xii} and infection control practices.
- 4.3 Maintain close communication with other individuals involved with the client.
- 4.4 Record the schedule and procedures used in music therapy treatment.
- 4.5 Evaluate the client's responses periodically to determine progress toward the goals and objectives.
- 4.6 Incorporate the results of such evaluations in subsequent treatment.
- 4.7 Consider the psychological effects of therapeutic separation as termination of services approaches.

5.0 Standard V - Documentation

The Music Therapist will document the client's referral to music therapy, assessment, placement, treatment plan, and ongoing progress in music therapy in a manner consistent with federal, state, and other regulations and policies.

5.1 The Music Therapist will periodically document the client's level of functioning with regard to the goals and objectives.

5.2 The documentation of progress will describe significant intervention techniques and the client's responses to them.

5.3 In all documentation relating to music therapy services, the Music Therapist will:

5.3.1 Write in an objective, professional style based on observable client responses.

5.3.2 Include the date, signature, and professional status of the therapist.

5.3.3 Place such documentation in the client's file and maintain its confidentiality unless proper authorization for release is obtained.

5.4 Upon obtaining written client permission, the Music Therapist will document and disseminate information to key service providers to ensure consistency of services.

5.5 The Music Therapist will document referrals made to other sources and will include plans for music therapy services as appropriate.

5.6 The documentation of all referrals will include date of referral, source of referral, and services requested.

6.0 Standard VI - Termination of Services

The Music Therapist will terminate music therapy services when the client has attained stated goals and objectives, fails to benefit from services, can no longer be scheduled, or is discharged. At the time of termination, consideration will be given for scheduling periodic reevaluation to determine the need for follow-up services. The Music Therapist will prepare the music therapy termination plan in accordance with federal, state, and facility regulations. The termination plan will:

6.1 Further optimize the goals of the individualized music therapy treatment plan.

6.2 Coordinate with the individualized treatment plans of other services received by the client.

6.3 Allow sufficient time for approval, coordination, and effective implementation whenever possible.

6.4 Summarize the client's progress and functioning level at the time of termination.

7.0 Standard VII - Continuing Education

7.1 It is the responsibility of the Music Therapist to maintain knowledge of current developments in research, theory, and techniques in music therapy related areas specific to the populations and therapeutic settings.

7.1.1 Related areas may include, but need not be limited to, psychopharmacology, neurology, psychology, physiology, special education, early childhood education and early intervention.

7.2 The Music Therapist will be familiar with current federal, state, and local laws pertaining to issues of client rights and confidentiality.

7.3 The Music Therapist will contribute to the education of others regarding the use and benefits of music therapy.

8.0 Standard VIII - Supervision

8.1 It is the responsibility of the Music Therapist to seek and participate in supervision on a regular basis.

8.1.1 Types of supervision may include but are not limited to direct observation, peer review, verbal feedback, group supervision, individual supervision, and music based supervision.

8.1.2 The Music Therapist may seek supervision from music therapists as well as other professionals including but not limited to psychologists, psychiatrists, social workers, art therapists, dance/movement therapists, drama therapists, physical therapists, occupational therapists, speech language pathologists, physicians, and nurses.

8.2 It is the responsibility of the Music Therapist providing supervision to maintain knowledge of current developments in research, theory, and techniques in music therapy supervision and supervision in general.

8.2.1 The Music Therapist providing supervision will be familiar with current federal, state, and local laws as well as the AMTA Code of Ethics as they pertain to supervision and confidentiality within supervision.

8.2.2 The Music Therapist providing supervision is required to will adhere to all AMTA Standards of Clinical Practice and will assure that the Music Therapist supervisee has read and agrees to adhere to the AMTA Standards of Clinical Practice. The Music Therapist providing supervision shall hold the supervisee accountable for adhering to the AMTA Standards of Clinical Practice.

8.2.3 The Music Therapist providing supervision will complete any necessary documentation pertaining to supervision accurately, completely, and in a timely manner.

8.2.4 The Music Therapist providing supervision will keep all supervision content confidential. All records will be kept for at least five years after the final supervision session.

EDUCATIONAL SETTINGS

These Standards of Clinical Practice are designed specifically for the Music Therapist working in educational settings. The Music Therapist will adhere to the General Standards of Clinical Practice (which are reprinted in sequence in this section), as well as the specific standards for educational settings described herein (in dark blue text). The Music Therapist will also adhere to the standards of other applicable music therapy service areas.

Music therapy in publicly funded educational settings for students with disabilities may be defined as the use of music as a medium for assisting the students in meeting defined educational goals and objectives. In providing this service, the Music Therapist works closely with all members of the treatment team. Music therapy in other educational settings may also encompass a broader range of therapeutic goals.

1.0 Standard I - Referral and Acceptance

A client will be accepted for music therapy in accordance with specific criteria.

1.1 A client may be a candidate for music therapy when a cognitive, communication, psychological, educational, social, or physiological need might be ameliorated or prevented by such services.

1.2 A client may be referred for an initial music therapy assessment by:

1.2.1 a Music Therapist

1.2.2 members of other disciplines or agencies

1.2.3 self

1.2.4 parents, guardians, advocates or designated representatives

1.3 The final decision to accept a client for music therapy assessment will be made by a Music Therapist.

2.0 Standard II - Assessment

A client will be assessed by a Music Therapist for music therapy services.

2.1 The music therapy assessment will include the general categories of psychological, cognitive, communicative, social, and physiological functioning focused on the client's needs and strengths. The assessment will also determine the client's responses to music, music skills and musical preferences.

2.2 The music therapy assessment will explore the client's culture. This can include but is not limited to race, ethnicity, language, religion/spirituality, socioeconomic status, family experiences, sexual orientation, gender identity or expression, and social organizations.

2.2.1 The Music Therapist should be a member of the team which writes the student's *individual plan.

2.3 All music therapy assessment methods will be appropriate for the client's chronological age, diagnoses, functioning level, and culture(s). The methods may include, but need not be limited to, observation during music or other situations, interview, verbal and nonverbal interventions, and testing. Information may also be obtained from different disciplines or sources such as the past and present medical and social history in accordance with HIPAA permission regulation.

2.4 All interpretations of test results will be based on appropriate norms or criterion referenced data ^{vii}.

2.5 The music therapy assessment procedures and results will become a part of the client's file.

2.6 The final decision to accept a client for music therapy services, either direct or consultative, will be made by a Music Therapist and, when applicable, will be in conjunction with the interdisciplinary team. Screening ^{vi} may be used as part of this process.

2.7 The results, conclusions, and implications of the music therapy assessment will become the basis for the client's music therapy program and will be communicated to others involved with provision of services to the client. When appropriate, the results will be communicated to the client.

2.8 When assessment indicates the client's need for other services, the Music Therapist will make an appropriate referral.

2.9 The music therapy assessment should be individualized according to the student's level of functioning.

3.0 Standard III - Treatment Planning

The Music Therapist will prepare a written individualized program plan based upon the music therapy assessment, the client's prognosis, and applicable information from other disciplines and sources. The client will participate in program plan development when appropriate. The music therapy program plan will be designed to:

3.1 Help the client attain and maintain the maximum level of functioning.

3.2 Comply with federal, state, and facility regulations.

3.3 Delineate the type, frequency, and duration of music therapy involvement.

3.4 Contain goals ^{viii} that focus on assessed needs and strengths of the client.

3.5 Contain objectives ^{ix} which are operationally defined for achieving the stated goals within estimated time frames.

3.6 Specify procedures, including music and music materials, for attaining the objectives.

3.6.1 The Music Therapist will include music, instruments, and musical elements, from the client's culture as appropriate.

3.7 Provide for periodic evaluation^x and appropriate modifications as needed.

3.8 Optimize, according to the best professional judgment^{xi} of the Music Therapist:

3.8.1 The program plans of other disciplines.

3.8.2 Established principles of normal growth and development.

3.9 Change to meet the priority needs of the client during crisis intervention.

3.10 Comply with infection control procedures.

3.11 Incorporate medical precautions as necessary.

4.0 Standard IV - Implementation

The Music Therapist will deliver services according to the individual plan.

4.1 Strive for the highest level and quality of music involvement consistent with the functioning level of the client.

4.1.1 The Music Therapist's provision of music will reflect his or her best abilities as a musician.

4.1.2 Appropriate musical instruments and materials, as well as the best possible sound reproduction equipment should be used in music therapy services.

4.1.3 The Music Therapist will make every effort to ensure safe and quality client care.

4.2 Use methodology that is consistent with recent advances in health, safety^{xii} and infection control practices.

4.3 Maintain close communication with other individuals involved with the client.

4.4 Record the schedule and procedures used in music therapy treatment.

4.5 Evaluate the client's responses periodically to determine progress toward the goals and objectives.

4.6 Incorporate the results of such evaluations in subsequent treatment.

4.7 Consider the psychological effects of therapeutic separation as termination of services approaches.

4.8 Evaluation must be made in terms of goals and objectives stated in the student's individual plan.

5.0 Standard V - Documentation

The Music Therapist will document the client's referral to music therapy, assessment, placement, treatment plan, and ongoing progress in music therapy in a manner consistent with federal, state, and other regulations and policies.

5.1 The Music Therapist will periodically document the client's level of functioning with regard to the goals and objectives.

5.2 The documentation of progress will describe significant intervention techniques and the client's responses to them.

5.3 In all documentation relating to music therapy services, the Music Therapist will:

5.3.1 Write in an objective, professional style based on observable client responses.

5.3.2 Include the date, signature, and professional status of the therapist.

5.3.3 Place such documentation in the client's file and maintain its confidentiality unless proper authorization for release is obtained.

5.4 Upon obtaining written client permission, the Music Therapist will document and disseminate information to key service providers to ensure consistency of services.

5.5 The Music Therapist will document referrals made to other sources and will include plans for music therapy services as appropriate.

5.6 The documentation of all referrals will include date of referral, source of referral, and services requested.

6.0 Standard VI - Termination of Services

The Music Therapist will terminate music therapy services when the client has attained stated goals and objectives, fails to benefit from services, can no longer be scheduled, or is discharged. At the time of termination, consideration will be given for scheduling periodic reevaluation to determine the need for follow-up services. The Music Therapist will prepare the music therapy termination plan in accordance with federal, state, and facility regulations. The termination plan will:

6.1 Further optimize the goals of the individualized music therapy treatment plan.

6.2 Coordinate with the individualized treatment plans of other services received by the client.

6.3 Allow sufficient time for approval, coordination, and effective implementation whenever possible.

6.4 Summarize the client's progress and functioning level at the time of termination.

7.0 Standard VII - Continuing Education

7.1 It is the responsibility of the Music Therapist to maintain knowledge of current developments in research, theory, and techniques in music therapy related areas specific to the populations and therapeutic settings.

7.1.1 Related areas may include, but need not be limited to psychopharmacology, neurology, psychology, physiology, special education, early childhood education and early intervention.

7.2 The Music Therapist will be familiar with current federal, state, and local laws pertaining to issues of client rights and confidentiality.

7.3 The Music Therapist will contribute to the education of others regarding the use and benefits of music therapy.

8.0 Standard VIII - Supervision

8.1 It is the responsibility of the Music Therapist to seek and participate in supervision on a regular basis.

8.1.1 Types of supervision may include but are not limited to direct observation, peer review, verbal feedback, group supervision, individual supervision, and music based supervision.

8.1.2 The Music Therapist may seek supervision from music therapists as well as other professionals including but not limited to psychologists, psychiatrists, social workers, art therapists, dance/movement therapists, drama therapists, physical therapists, occupational therapists, speech language pathologists, physicians, and nurses.

8.2 It is the responsibility of the Music Therapist providing supervision to maintain knowledge of current developments in research, theory, and techniques in music therapy supervision and supervision in general.

8.2.1 The Music Therapist providing supervision will be familiar with current federal, state, and local laws as well as the AMTA Code of Ethics as they pertain to supervision and confidentiality within supervision.

8.2.2 The Music Therapist providing supervision is required to will adhere to all AMTA Standards of Clinical Practice and will assure that the Music Therapist supervisee has read and agrees to adhere to the AMTA Standards of Clinical Practice. The Music Therapist providing supervision shall hold the supervisee accountable for adhering to the AMTA Standards of Clinical Practice.

8.2.3 The Music Therapist providing supervision will complete any necessary documentation pertaining to supervision accurately, completely, and in a timely manner.

8.2.4 The Music Therapist providing supervision will keep all supervision content confidential. All records will be kept for at least five years after the final supervision session.

OLDER ADULTS

These Standards of Clinical Practice are designed specifically for the Music Therapist working in settings with geriatric clients. The Music Therapist will adhere to the General Standards of Clinical Practice (which are reprinted in sequence in this section), and the specific standards for geriatric settings described herein (in dark blue text). The Music Therapist will also adhere to the standards of other applicable music therapy service areas.

Music therapy with clientele in geriatric settings may be defined as the specialized use of music with emphasis on the development, restoration or maintenance of each individual at the highest possible level of functioning.

1.0 Standard I - Referral and Acceptance

A client will be accepted for music therapy in accordance with specific criteria.

1.1 A client may be a candidate for music therapy when a cognitive, communicative, psychological, educational, social, or physiological need might be ameliorated or prevented by such services.

1.2 A client may be referred for an initial music therapy assessment by:

1.2.1 a Music Therapist

1.2.2 members of other disciplines or agencies

1.2.3 self

1.2.4 parents, guardians, advocates or designated representatives

1.3 The final decision to accept a client for music therapy assessment will be made by a Music Therapist.

2.0 Standard II - Assessment

A client will be assessed by a Music Therapist for music therapy services.

2.1 The music therapy assessment will include the general categories of psychological, cognitive, communicative, social, and physiological functioning focused on the client's needs and strengths. The assessment will also determine the client's responses to music, music skills and musical preferences.

2.2 The music therapy assessment will explore the client's culture. This can include but is not limited to race, ethnicity, language, religion/spirituality, socioeconomic status, family experiences, sexual orientation, gender identity or expression, and social organizations.

2.3 All music therapy assessment methods will be appropriate for the client's chronological age, diagnoses, functioning level, and culture(s). The methods may include, but need not be limited to, observation during music or other situations, interview, verbal and nonverbal interventions, and testing. Information may also be obtained from different disciplines or sources such as the past and present medical and social history in accordance with HIPAA permission regulation.

2.4 All interpretations of test results will be based on appropriate norms or criterion referenced data ^{vii}.

2.5 The music therapy assessment procedures and results will become a part of the client's file.

2.6 The final decision to accept a client for music therapy services, either direct or consultative, will be made by a Music Therapist and, when applicable, will be in conjunction with the interdisciplinary team. Screening ^{vi} may be used as part of this process.

2.7 The results, conclusions, and implications of the music therapy assessment will become the basis for the client's music therapy program and will be communicated to others involved with provision of services to the client. When appropriate, the results will be communicated to the client.

2.8 When assessment indicates the client's need for other services, the Music Therapist will make an appropriate referral.

2.9 The music therapy assessment will include current diagnosis and history will be performed in a manner congruent with the client's level of functioning to address the following areas:

2.9.1 Motor skills.

2.9.2. Reality orientation

2.9.3 Emotional status

2.9.4 Spatial and body concepts

2.9.5 Long and short term memory

2.9.6 Attending behaviors

2.9.7 Infection control precautions

2.9.8 Sensory acuity and perception

2.9.9 Independent functioning and adaptive needs

2.9.10 Coping skills

3.0 Standard III - Treatment Planning

The Music Therapist will prepare a written individualized program plan based upon the music therapy assessment, the client's prognosis, and applicable information from other disciplines and sources. The client will participate in program plan development when appropriate. The music therapy program plan will be designed to:

3.1 Help the client attain and maintain the maximum level of functioning.

- 3.2 Comply with federal, state, and facility regulations.
- 3.3 Delineate the type, frequency, and duration of music therapy involvement.
- 3.4 Contain goals ^{viii} that focus on assessed needs and strengths of the client.
- 3.5 Contain objectives ^{ix} which are operationally defined for achieving the stated goals within estimated time frames.
- 3.6 Specify procedures, including music and music materials, for attaining the objectives.
 - 3.6.1 The Music Therapist will include music, instruments, and musical elements, from the client's culture as appropriate.
- 3.7 Provide for periodic evaluation ^x and appropriate modifications as needed.
- 3.8 Optimize, according to the best professional judgment ^{xi} of the Music Therapist:
 - 3.8.1 The program plans of other disciplines.
 - 3.8.2 Established principles of normal growth and development.
- 3.9 Change to meet the priority needs of the client during crisis intervention.
- 3.10 Comply with infection control procedures.
- 3.11 Incorporate medical precautions as necessary.

4.0 Standard IV - Implementation

The Music Therapist will deliver services according to the written program plan and will:

- 4.1 Strive for the highest level and quality of music involvement consistent with the functioning level of the client.
 - 4.1.1 The Music Therapist's provision of music will reflect his or her best abilities as a musician.
 - 4.1.2 Appropriate musical instruments and materials, as well as the best possible sound reproduction equipment should be used in music therapy services.
 - 4.1.3 The Music Therapist will make every effort to ensure safe and quality client care.
- 4.2 Use methodology that is consistent with recent advances in health, safety ^{xii} and infection control practices.
- 4.3 Maintain close communication with other individuals involved with the client.
- 4.4 Record the schedule and procedures used in music therapy treatment.
- 4.5 Evaluate the client's responses periodically to determine progress toward the goals and objectives.
- 4.6 Incorporate the results of such evaluations in subsequent treatment.
- 4.7 Consider the psychological effects of therapeutic separation as termination of services approaches.

5.0 Standard V - Documentation

The Music Therapist will document the client's referral to music therapy, assessment, placement, treatment plan, and ongoing progress in music therapy in a manner consistent with federal, state, and other regulations and policies.

5.1 The Music Therapist will periodically document the client's level of functioning with regard to the goals and objectives.

5.2 The documentation of progress will describe significant intervention techniques and the client's responses to them.

5.3 In all documentation relating to music therapy services, the Music Therapist will:

5.3.1 Write in an objective, professional style based on observable client responses.

5.3.2 Include the date, signature, and professional status of the therapist.

5.3.3 Place such documentation in the client's file and maintain its confidentiality unless proper authorization for release is obtained.

5.4 Upon obtaining written client permission, the Music Therapist will document and disseminate information to key service providers to ensure consistency of services.

5.5 The Music Therapist will document referrals made to other sources and will include plans for music therapy services as appropriate.

5.6 The documentation of all referrals will include date of referral, source of referral, and services requested.

6.0 Standard VI - Termination of Services

The Music Therapist will terminate music therapy services when the client has attained stated goals and objectives, fails to benefit from services, can no longer be scheduled, or is discharged. At the time of termination, consideration will be given for scheduling periodic reevaluation to determine the need for follow-up services. The Music Therapist will prepare the music therapy termination plan in accordance with federal, state, and facility regulations. The termination plan will:

6.1 Further optimize the goals of the individualized music therapy treatment plan.

6.2 Coordinate with the individualized treatment plans of other services received by the client.

6.3 Allow sufficient time for approval, coordination, and effective implementation whenever possible.

6.4 Summarize the client's progress and functioning level at the time of termination.

7.0 Standard VII - Continuing Education

7.1 It is the responsibility of the Music Therapist to maintain knowledge of current developments in research, theory, and techniques in music therapy related areas specific to the populations and therapeutic settings.

7.1.1 Related areas may include, but need not be limited to, sensory processing, planning, and task execution, sensitivity training, specific diagnoses, and issues involved in death and dying, grief, loss and spirituality.

7.2 The Music Therapist will be familiar with current federal, state, and local laws pertaining to issues of client rights and confidentiality.

7.3 The Music Therapist will contribute to the education of others regarding the use and benefits of music therapy.

8.0 Standard VIII - Supervision

8.1 It is the responsibility of the Music Therapist to seek and participate in supervision on a regular basis.

8.1.1 Types of supervision may include but are not limited to direct observation, peer review, verbal feedback, group supervision, individual supervision, and music based supervision.

8.1.2 The Music Therapist may seek supervision from music therapists as well as other professionals including but not limited to psychologists, psychiatrists, social workers, art therapists, dance/movement therapists, drama therapists, physical therapists, occupational therapists, speech language pathologists, physicians, and nurses.

8.2 It is the responsibility of the Music Therapist providing supervision to maintain knowledge of current developments in research, theory, and techniques in music therapy supervision and supervision in general.

8.2.1 The Music Therapist providing supervision will be familiar with current federal, state, and local laws as well as the AMTA Code of Ethics as they pertain to supervision and confidentiality within supervision.

8.2.2 The Music Therapist providing supervision is required to will adhere to all AMTA Standards of Clinical Practice and will assure that the Music Therapist supervisee has read and agrees to adhere to the AMTA Standards of Clinical Practice. The Music Therapist providing supervision shall hold the supervisee accountable for adhering to the AMTA Standards of Clinical Practice.

8.2.3 The Music Therapist providing supervision will complete any necessary documentation pertaining to supervision accurately, completely, and in a timely manner.

8.2.4 The Music Therapist providing supervision will keep all supervision content confidential. All records will be kept for at least five years after the final supervision session.

MEDICAL SETTINGS

These Standards of Clinical Practice are designed specifically for the Music Therapist working in medical settings. The Music Therapist will adhere to the General Standards of Clinical Practice (which are reprinted in sequence in this section), and the specific standards for medical settings described herein (in dark blue text). The Music Therapist will also adhere to the standards of other applicable music therapy service areas.

Music therapy for clientele in medical settings is the specialized use of music in sites which may include, but need not be limited to, those designated as medical-surgical, pediatric, palliative care, obstetrics, rehabilitation and wellness care.

1.0 Standard I - Referral and Acceptance

A client will be accepted for music therapy in accordance with specific criteria.

1.1 A client may be a candidate for music therapy when a cognitive, communication, psychological, educational, social, or physiological need might be ameliorated or prevented by such services.

1.2 A client may be referred for an initial music therapy assessment by:

1.2.1 a Music Therapist

1.2.2 members of other disciplines or agencies

1.2.3 self

1.2.4 parents, guardians, advocates or designated representatives

1.3 The final decision to accept a client for music therapy assessment will be made by a Music Therapist.

1.3.1 Note: Some medical settings may require a physician's order for music therapy services.

2.0 Standard II - Assessment

A client will be assessed by a Music Therapist for music therapy services.

2.1 The music therapy assessment will include the general categories of psychological, cognitive, communicative, social, and physiological functioning focused on the client's needs and strengths. The assessment will also determine the client's responses to music, music skills and musical preferences.

2.2 The music therapy assessment will explore the client's culture. This can include but is not limited to race, ethnicity, language, religion/spirituality, socioeconomic status, family experiences, sexual orientation, gender identity or expression, and social organizations.

2.3 All music therapy assessment methods will be appropriate for the client's chronological age, diagnoses, functioning level, and culture(s). The methods may include, but need not be limited to, observation during music or other situations, interview, verbal and nonverbal interventions, and testing. Information may also be obtained from different disciplines or sources such as the past and present medical and social history in accordance with HIPAA permission regulation.

2.4 All interpretations of test results will be based on appropriate norms or criterion referenced data ^{vii}.

2.5 The music therapy assessment procedures and results will become a part of the client's file.

2.6 The final decision to accept a client for music therapy services, either direct or consultative, will be made by a Music Therapist and, when applicable, will be in conjunction with the interdisciplinary team. Screening ^{vi} may be used as part of this process.

2.7 The results, conclusions, and implications of the music therapy assessment will become the basis for the client's music therapy program and will be communicated to others involved with provision of services to the client. When appropriate, the results will be communicated to the client.

2.8 When assessment indicates the client's need for other services, the Music Therapist will make an appropriate referral.

2.9 The music therapy assessment will include current diagnosis and history will be performed in a manner congruent with the patient's level of functioning to address the following areas:

2.9.1 Emotional/psychosocial

2.9.2 Coping skills

2.9.3 Infection control precautions

2.9.4 Activity status, pre-operative and post-operative

2.9.5 Attitude toward surgery and/or medical procedures

2.9.6 Cardiac precautions

2.9.7 Impact of surgery and/or loss of body function on self-image

2.9.8 Medical equipment precautions

2.9.9 Medical regime and possible side effects

- 2.9.10 Mental status
- 2.9.11 Pain tolerance and threshold levels
- 2.9.12 Postural restrictions
- 2.9.13 Scheduling requirements, coordination with other medical treatments
- 2.9.14 Support during medical procedures

3.0 Standard III - Treatment Planning

The Music Therapist will prepare a written individualized program plan based upon the music therapy assessment, the client's prognosis, and applicable information from other disciplines and sources. The client will participate in program plan development when appropriate. The music therapy program plan will be designed to:

- 3.1 Help the client attain and maintain the maximum level of functioning.
- 3.2 Comply with federal, state, and facility regulations.
- 3.3 Delineate the type, frequency, and duration of music therapy involvement.
- 3.4 Contain goals ^{viii} that focus on assessed needs and strengths of the client.
- 3.5 Contain objectives ^{ix} which are operationally defined for achieving the stated goals within estimated time frames.
- 3.6 Specify procedures, including music and music materials, for attaining the objectives.
 - 3.6.1 The Music Therapist will include music, instruments, and musical elements, from the client's culture as appropriate.
- 3.7 Provide for periodic evaluation ^x and appropriate modifications as needed.
- 3.8 Optimize, according to the best professional judgment ^{xi} of the Music Therapist:
 - 3.8.1 The program plans of other disciplines.
 - 3.8.2 Established principles of normal growth and development.
- 3.9 Change to meet the priority needs of the client during crisis intervention.
- 3.10 Comply with infection control procedures.
- 3.11 Incorporate medical precautions as necessary.

4.0 Standard IV - Implementation

The Music Therapist will deliver services according to the written program plan and will:

- 4.1 Strive for the highest level and quality of music involvement consistent with the functioning level of the client.
 - 4.1.1 The Music Therapist's provision of music will reflect his or her best abilities as a musician.
 - 4.1.2 Appropriate musical instruments and materials, as well as the best possible sound reproduction equipment should be used in music therapy services.

- 4.1.3 The Music Therapist will make every effort to ensure safe and quality client care.
- 4.2 Use methodology that is consistent with recent advances in health, safety^{xii} and infection control practices.
- 4.3 Maintain close communication with other individuals involved with the client.
- 4.4 Record the schedule and procedures used in music therapy treatment.
- 4.5 Evaluate the client's responses periodically to determine progress toward the goals and objectives.
- 4.6 Incorporate the results of such evaluations in subsequent treatment.
- 4.7 Consider the psychological effects of therapeutic separation as termination of services approaches.
- 4.8 Include family member participation in the treatment plan when appropriate.
- 4.9 Disclose information to patient and family members consistent with the physician's judgment and discretion and in accordance with hospital regulations.

5.0 Standard V - Documentation

The Music Therapist will document the client's referral to music therapy, assessment, placement, treatment plan, and ongoing progress in music therapy in a manner consistent with federal, state, and other regulations and policies.

5.1 The Music Therapist will periodically document the client's level of functioning with regard to the goals and objectives.

5.2 The documentation of progress will describe significant intervention techniques and the client's responses to them.

5.3 In all documentation relating to music therapy services, the Music Therapist will:

5.3.1 Write in an objective, professional style based on observable client responses.

5.3.2 Include the date, signature, and professional status of the therapist.

5.3.3 Place such documentation in the client's file and maintain its confidentiality unless proper authorization for release is obtained.

5.3.4 The documentation of the referral will include confirmation of physician orders when applicable.

5.3.5 The Music Therapist will complete a discharge summary based on the treatment team's protocol.

5.4 Upon obtaining written client permission, the Music Therapist will document and disseminate information to key service providers to ensure consistency of services.

5.5 The Music Therapist will document referrals made to other sources and will include plans for music therapy services as appropriate.

5.6 The documentation of all referrals will include date of referral, source of referral, and services requested.

5.6.1 The Music Therapist will provide written documentation of music therapy services for patients based on the treatment team's protocol.

6.0 Standard VI - Termination of Services

The Music Therapist will terminate music therapy services when the client has attained stated goals and objectives, fails to benefit from services, can no longer be scheduled, or is discharged. At the time of termination, consideration will be given for scheduling periodic reevaluation to determine the need for follow-up services. The Music Therapist will prepare the music therapy termination plan in accordance with federal, state, and facility regulations. The termination plan will:

- 6.1 Further optimize the goals of the individualized music therapy treatment plan.
- 6.2 Coordinate with the individualized treatment plans of other services received by the client.
- 6.3 Allow sufficient time for approval, coordination, and effective implementation whenever possible.
- 6.4 Summarize the client's progress and functioning level at the time of termination.
- 6.5 Include consultation with the attending physician and/or other treatment team members regarding termination of music therapy services when appropriate.

7.0 Standard VII - Continuing Education

7.1 It is the responsibility of the Music Therapist to maintain knowledge of current developments in research, theory, and techniques in music therapy related areas specific to the populations and therapeutic settings.

7.1.1 Related areas may include, but need not be limited to, basic medical terminology, pharmacology, and issues involved in death, dying, trauma, grief and loss, and spirituality.

7.1.2 Some form of personal counseling for the Music Therapist is recommended.

7.2 The Music Therapist will be familiar with current federal, state, and local laws pertaining to issues of client rights and confidentiality.

7.3 The Music Therapist will contribute to the education of others regarding the use and benefits of music therapy.

8.0 Standard VIII - Supervision

8.1 It is the responsibility of the Music Therapist to seek and participate in supervision on a regular basis.

8.1.1 Types of supervision may include but are not limited to direct observation, peer review, verbal feedback, group supervision, individual supervision, and music based supervision.

8.1.2 The Music Therapist may seek supervision from music therapists as well as other professionals including but not limited to psychologists, psychiatrists, social workers, art therapists, dance/movement therapists, drama therapists, physical therapists, occupational therapists, speech language pathologists, physicians, and nurses.

8.2 It is the responsibility of the Music Therapist providing supervision to maintain knowledge of current developments in research, theory, and techniques in music therapy supervision and supervision in general.

8.2.1 The Music Therapist providing supervision will be familiar with current federal, state, and local laws as well as the AMTA Code of Ethics as they pertain to supervision and confidentiality within supervision.

8.2.2 The Music Therapist providing supervision is required to will adhere to all AMTA Standards of Clinical Practice and will assure that the Music Therapist supervisee has read and agrees to adhere to the AMTA Standards of Clinical Practice. The Music Therapist providing supervision shall hold the supervisee accountable for adhering to the AMTA Standards of Clinical Practice.

8.2.3 The Music Therapist providing supervision will complete any necessary documentation pertaining to supervision accurately, completely, and in a timely manner.

8.2.4 The Music Therapist providing supervision will keep all supervision content confidential. All records will be kept for at least five years after the final supervision session.

MENTAL HEALTH

These Standards of Clinical Practice are designed for the Music Therapist working with clientele who require mental health services. The Music Therapist will adhere to the General Standards of Clinical Practice (which are reprinted in sequence in this section) as well as the specific standards described herein (in dark blue text). The Music Therapist will also adhere to the standards of other applicable music therapy service areas.

Music therapy with clientele who require mental health services is the specialized use of music to restore, maintain, and improve the following areas of functioning: cognitive, psychological, social/emotional, affective, communicative, and physiological functioning.

1.0 Standard I - Referral and Acceptance

A client will be accepted for music therapy in accordance with specific criteria.

1.1 A client may be a candidate for music therapy when a cognitive, communication, psychological, educational, social, or physiological need might be ameliorated or prevented by such services.

1.2 A client may be referred for an initial music therapy assessment by:

1.2.1 a Music Therapist

1.2.2 members of other disciplines or agencies

1.2.3 self

1.2.4 parents, guardians, advocates or designated representatives

1.2.5 Members of a treatment team

1.3 The final decision to accept a client for music therapy assessment will be made by a Music Therapist.

2.0 Standard II - Assessment

A client will be assessed by a Music Therapist for music therapy services.

2.1 The music therapy assessment will include the general categories of psychological, cognitive, communicative, social, and physiological functioning focused on the client's needs and strengths. The assessment will also determine the client's responses to music, music skills and musical preferences.

2.2 The music therapy assessment will explore the client's culture. This can include but is not limited to race, ethnicity, language, religion/spirituality, socioeconomic status, family experiences, sexual orientation, gender identity or expression, and social organizations.

2.3 All music therapy assessment methods will be appropriate for the client's chronological age, diagnoses, functioning level, and culture(s). The methods may include, but need not be limited to, observation during music or other situations, interview, verbal and nonverbal interventions, and testing. Information may also be obtained from different disciplines or sources such as the past and present medical and social history in accordance with HIPAA permission regulation.

2.4 All interpretations of test results will be based on appropriate norms or criterion referenced data ^{vii}.

2.5 The music therapy assessment procedures and results will become a part of the client's file.

2.6 The final decision to accept a client for music therapy services, either direct or consultative, will be made by a Music Therapist and, when applicable, will be in conjunction with the interdisciplinary team. Screening ^{vi} may be used as part of this process.

2.7 The results, conclusions, and implications of the music therapy assessment will become the basis for the client's music therapy program and will be communicated to others involved with provision of services to the client. When appropriate, the results will be communicated to the client.

2.8 When assessment indicates the client's need for other services, the Music Therapist will make an appropriate referral.

2.9 The music therapy assessment will include current diagnosis and history will be performed in a manner congruent with the client's level of functioning to address the following areas:

2.9.1 Motor functioning

2.9.2 Sensory processing, planning and task execution

2.9.3 Substance use or abuse

2.9.4 Reality orientation

2.9.5 Emotional status

2.9.6 Vocational status

2.9.7 Educational background

2.9.8 Client's use of music

2.9.9 Developmental level

2.9.10 Coping skills

2.9.11 Infection control precautions

3.0 Standard III - Treatment Planning

The Music Therapist will prepare a written individualized program plan based upon the music therapy assessment, the client's prognosis, and applicable information from other disciplines and sources. The client will participate in program plan development when appropriate. The music therapy program plan will be designed to:

3.1 Help the client attain and maintain the maximum level of functioning.

3.2 Comply with federal, state, and facility regulations.

3.3 Delineate the type, frequency, and duration of music therapy involvement.

3.4 Contain goals ^{viii} that focus on assessed needs and strengths of the client.

3.5 Contain objectives ^{ix} which are operationally defined for achieving the stated goals within estimated time frames.

3.6 Specify procedures, including music and music materials, for attaining the objectives.

3.6.1 The Music Therapist will include music, instruments, and musical elements, from the client's culture as appropriate.

3.7 Provide for periodic evaluation^x and appropriate modifications as needed.

3.8 Optimize, according to the best professional judgment^{xi} of the Music Therapist:

3.8.1 The program plans of other disciplines.

3.8.2 Established principles of normal growth and development.

3.9 Change to meet the priority needs of the client during crisis intervention.

3.10 Comply with infection control procedures.

3.11 Incorporate medical precautions as necessary.

4.0 Standard IV - Implementation

The Music Therapist will deliver services according to the written program plan and will:

4.1 Strive for the highest level and quality of music involvement consistent with the functioning level of the client.

4.1.1 The Music Therapist's provision of music will reflect his or her best abilities as a musician.

4.1.2 Appropriate musical instruments and materials, as well as the best possible sound reproduction equipment should be used in music therapy services.

4.1.3 The Music Therapist will make every effort to ensure safe and quality client care.

4.2 Use methodology that is consistent with recent advances in health, safety^{xii} and infection control practices.

4.3 Maintain close communication with other individuals involved with the client.

4.4 Record the schedule and procedures used in music therapy treatment.

4.5 Evaluate the client's responses periodically to determine progress toward the goals and objectives.

4.6 Incorporate the results of such evaluations in subsequent treatment.

4.7 Consider the psychological effects of therapeutic separation as termination of services approaches.

5.0 Standard V - Documentation

The Music Therapist will document the client's referral to music therapy, assessment, placement, treatment plan, and ongoing progress in music therapy in a manner consistent with federal, state, and other regulations and policies.

5.1 The Music Therapist will periodically document the client's level of functioning with regard to the goals and objectives.

5.2 The documentation of progress will describe significant intervention techniques and the client's responses to them.

5.3 In all documentation relating to music therapy services, the Music Therapist will:

5.3.1 Write in an objective, professional style based on observable client responses.

5.3.2 Include the date, signature, and professional status of the therapist.

5.3.3 Place such documentation in the client's file and maintain its confidentiality unless proper authorization for release is obtained.

5.4 Upon obtaining written client permission, the Music Therapist will document and disseminate information to key service providers to ensure consistency of services.

5.5 The Music Therapist will document referrals made to other sources and will include plans for music therapy services as appropriate.

5.6 The documentation of all referrals will include date of referral, source of referral, and services requested.

6.0 Standard VI - Termination of Services

The Music Therapist will terminate music therapy services when the client has attained stated goals and objectives, fails to benefit from services, can no longer be scheduled, or is discharged. At the time of termination, consideration will be given for scheduling periodic reevaluation to determine the need for follow-up services. The Music Therapist will prepare the music therapy termination plan in accordance with federal, state, and facility regulations. The termination plan will:

6.1 Further optimize the goals of the individualized music therapy treatment plan.

6.2 Coordinate with the individualized treatment plans of other services received by the client.

6.3 Allow sufficient time for approval, coordination, and effective implementation whenever possible.

6.4 Summarize the client's progress and functioning level at the time of termination.

7.0 Standard VII - Continuing Education

7.1 It is the responsibility of the Music Therapist to maintain knowledge of current developments in research, theory, and techniques in music therapy related areas specific to the populations and therapeutic settings.

7.1.1 Related areas may include, but need not be limited to, mental health disorders, specific areas of dysfunction, diagnostic knowledge, psychotherapy, treatment approaches including music, leisure education, administrative skills, and psychopharmacology.

7.1.2 Some form of *personal counseling for the Music Therapist is recommended.

7.2 The Music Therapist will be familiar with current federal, state, and local laws pertaining to issues of client rights and confidentiality.

7.3 The Music Therapist will contribute to the education of others regarding the use and benefits of music therapy.

8.0 Standard VIII - Supervision

8.1 It is the responsibility of the Music Therapist to seek and participate in supervision on a regular basis.

8.1.1 Types of supervision may include but are not limited to direct observation, peer review, verbal feedback, group supervision, individual supervision, and music based supervision.

8.1.2 The Music Therapist may seek supervision from music therapists as well as other professionals including but not limited to psychologists, psychiatrists, social workers, art therapists, dance/movement therapists, drama therapists, physical therapists, occupational therapists, speech language pathologists, physicians, and nurses.

8.2 It is the responsibility of the Music Therapist providing supervision to maintain knowledge of current developments in research, theory, and techniques in music therapy supervision and supervision in general.

8.2.1 The Music Therapist providing supervision will be familiar with current federal, state, and local laws as well as the AMTA Code of Ethics as they pertain to supervision and confidentiality within supervision.

8.2.2 The Music Therapist providing supervision is required to will adhere to all AMTA Standards of Clinical Practice and will assure that the Music Therapist supervisee has read and agrees to adhere to the AMTA Standards of Clinical Practice. The Music Therapist providing supervision shall hold the supervisee accountable for adhering to the AMTA Standards of Clinical Practice.

8.2.3 The Music Therapist providing supervision will complete any necessary documentation pertaining to supervision accurately, completely, and in a timely manner.

8.2.4 The Music Therapist providing supervision will keep all supervision content confidential. All records will be kept for at least five years after the final supervision session.

PHYSICAL DISABILITIES

These Standards of Clinical Practice are designed specifically for the Music Therapist working with clients who have physical disabilities. The Music Therapist will adhere to the General Standards of Clinical Practice (which are reprinted in sequence in this section), as well as the specific standards for clients with physical disabilities described herein (in dark blue text). The Music Therapist will also adhere to the standards of other applicable music therapy service areas.

Music therapy with clients who have physical disabilities is the specialized use of music to help attain and maintain maximum levels of functioning in the areas of physical, cognitive, communicative, and social/emotional health.

1.0 Standard I - Referral and Acceptance

A client will be accepted for music therapy in accordance with specific criteria.

1.1 A client may be a candidate for music therapy when a cognitive, communication, psychological, educational, social, or physiological need might be ameliorated or prevented by such services.

1.2 A client may be referred for an initial music therapy assessment by:

1.2.1 a Music Therapist

1.2.2 members of other disciplines or agencies

1.2.3 self

1.2.4 parents, guardians, advocates or designated representatives

1.3 The final decision to accept a client for music therapy assessment will be made by a Music Therapist.

1.4 Music therapy may be indicated when an individual's well-being is affected by congenital factors, trauma, injury, chronic illness, or other health-related conditions.

2.0 Standard II - Assessment

A client will be assessed by a Music Therapist for music therapy services.

2.1 The music therapy assessment will include the general categories of psychological, cognitive, communicative, social, and physiological functioning focused on the client's needs and strengths. The assessment will also determine the client's responses to music, music skills and musical preferences.

2.2 The music therapy assessment will explore the client's culture. This can include but is not limited to race, ethnicity, language, religion/spirituality, socioeconomic status, family experiences, sexual orientation, gender identity or expression, and social organizations.

2.3 All music therapy assessment methods will be appropriate for the client's chronological age, diagnoses, functioning level, and culture(s). The methods may include, but need not be limited to, observation during music or other situations, interview, verbal and nonverbal interventions, and testing. Information may also be obtained from different disciplines or sources such as the past and present medical and social history in accordance with HIPAA permission regulation.

2.4 All interpretations of test results will be based on appropriate norms or criterion referenced data ^{vii}.

2.5 The music therapy assessment procedures and results will become a part of the client's file.

2.6 The final decision to accept a client for music therapy services, either direct or consultative, will be made by a Music Therapist and, when applicable, will be in conjunction with the interdisciplinary team. Screening ^{vi} may be used as part of this process.

2.7 The results, conclusions, and implications of the music therapy assessment will become the basis for the client's music therapy program and will be communicated to others involved with provision of services to the client. When appropriate, the results will be communicated to the client.

2.8 When assessment indicates the client's need for other services, the Music Therapist will make an appropriate referral.

2.9 The music therapy assessment will include current diagnosis and history will be performed in a manner congruent with the client's level of functioning, to address the following areas:

2.9.1 Motor skills

2.9.2 Sensory processing, planning and task execution

2.9.3 Emotional status

2.9.4 Vocational status

2.9.5 Coping skills

2.9.6 Infection control precautions

2.9.7 Activity status

2.9.8 Impact of surgery &/or loss of body function on self-image.

2.9.9 Medical regime & possible side effects

2.9.10 Mental status

2.9.11 Postural restrictions

- 2.9.12 Spatial & body concepts
- 2.9.13 Sensory acuity & perception
- 2.9.14 Independent functioning & adaptive needs
- 2.9.15 Pain tolerance and pain level

3.0 Standard III - Treatment Planning

The Music Therapist will prepare a written individualized program plan based upon the music therapy assessment, the client's prognosis, and applicable information from other disciplines and sources. The client will participate in program plan development when appropriate. The music therapy program plan will be designed to:

- 3.1 Help the client attain and maintain the maximum level of functioning.
- 3.2 Comply with federal, state, and facility regulations.
- 3.3 Delineate the type, frequency, and duration of music therapy involvement.
- 3.4 Contain goals ^{viii} that focus on assessed needs and strengths of the client.
- 3.5 Contain objectives ^{ix} which are operationally defined for achieving the stated goals within estimated time frames.
- 3.6 Specify procedures, including music and music materials, for attaining the objectives.
 - 3.6.1 The Music Therapist will include music, instruments, and musical elements, from the client's culture as appropriate.
- 3.7 Provide for periodic evaluation ^x and appropriate modifications as needed.
- 3.8 Optimize, according to the best professional judgment ^{xi} of the Music Therapist:
 - 3.8.1 The program plans of other disciplines.
 - 3.8.2 Established principles of normal growth and development.
- 3.9 Change to meet the priority needs of the client during crisis intervention.
- 3.10 Comply with infection control procedures.
- 3.11 Comply with established principles in areas such as facilitation, positioning, sensory stimulation, and sensori-motor integration.

4.0 Standard IV - Implementation

The Music Therapist will deliver services according to the written program plan and will:

- 4.1 Strive for the highest level and quality of music involvement consistent with the functioning level of the client.
 - 4.1.1 The Music Therapist's provision of music will reflect his or her best abilities as a musician.
 - 4.1.2 Appropriate musical instruments and materials, as well as the best possible sound reproduction equipment should be used in music therapy services.

- 4.1.3 The Music Therapist will make every effort to ensure safe and quality client care.
- 4.2 Use methodology that is consistent with recent advances in health, safety^{xii} and infection control practices.
- 4.3 Maintain close communication with other individuals involved with the client.
- 4.4 Record the schedule and procedures used in music therapy treatment.
- 4.5 Evaluate the client's responses periodically to determine progress toward the goals and objectives.
- 4.6 Incorporate the results of such evaluations in subsequent treatment.
- 4.7 Consider the psychological effects of therapeutic separation as termination of services approaches.

5.0 Standard V - Documentation

The Music Therapist will document the client's referral to music therapy, assessment, placement, treatment plan, and ongoing progress in music therapy in a manner consistent with federal, state, and other regulations and policies.

- 5.1 The Music Therapist will periodically document the client's level of functioning with regard to the goals and objectives.
- 5.2 The documentation of progress will describe significant intervention techniques and the client's responses to them.
- 5.3 In all documentation relating to music therapy services, the Music Therapist will:
 - 5.3.1 Write in an objective, professional style based on observable client responses.
 - 5.3.2 Include the date, signature, and professional status of the therapist.
 - 5.3.3 Place such documentation in the client's file and maintain its confidentiality unless proper authorization for release is obtained.
- 5.4 Upon obtaining written client permission, the Music Therapist will document and disseminate information to key service providers to ensure consistency of services.
- 5.5 The Music Therapist will document referrals made to other sources and will include plans for music therapy services as appropriate.
- 5.6 The documentation of all referrals will include date of referral, source of referral, and services requested.

6.0 Standard VI - Termination of Services

The Music Therapist will terminate music therapy services when the client has attained stated goals and objectives, fails to benefit from services, can no longer be scheduled, or is discharged. At the time of termination, consideration will be given for scheduling periodic reevaluation to determine the need for follow-up services. The Music Therapist will prepare the music therapy termination plan in accordance with federal, state, and facility regulations. The termination plan will:

- 6.1 Further optimize the goals of the individualized music therapy treatment plan.
- 6.2 Coordinate with the individualized treatment plans of other services received by the client.
- 6.3 Allow sufficient time for approval, coordination, and effective implementation whenever possible.

6.4 Summarize the client's progress and functioning level at the time of termination.

6.5 Include a description of methods, procedures, and materials used, such as adaptive devices and behavioral techniques.

7.0 Standard VII - Continuing Education

7.1 It is the responsibility of the Music Therapist to maintain knowledge of current developments in research, theory, and techniques in music therapy related areas specific to the populations and therapeutic settings.

7.2 The Music Therapist will be familiar with current federal, state, and local laws pertaining to issues of client rights and confidentiality.

7.3 The Music Therapist will contribute to the education of others regarding the use and benefits of music therapy.

8.0 Standard VIII - Supervision

8.1 It is the responsibility of the Music Therapist to seek and participate in supervision on a regular basis.

8.1.1 Types of supervision may include but are not limited to direct observation, peer review, verbal feedback, group supervision, individual supervision, and music based supervision.

8.1.2 The Music Therapist may seek supervision from music therapists as well as other professionals including but not limited to psychologists, psychiatrists, social workers, art therapists, dance/movement therapists, drama therapists, physical therapists, occupational therapists, speech language pathologists, physicians, and nurses.

8.2 It is the responsibility of the Music Therapist providing supervision to maintain knowledge of current developments in research, theory, and techniques in music therapy supervision and supervision in general.

8.2.1 The Music Therapist providing supervision will be familiar with current federal, state, and local laws as well as the AMTA Code of Ethics as they pertain to supervision and confidentiality within supervision.

8.2.2 The Music Therapist providing supervision is required to will adhere to all AMTA Standards of Clinical Practice and will assure that the Music Therapist supervisee has read and agrees to adhere to the AMTA Standards of Clinical Practice. The Music Therapist providing supervision shall hold the supervisee accountable for adhering to the AMTA Standards of Clinical Practice.

8.2.3 The Music Therapist providing supervision will complete any necessary documentation pertaining to supervision accurately, completely, and in a timely manner.

8.2.4 The Music Therapist providing supervision will keep all supervision content confidential. All records will be kept for at least five years after the final supervision session.

PRIVATE PRACTICE

These Standards of Clinical Practice are designed specifically for the Music Therapist working in private practice. The Music Therapist will adhere to the General Standards of Clinical Practice (which are reprinted in sequence in this section), and the specific standards for private practice described herein. The Music Therapist will also adhere to the standards of other applicable music therapy service areas.

1.0 Standard I - Referral and Acceptance

The Music Therapist responds to a referral or request for services and accepts or declines a case at his or her own professional discretion.

1.1 A client may be a candidate for music therapy when a cognitive, communication, psychological, educational, social, or physiological need might be ameliorated or prevented by such services.

1.2 A client may be referred for an initial music therapy assessment by:

1.2.1 a Music Therapist

1.2.2 members of other disciplines or agencies

1.2.3 self

1.2.4 parents, guardians, advocates or designated representatives

1.3 The final decision to accept a client for music therapy assessment will be made by a Music Therapist.

1.4 The Music Therapist will provide acknowledgment to the referral source.

1.5 Prior to or at the onset of service delivery, the Music Therapist will enter into a mutually acceptable service contract with the client or their designated representative. The contract will include:

1.5.1 Frequency of sessions

1.5.2 Length of each session

1.5.3 Projected length of music therapy services

1.5.4 Terms of payment for services

1.6 The Music Therapist will adopt a fee schedule which fair and appropriate for professional services rendered.

2.0 Standard II - Assessment

A client will be assessed by a Music Therapist for music therapy services.

2.1 The music therapy assessment will include the general categories of psychological, cognitive, communicative, social, and physiological functioning focused on the client's needs and strengths. The assessment will also determine the client's responses to music, music skills and musical preferences.

2.2 The music therapy assessment will explore the client's culture. This can include but is not limited to race, ethnicity, language, religion/spirituality, socioeconomic status, family experiences, sexual orientation, gender identity or expression, and social organizations.

2.3 All music therapy assessment methods will be appropriate for the client's chronological age, diagnoses, functioning level, and culture(s). The methods may include, but need not be limited to, observation during music or other situations, interview, verbal and nonverbal interventions, and testing. Information may also be obtained from different disciplines or sources such as the past and present medical and social history in accordance with HIPAA permission regulation.

2.4 All interpretations of test results will be based on appropriate norms or criterion referenced data ^{vii}.

2.5 The music therapy assessment procedures and results will become a part of the client's file.

2.6 The final decision to accept a client for music therapy services, either direct or consultative, will be made by a Music Therapist and, when applicable, will be in conjunction with the interdisciplinary team. Screening ^{vi} may be used as part of this process.

2.7 The results, conclusions, and implications of the music therapy assessment will become the basis for the client's music therapy program and will be communicated to others involved with provision of services to the client. When appropriate, the results will be communicated to the client.

2.8 When assessment indicates the client's need for other services, the Music Therapist will make an appropriate referral.

2.8 The music therapy assessment will include the client's current diagnosis and history will be performed in a manner congruent with the client's level of functioning to address areas pertinent to each specific client in treatment.

3.0 Standard III - Treatment Planning

The Music Therapist will prepare a written individualized program plan based upon the music therapy assessment, the client's prognosis, and applicable information from other disciplines and sources. The client will participate in program plan development when appropriate. The music therapy program plan will be designed to:

- 3.1 Help the client attain and maintain the maximum level of functioning.
- 3.2 Comply with federal, state, and facility regulations.
- 3.3 Delineate the type, frequency, and duration of music therapy involvement.
- 3.4 Contain goals ^{viii} that focus on assessed needs and strengths of the client.
- 3.5 Contain objectives ^{ix} which are operationally defined for achieving the stated goals within estimated time frames.
- 3.6 Specify procedures, including music and music materials, for attaining the objectives.
 - 3.6.1 The Music Therapist will include music, instruments, and musical elements, from the client's culture as appropriate.
- 3.7 Provide for periodic evaluation ^x and appropriate modifications as needed.
- 3.8 Optimize, according to the best professional judgment ^{xi} of the Music Therapist:
 - 3.8.1 The program plans of other disciplines.
 - 3.8.2 Established principles of normal growth and development.
- 3.9 Change to meet the priority needs of the client during crisis intervention.
- 3.10 Comply with infection control procedures.
- 3.11 Incorporate medical precautions as necessary.

4.0 Standard IV - Implementation

The Music Therapist will deliver services according to the written program plan and will:

- 4.1 Strive for the highest level and quality of music involvement consistent with the functioning level of the client.
 - 4.1.1 The Music Therapist's provision of music will reflect his or her best abilities as a musician.
 - 4.1.2 Appropriate musical instruments and materials, as well as the best possible sound reproduction equipment should be used in music therapy services.

- 4.1.3 The Music Therapist will make every effort to ensure safe and quality client care.
- 4.2 Use methodology that is consistent with recent advances in health, safety^{xii} and infection control practices.
- 4.3 Maintain close communication with other individuals involved with the client.
- 4.4 Record the schedule and procedures used in music therapy treatment.
- 4.5 Evaluate the client's responses periodically to determine progress toward the goals and objectives.
- 4.6 Incorporate the results of such evaluations in subsequent treatment.
- 4.7 Consider the psychological effects of therapeutic separation as termination of services approaches.

5.0 Standard V - Documentation

The Music Therapist will document the client's referral to music therapy, assessment, placement, treatment plan, and ongoing progress in music therapy in a manner consistent with federal, state, and other regulations and policies.

- 5.1 The Music Therapist will periodically document the client's level of functioning with regard to the goals and objectives.
- 5.2 The documentation of progress will describe significant intervention techniques and the client's responses to them.
- 5.3 In all documentation relating to music therapy services, the Music Therapist will:
 - 5.3.1 Write in an objective, professional style based on observable client responses.
 - 5.3.2 Include the date, signature, and professional status of the therapist.
 - 5.3.3 Place such documentation in the client's file and maintain its confidentiality unless proper authorization for release is obtained.
- 5.4 Upon obtaining written client permission, the Music Therapist will document and disseminate information to key service providers to ensure consistency of services.
- 5.5 The Music Therapist will document referrals made to other sources and will include plans for music therapy services as appropriate.
- 5.6 Periodic evaluation will be sent to the referral source when appropriate.

5.7 The Music Therapist will document:

- 5.7.1 Each session with the client
- 5.7.2 The client's payment for services

6.0 Standard VI - Termination of Services

The Music Therapist will terminate music therapy services when the client has attained stated goals and objectives, fails to benefit from services, can no longer be scheduled, or is discharged. At the time of termination, consideration will be given for scheduling periodic reevaluation to determine the need for follow-up services. The Music Therapist will prepare the music therapy termination plan in accordance with federal, state, and facility regulations. The termination plan will:

- 6.1 Further optimize the goals of the individualized music therapy treatment plan.
- 6.2 Coordinate with the individualized treatment plans of other services received by the client.
- 6.3 Allow sufficient time for approval, coordination, and effective implementation whenever possible.
- 6.4 Summarize the client's progress and functioning level at the time of termination.

7.0 Standard VII - Continuing Education

7.1 It is the responsibility of the Music Therapist to maintain knowledge of current developments in research, theory, and techniques in music therapy related areas specific to the populations and therapeutic settings.

7.1.1 The Music Therapist in private practice will maintain knowledge of current developments in research, theory, and techniques concerning the specific clients receiving music therapy services.

7.2 The Music Therapist will be familiar with current federal, state, and local laws pertaining to issues of client rights and confidentiality.

7.3 The Music Therapist will contribute to the education of others regarding the use and benefits of music therapy.

8.0 Standard VIII - Supervision

8.1 It is the responsibility of the Music Therapist to seek and participate in supervision on a regular basis.

8.1.1 Types of supervision may include but are not limited to direct observation, peer review, verbal feedback, group supervision, individual supervision, and music based supervision.

8.1.2 The Music Therapist may seek supervision from music therapists as well as other professionals including but not limited to psychologists, psychiatrists, social workers, art therapists, dance/movement therapists, drama therapists, physical therapists, occupational therapists, speech language pathologists, physicians, and nurses.

8.2 It is the responsibility of the Music Therapist providing supervision to maintain knowledge of current developments in research, theory, and techniques in music therapy supervision and supervision in general.

8.2.1 The Music Therapist providing supervision will be familiar with current federal, state, and local laws as well as the AMTA Code of Ethics as they pertain to supervision and confidentiality within supervision.

8.2.2 The Music Therapist providing supervision is required to will adhere to all AMTA Standards of Clinical Practice and will assure that the Music Therapist supervisee has read and agrees to adhere to the AMTA Standards of Clinical Practice. The Music Therapist providing supervision shall hold the supervisee accountable for adhering to the AMTA Standards of Clinical Practice.

8.2.3 The Music Therapist providing supervision will complete any necessary documentation pertaining to supervision accurately, completely, and in a timely manner.

8.2.4 The Music Therapist providing supervision will keep all supervision content confidential. All records will be kept for at least five years after the final supervision session.

WELLNESS

These Standards of Clinical Practice are designed specifically for the Music Therapist working with individuals seeking *personal growth. The Music Therapist will adhere to the General Standards of Clinical Practice (which are reprinted in sequence in this section), and the specific standards for wellness described herein. The Music Therapist will also adhere to the standards of other applicable music therapy service areas.

Music therapy in wellness involves the specialized use of music to enhance quality of life, maximize well being and potential, and increase self-awareness in individuals seeking music therapy services.

1.0 Standard I - Referral and Acceptance

The Music Therapist responds to a request for services and accepts or declines at his or her own professional discretion.

1.1 A client may be a candidate for music therapy when a cognitive, communication, psychological, educational, social, or physiological need might be ameliorated or prevented by such services.

1.2 A client may be referred for an initial music therapy assessment by:

1.2.1 a Music Therapist

1.2.2 members of other disciplines or agencies

1.2.3 self

1.2.4 parents, guardians, advocates or designated representatives

1.3 The final decision to accept a client for music therapy assessment will be made by a Music Therapist.

1.4 The Music Therapist and client will agree upon services to be rendered prior to or at the onset of delivery. The agreement will include:

1.4.1 Frequency of sessions

1.4.2 Length of each session

1.4.3 Projected length of music therapy services

1.4.4 Terms of payment for services

1.5 The Music Therapist will adopt a fee schedule which is fair and appropriate for professional services rendered.

2.0 Standard II – Assessment

Assessment in this practice area is process oriented and is negotiated by the Music Therapist and the client.

2.1 The music therapy assessment will include the general categories of psychological, cognitive, communicative, social, and physiological functioning focused on the client's needs and strengths. The assessment will also determine the client's responses to music, music skills and musical preferences.

2.2 The music therapy assessment will explore the client's culture. This can include but is not limited to race, ethnicity, language, religion/spirituality, socioeconomic status, family experiences, sexual orientation, gender identity or expression, and social organizations.

2.3 All music therapy assessment methods will be appropriate for the client's chronological age, diagnoses, functioning level, and culture(s). The methods may include, but need not be limited to, observation during music or other situations, interview, verbal and nonverbal interventions, and testing. Information may also be obtained from different disciplines or sources such as the past and present medical and social history in accordance with HIPAA permission regulation.

2.4 All interpretations of test results will be based on appropriate norms or criterion referenced data ^{vii}.

2.5 The music therapy assessment procedures and results will become a part of the client's file.

2.6 The final decision to accept a client for music therapy services, either direct or consultative, will be made by a Music Therapist and, when applicable, will be in conjunction with the interdisciplinary team. Screening^{vi} may be used as part of this process.

2.7 The results, conclusions, and implications of the music therapy assessment will become the basis for the client's music therapy program and will be communicated to others involved with provision of services to the client. When appropriate, the results will be communicated to the client.

2.8 When assessment indicates the client's need for other services, the Music Therapist will make an appropriate referral.

3.0 Standard III - Treatment Planning

The Music Therapist will prepare a program plan based on the agreement for services.

3.1 Help the client attain and maintain the maximum level of functioning.

3.2 Comply with federal, state, and facility regulations.

3.3 Delineate the type, frequency, and duration of music therapy involvement.

3.4 Contain goals^{viii} that focus on assessed needs and strengths of the client.

3.5 Contain objectives^{ix} which are operationally defined for achieving the stated goals within estimated time frames.

3.6 Specify procedures, including music and music materials, for attaining the objectives.

3.6.1 The Music Therapist will include music, instruments, and musical elements, from the client's culture as appropriate.

3.7 Provide for periodic evaluation^x and appropriate modifications as needed.

3.8 Optimize, according to the best professional judgment^{xi} of the Music Therapist:

3.8.1 The program plans of other disciplines.

3.8.2 Established principles of normal growth and development.

3.9 Change to meet the priority needs of the client during crisis intervention.

3.10 Comply with infection control procedures.

3.11 Incorporate medical precautions as necessary.

4.0 Standard IV – Implementation

Communication with others will be contingent upon client consent when appropriate.

4.1 Strive for the highest level and quality of music involvement consistent with the functioning level of the client.

4.1.1 The Music Therapist's provision of music will reflect his or her best abilities as a musician.

4.1.2 Appropriate musical instruments and materials, as well as the best possible sound reproduction equipment should be used in music therapy services.

4.1.3 The Music Therapist will make every effort to ensure safe and quality client care.

4.2 Use methodology that is consistent with recent advances in health, safety^{xiii} and infection control practices.

4.3 Maintain close communication with other individuals involved with the client.

4.4 Record the schedule and procedures used in music therapy treatment.

4.5 Evaluate the client's responses periodically to determine progress toward the goals and objectives.

4.6 Incorporate the results of such evaluations in subsequent treatment.

4.7 Consider the psychological effects of therapeutic separation as termination of services approaches.

5.0 Standard V - Documentation

The Music Therapist will document in a manner consistent with client agreement.

5.1 The Music Therapist will periodically document the client's level of functioning with regard to the goals and objectives.

5.2 The documentation of progress will describe significant intervention techniques and the client's responses to them.

5.3 In all documentation relating to music therapy services, the Music Therapist will:

5.3.1 Write in an objective, professional style based on observable client responses.

5.3.2 Include the date, signature, and professional status of the therapist.

5.3.3 Place such documentation in the client's file and maintain its confidentiality unless proper authorization for release is obtained.

5.4 Upon obtaining written client permission, the Music Therapist will document and disseminate information to key service providers to ensure consistency of services.

5.5 The Music Therapist will document referrals made to other sources and will include plans for music therapy services as appropriate.

5.6 The documentation of all referrals will include date of referral, source of referral, and services requested.

6.0 Standard VI - Termination of Services

The Music Therapist will terminate music therapy services when the client has attained stated goals and objectives, fails to benefit from services, can no longer be scheduled, or is discharged. At the time of termination, consideration will be given for scheduling periodic reevaluation to determine the need for follow-up services. The Music Therapist will prepare the music therapy termination plan in accordance with federal, state, and facility regulations. The termination plan will:

6.1 Further optimize the goals of the individualized music therapy treatment plan.

6.2 Coordinate with the individualized treatment plans of other services received by the client.

6.3 Allow sufficient time for approval, coordination, and effective implementation whenever possible.

6.4 Summarize the client's progress and functioning level at the time of termination.

7.0 Standard VII - Continuing Education

7.1 It is the responsibility of the Music Therapist to maintain knowledge of current developments in research, theory, and techniques in music therapy related areas specific to the populations and therapeutic settings.

7.2 The Music Therapist will be familiar with current federal, state, and local laws pertaining to issues of client rights and confidentiality.

7.3 The Music Therapist will contribute to the education of others regarding the use and benefits of music therapy.

8.0 Standard VIII – Supervision

8.1 It is the responsibility of the Music Therapist to seek and participate in supervision on a regular basis.

8.1.1 Types of supervision may include but are not limited to direct observation, peer review, verbal feedback, group supervision, individual supervision, and music based supervision.

8.1.2 The Music Therapist may seek supervision from music therapists as well as other professionals including but not limited to psychologists, psychiatrists, social workers, art therapists, dance/movement therapists, drama therapists, physical therapists, occupational therapists, speech language pathologists, physicians, and nurses.

8.2 It is the responsibility of the Music Therapist providing supervision to maintain knowledge of current developments in research, theory, and techniques in music therapy supervision and supervision in general.

8.2.1 The Music Therapist providing supervision will be familiar with current federal, state, and local laws as well as the AMTA Code of Ethics as they pertain to supervision and confidentiality within supervision.

8.2.2 The Music Therapist providing supervision is required to will adhere to all AMTA Standards of Clinical Practice and will assure that the Music Therapist supervisee has read and agrees to adhere to the AMTA Standards of Clinical Practice. The Music Therapist providing supervision shall hold the supervisee accountable for adhering to the AMTA Standards of Clinical Practice.

8.2.3 The Music Therapist providing supervision will complete any necessary documentation pertaining to supervision accurately, completely, and in a timely manner.

8.2.4 The Music Therapist providing supervision will keep all supervision content confidential. All records will be kept for at least five years after the final supervision session.

Please feel free to reproduce these Standards of Clinical Practice. However, the standards for specific areas of music therapy services are not to be reproduced separately.

Adopted: Nov. 11, 1982. Revised: Nov. 21, 1987; Nov. 18, 1988; Nov. 21, 1992; Apr. 17, 1998; Nov. 18, 1999; Nov. 1, 2002, Nov. 21, 2003; Nov. 20, 2005, Nov. 14, 2009; Nov. 2010; Nov. 19, 2011, Nov. 2013

FOOTNOTES

i. Music Therapist - Professional Music Therapists who hold the professional credential MT-BC or the professional designation RMT (Registered Music Therapist), CMT (Certified Music Therapist) or ACMT (Advanced Certified Music Therapist). Further information on credentials and designations is available from the Certification Board for Music Therapists (CBMT) or the National Music Therapy Registry (NMTR)

- ii. Intellectual and developmental disabilities - Refers to one or more conditions of childhood or adolescence which interfere with normal development and or adaptive functioning (e.g., autism, mental retardation, sensory/motor/physical/cognitive impairments). Defined (PL 95-682) as chronic mental or physical impairment manifested before age 22. Results in substantial functional limitations in three or more areas of life activities: self care; learning; mobility; self direction; economic sufficiency; receptive and expressive language; capacity for independent living. Requires lifelong individually planned services.
- iii. Assessment - The process of determining the client's present level of functioning. Screening may be incorporated into this process.
- iv. Treatment plan - A program of therapeutic or educational intervention, e.g. IEP (Individual Educational Plan)/ITP (Individual Treatment Plan)/IFSP (Individualized Family Service Plan)/ISP (Individual Service Plan)/IHP (Individual Habilitative Plan), which focuses on the specific needs and strengths of the individual client.
- v. Best professional judgment - The Music Therapist's use of current knowledge that exists in music therapy and related fields in making decisions regarding the provision of music therapy services.
- vi. Screening - An intake procedure wherein the music therapist meets with the client to determine whether or not formal assessment and treatment are indicated.
- vii. Appropriate norms or criterion-referenced data - Standardized tests, whose interpretations are based on data derived from "normal" populations, are generally not beneficial for program planning. Such tests should be used with caution. Criterion-referenced assessments, designed with the client's level of functioning in mind, are usually more helpful in determining both the strengths and weaknesses of the client.
- viii. Goal - A projected outcome of a treatment plan. Goals are often stated in broad terms, as opposed to objectives which are stated more specifically.
- ix. Objective - One of a series of progressive accomplishments leading toward goal attainment; may include conditions under which the expected outcome occurs.
- x. Evaluation - The review of a client's status in reference to the program plan goals, with consideration given to the appropriateness and/or necessary modification of the plan.
- xi. Best professional judgment - The Music Therapist's use of current knowledge that exists in music therapy and related fields in making decisions regarding the provision of music therapy services.
- xii. Safety - Avoidance of harm through structuring care processes, supplies, equipment, and the environment to reduce/eliminate client and staff injuries, infection, and care errors. A safe auditory environment includes protecting clients from continued exposure to loud sounds. For example, continued exposure to sound levels above 85 dB TWA (Time Weighted Average) for more than 8 hours can result in hearing loss (2002) Occupational Safety and Health Centers for Disease Control and Prevention <http://www.cdc.gov/niosh/98-126a.html> accessed: 8-1-02

American Music Therapy Association Standards for Education and Clinical Training

Preamble

The American Music Therapy Association, Inc., aims to establish and maintain competency based standards for all three levels of education (bachelor's, master's, and doctoral), with guidelines for the various curricular structures appropriate to different degrees, as defined by the National Association of Schools of Music (NASM). Using this competency based system, the Association formulates competency objectives or learning outcomes for the various degree programs, based on what knowledge, skills, and abilities are needed by music therapists to work in various capacities in the field. Academic institutions should take primary responsibility for designing, providing, and overseeing the full range of learning experiences needed by students to acquire these competencies, including the necessary clinical training.

A bachelor's degree program should be designed to impart professional level competencies as specified in the *AMTA Professional Competencies*, while also meeting the curricular design outlined by NASM. Since education and clinical training form an integrated continuum for student learning at the professional level, academic institutions should take responsibility not only for academic components of the degree, but also for the full range of clinical training experiences needed by students to achieve competency objectives for the degree. This would include developing and overseeing student placements for both pre internship and internship training.

A master's degree program should be designed to impart selected and specified advanced competencies, drawn from the *AMTA Advanced Competencies*, which would provide breadth and depth beyond the *AMTA Professional Competencies* that are required for entrance into the music therapy profession. At this level the degree should address the practice of music therapy wherein the music therapist applies and integrates a comprehensive synthesis of theories, research, treatment knowledge, musicianship, clinical skills, and personal awareness to address client needs. The curricular design would be appropriate to the degree title, per agreement between AMTA and NASM.

The doctoral degree should be designed to impart advanced competence in research, theory development, clinical practice, supervision, college teaching, and/or clinical administration, depending upon the title and purpose of the program. AMTA will work with NASM in the delineation of the doctoral degree in music therapy.

Academic institutions and internship sites should take primary responsibility for assuring the quality of their programs, jointly and/or separately. This is accomplished by regular, competency based evaluations of their programs and graduates by faculty, supervisors, and/or students. The Association will assure the quality of education and clinical training through its approval standards and review procedures. The Association encourages diversity among institutions and programs and respects the operational integrity within academic and clinical training programs.

In implementing these standards, the Association shares the beliefs that education and clinical training are not separate processes, but reflect a continuum of music therapy education; that education and clinical training must be competency based at all levels; that education and clinical training must be student centered; and that education and clinical training must exist in a perspective of continuous change to remain current. The Association also believes in the importance of music as central to music therapy and that music study must be at the core of education and clinical training.

The Association's standards are based on a vision of the future for music therapy education and clinical training. In establishing and maintaining these standards, it has a responsibility related to education and clinical training in relationship to the outside world that includes clients, professionals of other disciplines, and settings. The Association's relationships with the outside world include the identification of levels of professional practice and training, interface with professionals of other disciplines and with their professional associations, involvement with regulatory entities, and alliances in the private sector. The Association works from a philosophy of inclusiveness that embraces a wide range of approaches and a broad base of therapeutic models including uses of music for persons with disabilities and disease, as well as those who desire music therapy for health, wellness, and prevention. The Association must therefore give academic institutions and clinical training programs the flexibility they need to simultaneously meet student needs, market needs, client needs, and quality standards.

The Association believes it can maintain high quality in education and clinical training while it provides for maximum flexibility in the ways professional standards and competencies are implemented. It also believes that standards can be implemented in ways that prevent overregulation and micromanagement. Quality assurance for education and clinical training must be accomplished at the local level, managed by the academic faculty at the academic institutions and the music therapy supervisors at clinical training sites rather than solely by the Association. The Association shall use these competency based standards as the basis for evaluating academic and clinical training programs and awarding its approval.

These standards must be viewed along with the Association's *Professional Competencies, Advanced Competencies, Standards of Clinical Practice, Advisory on Levels of Practice in Music Therapy, Code of Ethics, Policies and Procedures for Academic Program Approval, and National Roster Internship Guidelines*. In addition, academic programs in music therapy should refer to the *NASM Handbook* for general standards and competencies common to all professional baccalaureate and graduate degree programs in music, as well as specific baccalaureate and graduate degree programs in music therapy. Academic institutions and clinical training programs have the responsibility for determining how their programs will impart the required professional and/or advanced competencies to students (i.e., through which courses, requirements, clinical training experiences, etc.). The standards have been designed to allow institutions and programs to meet this responsibility in ways that are consistent with their own philosophies, objectives, and resources. All AMTA approved academic and clinical training programs will strive to attain these standards.

AMTA Standards for Education and Clinical Training

1.0 GENERAL STANDARDS FOR ACADEMIC INSTITUTIONS

1.1 Only regionally accredited, degree-granting institutions awarding at least the bachelor's degree may offer an academic program in music therapy eligible for program approval by the Association.

1.2 The Association will grant academic program approval only when every music therapy curricular program of the applicant institution (including graduate work, if offered) meets the standards of the Association. *Note: This policy excludes doctoral degree programs in music therapy until such time as AMTA and NASM have worked together to delineate the doctoral degree in music therapy.*

1.3 The administrative section of the academic institution housing the music therapy unit shall have a clearly defined organizational structure, with administrative officers who involve music therapy faculty at the appropriate level of decision making and who provide the necessary support systems for effective implementation of the program.

1.4 The music therapy unit shall be administratively organized in a way that enables students to complete the program and accomplish its educational objectives within the designated time frame.

1.5 The academic institution shall have the space, equipment, library, technology, and instrument resources necessary to support degree objectives.

1.6 The rationale and objectives of each music therapy degree program offered by the academic institution shall be clearly defined, responsive to significant trends and needs in the profession, and consistent with clinical and ethical standards of practice.

1.7 The degree title shall be consistent with educational objectives and curricular requirements of the program.

1.8 The music therapy unit shall have criteria and procedures for admission that reflect the abilities and qualities needed by the student to accomplish degree objectives. The unit shall also have criteria and procedures for determining advanced standing and transfer credit.

1.9 The music therapy unit shall have criteria and procedures for determining student retention, and specifying conditions for dismissal. These shall reflect the level of competence expected of students at various stages during and upon completion of the program.

1.10 The music therapy unit shall take primary responsibility for academic advisement and career counseling of all music therapy majors.

1.11 The music therapy unit shall conduct periodic evaluation of its programs and graduates according to competency objectives of each degree program. The results of these evaluations shall be used as the basis of program development, quality control, and change.

1.12 All music therapy programs in branch campuses or extension programs must meet all NASM Standards for Branch Campuses and External Programs.

1.13 All programs approved by the Association that offer distance learning programs must meet NASM Standards for Distance Learning and the AMTA Guidelines for Distance Learning.

2.0 STANDARDS FOR COMPETENCY-BASED EDUCATION

2.1 The Association shall establish and maintain competency-based standards for ensuring the quality of education and clinical training in the field. Specifically:

2.1.1 The Association shall establish educational objectives for academic and clinical training programs that are outcome specific. That is, the standards shall specify learning outcomes, or the various areas of knowledge, skills, and abilities that graduates will acquire as a result of the program.

2.1.2 The Association shall formulate and update these competency objectives based on what knowledge, skills, and abilities are needed by graduates to perform the various levels and types of responsibilities of a professional music therapist. As such, the standards must continually reflect current practices in both treatment and prevention, illness and wellness; embrace diverse models, orientations and applications of music therapy; address consumer needs; and stimulate growth of the discipline and profession.

2.1.3 The Association shall use these competency-based standards as the basis for evaluating academic and clinical training programs and awarding its approval.

2.2 The Association shall establish curricular structures for academic programs based on competency objectives and title of the degree. A curricular structure gives credit distributions for broad areas of study that must be included in each degree type (e.g., for the M.M. degree, 40% in music therapy, 30% in music, 30% in electives). These curricular structures shall be consistent with those outlined by NASM.

2.3 Academic institutions shall design degree programs in music therapy according to the competency objectives required or recommended by AMTA and the appropriate curricular structure.

2.4 Internship programs shall be designed according to competency objectives delineated by the Association, and in relation to the competency objectives addressed by affiliate academic institutions.

2.5 The academic institution and internship program shall evaluate students of its programs according to the competency requirements established by AMTA, and shall use the evaluation in determining each student's readiness for graduation.

3.0 STANDARDS FOR BACHELOR'S DEGREES

3.1 Academic Component

3.1.1 The bachelor's degree in music therapy (and equivalency programs) shall be designed to impart professional competencies in three main areas: musical foundations, clinical foundations, and music therapy foundations and principles, as specified in the *AMTA Professional Competencies*. A program of academic coursework and clinical training that gives students who have degrees outside of music therapy the equivalent of a bachelor's degree in music therapy may be offered post-baccalaureate. For equivalency programs combined with the master's degree, all AMTA Standards for Master's Degrees must be met.

3.1.2 In compliance with NASM Standards, the bachelor's degree in music therapy shall be divided into areas of study as follows (based on 120 semester hours or its equivalent). *Please note that the following outline of content areas listed below is not intended to designate course titles.*

Musical Foundations (45%)

Music Theory
Composition and Arranging
Music History and Literature
Applied Music Major
Ensembles
Conducting
Functional Piano, Guitar, Percussion, and Voice
Improvisation

Clinical Foundations (15%)

Exceptionality and Psychopathology
Normal Human Development
Principles of Therapy
The Therapeutic Relationship

Music Therapy (15%)

Foundations and Principles
Assessment and Evaluation
Methods and Techniques
Pre-Internship and Internship Courses
Psychology of Music
Music Therapy Research
Influence of Music on Behavior
Music Therapy with Various Populations

General Education (20-25%)

English, Math, Social Sciences, Arts,
Humanities, Physical Sciences, etc.

Electives (5%)

3.1.3 The academic institution shall take primary responsibility for the education and clinical training of its students at the professional level. This involves: offering the necessary academic courses to achieve required competency objectives, organizing and overseeing the student's clinical training, integrating the student's academic and clinical learning experiences according to developmental sequences, and evaluating student competence at various stages of the program.

3.1.4 The music therapy unit shall evaluate each student's competence level in the required areas prior to completion of degree or equivalency requirements.

3.2 Clinical Training Component

3.2.1 The academic institution shall take primary responsibility for providing students with the entire continuum of clinical training experiences with a representative range of client populations across the lifespan in diverse settings. Toward that end, the academic institution shall establish and maintain training and internship agreements with a sufficient number and diversity of field agencies that have the client population, supervisory personnel, and program resources needed to train interns and/or provide pre-internship clinical training experiences. Qualified supervision of clinical training is required and coordinated or verified by the academic institution.

3.2.2 The academic institution shall design its own clinical training program, including types of pre-internship and internship requirements, the number of hours for each placement, the variety of client types involved, and whether internship sites will be approved by the Association, the academic institution, or both. These pre-internship and internship experiences shall be designed, like academic components of the program, to enable students to acquire specific professional level competencies. At least three different populations should be included in pre-internship training. A qualified, credentialed music therapist must provide direct supervision to the pre-internship student, observing the student for a minimum of 40% of pre-internship clinical sessions. (See Qualification Standards for definition of pre-internship supervisor.) Direct supervision includes observation of the student's clinical work with

feedback provided to the student. The academic institution shall describe the design of its clinical training program in the application for approval or re-approval by the Association.

NOTE: Academic course hours that include role-playing or instructing students in music skills, session planning, documentation, and related skills for hypothetical clinical sessions in music therapy may not be utilized as clinical training hours.

3.2.3 Internship, here defined as the culminating, in-depth supervised clinical training at the professional level, may be designed in different ways: part or full time, in one or more settings, for varying periods or time frames, and near or distant from the academic institution. Internships are always under continuous, qualified supervision by a credentialed music therapist. (See Qualification Standards for definition of internship supervisor.) Each internship shall be designed or selected to meet the individual needs of the student. This requires joint planning by the academic faculty, the internship supervisor, and the student, as well as continuous communication throughout the student's placement.

3.2.4 Internship programs may be approved by an academic institution, the Association, or both. Academic institutions will maintain information about affiliated internship programs that they have selected and approved for their own students, and the Association will maintain a national roster of all AMTA-approved internship sites open to any student from any academic institution. Internship sites may choose to establish both university-affiliated internship(s) and a national roster internship program so long as the internship site stays within the standards set by the National Roster Internship Guidelines. The internship supervisor shall make final acceptance decisions regarding applicants for their internship, regardless of whether the internship has been approved by the academic institution or the Association.

3.2.5 University-affiliated internship programs must meet all AMTA standards of the Clinical Training Component and Qualifications for Clinical Supervisors in this document, as well as AMTA Guidelines for Distance Learning (if applicable). These programs will be reviewed in conjunction with academic program approval or re-approval by the Association. University-affiliated internships must be designed so that the music therapy intern spends at least half of the internship hours at one or more placements under the direct supervision of a credentialed music therapist who regularly provides professional music therapy services at that placement(s). For any portion of the internship when there cannot be a music therapist on site, the student must have a credentialed music therapist providing direct supervision under the auspices of the university. Direct supervision includes observation of the intern's clinical work with feedback provided to the intern.

3.2.6 The academic institution shall develop an individualized training plan with each student for completion of all facets of clinical training based on the AMTA competencies, student's needs, student's competencies, and life circumstances. The various clinical training supervisors will work in partnership with the academic faculty to develop the student's competencies and to meet the individualized training plan. It is recommended that this training plan for clinical training shall include specification of placements, minimum hours in each aspect of clinical training including both pre-internship and internship experiences, and the roles and responsibilities of the student, the qualified on-site supervisor, and the academic faculty. A written internship agreement will also be made between the student, internship supervisor, and the academic faculty to describe the student's level of performance at the initiation of the internship. The academic faculty will assume responsibility for the initiation of the internship agreement with the intern and the internship director. The internship agreement shall include

The academic institution's evaluation of the student's level of achievement on each of the AMTA Professional Competencies based on information gathered from music therapy faculty, recent supervisors, written evaluations of clinical work, and the student.
The number of clinical training hours the student has completed (> 180) and the minimum number of hours required for internship (> 900) to a total of > 1200).
The starting and estimated ending dates of the internship. For national roster sites, these are provided by the internship director.
Any academic requirements the student must fulfill for the University during internship. The signature of the internship director on the internship agreement signifies that these requirements may be reasonably completed over and above the site's requirements of the intern.

All parties will participate in the formulation of the agreement which should be completed by the end of the first week of the internship. The agreement will carry the signatures of the academic faculty involved in assessing student competence, the internship director, and the student.

The internship agreement may also include other pertinent information, such as the length of the internship; the student's work schedule; the supervision plan; role and responsibilities of each party; and health, liability, and insurance issues. The content and format of each internship agreement may vary according to the situation and parties involved. This internship agreement is required for both the university affiliated and AMTA national roster internship programs. These individualized training plans and internship agreements are separate and distinct from any affiliation agreements or other legal documents that delineate the terms of the relationship between the university and the clinical training site(s).

3.2.7 The internship program shall have its own competency-based evaluation system to determine whether each intern has attained required AMTA competencies. The internship program shall also solicit intern site evaluations for quality assurance purposes. These evaluations shall be forwarded to the intern's academic institution.

3.2.8 Every student must complete a minimum of 1200 hours of clinical training, with at least 15% (180 hours) in pre-internship experiences and at least 75% (900 hours) in internship experiences. Clinical training is defined as the entire continuum of supervised field experiences, including observing, assisting, co-leading, leading, and assuming full responsibility for program planning and music therapy treatment implementation with clients. It is recommended that hours of clinical training include both direct client contact and other activities that relate directly to clinical sessions in music therapy. Such experiences also may include time in group and individual supervision of client sessions, session planning, and documentation for clients.

Academic institutions may opt to require more than the minimum total number of hours, and internship programs may opt to require more hours than the referring or affiliate academic institution. In addition, when a student is unable to demonstrate required professional level competencies, additional hours of internship may be required of the student by the academic institution in consultation with the internship supervisor.

3.2.9 The internship must be satisfactorily completed before the conferral of any music therapy degree or completion of a non-degree equivalency program. The student must have received a grade of C- or better in all foundational music therapy courses in order to be eligible for internship. The academic institution has the ultimate responsibility to determine whether these requirements have been successfully met.

NOTE: *Foundational coursework related to the professional competencies must be completed prior to beginning internship. If an academic program chooses to offer coursework concurrent with internship, the course content should be integrated with the internship and provide an in-depth examination of topics related to the internship experience.*

3.2.10 Existing internship sites already approved by the Association shall maintain their approval status pending adherence to the National Roster Internship Guidelines.

4.0 STANDARDS FOR MASTER'S DEGREES

The purpose of the master's degree programs in music therapy is to impart advanced competencies, as specified in the *AMTA Advanced Competencies*. These degree programs provide breadth and depth beyond the *AMTA Professional Competencies* required for entrance into the music therapy profession.

4.1 Curricular Standards: Each graduate student in a master's degree program is expected to gain in-depth knowledge and competence in both of the following areas. These areas may be addressed in either separate or combined coursework as deemed appropriate.

4.1.1 Music Therapy Theory (e.g., principles, foundations, current theories of music therapy practice, supervision, education, implications for research);

4.1.2 Advanced Clinical Skills: In-depth understanding of the clinical and supervisory roles and responsibilities of a music therapist. Advanced clinical skills are acquired through one or more clinical component(s) supervised under the auspices of the institution. These clinical component(s) are defined as substantive music therapy fieldwork experiences that focus on clinical practice and occur after the 1200 hours of required clinical training and acquisition of the AMTA Professional Competencies. Students in advanced clinical training courses should demonstrate a depth of understanding of relevant and advanced clinical approaches, theoretical frameworks, and/or advanced clinical supervisory theories and techniques. Each institution must specify the minimum required number of hours and the method of supervision. Students must be evaluated based on the AMTA Advanced Competencies.

In addition, each graduate student in a master's degree program is expected to gain in-depth knowledge and competence in one or more of the following areas:

4.1.3 Research (e.g., quantitative and qualitative research designs and their application to music therapy practice, supervision, administration, higher education);

4.1.4 Musical Development and Personal Growth (e.g., leadership skills, self-awareness, music skills, improvisation skills in various musical styles, music technology);

4.1.5 Clinical Administration (e.g., laws and regulations governing the provision of education and health services, the roles of a clinical administrator in institutions and clinical settings).

4.2 Curricular Structures

4.2.1 Practice-Oriented Degrees. These degrees focus on the preparation of music therapists for advanced clinical practice.

4.2.2 Research-Oriented Degrees. These degrees focus on the preparation of scholars and researchers in music therapy, preparing graduates for doctoral study.

4.2.3 Degrees Combining Research and Practice Orientations. These degrees focus on the simultaneous development of the ability to produce research findings and utilize, combine, or integrate these findings within the practice of music therapy.

4.2.4 Graduate education requires the provision of certain kinds of experiences that go beyond those typically provided in undergraduate programs. These include opportunities for active participation in small seminars and tutorials and ongoing consultation with faculty prior to and during preparation of a final project over an extended period of time.

4.2.5 A culminating project such as a thesis, clinical paper, or demonstration project is required.

4.2.6 Master's degree programs include requirements and opportunities for studies that relate directly to the educational objectives of the degree program, including supportive studies in music and related fields.

4.2.7 Within master's degree programs, academic institutions are encouraged to develop graduate level specialization areas and courses on advanced topics based on faculty expertise and other resources available at the institution. Therefore, the curriculum and the requirements of each program must be tailored to the resources available, the mission of the institution, and the contribution they aspire to make to the profession of music therapy.

4.2.8 At least one-half of the credits required for the master's degree must be in courses intended for graduate students only. A single course that carries both an undergraduate and a graduate designation is not considered a course intended for graduate students only. To obtain graduate credit, students enrolled in a single course that carries a separate undergraduate and graduate designation or number must complete specific published requirements that are at a graduate level. Distinctions between undergraduate and graduate expectations must be delineated for such courses in the course syllabi. Only courses taken after undergraduate courses that are prerequisite to a given graduate program may receive graduate credit in that program.

4.2.9 Students entering the master's degree without the bachelor's degree in music therapy and/or the MT-BC credential must take a minimum of 30 semester hours or 45 quarter hours graduate credits toward advanced competence in addition to and beyond any courses needed to demonstrate *AMTA Professional Competencies*.

4.2.10 A master's degree in music therapy must include a minimum of 12 semester hours or 18 quarter hours of graduate credits in music therapy in addition to and beyond any courses needed to demonstrate the *AMTA Professional Competencies*. These courses must be intended for graduate students only and should not carry designations for both graduate and undergraduate students.

4.3 Degree Formats and Titles

4.3.1 Master of Music degree places advanced music therapy studies within a musical context: 40% music therapy, 30% music, and 30% electives in related areas. The studies in music may include coursework in diverse areas (e.g., performance, ethnomusicology, advanced musicianship, and analysis). The electives consist of supportive studies in related areas that bear directly on the specific educational objectives of the degree program.

4.3.2 Master of Music Therapy degree places advanced music therapy studies within a disciplinary context of theory, research, and practice in music therapy: 50% music therapy and 50% electives. The electives consist of supportive studies in related areas that bear directly on the specific educational objectives of the degree program.

4.3.3 Master of Arts or Master of Music Education degree places advanced music therapy studies within the context of creative arts therapy, expressive therapies, psychology, counseling, social sciences, education, arts, and/or humanities: 40% music therapy, 30% specialization field, and 30% electives. The electives consist of supportive studies that bear directly on the specific educational objectives of the degree program.

4.3.4 Master of Science degree places advanced music therapy studies within the context of medicine, allied health, and the physical sciences: 40% music therapy, 30% science specialization, and 30% electives. The electives consist of supportive studies that bear directly on the specific educational objectives of the degree program.

4.3.5 Master's degrees in music therapy may be designed additionally to prepare certified professionals for state licensure.

5.0 STANDARD FOR DOCTORAL DEGREES

The doctoral degree shall impart advanced competence in research, theory development, clinical practice, supervision, college teaching, and/or clinical administration, depending on the title and purpose of the program. Requirements for the doctoral degree must remain flexible to ensure growth and development of the profession. The academic and clinical components of each doctoral degree must be formulated by the institution according to student need and demand, emerging needs of the profession, faculty expertise, educational mission of the institution, and the resources available. Admission of candidates for doctoral degrees in music therapy should require at least three years of full-time clinical experience in music therapy or its equivalent in part-time work. Doctoral students who have less than five years full-time clinical experience in music therapy or the equivalent in part-time experience should be encouraged to acquire additional experience during the course of the doctoral program. AMTA and NASM will work together in the delineation of the doctoral degree in music therapy.

6.0 STANDARDS FOR QUALIFICATIONS AND STAFFING

The following are minimal qualification standards to be used by academic institutions when hiring faculty, selecting clinical supervisors, making placements, and approving their own internship programs, and by the Association in endorsing internship programs for the national roster. These standards shall be upheld by the Association through its initial and periodic reviews of academic institutions and internship programs on the national roster, rather than through authorization of individual faculty and supervisors.

6.1 Academic Faculty

6.1.1 *Undergraduate Faculty*: An individual employed full-time at a college or university with primary responsibilities for teaching music therapy and/or directing a music therapy program at the undergraduate level.

- Holds an appropriate professional credential or designation in music therapy;
- Holds a master's degree in music therapy or related area, with a minimum of 12 semester hours or the equivalent of graduate credits in music therapy beyond the undergraduate equivalency requirements;
- Has at least three years of full-time clinical experience in music therapy or its equivalent in part-time work;
- Pursues continuing education relevant to his/her teaching responsibilities;
- Demonstrates the following: mastery of all professional level and applicable advanced competencies in music therapy; effectiveness as a music therapy clinician in at least one area of practice; the ability to teach and clinically supervise undergraduate students; and the ability to organize and administer an undergraduate music therapy program.

6.1.2 *Graduate Faculty*: An individual employed full-time at a college or university with primary responsibilities for teaching music therapy and/or directing music therapy programs at the master's and/or doctoral level.

Holds an appropriate professional credential or designation in music therapy;
Holds a master's degree in music therapy or related area, with a minimum of 12 semester hours or the equivalent of graduate credits in music therapy beyond the undergraduate equivalency requirements. A doctorate is preferred.
Has at least five years of full-time clinical experience in music therapy or its equivalent in part-time work;
Pursues continuing education relevant to his/her teaching responsibilities;
Demonstrates the following: mastery of all professional level and applicable advanced competencies in music therapy; effectiveness as a music therapy clinician in at least one area of practice; the ability to teach and clinically supervise graduate students; ability to guide graduate research; and the ability to organize and administer a graduate music therapy program.

6.1.3 *Adjunct Faculty*: An individual employed by a college or university to teach specific courses in music therapy on a part-time basis.

Holds an appropriate professional credential or designation in music therapy;
Holds a bachelor's degree in music therapy or its equivalent;
Has at least two years of full-time clinical experience in music therapy or its equivalent in part-time work;
Pursues continuing education relevant to his/her teaching responsibilities
Demonstrates specific competencies appropriate to the teaching assignment.

6.1.4 *Academic Program Director (or equivalent institutional title)*: An individual employed full-time by the university with primary responsibilities for directing/coordinating the music therapy program. These responsibilities may be assumed by an existing undergraduate or graduate music therapy faculty member. For undergraduate programs, the program director must meet the requirements for Standard 6.1.1. For graduate programs, the program director must meet the requirements for Standard 6.1.2. Their degrees, credentials, and experience reflect the degree program(s) that they are managing. The Academic Program Director:

Is accountable for upholding the educational and clinical training standards of the music therapy program
Is accountable for upholding the AMTA Standards for Education and Clinical Training and the AMTA Code of Ethics.
Receives, responds to, and distributes communication from AMTA regarding program status to appropriate music therapy faculty and administration.
Is responsible for monitoring and communicating eligibility of music therapy students for internship via a letter of eligibility.
Is responsible for monitoring and communicating eligibility of music therapy students to register for the CBMT exam.

6.2 Clinical Supervisors

6.2.1 *Pre-internship Supervisor*: An individual who has a clinical practice in music therapy (either private or facility-based) and supervises students in introductory music therapy clinical training (variously called fieldwork, practicum, pre-clinical, etc.).

Holds an appropriate professional credential or designation in music therapy;
Holds a bachelor's degree in music therapy or its equivalent;
Has at least one year of full-time clinical experience in music therapy or its equivalent in part-time work;
Pursues continuing education relevant to his/her clinical and supervisory responsibilities;
Demonstrates the following: all professional level competencies; effectiveness as a music therapy clinician in at least one area of practice; general understanding of the supervisory needs of pre-internship students, and professional level skills in supervision.

NOTE: In an exceptional case, a student may have an on-site supervisor or facility coordinator who may not be a music therapist but holds a professional, clinical credential (e.g., OT, nurse, special educator, etc.). Under these circumstances, the student must have a credentialed music therapist as a supervisor under the auspices of the university. A pre-internship supervisor (a credentialed music therapist) must provide direct supervision to the student, observing the student for a minimum of 40% of pre-internship clinical sessions. Direct supervision includes observation of the student's clinical work with feedback provided to the student.

6.2.2 *Internship Supervisor:* An individual who has a clinical practice in music therapy (either private or institutional) and supervises students in the final field experiences required for the music therapy degree or equivalency program.

Hold an appropriate professional credential or designation in music therapy;
Hold a bachelor's degree in music therapy or its equivalent;
Has at least two years of full-time clinical experience in music therapy or its equivalent in part-time work;
Has sufficient experience working in the internship setting as defined in the *National Roster Internship Guidelines* or by the university program.
Pursues continuing education relevant to his/her clinical and supervisory responsibilities;
Demonstrates the following: all professional level competencies; effectiveness as a music therapy clinician in at least one area of practice; general understanding of the supervisory needs of internship students, and established skills in supervision.

6.3 Staffing

6.3.1 Academic institutions shall have a minimum of one full-time faculty position in music therapy for each degree program offered. If an equivalency program is offered in an institution without a degree program in music therapy, the institution shall have a minimum of one full-time faculty position in music therapy who meets the standards for academic undergraduate faculty stated in Standard 6.1.1. Additional full or part-time faculty may be required depending upon student enrollment in each degree program and teaching loads.

7.0 STANDARDS FOR QUALITY ASSURANCE

7.1 Differential Roles

7.1.1 The academic institution and internship site shall take primary responsibility for assuring the quality of their programs, jointly and/or separately. This shall be accomplished by regular, competency-based evaluations of its programs and graduates, by faculty, supervisors, and/or students. Each academic institution and internship program shall develop its own system of evaluation, and shall use the results as the basis for program development, quality assurance, and program change.

7.1.2 AMTA shall assure the quality of education and clinical training by: a) establishing and maintaining standards of excellence for education and clinical training in the field; and b) using these standards as evaluative criteria for granting its approval to academic institutions and internship programs.

7.1.3 AMTA shall consider academic institutions and/or internship programs for approval upon initial application and review, and every ten years thereafter in conjunction with the NASM accreditation/affirmation review.

7.2 National Association of Schools of Music (NASM)

7.2.1 Only academic institutions accredited or affirmed by NASM are eligible to apply for AMTA approval. Schools that are eligible for NASM membership must be accredited by NASM. Schools that are ineligible for NASM accreditation must obtain a Statement of Affirmation from NASM through the Alternative Review Process for music therapy programs. Correspondence will be noted as confidential.

8.0 GUIDELINES FOR DISTANCE LEARNING

Rationale: Technology is rapidly becoming integrated into all aspects of our daily lives. The utilization of technology in education in university teaching is a natural step. With this in mind, it is imperative that the American Music Therapy Association (AMTA) formulate guidelines for distance learning in education. Technology beyond the posting of syllabi, course outlines, and use as a communication device, is currently being used in 50% of music therapy undergraduate and 58% of graduate programs in the United States (Keith & Vega, 2006). Of those undergraduate training programs,

45% of these programs use face-to-face instruction and use technology only for discussions and online assignments. American Music Therapy Association receives a significant number of requests from prospective music therapy candidates who are unable to move geographically to institutions with AMTA approved music therapy programs. The AMTA Academic Program Approval Committee has received applications for new program approval for distance learning programs and is therefore in need of standards and guidelines for its program approval process. Institutions are encouraged to be innovative both in education delivery and financially. It is recognized that with the rapid changes in technology, these standards and guidelines will require flexibility and will be in a continued state of development.

8.1 Definition: The National Association of Schools of Music (NASM) defines distance learning as learning that "involves programs of study delivered entirely or partially away from regular face-to-face interactions between teachers and students in classrooms, tutorials, laboratories, and rehearsals associated with course work, degrees, and programs on the campus. . . . Programs in which more than 40% of their requirements are fulfilled through distance learning will be designated as distance learning programs.. The distance aspect of these programs may be conducted through a variety of means, including teaching and learning through electronic systems..."

8.2 Standards Applications: The American Music Therapy Association requires that all AMTA approved music therapy programs meet the NASM standards for distance learning: "Distance learning programs must meet all NASM operational and curricular standards for programs of their type and content. This means that the functions and competencies required by applicable standards are met even when distance learning mechanisms predominate in the total delivery system." (NASM) The American Music Therapy Association also requires that baccalaureate, equivalency, and master's degree programs in music therapy meet AMTA Standards for Education and Clinical Training when such programs meet the above criteria for distance learning. All new distance learning programs that meet the above criteria must apply for AMTA academic program approval even if the existing degree/equivalency program already has AMTA program approval.

8.3 General Standards: There are several NASM standards that must be fully addressed before a music therapy program initiates a distance learning format. They include the following:

8.3.1 Financial and Technical Support. "The institution must provide financial and technical support commensurate with the purpose, size, scope, and content of its distance learning programs." (NASM)

8.3.2 Student Evaluations "Specific student evaluation points shall be established throughout the time period of each course or program." (NASM)

8.3.3 Student Technical Competence and Equipment Requirements. "The institution must determine and publish for each distance learning program or course (a) requirements for technical competence and (b) any technical equipment requirements. The institution must have means for assessing the extent to which prospective students meet these requirements before they are accepted or enrolled. The institution shall publish information regarding the availability of academic and technical support services." (NASM)

8.3.4 Distance Learning vs. Traditional Learning. "When an identical program, or a program with an identical title, is offered through distance learning as well as on campus, the institution must be able to demonstrate functional equivalency in all aspects of each program. Mechanisms must be established to assure equal quality among delivery systems." (NASM)

8.3.5 Student Instructions, Expectations, and Evaluation. "Instructions to students, expectations for achievement, and evaluation criteria must be clearly stated and readily available to all involved in a particular distance learning program. Students must be fully informed of means for asking questions and otherwise communicating with instructors and students as required." (NASM)

8.4 Guidelines for Music Therapy Programs

8.4.1 Hours of Face-to-Face Instruction: Distance learning programs should specify how much face-to-face instruction will occur per course, if any. Such courses are often referred to as "hybrid courses" (also known as blended or mixed mode courses) in which a significant portion of the learning activities have been moved online. Faculty need to be knowledgeable about modules and course management systems specific to their college/university, different file types, browsers, broadcasting systems, etc., and continue to keep updated with new technology.

8.4.2 Office Hours: The course instructor may fulfill office hours either by posting virtual office hours or by instituting a policy of responding to student needs within a 48 hour time frame.

8.4.3 Support Services: The methods and technological requirements for online learning should be published (e.g., Discussion Board on Blackboard, webinars, Skype, etc.). It is suggested that each course of study devote time to teaching the use of technology in the program. The program shall publish information regarding the availability of academic and technical support services. Any online courses outside of music therapy that are available for support should also be indicated. Provisions for using library resources should be published.

8.4.4 Admission: Admission will be in compliance with each university's admission policies and procedures for music therapy programs.

8.4.5 Residency Requirement and Transfer Credits: If the university has a "residency requirement," such a requirement will be honored by the music therapy programs. Furthermore, music therapy core courses and clinical training from AMTA approved institutions will be eligible for transfer as determined by the university's policies and evaluation of student competencies. The number of credit hours that can be taken at another educational institution and in what areas should be indicated to the student at the time of admission.

8.4.6 Music Therapy Courses: Music therapy programs must meet the curricular structures as outlined in the *AMTA Standards for Education and Clinical Training*. Academic faculty should determine what learning should be done in residence as opposed to online and how this must be implemented. Course syllabi should clearly provide the course outline and assignments to indicate what each course entails, including the technological requirements and the online course management systems. Means of evaluation of the student's work at periodic times throughout the course must be provided in the syllabi. Course syllabi should indicate the **AMTA Professional Competencies** and/or **Advanced Competencies** (whichever if applicable) that will be addressed in the course(s) and how these competencies will be evaluated using distance learning methods.

8.4.7 Academic Faculty: Academic faculty teaching music therapy courses must meet AMTA standards for academic faculty. These guidelines for distance learning apply to all baccalaureate, equivalency, and master's degree programs in music therapy. Administering an online program and teaching online courses will require a significant amount of time over and beyond the credits awarded for the course. Load issues and overload issues should be taken into account when designing the program and distributed in a fair and equitable way to the music therapy faculty.

8.4.8 Music Competencies: Each student's music competencies in performance and functional music skills will be evaluated prior to acceptance into a distance learning program and upon completion of the program will meet AMTA standards stated in the Professional Competencies and/or Advanced Competencies (whichever is applicable to the degree/equivalency programs). This includes competencies in functional keyboard, guitar, voice, percussion, and improvisation. Music competencies may be evaluated through face-to-face auditions, web-based conferencing juries, or through videotaping. Credit for functional music skills may be acquired either at the college/university offering the program or transferred in from other academic institutions. Requirements for meeting any deficiencies in these areas must be specified in a plan for the student's remediation and continued evaluation. Methods of evaluating musical proficiencies long distance must be specified.

8.4.9 Clinical Training: The pre-internship and internship learning experiences for students should meet all AMTA standards for clinical training. Pre-internship field experiences may be established through distance learning. There should be legal contracts and/or affiliation agreements for these distance learning relationships which specify the roles and responsibilities of the academic faculty, pre-internship supervisors, internship supervisors, and the student. The music therapy faculty/staff at the academic program site (full-time or adjunct) should provide training and supervision for the on-site pre-internship and (if applicable) university affiliated internship clinical training supervisors and serve as a liaison between the academic program and the pre-internship/internship clinical training program(s). All clinical training supervisors must meet the AMTA "Standards for Qualifications and Staffing" for Pre-internship Supervisor and Internship Supervisor (whichever is applicable), including that of holding an appropriate professional credential or designation in music therapy (e.g., MT-BC; ACMT; CMT; RMT).

8.4.10 Online Supervision: Online supervision may be provided for the clinical supervisors along with site visits by the academic faculty. Supervision for the student's clinical training experiences includes individual supervision of the student by the qualified music therapist at the host site, as well as supervision by the academic faculty. Feedback of the student's clinical work can be provided to academic faculty through such means as audio-visual media and other forms of technology and telecommunications to evaluate the student's clinical competencies. Please note that the issues related to client confidentiality must be addressed.

8.4.11 Group Supervision: Group supervision may also be provided through online discussion boards such as those found in Blackboard and/or live-time webinars with faculty and students. Please note that the issues related to client confidentiality must be addressed.

8.4.12 Related Coursework: The music therapy program should state explicitly whether courses that are required outside of the music therapy program (e.g., psychology, statistics or other research courses) are also available in distance-learning format.

Keith, D. & Vega, V. P. (2006) A survey of online courses in music therapy. Unpublished manuscript.

Glossary of Selected Terms

AAMT: The American Association for Music Therapy was one of the two former organizations that merged to form the American Music Therapy Association.

Academic Institution: A college or university offering music therapy degree program(s).

Academic Faculty: The full-time, part-time and adjunct teaching professionals in an academic institution that have responsibility for instruction, research, and service as per academic institution policies. Academic faculty members have responsibility for the music therapy academic program(s).

Accreditation (NASM): The process whereby a private, governmentally authorized agency grants public recognition to an academic institution that meets standards of quality for higher education in a particular field, as determined through initial and subsequent periodic reviews. In the field of music, the National Association of Schools of Music (NASM) is the only authorized accrediting agency empowered to accredit academic institutions offering music degrees in any area in the United States. Thus, NASM accreditation (or "NASM membership") signifies that all the music degrees offered by an academic institution have been evaluated by NASM and found to be consistent with national standards. *Please note the following differences between NASM accreditation, NASM affirmation, and AMTA approval:* NASM accredits an academic institution based on the quality of all of its music degree programs; NASM affirms an institution ineligible for NASM accreditation, based on the adequacy of its music resources for music therapy programs; AMTA approves an academic institution based on the quality of its music therapy programs only. See respective definitions.

ACMT: "Advanced Certified Music Therapist" is a designation formerly given by the American Association for Music Therapy.

Affirmation (NASM): NASM offers an alternative review process for music therapy programs that are ineligible to apply for NASM accreditation (e.g., in an institution in a foreign country). The alternative review process leads to a statement of affirmation from NASM assuring that the institution and its music programs provide a context for and qualitative outcome by the music therapy program consistent with NASM standards. Academic institutions that meet NASM standards and receive such affirmation are not "accredited" members of NASM. *Please see under "Accreditation (NASM)" for an explanation of the differences between NASM accreditation, NASM affirmation, and AMTA approval.*

AMTA: The American Music Therapy Association is the organization formed by the unification of AAMT and NAMT.

Appropriate Music Therapy Credential or Designation: Appropriate music therapy credentials or designations include three designations that were issued by the former Associations—RMT or Registered Music Therapist, CMT or Certified Music Therapist, and ACMT or Advanced Certification in Music Therapy; and the MT-BC or Music Therapist-Board Certified, which is the professional credential in music therapy granted in the United States. An appropriate music therapy credential or designation could also include a professional designation or credential from a country other than the United States.

Approval of Academic Institutions: Approval is a process whereby the professional association in music therapy grants public recognition to an academic institution for its degree (and/or equivalency) programs in music therapy. Approval is granted when the degree program meets the Association's standards of quality, as determined through initial and periodic review by the Association. *Please see under "Accreditation (NASM)" for an explanation of the differences between NASM accreditation, NASM affirmation, and AMTA approval.*

Approval of Internship Sites: Internship approval by AMTA is the process by which AMTA determines that an internship site meets its standards of quality and grants public recognition to that fact. The Association maintains a national roster of approved internship sites for use by approved academic institutions and their students. Academic institutions also may approve and individually affiliate with internship sites. These university-affiliated internship programs will be reviewed in conjunction with academic program approval or re-approval by the Association.

Approval Review Process: The entire sequence of procedures established by AMTA for the evaluation of an academic institution or internship site. The "review" typically involves application by the academic institution or internship site using established forms, a process of evaluation by designated committees within the Association according to the standards and criteria for approval established by the association, and procedures for communication and appeal.

Board Certification: The credential of Music Therapist-Board Certified (MT-BC) is initially obtained by successful passage of the national board certification examination designed and administered by the Certification Board for Music Therapists (CBMT). Each certificant must re-certify every five years. Re-certification may be accomplished either through re-examination or through accrual of appropriate continuing education as specified by CBMT.

CBMT: The Certification Board for Music Therapists.

Clinical Training: Clinical training is the entire continuum of supervised field experiences, including observing, assisting, co-leading, leading, and assuming full responsibility for program planning and music therapy treatment implementation with clients. This continuum includes all experiences formerly called observations, fieldwork, field experience, practicum, pre-clinical experience, and internship. For the sake of clarity, clinical training has been conceived as having two main components: pre-internship and internship. Pre-internship training consists of all the various practical field experiences taken by a student in conjunction with music therapy coursework as pre-requisites for internship placement. This may include experiences formerly called observations, practica, fieldwork, pre-clinical placements, etc. The internship is the culminating, in-depth supervised clinical training experience in a degree program in music therapy (or its equivalent) that leads to the achievement of the professional competency objectives.

CMT: "Certified Music Therapist" is a designation formerly given by the American Association for Music Therapy.

Competency-Based Education in Music Therapy: An approach to higher education and clinical training which has the following components: 1) the specification of student competencies or learning outcomes that serve as educational objectives for the program; 2) the distribution of these competency objectives into a developmentally sequenced curriculum of instruction, study, and/or practical training, 3) the design of specific courses and practical or field experiences to meet designated competency objectives, and 4) methods of quality assurance based on student competence upon completion of the program. The inventory entitled the *AMTA Professional Competencies* lists the professional competencies and the *AMTA Advanced Competencies* lists the advanced competencies.

Credential: *Please see "Appropriate Music Therapy Credential or Designation."*

Equivalency Program: A program of academic coursework and clinical training that gives students who have degrees outside of music therapy the equivalent of a bachelor's degree in music therapy. Like the bachelor's degree, an equivalency program is designed to impart professional level competencies in music therapy and to prepare the student to begin professional practice. Usually, the equivalency program consists of all core music therapy courses at the undergraduate level, all clinical training requirements, plus any pertinent courses in other fields (e.g., abnormal psychology). In those academic institutions offering a bachelor's degree, the student usually earns undergraduate credit for these equivalency courses, while in some that only offer the master's degree, students earn graduate credit for the same courses. It should be noted that an equivalency program is always regarded as professional level, regardless of the level of credit awarded for the coursework.

Internship: The culminating, in-depth supervised clinical training experience in a professional level degree program (or its equivalent) in music therapy.

Music Therapy Unit: The academic department, section, division, or subdivision within a college or university that takes administrative and programmatic responsibility for the music therapy degree(s) offered (e.g., a department of music therapy, a music therapy section within the department of music education, a music therapy program within the division of arts).

MT-BC: Music Therapist-Board Certified. Also see Board Certification.

NAMT: The National Association for Music Therapy was one of the two former organizations that merged to form the American Music Therapy Association.

NASM: The National Association of Schools of Music is the sole agency designated by the government to accredit music schools in the USA. (Refer to "Accreditation.")

Pre-internship: Pre-internship training is constituted by clinical training experiences conducted in conjunction with academic work in music therapy that are prerequisites for internship placement. This may include experiences formerly called observations, practica, fieldwork, pre-clinical placements, etc. Pre-internship experiences include both direct client contact and other activities that relate directly to clinical sessions in music therapy.

Professional Designation: Please see "*Appropriate Music Therapy Credential or Designation.*"

RMT: Registered Music Therapist is a designation formerly given by the National Association for Music Therapy.



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AMTA PROFESSIONAL COMPETENCIES

Preamble to *AMTA Professional Competencies*

The American Music Therapy Association has established competency-based standards for ensuring the quality of education and clinical training in the field of music therapy. As the clinical and research activities of music therapy provide new information, the competency requirements need to be reevaluated regularly to ensure consistency with current trends and needs of the profession and to reflect the growth of the knowledge base of the profession. The Association updates these competencies based on what knowledge, skills, and abilities are needed to perform the various levels and types of responsibilities to practice at a professional level.

In November 2005 the AMTA Assembly of Delegates adopted the *Advisory on Levels of Practice in Music Therapy*. This Advisory, which was developed by the Education and Training Advisory Board, distinguishes two Levels of Practice within the music therapy profession: Professional Level of Practice and Advanced Level of Practice. This Advisory describes the Professional Level of Practice as follows:

A music therapist at the Professional Level of Practice has a Bachelor's degree or its equivalent in music therapy and a current professional designation or credential in music therapy (i.e., ACMT, CMT, MT-BC, or RMT). At this level, the therapist has the ability to assume a supportive role in treating clients, collaborating within an interdisciplinary team to contribute to the client's overall treatment plan.

The *AMTA Professional Competencies* are based on music therapy competencies authored for the former American Association for Music Therapy (AAMT) by Bruscia, Hesser, and Boxhill (1981). The former National Association for Music Therapy (NAMT) in turn adapted these competencies as the *NAMT Professional Competencies* revised in 1996. In its final report the Commission on Education and Clinical Training recommended the use of these competencies, and this recommendation was approved by the AMTA Assembly of Delegates in November 1999. The *AMTA Professional Competencies* has had several minor revisions since its adoption in 1999.

A. MUSIC FOUNDATIONS

1. Music Theory and History
 - 1.1 Recognize standard works in the literature.
 - 1.2 Identify the elemental, structural, and stylistic characteristics of music from various periods and cultures.
 - 1.3 Sight-sing melodies of both diatonic and chromatic makeup.
 - 1.4 Take aural dictation of melodies, rhythms, and chord progressions.
 - 1.5 Transpose simple compositions.
2. Composition and Arranging Skills
 - 2.1 Compose songs with simple accompaniment.

- 2.2 Adapt, arrange, transpose, and simplify music compositions for small vocal and nonsymphonic instrumental ensembles.
- 3. Major Performance Medium Skills
 - 3.1 Perform appropriate undergraduate repertoire; demonstrate musicianship, technical proficiency, and interpretive understanding on a principal instrument/voice.
 - 3.2 Perform in small and large ensembles.
- 4. Functional Music Skills
 - 4.1 Demonstrate a basic foundation on voice, piano, guitar, and percussion.
 - 4.1.1 Lead and accompany proficiently on instruments including, but not limited to, voice, piano, guitar, and percussion.
 - 4.1.2 Play basic chord progressions in several major and minor keys with varied accompaniment patterns.
 - 4.1.3 Play and sing a basic repertoire of traditional, folk, and popular songs with and without printed music.
 - 4.1.4 Sing in tune with a pleasing quality and adequate volume both with accompaniment and a capella.
 - 4.1.5 Sight-read simple compositions and song accompaniments.
 - 4.1.6 Harmonize and transpose simple compositions in several keys.
 - 4.1.7 Tune stringed instruments using standard and other tunings.
 - 4.1.8 Utilize basic percussion techniques on several standard and ethnic instruments.
 - 4.2 Develop original melodies, simple accompaniments, and short pieces extemporaneously in a variety of moods and styles, vocally and instrumentally.
 - 4.3 Improvise on pitched and unpitched instruments, and vocally in a variety of settings including individual, dyad, small or large group.
 - 4.4 Care for and maintain instruments.
- 5. Conducting Skills
 - 5.1 Conduct basic patterns with technical accuracy.
 - 5.2 Conduct small and large vocal and instrumental ensembles.
- 6. Movement Skills
 - 6.1 Direct structured and improvisatory movement experiences.
 - 6.2 Move in a structured and/or improvisatory manner for expressive purposes.

B. CLINICAL FOUNDATIONS

- 7. Therapeutic Applications
 - 7.1 Demonstrate basic knowledge of the potential, limitations, and problems of populations specified in the Standards of Clinical Practice.
 - 7.2 Demonstrate basic knowledge of the causes, symptoms of, and basic terminology used in medical, mental health, and educational classifications.
 - 7.3 Demonstrate basic knowledge of typical and atypical human systems and development (e.g., anatomical, physiological, psychological, social.)
 - 7.4 Demonstrate basic understanding of the primary neurological processes of the brain.
- 8. Therapeutic Principles
 - 8.1 Demonstrate basic knowledge of the dynamics and processes of a therapist-client relationship.
 - 8.2 Demonstrate basic knowledge of the dynamics and processes of therapy groups.
 - 8.3 Demonstrate basic knowledge of accepted methods of major therapeutic approaches.
- 9. The Therapeutic Relationship
 - 9.1 Recognize the impact of one's own feelings, attitudes, and actions on the client and the therapy process.

- 9.2 Establish and maintain interpersonal relationships with clients and team members that are appropriate and conducive to therapy.
- 9.3 Use oneself effectively in the therapist role in both individual and group therapy, e.g., appropriate self-disclosure, authenticity, empathy, etc. toward affecting desired therapeutic outcomes.
- 9.4 Utilize the dynamics and processes of groups to achieve therapeutic goals
- 9.5 Demonstrate awareness of the influence of race, ethnicity, language, religion, marital status, gender, gender identity or expression, sexual orientation, age, ability, socioeconomic status, or political affiliation on the therapeutic process.

C. MUSIC THERAPY

10. Foundations and Principles

Apply basic knowledge of:

- 10.1 Existing music therapy methods, techniques, materials, and equipment with their appropriate applications.
- 10.2 Principles and methods of music therapy assessment, treatment, evaluation, and termination for the populations specified in the Standards of Clinical Practice.
- 10.3 The psychological aspects of musical behavior and experience including, but not limited to, perception, cognition, affective response, learning, development, preference, and creativity.
- 10.4 The physiological aspects of the musical experience including, but not limited to, central nervous system, peripheral nervous system, and psychomotor responses.
- 10.5 Philosophical, psychological, physiological, and sociological basis of music as therapy.
- 10.6 Use of current technologies in music therapy assessment, treatment, evaluation, and termination.

11. Client Assessment

- 11.1 Select and implement effective culturally-based methods for assessing the client's strengths, needs, musical preferences, level of musical functioning, and development.
- 11.2 Observe and record accurately the client's responses to assessment.
- 11.3 Identify the client's functional and dysfunctional behaviors.
- 11.4 Identify the client's therapeutic needs through an analysis and interpretation of assessment data.
- 11.5 Communicate assessment findings and recommendations in written and verbal forms.

12. Treatment Planning

- 12.1 Select or create music therapy experiences that meet the client's objectives.
- 12.2 Formulate goals and objectives for individual and group therapy based upon assessment findings.
- 12.3 Identify the client's primary treatment needs in music therapy.
- 12.4 Provide preliminary estimates of frequency and duration of treatment.
- 12.5 Select and adapt music, musical instruments, and equipment consistent with the strengths and needs of the client.
- 12.6 Formulate music therapy strategies for individuals and groups based upon the goals and objectives adopted.
- 12.7 Create a physical environment (e.g., arrangement of space, furniture, equipment, and instruments that is conducive to therapy).
- 12.8 Plan and sequence music therapy sessions.
- 12.9 Determine the client's appropriate music therapy group and/or individual placement.
- 12.10 Coordinate treatment plan with other professionals.

13. Therapy Implementation

- 13.1 Recognize, interpret, and respond appropriately to significant events in music therapy sessions as they occur.

- 13.2 Provide music therapy experiences that address assessed goals and objectives for populations specified in the Standards of Clinical Practice.
- 13.3 Provide verbal and nonverbal directions and cues necessary for successful client participation.
- 13.4 Provide models for and communicate expectations of behavior to clients.
- 13.5 Utilize therapeutic verbal skills in music therapy sessions.
- 13.6 Provide feedback on, reflect, rephrase, and translate the client's communications.
- 13.7 Assist the client in communicating more effectively.
- 13.8 Sequence and pace music experiences within a session according to the client's needs and situational factors.
- 13.9 Conduct or facilitate group and individual music therapy.
- 13.10 Implement music therapy program according to treatment plan.
- 13.11 Promote a sense of group cohesiveness and/or a feeling of group membership.
- 13.12 Develop and maintain a repertoire of music for age, culture, and stylistic differences.
- 13.13 Recognize and respond appropriately to effects of the client's medications.
- 13.14 Maintain a working knowledge of new technologies and implement as needed to support client progress towards treatment goals and objectives.
- 14. Therapy Evaluation
 - 14.1 Design and implement methods for evaluating and measuring client progress and the effectiveness of therapeutic strategies.
 - 14.2 Establish and work within realistic time frames for evaluating the effects of therapy.
 - 14.3 Recognize significant changes and patterns in the client's response to therapy.
 - 14.4 Recognize and respond appropriately to situations in which there are clear and present dangers to the client and/or others.
 - 14.5 Modify treatment approaches based on the client's response to therapy.
 - 14.6 Review and revise treatment plan as needed.
- 15. Documentation
 - 15.1 Produce documentation that accurately reflects client outcomes and meet the requirements of internal and external legal, regulatory, and reimbursement bodies.
 - 15.2 Document clinical data.
 - 15.3 Write professional reports describing the client throughout all phases of the music therapy process in an accurate, concise, and objective manner.
 - 15.4 Effectively communicate orally and in writing with the client and client's team members.
 - 15.5 Document and revise the treatment plan and document changes to the treatment plan.
 - 15.6 Develop and use data-gathering techniques during all phases of the clinical process including assessment, treatment, evaluation, and termination.
- 16. Termination/Discharge Planning
 - 16.1 Assess potential benefits/detriments of termination of music therapy.
 - 16.2 Develop and implement a music therapy termination plan.
 - 16.3 Integrate music therapy termination plan with plans for the client's discharge from the facility.
 - 16.4 Inform and prepare the client for approaching termination from music therapy.
 - 16.5 Establish closure of music therapy services by time of termination/discharge.
- 17. Professional Role/Ethics
 - 17.1 Interpret and adhere to the AMTA Code of Ethics.
 - 17.2 Adhere to the Standards of Clinical Practice.
 - 17.3 Demonstrate dependability: follow through with all tasks regarding education and professional training.
 - 17.4 Accept criticism/feedback with willingness and follow through in a productive manner.
 - 17.5 Resolve conflicts in a positive and constructive manner.
 - 17.6 Meet deadlines without prompting.

- 17.7 Express thoughts and personal feelings in a consistently constructive manner.
- 17.8 Demonstrate critical self-awareness of strengths and weaknesses.
- 17.9 Demonstrate knowledge of and respect for diverse cultural backgrounds.
- 17.10 Treat all persons with dignity and respect, regardless of differences in race, ethnicity, language, religion, marital status, gender, gender identity or expression, sexual orientation, age, ability, socioeconomic status, or political affiliation.
- 17.11 Demonstrate skill in working with culturally diverse populations.
- 17.12 Adhere to all laws and regulations regarding the human rights of clients, including confidentiality.
- 17.13 Demonstrate the ability to locate information on regulatory issues and to respond to calls for action affecting music therapy practice.
- 17.14 Demonstrate basic knowledge of professional music therapy organizations and how these organizations influence clinical practice.
- 17.15 Demonstrate basic knowledge of music therapy service reimbursement and financing sources (e.g., Medicare, Medicaid, Private Health Insurance, State and Local Health and/or Education Agencies, Grants).
- 17.16 Adhere to clinical and ethical standards and laws when utilizing technology in any professional capacity.
- 18. Interprofessional Collaboration
 - 18.1 Demonstrate a basic understanding of professional roles and duties and develop working relationships with other disciplines in client treatment programs.
 - 18.2 Communicate to other departments and staff the rationale for music therapy services and the role of the music therapist.
 - 18.3 Define the role of music therapy in the client's total treatment program.
 - 18.4 Collaborate with team members in designing and implementing interdisciplinary treatment programs.
- 19. Supervision and Administration
 - 19.1 Participate in and benefit from multiple forms of supervision (e.g., peer, clinical).
 - 19.2 Manage and maintain music therapy equipment and supplies.
 - 19.3 Perform administrative duties usually required of clinicians (e.g., scheduling therapy, programmatic budgeting, maintaining record files).
 - 19.4 Write proposals to create new and/or maintain existing music therapy programs.
- 20. Research Methods
 - 20.1 Interpret information in the professional research literature.
 - 20.2 Demonstrate basic knowledge of the purpose and methodology of historical, quantitative, and qualitative research.
 - 20.3 Perform a data-based literature search.
 - 20.4 Integrate the best available research, music therapists' expertise, and the needs, values, and preferences of the individual(s) served.

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Revised 11/30/08

Revised 7/10/13

Revised 11/23/13



THE CERTIFICATION BOARD
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BOARD CERTIFICATION DOMAINS

FROM THE 2014 MUSIC THERAPY PRACTICE ANALYSIS STUDY, EFFECTIVE APRIL 1, 2015

I. Referral, Assessment, and Treatment Planning: 40 items

A. Referral

1. Utilize or develop appropriate referral protocol for population.
2. Evaluate the appropriateness of a referral for music therapy services.
3. Prioritize referrals according to immediate client needs when appropriate.
4. Educate staff, treatment team, or other professionals regarding appropriate referral criteria for music therapy based on population needs

B. Assessment

1. Observe client in music and/or non-music settings.
2. Obtain client information from available resources (e.g., client, caregiver, documentation, family members, other professionals, treatment team members).
3. Identify client functioning level, strengths, and areas of need within the following domains:
 - a) cognitive.
 - b) communicative.
 - c) emotional.
 - d) musical.
 - e) physiological.
 - f) psychosocial.
 - g) sensorimotor.
 - h) spiritual.
4. Identify client's:
 - a) active symptoms.
 - b) behaviors.
 - c) clinical history.
 - d) cultural and spiritual background, when indicated.
 - e) family dynamics and support systems.
 - f) learning styles.
 - g) manifestations of affective state.
 - h) music background and skills.
 - i) preferences.
 - j) social and interpersonal relationships.
 - k) stressors related to present status.
 - l) resources.
5. Document intake and assessment information.
6. Understand the possible effects of medical and psychotropic drugs.
7. Select musical assessment tools and procedures.
8. Select non-musical assessment tools and procedures.
9. Adapt existing assessment tools and procedures.
10. Develop assessment tools and procedures.

11. Create an assessment environment or space conducive to the assessment protocol and/or client's needs.
12. Engage client in musical and non-musical experiences to obtain assessment data.
13. Identify client response to different:
 - a) types of musical experiences (e.g., improvising, recreating, composing, and listening) and their variations.
 - b) types of non-musical experiences.
 - c) styles of music.
 - d) elements of music (e.g., tempo, pitch, timbre, melody, harmony, rhythm, meter, dynamics, form, lyrics).

C. Interpret Assessment Information and Communicate Results

1. Evaluate reliability and presence of bias in information from available resources.
2. Identify factors which may impact accuracy of information gathered during assessment (e.g., precipitating events, medications, health considerations).
3. Draw conclusions and make recommendations based on analysis and synthesis of assessment findings.
4. Acknowledge therapist's bias and limitations in interpreting assessment information (e.g., cultural differences, clinical orientation).
5. Communicate assessment findings and recommendations in oral, written, or other forms (e.g., video, audio).

D. Treatment Planning

1. Involve client in the treatment planning process, when appropriate.
2. Consult the following in the treatment planning process:
 - a) clinical and research literature and other resources.
 - b) client's family, caregivers, or personal network, when appropriate.
 - c) other professionals, when appropriate.
3. Coordinate treatment with other professional.
4. Evaluate the role of music therapy within the overall therapeutic program.
5. Consider length of treatment when establishing client goals and objectives.
6. Establish client goals and objectives that are:
 - a) achievable.
 - b) measurable.
 - c) realistic.
 - d) specific.
 - e) time-bound.

7. Use a data collection system for measuring clinical outcomes to reflect criteria in objective.
8. Create environment or space conducive to client engagement.
9. Consider client's age, culture, language, music background, and preferences when designing music therapy experiences.
10. Design music therapy experiences that address client goals and objectives based on available research; clinical expertise; and the needs, values, and preferences of the client.
11. Use appropriate musical instruments and equipment consistent with treatment needs.
12. Use non-music materials consistent with music therapy goals and clients' learning styles (e.g., adaptive devices, visual aids).
13. Plan sessions of appropriate duration and frequency.
14. Determine group and/or individual placement based on assessment findings.
15. Structure and organize music therapy experiences within each session to create therapeutic contour (e.g., transitions, pacing, sequencing, energy level, intensity).
16. Design programs to reinforce goals and objectives for implementation outside the music therapy setting.
17. Document treatment plan.

- r) functional independence.
 - s) generalization of skills to other settings.
 - t) grief and loss.
 - u) group cohesion and/or a feeling of group membership.
 - v) impulse control.
 - w) interactive response.
 - x) initiation and self-motivation.
 - y) memory.
 - z) motor skills.
 - aa) musical and other creative responses.
 - ab) neurological and cognitive function.
 - ac) nonverbal expression.
 - ad) on-task behavior.
 - ae) oral motor control.
 - af) pain (i.e., physical, psychological).
 - ag) participation/engagement.
 - ah) physiological symptoms.
 - ai) pragmatics of speech.
 - aj) preparedness for stressful situations.
 - ak) quality of life.
 - al) range of motion.
 - am) reality orientation.
 - an) responsibility for self.
 - ao) self-awareness and insight.
 - ap) self-esteem.
 - aq) sense of self with others.
 - ar) sensorimotor skills.
 - as) sensory integration.
 - at) sensory orientation (i.e., maintenance attention, vigilance).
 - au) sensory perception.
 - av) social skills and interactions.
 - aw) spirituality.
 - ax) spontaneous communication/interactions.
 - ay) strength and endurance.
 - az) support systems.
 - ba) verbal and nonverbal communication.
 - bb) verbal and/or vocal responses.
 - bc) vocal production.
 - bd) wellness..
3. Recognize how the following theoretical orientations inform music therapy practice:
 - a) behavioral.
 - b) cognitive.
 - c) holistic.
 - d) humanistic/existential.
 - e) neuroscience.
 - f) psychodynamic.
 4. Recognize how the following music therapy treatment approaches and models inform clinical practice:
 - a) behavioral.
 - b) culture centered.
 - c) community music therapy.
 - d) developmental.
 - e) humanistic.
 - f) improvisational.
 - g) medical.

II. Treatment Implementation and Termination: 70 items

A. Implementation

1. Develop a therapeutic relationship by:
 - a) building trust and rapport.
 - b) being fully present and authentic.
 - c) establishing boundaries and communicating expectations.
 - d) providing ongoing acknowledgement and reflection.
 - e) providing a safe and contained environment.
 - f) recognizing and managing aspects of one's own feelings and behaviors that affect the therapeutic process.
 - g) recognizing and working with transference and countertransference dynamics.
 - h) understanding group dynamics and process.
2. Provide music therapy experiences to address client's:
 - a) ability to empathize.
 - b) ability to use music independently for self-care.
 - c) abuse and trauma.
 - d) activities of daily living.
 - e) adjustment to life changes or temporary or permanent changes in ability.
 - f) aesthetic sensitivity
 - g) affect, emotions and moods.
 - h) agitation.
 - i) aggression.
 - j) anticipatory grief.
 - k) attention (i.e., focused, sustained, selective, alternating, divided).
 - l) auditory perception.
 - m) autonomy.
 - n) bereavement.
 - o) coping skills.
 - p) development of speech.
 - q) executive functions (e.g., decision making, problem solving).

- h) neurological.
- i) psychodynamic.
- 5. To achieve therapeutic goals:
 - a) apply the elements of music (e.g., tempo, pitch, timbre, melody, harmony, rhythm, meter, dynamics).
 - b) apply receptive music methods.
 - c) apply standard and alternate guitar tunings.
 - d) apply a variety of scales, modes, and harmonic progressions.
 - e) arrange, transpose, or adapt music.
 - f) compose vocal and instrumental music.
 - g) empathize with client's music experience.
 - h) employ active listening.
 - i) employ functional skills with:
 - 1.) voice.
 - 2.) keyboard.
 - 3.) guitar.
 - 4.) percussion instruments.
 - j) employ music relaxation and/or stress reduction techniques.
 - k) exercise leadership and/or group management skills.
 - l) facilitate community building activities.
 - m) facilitate transfer of therapeutic progress into everyday life.
 - n) identify and respond to significant events.
 - o) improvise instrumental and vocally.
 - p) integrate current technology into music therapy practice according to client need.
 - q) integrate movement with music.
 - r) observe client responses.
 - s) provide visual, auditory, or tactile cues.
 - t) provide verbal and nonverbal guidance.
 - u) provide guidance to caregivers and staff to sustain and support the client's therapeutic progress.
 - v) mediate problems among clients within the session.
 - w) select adaptive materials and equipment.
 - x) share musical experience and expression with clients.
 - y) sight-read.
 - z) use creativity and flexibility in meeting client's changing needs.
 - aa) use music to communicate with client.
 - ab) use song and lyric analysis.
 - ac) utilize a varied music repertoire (e.g., blues, classical, folk, jazz, pop) from a variety of cultures and subcultures.

B. Safety

1. Recognize and respond to situations in which there are clear and present dangers to a client and/or others.
2. Recognize the potential harm of music experiences and use them with care.
3. Recognize the potential harm of verbal and physical interventions during music experiences and use them with care.
4. Observe infection control protocols (e.g., universal precautions, disinfecting instruments).
5. Recognize the client populations and health conditions for which music experiences are contraindicated and adapt treatment as indicated.

6. Comply with safety protocols with regard to transport and physical support of clients.
7. Inspect materials and instruments on a regular basis.

C. Termination and Closure

1. Assess potential benefits and detriments of termination.
2. Determine exit criteria.
3. Inform and prepare client.
4. Coordinate termination with a client's overall treatment.
5. Provide a client with transitional support and recommendations.
6. Help client work through feelings about termination.
7. Address client needs during staffing changes (e.g., therapist leaves job, job transfer, leave of absence).

III. Ongoing Documentation and Evaluation of Treatment: 10 items

A. Documentation

1. Develop and use data-gathering techniques and forms.
2. Record client responses, progress, and outcomes.
3. Employ language appropriate to population and facility.
4. Document music therapy termination and follow-up plans.
5. Provide periodic treatment summaries.
6. Adhere to internal and external legal, regulatory, and reimbursement requirements.
7. Provide written documentation that demonstrates evidence-based outcomes related to addressed goals/interventions.

B. Evaluation

1. Identify information that is relevant to client's treatment process.
2. Differentiate between empirical information and therapist's interpretation.
3. Acknowledge therapist's bias and limitations in interpreting information (e.g., cultural differences, clinical orientation).
4. Review treatment plan regularly.
5. Modify treatment plan regularly.
6. Respond to signs of distress (e.g., psychological, physical) and limits of client tolerance to treatment.
7. Analyze all available data to determine effectiveness of therapy.
8. Consult with music therapy and non-music therapy professionals.
9. Communicate with client and/or client's family, caregivers, treatment team, and personal network as appropriate.
10. Make recommendations and referrals as indicated.
11. Compare the client and therapist subjective experience/response to the elements, forms, and structures of music.

IV. Professional Development and Responsibilities: 10 items

A. Professional Development

1. Assess areas for professional growth and set goals.
2. Review current research and literature in music therapy and related disciplines.
3. Participate in continuing education.

4. Engage in collaborative work with colleagues.
5. Seek out and utilize supervision and/or consultation.
6. Expand music skills.
7. Develop and enhance technology skills.

B. Professional Responsibilities

1. Document all treatment related communications.
2. Document all non-treatment related communications.
3. Maintain and expand music repertoire.
4. Interact with the client in an authentic, ethical, and culturally competent manner that respects privacy, dignity, and human rights.
5. Respond to public inquiries about music therapy.
6. Conduct information sharing sessions, such as in-service workshops, for professionals and/or the community.
7. Communicate with colleagues regarding professional issues.
8. Maintain professional and effective working relationships with colleagues and community members.
9. Work within a facility's organizational structure, policies, standards, and procedures.
10. Maintain client confidentiality as required by law (e.g., HIPAA, IDEA).
11. Supervise staff, volunteers, practicum students, or interns.
12. Adhere to the CBMT Code of Professional Practice.
13. Fulfill legal responsibilities associated with professional role (e.g., mandated reporting, release of information).
14. Practice within scope of education, training, and abilities.
15. Maintain equipment and supplies.
16. Engage in business management tasks (e.g., marketing, payroll, contracts, taxes, insurance).
17. Prepare and maintain a music therapy program budget.
18. Prepare accountability documentation for facility administration and/or local, state, and federal agencies.
19. Maintain assigned caseload files (e.g., electronic, digital, audio, video, hard copies) in an orderly manner.
20. Serve as a representative, spokesperson, ambassador, or advocate for the profession of music therapy.

This document, CBMT Board Certification Domains, was developed from the results of the 2014 Music Therapy Practice Analysis Study. CBMT Board Certification Domains defines the body of knowledge that represents competent practice in the profession of music therapy and identifies what a board certified music therapist, a credentialed MT-BC, may do in practice. Continuing Music Therapy Education credits must relate to an area identified in the CBMT Board Certification Domains. This new document will be utilized as the source of reference for exam content, certification, and recertification requirements beginning on April 1, 2015.

AMTA Code of Ethics

Preamble

The Code of Ethics of the American Music Therapy Association, Inc., summarizes our values as professionals and describes principles and standards for guiding the practice of music therapy in a responsible, fair, and accountable manner. We, the members of the American Music Therapy Association, hold Kindness, Social Responsibility, Dignity and Respect, Equality, Accountability, Excellence, Integrity, and Courage to be Core Values. These values are reflected in five ethical principles which include (1) respecting the dignity and rights of all, (2) acting with compassion, (3) being accountable, (4) demonstrating integrity and veracity, and (5) striving for excellence. These values and principles provide guidelines for ethical decision-making in our daily practice. Standards of behavior guide our conduct as professionals. Ethical practice is more than following a list of rules. It is a commitment to virtuous, caring, courageous thinking that involves self-examination and the well-being of others as our highest intent. We commit ourselves to uphold the value and worth of every person, and to treat all with dignity.

Music therapists who encounter ethical dilemmas are advised to follow a decision-making process available in the literature (Dileo, 2000; Swisher, Arslanian, & Davis 2005, & Markkula Center for Applied Ethics). Music therapists are advised to also consult the Scope of Music Therapy Practice and the AMTA Standards of Clinical Practice for more detailed information to guide clinical decision-making.

It is important for music therapists to recognize our responsibility to adhere to laws, regulations, or policies of organizations and other governing bodies outside the AMTA. In cases where such laws, regulations, or governing body policies conflict with ethical responsibilities, the music therapist will address and seek to resolve this conflict with those in decision-making positions with the best interests of the client foremost in mind. Music therapists are reminded that we practice within the norms and standards of the communities in which we work and that our behavior may influence public attitude toward the profession.

Purpose

This Code of Ethics describes the highest ideals for music therapists as an aspirational guide to professional conduct. It is equally intended to educate and guide music therapists in ethical practice, as well as inform those outside the profession.

Applicability

This Code of Ethics is applicable to all those holding the MT-BC credential or a professional designation from the National Music Therapy Registry (ACMT, CMT, RMT), and professional membership in the American Music Therapy Association. This Code is also applicable to music therapy students and interns under clinical supervision. All music therapy practitioners are expected to uphold the spirit and purpose of the Code, and to practice according to these standards.

Upholding our right to freedom of inquiry and communication, we accept the responsibilities inherent in such freedom: competency, objectivity, consistency, integrity, and continual concern for the best

interests of society and our profession. **Therefore, we collectively and individually affirm the following declarations of professional conduct.**

Core Values

This Code of Ethics is grounded in a set of eight Core Values: *1. Kindness, 2. Social Responsibility, 3. Dignity/Respect, 4. Equality, 5. Accountability, 6. Excellence, 7. Integrity, and 8. Courage.* These Core Values provide a foundation to guide music therapists in their practice and interactions. These Core Values should be considered in determining all ethical courses of action. (See glossary for detailed definition of these values)

Principles for Ethical Practice

Principle #1 Respect dignity and rights of all

Music therapists respect the dignity and rights of all people; this informs our relationships with clients, colleagues, students, research subjects, and all people we encounter. By acknowledging the worth of all people, this principle also encourages the music therapist to reflect sensitivity in all interactions.

To operationalize this principle, the music therapist will:

- 1.1 provide quality client care regardless of the client's race, religion, age, sex, sexual orientation, gender identity or gender expression, ethnic or national origin, disability, health status, socioeconomic status, marital status, or political affiliation.
- 1.2 identify and recognize their personal biases, avoiding discrimination in relationships with clients, colleagues, and others in all settings.
- 1.3 respect, acknowledge, and protect the rights of all clients, including the rights to safety, treatment, respect, dignity, and self-determination, as well as the rights to choose a provider, to exercise legal and civil rights, and to participate in treatment decisions.
- 1.4 respect the client's right of ownership to creative products as a result of participation in music therapy.
- 1.5 obtain informed consent from the client or legal guardian. In cases in which the client is unable to provide consent, assent will nonetheless be sought.
- 1.6 respect and protect the client's confidentiality at all times and following any applicable institutional or legal rules and regulations. The music therapist will inform the client of all limitations to confidentiality prior to the beginning of treatment.
- 1.7 protect the rights of clients, students and research participants under applicable policies, laws and regulations. Music therapists will ensure students, researchers, volunteers, and employees abide by privacy laws and exceptions as currently defined in Pub.L. 104-191 - Health Insurance Portability and Accountability Act and Pub. L. 93-380 - Family Educational Rights and Privacy Act, and Title IX- Education Amendments Act.
- 1.8 acquire knowledge and information about the specific cultural group(s) with whom they work, seeking supervision and education as needed.

1.9 avoid entering into dual relationships when doing so would violate professional boundaries or clinical objectivity.

1.10 avoid accepting gifts or other considerations that could influence or give an appearance of influencing professional judgment.

1.11 avoid engaging in sexual or romantic relationships with clients, their family members, caregivers, students, trainees, research participants, or employees.

1.12 work collaboratively with peers using open direct communication to resolve differences of opinion or to recognize others' perceptions.

1.13 respect the professional services offered by colleagues in music therapy and other disciplines and endeavor to communicate openly when a change in provider occurs or is pending.

Principle #2 Act with compassion

As music therapists we are often confronted with much suffering and feel the need to assist in the alleviation of discomfort. By manifesting patience, wisdom, and genuine desire to help meet the needs of our clients, we offer compassion to those we serve. In addition, it is important for music therapists to extend compassion to themselves when confronted with their own human limitations.

To operationalize this principle, the music therapist will:

2.1 act with the best interest of clients in mind at all times.

2.2 actively listen to their clients and affirm and validate their experiences.

2.3 be aware and accepting of client's individual factors and cultural differences in the treatment process.

2.4 empower clients to make desired changes in their lives.

2.5 act with compassion and genuine interest when dealing with peers.

2.6 seek peer/professional supervision to assist with reflection and practice improvement.

2.7 practice self-kindness and mindfulness and extend compassion to self if faced with feelings of inadequacy or failure.

Principle #3 Be accountable

The act of being accountable encompasses the obligation to report, explain, and be answerable for resulting consequences. Accountability is valued as a means to establish trust and strengthen professional and client-based relationships. The music therapist will be honest, fair, accurate, respectful, timely, and maintain privacy in all interactions.

To operationalize this principle, the music therapist will:

3.1 fulfill their legal and professional obligations to the profession with respect to any applicable local, state, and federal laws and regulations, and employer policies.

- 3.2 accurately inform potential and current clients of credentials and fulfill educational requirements for maintenance and renewal.
- 3.3 work in a manner to reflect truthful and fair business practices that benefit clients, society, and the profession.
- 3.4 seek remuneration that is fair and reasonable.
- 3.5 conduct, document, and report professional, academic, and research activities in an accurate and timely manner, and in accordance with applicable regulations and best practices.
- 3.6 identify and fully disclose errors, adverse, or sentinel events that compromise the safety of clients and others, to all appropriate persons.
- 3.7 differentiate personal views from those of the profession, the employer or agency.
- 3.8 report any illegal actions to authorities.
- 3.9 give credit and recognition when using the ideas and work of others.
- 3.10 provide comprehensive, accurate, and objective information about expectations for treatment outcomes.
- 3.11 offer services commensurate with training and corresponding scope(s) of practice(s), recognizing personal limitations.
- 3.12 exercise caution and professional judgment in all electronic, written, verbal, and inferred communications being especially aware of electronic messages and potential public access.
- 3.13 be familiar with the Code of Ethics, abide by its principles and report witnessed violations to the Ethics Board, refraining from frivolous or punitive reporting. When a question arises regarding behaviors and ethics, the member is encouraged to consult with the Ethics Board.
- 3.14 cooperate and participate in ethics board inquiries and processes when requested to do so.

Principle #4. Demonstrate integrity and veracity

Demonstrating integrity and veracity challenges each individual to act with truthfulness and accuracy in all communications. These qualities compel us to be incorruptible and devoted to truth in all professional relationships and interactions. Additionally, adherence to the principle of veracity requires thoughtful analysis of how full disclosure of information may affect outcomes. If there are circumstances in which a music therapist must weigh the consequences when two or more values are in conflict, it is incumbent upon the music therapist to seek peer supervision or counsel from other resources.

To operationalize this principle, the music therapist will:

- 4.1 demonstrate truthfulness while using discernment and judgement while contemplating potential outcomes.

- 4.2 use resources available to them to enhance and better their practice (e.g., peer/professional supervision).
- 4.3 use caution when predicting the potential outcomes of services offered.
- 4.4 truthfully and accurately document outcomes of treatment.
- 4.5 fully disclose any financial interest in products or services that they recommend to clients.
- 4.6 make referrals to other professionals to address client needs beyond the scope of music therapy practice or beyond the therapist's professional competence.
- 4.7 provide accurate information to clients entering into a therapeutic or research relationship, and obtain informed consent from the client or research participant.
- 4.8 ensure that billing and business practices are accurate and reflect the nature and extent of the services provided.

Principle #5. Strive for excellence

The music therapist seeks to continually improve skills and knowledge, evaluating the strength and applicability of evidence into all areas of professional practice and behavior. Striving for excellence in music therapy encompasses all aspects of music therapy: education, training, supervision, clinical practice, business and research. Striving for excellence does not imply perfection, but the ongoing commitment to expand our knowledge and skills in all areas.

To operationalize this principle, the music therapist will:

- 5.1 achieve and maintain professional competence through learning and personal growth, and encourage colleagues to do the same.
- 5.2 strive to be self-aware and to continually improve skills and knowledge by integrating the best available evidence and findings from research to maintain best practices.
- 5.3 use caution, critical thinking, and strong consideration of the best available evidence when incorporating new and evolving interventions and technologies into their practice, education, or supervision.
- 5.4 will serve as a positive role model for students and interns regarding professional behavior, most especially regarding ethical behavior; assuring that students learn about and operate under the guidelines of this Code.
- 5.5 educators and clinical training directors ensure that students and interns meet or exceed the AMTA professional competencies before recommending entrance into the profession.

Music therapists are reminded that a Code of Ethics cannot describe every possible situation but offers the music therapist guidelines for ethical decision-making and professional conduct. Music therapists are encouraged to seek supervision or assistance as needed.

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FRESHMAN-FALL						SPRING						OTHER					
Course No.	Course Title	Domain	Credit	Grade	Min./Notes	Course No.	Course Title	Domain	Credit	Grade	Min./Notes						
AP__	102 Applied Major*		3		C min.	AP__	102 Applied Major*		3		C min.						
APCP	105 Basic Piano and Keyboard Harmony Skills I [^] <u>OR</u>		1.5			APCP	106 Basic Piano and Keyboard Harmony Skills II <u>OR</u>		1.5								
AP__	101 Applied Minor (<i>keyboard majors only</i>)					AP__	101 Applied Minor (<i>keyboard majors only</i>)										
MUEN	Ensemble	D2	1			MUEN	Ensemble	D2	1								
MUTC	101 Introduction to Music Theory*		3		C min.	MUTC	102 Diatonic Harmony and Simple Forms*		3		C min.						
MUTH	105 Introduction to Music Therapy*		3		C min.	MUTC	109 Ear Training I*		2		C min.						
PRF	101 Performance Forum		0.5			MUTH	106 Music Therapy Musicianship*		3		C min.						
ENG	101 Composition	D1-WC	3			PRF	101 Performance Forum		0.5								
FYS	101 Going Global: First-Year Seminar	D7	3			PSY	101 General Psychology	D6	3								
SEMESTER TOTAL						SEMESTER TOTAL											
18						17											
SOPHOMORE-FALL						SPRING											
AP__	202 Applied Major*		3		C min.	AP__	202 Applied Major*		3		C min.						
APCP	205 Basic Piano and Keyboard Harmony Skills III <u>OR</u>		1.5			APCP	206 Basic Piano and Keyboard Harmony Skills IV <u>OR</u>		1.5								
AP__	201 Applied Minor (<i>keyboard majors only</i>)					AP__	201 Applied Minor (<i>keyboard majors only</i>)										
MUEN	Ensemble	D2	1			MUEN	Ensemble	D2	1								
MUPP	233 Voice Class (<i>non-voice majors/minors only</i>)		1			MULT	211 Core Western Music History I	D6	3								
MUTC	201 Chromatic Harmony and Compound Forms		3			MUTC	202 Post-Tonal Theory		2								
MUTC	208 Ear Training II*		2		C min.	MUTC	209 Ear Training III		2								
MUTH	221 Standards of Clinical Practice*	D1-OC	3		C min.	MUTH	206 Music Therapy Methods*		3		C min.						
PRF	201 Health Issues for Artists		0.5			PRF	101 Performance Forum		0.5								
SEMESTER TOTAL for Voice Major/Minor						SEMESTER TOTAL											
14						16											
SEMESTER TOTAL for Non-Voice Major/Minor																	
15																	
						Sophomore Screening Passed <input type="checkbox"/> Date: _____											
JUNIOR-FALL						SPRING											
AP__	302 Applied Major*		3		C min.	AP__	302 Applied Major*		3		C min.						
MUEN	Ensemble	D2	1			MUEN	Ensemble	D2	1								
MULT	212 Core Western Music History II	D6	3			MUPP	341 Half Recital*		1		C min.						
MUTH	373 Music Therapy Practicum I*		3		C min.	MUTH	331 Psychology of Music*		3		C min.						
PRF	101 Performance Forum		0.5			MUTH	374 Music Therapy Practicum II*		3		C min.						
PSY	310 Abnormal Psychology		3			PRF	101 Performance Forum		0.5								
	General Edu. Elective: Moral Reasoning	D5	3				Clinical Foundation Elective#		3								
SEMESTER TOTAL						SEMESTER TOTAL											
16.5						17.5											
						MATH 207 Introduction to Statistics											
						D3 3											
SENIOR-FALL						SPRING											
MUCO	361 Beginning Choral and Instrumental Conducting*		1.5		C min.	MUTH	482 Music Therapy Internship* <u>OR</u>		12		C min.						
MULT	Music Literature Elective *		3			MUTH	483 Music Therapy Internship I* <u>plus</u>		3		C min.						
MUTH	401 Music Therapy Seminar*		2		C min.	MUTH	484 Music Therapy Internship II* <u>plus</u>		3		C min.						
MUTH	473 Music Therapy Practicum III*		3		C min.	MUTH	485 Music Therapy Internship III* <u>plus</u>		3		C min.						
	Clinical Foundation Elective#		3			MUTH	486 Music Therapy Internship IV*		3		C min.						
BIO	231 Human Anatomy and Physiology I	D4	4			SEMESTER TOTAL											
SEMESTER TOTAL						12											
SEMESTER TOTAL						16.5											
Piano Proficiency Completion:																	
Applied Class Piano Sequence Completed <input type="checkbox"/>																	
Piano Proficiency Exam Passed <input type="checkbox"/> Date: _____																	
Credits completed with:																	
* Minimum grade of C required.																	
* Music Literature Elective - Select one from the following: MULT 210 (Survey of Early Music), MULT 270 (Introduction to Indigenous Music Cultures), MULT 271 (Women in Music), MULT 272 (Introduction to Performance Studies), MULT 273 (History of Rock Music), MULT 274 (Introduction to Music and Sound in Film), or MULT 432 (Jazz History).																	
# Clinical Foundation Elective - Select from the following: BIO 201 (Medical Terminology), MUTH 495 (Special Topics), SOC 101 (Introduction to Sociology), PSY Elective, or additional electives approved by advisor.																	
^ Students who pass the Piano Proficiency Exam and are exempt from applied class piano must make up the credits with either additional study in applied piano (APPN) or open electives. Keyboard majors are required to complete four semesters of minor study on one of the following applied instruments: harpsichord, jazz piano, organ or voice (voice minor screening is required).																	
Tracking sheets serve as condensed curriculum requirement reference sheets. Refer to the 2018-2019 Undergraduate Catalog for a complete and FINAL listing of ALL curriculum requirements for which degree audits will be based.																	
						<table border="1"> <tr> <td>DEGREE TOTAL FOR VOICE MAJOR/MINOR</td> <td>127.5</td> </tr> <tr> <td>DEGREE TOTAL FOR NON-VOICE MAJOR/MINOR</td> <td>128.5</td> </tr> </table>						DEGREE TOTAL FOR VOICE MAJOR/MINOR	127.5	DEGREE TOTAL FOR NON-VOICE MAJOR/MINOR	128.5		
DEGREE TOTAL FOR VOICE MAJOR/MINOR	127.5																
DEGREE TOTAL FOR NON-VOICE MAJOR/MINOR	128.5																
						General Education Domains D1-Effective Communication Written Communication (WC) Oral Communication (OC) D2-Artistic Expression D3-Quantitative Literacy D4-The Nature of Science D5-Moral Reasoning D6-The Individual in Society D7-The Individual in the World											



THE CERTIFICATION BOARD
FOR MUSIC THERAPISTS

CBMT CODE OF PROFESSIONAL PRACTICE

PREAMBLE

The CBMT is a nonprofit organization which provides board certification and recertification for music therapists to practice music therapy. The members of the Board of Directors comprise a diverse group of experts in music therapy. The Board is national in scope and blends both academicians and clinicians for the purpose of establishing rigorous standards which have a basis in a real world practice, and enforcing those standards for the protection of consumers of music therapy services and the public.

The CBMT recognizes that music therapy is not best delivered by any one sub-specialty, or single approach. For this reason, the CBMT represents a comprehensive focus. Certification is offered to therapists from a wide variety of practice areas, who meet high standards to the Practice of Music Therapy. To the extent that standards are rigorously adhered to, it is the aim of the CBMT to be inclusive, and not to be restrictive to any sub-specialty.

Maintenance of board certification will require adherence to the CBMT's Code of Professional Practice. Individuals who fail to meet these requirements may have their certification suspended or revoked. The CBMT does not guarantee the job performance of any individual.

I. COMPLIANCE WITH CODE OF PROFESSIONAL PRACTICE

As a condition of eligibility for and continued maintenance of any CBMT certification, each certificant agrees to the following:

A. Compliance with CBMT Standards, Policies and Procedures

No individual is eligible to apply for or maintain certification unless in compliance with all the CBMT standards, policies and procedures. Each individual bears the burden for showing and maintaining compliance at all times. The CBMT may deny, revoke, or otherwise act upon certification or recertification when an individual is not in compliance with all the CBMT standards, policies, and procedures. Nothing provided herein shall preclude administrative requests by the CBMT for additional information to supplement or complete any application for certification or recertification.

B. Notification

The individual shall notify the CBMT within sixty (60) days of occurrence of any change in name, address, telephone number, and any other facts bearing on eligibility or certification (including but not limited to: filing of any criminal charge, indictment, or litigation; conviction; plea of guilty; plea of nolo contendere; or disciplinary action by a licensing board or professional organization). A certificant shall not make and shall correct immediately any statement concerning the certificant's status which is or becomes inaccurate, untrue, or misleading.

All references to 'days' in the CBMT standards, policies and procedures shall mean calendar days. Communications required by the CBMT must be transmitted by certified mail, return receipt requested, or other verifiable methods of delivery when specified. The certificant agrees to provide the CBMT with confirmation of compliance with the CBMT requirements as requested by the CBMT.

C. Property of the CBMT

The examinations and certificates of the CBMT, the name Certification Board for Music Therapists, and abbreviations relating thereto are all the exclusive property of the CBMT and may not be used in any way without the express prior written consent of the CBMT. In case of suspension, limitation, revocation, or resignation from the CBMT or as otherwise requested by the CBMT, the individual shall immediately relinquish, refrain from using, and correct at the individual's expense any outdated or otherwise inaccurate use of any certificate, logo, emblem, and the CBMT name and related abbreviations. If the individual refuses to relinquish immediately, refrain from using and correct at his or her expense any misuse or misleading use of any of the above items when requested, the individual agrees that the CBMT shall be entitled to obtain all relief permitted by law.

II. APPLICATION AND CERTIFICATION STANDARDS

In order to protect consumers of music therapy services and the public from harm and to insure the validity of the MT-BC credential for the professional and public good, CBMT may revoke or otherwise take action with regard to the application or certification of a certificant in the case of:

- A. Ineligibility for certification, regardless of when the ineligibility is discovered;
- B. Failure to pay fees required by the CBMT;
- C. Unauthorized possession of, use of, or access to the CBMT examinations, certificates, and logos of the CBMT, the name 'Certification Board for Music Therapists', and abbreviations relating thereto, and any other CBMT documents and materials;
- D. Obtaining or attempting to obtain certification or recertification by a false or misleading statement or failure to make a required statement; fraud or deceit in an application, reapplication, representation of event/s, or any other communication to the CBMT;

- E. Misrepresentation of the CBMT certification or certification status;
- F. Failure to provide any written information required by the CBMT;
- G. Failure to maintain confidentiality as required by law;
- H. Gross or repeated negligence or malpractice in professional practice, including sexual relationships with clients, and sexual, physical, social, or financial exploitation;
- I. Limitation or sanction (including but not limited to revocation or suspension by a regulatory board or professional organization) relating to music therapy practice, public health or safety, or music therapy certification or recertification;
- J. The conviction of, plea of guilty or plea of nolo contendere to a felony or misdemeanor related to music therapy practice or public health and safety;
- K. Failure to timely update information to CBMT; or
- L. Other violation of a CBMT standard, policy or procedure as outlined in the CBMT Candidate Handbook, Recertification Manual, or other materials provided to certificants.

III. ESTABLISHMENT OF SPECIAL DISCIPLINARY REVIEW AND DISCIPLINARY HEARING COMMITTEES

- A. Upon the recommendation by the Chair, the CBMT Board of Directors may elect by a majority vote (i) a Disciplinary Review Committee and (ii) a Disciplinary Hearing Committee, to consider alleged violations of any CBMT disciplinary standards set forth in Section III.1-12 above or any other CBMT standard, policy, or procedure.
- B. Each of these Committees shall be composed of three members drawn from CBMT certificants.
- C. A committee member's term of office on the committee shall run for three years and may be renewed.
- D. A committee member may serve on only one committee and may not serve on any matter in which his or her impartiality or the presence of actual or apparent conflict of interest might reasonably be questioned.
- E. At all times during the CBMT's handling of the matter, the CBMT must exist as an impartial review body. If at any time during the CBMT's review of a matter, any member of the CBMT Disciplinary Review Committee, Disciplinary Hearing Committee, or Board of Directors identifies a situation where his or her judgment may be biased or impartiality may be compromised, (including employment with a competing organization), the member is required to report such matter to the Executive Director immediately. The Executive Director and Board Chair shall confer to determine whether a conflict exists, and if so, shall replace the member.
- F. Committee action shall be determined by majority vote.
- G. When a committee member is unavailable to serve due to resignation, disqualification, or other circumstance, the Chair of CBMT shall designate another individual to serve as an interim member.

IV. REVIEW AND APPEAL PROCEDURES

A. Submission of Allegations

- i. Allegations of a violation of a CBMT disciplinary standard or other CBMT standard, policy or procedure are to be referred to the Executive Director for disposition. Persons concerned with possible violation of CBMT's rules should identify the persons alleged to be involved and the facts concerning the alleged conduct in as much detail and specificity as possible with available documentation in a written statement addressed to the Executive Director. The statement should identify by name, address and telephone number the person making the information known to the CBMT and others who may have knowledge of the facts and circumstances concerning the alleged conduct. Additional information relating to the content or form of the information may be requested.
- ii. The Executive Director shall make a determination of the substance of the allegations within sixty (60) days and after consultation with counsel.
- iii. If the Executive Director determines that the allegations are frivolous or fail to state a violation of CBMT's standards, the Executive Director shall take no further action and so apprise the Board and the complainant (if any).
- iv. If the Executive Director determines that good cause may exist to question compliance with CBMT's standards, the Executive Director shall transmit the allegations to the Disciplinary Review Committee.

B. Procedures of the Disciplinary Review Committee

- i. The Disciplinary Review Committee shall investigate the allegations after receipt of the documentation from the Executive Director. If the majority of the Committee determines after such investigation that the allegations and facts are inadequate to sustain a finding of a violation of CBMT disciplinary standards, no further adverse action shall be taken. The Board and the complainant (if any) shall be so apprised.
- ii. If the Committee finds by majority vote that good cause exists to question whether a violation of a CBMT disciplinary standard has occurred, the Committee shall transmit a statement of allegations to the certificant by certified mail, return receipt requested, setting forth:
 - a. The applicable standard;
 - b. Of facts constituting the alleged violation of the standard;
 - c. That the certificant may proceed to request: (i) review of written submission by the Disciplinary Hearing Committee; (ii) a telephone conference of the Disciplinary Hearing Committee; or (iii) an in-person hearing (at least held annually proximate to the annual meeting of the CBMT) for the disposition of the allegations, with the certificant bearing his or her own expenses for such matter;
 - d. That the certificant shall have fifteen (15) days after receipt of such statement to notify the Executive Director if he or she disputes the allegations, has comments on available sanctions, and/or requests a written review, telephone conference, or in-person hearing on the record;

- e. That, in the event of an oral hearing in person or by phone, the certificant may appear in person with or without the assistance of counsel, may examine and cross-examine any witness under oath, and produce evidence on his or her behalf;
- f. That the truth of allegations or failure to respond may result in sanctions including possible revocation of certification; and
- g. That if the certificant does not dispute the allegations or request a review hearing, the certificant consents that the Committee may render a decision and apply available sanctions. (Available sanctions are set out in Section V, below.)

iii. The Disciplinary Review Committee may offer the individual the opportunity to negotiate a specific sanction in lieu of proceeding with a written review or hearing. The individual may ask the Disciplinary Review Committee to modify its offer, and the Committee may do so in its sole discretion. Any agreed-upon sanction must be documented in writing and signed by CBMT and the individual. If the individual is unwilling to accept the Disciplinary Review Committee's offer, the requested review or hearing will proceed as provided below.

C. Procedures of the Disciplinary Hearing Committee

i. **Written Review.** If the individual requests a review by written briefing, the Disciplinary Review Committee will forward the allegations and response of the individual to the Disciplinary Hearing Committee. Written briefing may be submitted within thirty (30) days following receipt of the written review request by the Disciplinary Hearing Committee. The Disciplinary Hearing Committee will render a decision based on the record below and written briefs (if any) without an oral hearing.

ii. **Oral Hearing.** If the individual requests a hearing:

a. The Disciplinary Review Committee will:

- (1) forward the allegations and response of the certificant to the Disciplinary Hearing Committee; and
- (2) designate one of its members to present the allegations and any substantiating evidence, examine and cross-examine witness(es) and otherwise present the matter during any hearing of the Disciplinary Hearing Committee.

b. The Disciplinary Hearing Committee shall then:

- (1) schedule a telephone or in-person hearing as directed by the certificant;
- (2) send by certified mail, return receipt requested, a Notice of Hearing to the certificant. The Notice of Hearing will include a statement of the time and place selected by the Disciplinary Hearing Committee. The certificant may request a modification of the date of the hearing for good cause. Failure to respond to the Notice of Hearing or failure to appear without good cause will be deemed to be the individual's consent for the Disciplinary Hearing Committee to administer any sanction which it considers appropriate.

c. The Disciplinary Hearing Committee shall maintain a verbatim audio and/or video tape or written transcript of any telephone conference or in-person hearing.

d. The CBMT and the certificant may consult with and be represented by counsel, make opening statements, present documents and testimony, examine and cross-examine witnesses under oath, make closing statements, and present written briefs as scheduled by a Disciplinary Hearing Committee.

e. The Disciplinary Hearing Committee shall determine all matters relating to the hearing or review. The hearing or review and related matters shall be determined on the record by majority vote.

f. Formal rules of evidence shall not apply. Relevant evidence may be admitted. Disputed questions of admissibility shall be determined by majority vote of the Disciplinary Hearing Committee.

iii. In all written reviews and oral hearings:

a. The Disciplinary Hearing Committee may accept, reject, or modify the recommendation of the Disciplinary Review Committee, either with respect to the determination of a violation or the recommended sanction.

b. Proof shall be by preponderance of the evidence.

c. Whenever mental or physical disability is alleged, the certificant may be required to undergo a physical or mental examination at the expense of the certificant. The report of such an examination shall become part of the evidence considered.

d. The Disciplinary Hearing Committee shall issue a written decision following the hearing or review and any briefing. The decision shall contain factual findings, legal conclusions, and any sanctions applied. The decision of the Disciplinary Hearing Committee shall be mailed promptly by certified mail, return receipt requested, to the certificant. If the decision rendered by the Disciplinary Hearing Committee is that the allegations are not supported, no further action on them shall occur.

D. Appeal Procedures

i. If the decision rendered by the Disciplinary Hearing Committee is not favorable to the certificant, the certificant may appeal the decision to the CBMT Board of Directors by submitting a written appeal statement within thirty (30) days following receipt of the decision of the Disciplinary Hearing Committee. CBMT may file a written response to the statement of the certificant.

ii. The CBMT Board of Directors by majority vote shall render a decision on the appeal without oral hearing, although written briefing may be submitted by the certificant and CBMT.

iii. The decision of the CBMT Board of Directors shall be rendered in writing following receipt and review of any briefing. The decision shall contain factual findings, legal conclusions, and any sanctions applied and shall be final. The decision shall be transmitted to the certificant by certified mail, return receipt requested.

iv. A Director may not: (a) review a matter at the appeal stage if he/she heard the matter as a member of the Disciplinary Hearing Committee; (b) review any matter in which his/her impartiality might reasonably be questioned, or (c) review any matter which presents an actual, apparent, or potential conflict of interest.

v. In all reviews:

a. The Board of Directors may affirm or overrule and remand the determination of the Disciplinary Hearing Committee.

b. In order to overturn a decision of the Disciplinary Hearing Committee, the individual must demonstrate that the Committee's decision was arbitrary or capricious [e.g., was inappropriate because of: (a) material errors of fact, or (b) failure of the Disciplinary Review Committee or the Disciplinary Hearing Committee to conform to published criteria, policies, or procedures]. Proof is by preponderance of the evidence.

V. SANCTIONS

A. Sanctions for violation of any CBMT standard set forth herein or any other CBMT standard, policy, or procedure may include one or more of:

- i. Mandatory remediation through specific education, treatment, and/or supervision;
- ii. Written reprimand to be maintained in certificant's permanent file;
- iii. Suspension of board certification with the right to re-apply after a specified date;
- iv. Probation;
- v. Non-renewal of certification;
- vi. Revocation of certification; and
- vii. Other corrective action.

B. The sanction must reasonably relate to the nature and severity of the violation, focusing on reformation of the conduct of the individual and deterrence of similar conduct by others. The sanction decision may also take into account aggravating circumstances, prior disciplinary history, and mitigating circumstances. No single sanction will be appropriate in all situations.

VI. SUMMARY PROCEDURE

Whenever the Executive Director determines that there is cause to believe that a threat of immediate and irreparable harm to the public exists, the Executive Director shall forward the allegations to the CBMT Board. The Board shall review the matter immediately, and provide telephonic or other expedited notice and review procedure to the certificant. Following such notice and opportunity by the individual to be heard, if the Board determines that a threat of immediate and irreparable injury to the public exists, certification may be suspended for up to ninety (90) days pending a full review as provided herein.

VII. PERIOD OF INELIGIBILITY FOLLOWING REVOCATION

If certification is revoked based on noncompliance with the Code of Professional Practice, then the individual is automatically ineligible to apply for certification or re-certification for the periods of time listed below:

A. In the event of a felony conviction directly related to music therapy practice or public health and/or safety, no earlier than seven (7) years from the exhaustion of appeals or release from confinement (if any), or the end of probation, whichever is later:

B. In any other event, no earlier than five (5) years from the final decision of revocation. After these periods of time, eligibility will be considered as set forth in CBMT's Eligibility Review and Appeal Policy.

After these periods of time, eligibility will be considered as set forth in CBMT's Eligibility Review and Appeal Policy.

VIII. CONTINUING JURISDICTION

CBMT retains jurisdiction to review and issue decisions regarding any matter which occurred prior to the termination, expiration, or relinquishment of certification.

ADOPTED: FEBRUARY 8, 1997

EFFECTIVE DATE: JANUARY 1, 1998

REVISED: FEBRUARY 7, 1998

REVISED: FEBRUARY 8, 2001

REVISED: OCTOBER 4, 2011

**Virginia Department of Health Professions
Board of Health Professions**

Appendix

**QUESTIONS TO BE CONSIDERED FOR THE EVALUATION OF THE NEED FOR
REGULATION OF A HEALTH OCCUPATION OR PROFESSION**

A. GENERAL INFORMATION

1. What occupational or professional group is seeking regulation?

Board Certified Music Therapists (MT-BC)

2. What is the level or degree of regulation sought?

Licensure

3. Identify by title the association, organization, or other group representing Virginia-based practitioners. (If more than one organization, provide the information requested below for each organization.)

(a) Certification Board for Music Therapists (CBMT)

(b) American Music Therapy Association (AMTA)

(c) Virginia Music Therapy Association (VMTA)

4. Estimate the number of practitioners (members and nonmembers) in the Commonwealth.

According to CBMT, as of January 2019, there are 227 board certified music therapists in Virginia eligible for regulation by the state.

5. How many of these practitioners are members of the group preparing the proposal? (If several levels or types of membership are relevant to this proposal, explain these levels and provide the number of members, by type).

All 227 board certified music therapists in Virginia are included in the groups preparing this proposal.

According to the Work Force Analysis Survey conducted by the American Music Therapy Association (AMTA) in 2018, there were 102 Music Therapists in Virginia who were 2018 members of AMTA. While AMTA professional membership is voluntary, CBMT board certification is the national credential required by the profession. AMTA and CBMT work collaboratively to represent the entire music therapy profession and assist with recognition of the profession and its credential by advocating for inclusion in state statutes and regulations.

6. Do other organizations also represent practitioners of this occupation/profession in Virginia? If yes, provide contact information for these organizations.

(a) Certification Board for Music Therapists (CBMT)

Contact Person: Dena Register, PhD, MT-BC

Regulatory Affairs Advisor

506 E Lancaster Ave, Suite 102

Downingtown, PA 19335

1.800.765.CBMT (2268)

1.610.269.8900

dregister@cbmt.org

info@cbmt.org

www.cbmt.org

(b) American Music Therapy Association (AMTA)

Contact Person: Judy Simpson, MT-BC

Director of Government Relations

8455 Colesville Road, Suite 1000,

Silver Spring MD 20910

301.589.3300

simpson@musictherapy.org

info@musictherapy.org

www.musictherapy.org

(c) Virginia Music Therapy Association (VMTA)

Contact Person: Nicole Drozd, MS, MT-BC

President

315.489.1590

drozd.nicole@gmail.com

www.virginiamusictherapy.org

7. Provide the name, title, organizational name, mailing address, and telephone number of the responsible contact person(s) for the organization preparing this proposal.

Tracy Bowdish, MM, MT-BC

Co-Chair, Virginia State Task Force for the American Music Therapy Association (AMTA)
and the Certification Board for Music Therapists (CBMT)

8336 Mona Avenue

Norfolk, VA 23518

320.309.4952

Shelby Reynolds, MT-BC

Co-Chair, Virginia State Task Force for the American Music Therapy Association (AMTA)
and the Certification Board for Music Therapists (CBMT)

25 Lovings Lane

Fredericksburg, VA 22406

540.222.9627

8. How was this organization and individual selected to prepare this proposal?

The Virginia State Task Force has been charged by the Mid-Atlantic Region of the American Music Therapy Association. The “Charge to the Virginia State Task Force on Occupational Regulation” states the following, “The VASTF will also work collaboratively with AMTA and CBMT to implement the State Recognition Operational Plan and to work to fulfill the AMTA mission of increasing awareness of the benefits of music therapy and increasing access to quality music therapy services within their state.” Tracy Bowdish and Shelby Reynolds serve as co-chairs for the Virginia State Task Force, which is a group of five music therapists and one student member from across the state.

9. Are there other occupations/professions within the broad occupational grouping? What organization(s) represent these entities? (List those in existence and any that are emerging).

There are no other occupations/professions within music therapy.

10. For each association or organization listed above, provide the name and contact information of the *national* organizations with which the state associations are affiliated.

Not applicable

B. QUESTIONS WHICH ADDRESS THE CRITERIA

Criterion One: Risk for Harm to the Consumer. The unregulated practice of the health occupation will harm or endanger the public health, safety or welfare. The harm is recognizable and not remote or dependent on tenuous argument. The harm results from: (a) practices inherent in the occupation, (b) characteristics of the clients served, (c) the setting or supervisory arrangements for the delivery of health services, or (d) from any combination of these factors.

1. Provide a description of the typical functions performed and services provided by members of this occupational group.

The Scope of Music Therapy Practice (attached) defines the range of responsibilities of a fully qualified music therapy professional with requisite education, clinical training, and board certification. Professional music therapists are qualified to complete the following tasks independently, and when applicable, in conjunction with an interdisciplinary treatment team:

- Accept referrals for music therapy services from medical, developmental, mental health, and education professionals; family members; clients; caregivers; or others involved and authorized with provision of client services. Before providing music therapy services to a client for an identified clinical or developmental need, the music therapist collaborates, as applicable, with the primary care provider(s) to review the client's diagnosis, treatment needs, and treatment plan. During the provision of music therapy services to a client, the music therapist collaborates, as applicable, with the client's treatment team;
- Conduct a music therapy assessment of a client to determine if treatment is indicated. If treatment is indicated, the music therapist collects systematic, comprehensive, and accurate information to determine the appropriate music therapy interventions to provide for the client;

- Develop an individualized music therapy treatment plan for the client that is based upon the results of the music therapy assessment. The music therapy treatment plan includes individualized goals and objectives that focus on the needs and strengths of the client and specify music therapy approaches and interventions to be used to address these goals and objectives;
- Implement an individualized music therapy treatment plan that is consistent with or complementary to any other developmental, rehabilitative, habilitative, medical, mental health, preventive, wellness care, or educational services being provided to the client;
- Evaluate the client's response to music therapy, documenting changes and progress in the music therapy treatment plan, and suggesting modifications, as appropriate;
- Develop a plan for determining when the provision of music therapy services is no longer needed in collaboration with the client, physician, or other provider of health care or education of the client, family members of the client, and any other appropriate person upon whom the client relies for support;
- Minimize any barriers to ensure that the client receives music therapy services in the least restrictive environment;
- Educate and collaborate with the client and the family, caregiver of the client, or any other appropriate person regarding the needs of the client that are being addressed in music therapy and the manner in which the music therapy treatment addresses those needs; and
- Utilize appropriate knowledge and skills to inform practice including use of research, reasoning, and problem-solving skills to determine appropriate actions in the context of each specific clinical setting.

2. **Has the public actually been harmed by unregulated providers or by providers who are regulated in other states? If so, how is the evidence of harm documented (i.e., court case or disciplinary or other administrative action)? Was is physical, emotional, mental, social, or financial?**

No known official complaints have been made to the state regarding music therapy being unregulated. It is currently difficult to accurately track public complaints as there is no mechanism in place for the public to file complaints in Virginia. One of the reasons state recognition is being sought is to then have a mechanism in place to more accurately address public complaints in the state. While it can be difficult to understand how music can cause harm, there are several examples of how the improper use of a music stimulus can be medically and emotionally harmful, especially for individuals with complex dementias, mental health issues, or the medically fragile.

A case example is provided here:

A nursing home patient with Lewy body dementia, was engaged in a group music sing-along that utilized songs from the big band era. **Lewy Body dementia is different from the more common dementia of Alzheimer's type. People with Lewy Body dementia often have delusions, hallucinations, difficulty interpreting information, and behaviors.**

At some point the man became progressively upset, and started yelling and threatening others patients and staff. The musician facilitating the sing-along decided to try a

different song to engage this man and calm him down. Unfortunately, the song choice only exacerbated the mood and situation. The patient, very distraught and confused, struck another patient and staff member, and in the process stood up and fell. This resulted in a high fracture of the right femur, a skin tear wound, and the patient who was hit suffered emotional confusion and pain.

The cost of this incident went beyond harm or money. The patient's family, deeply saddened and frustrated by the progression of dementia, was notified that they would likely have to find a different placement for their family member in a more limiting "secure" facility. Nurses had incident reports to complete, and residents and families were distressed by the event. Staff stress was elevated by the incident, and the patient spent countless hours in pain and confusion. The awful cycle of pain, confusion, and fatigue was quite difficult to moderate and support, and the patient became isolated and often inconsolable.

One problem: it is all too easy to relegate such an event to the consequences of dementia. A review, and investigation into the antecedent of this event was found to be a progression of bad decision-making and choices within the environment of the activity setting, placement of the patient, and the clear and observed effect of music and music activity increasing agitation, confusion, and distress.

The group was facilitated by an entertainer that contracted with small nursing homes and group homes. Part of his brochure included the term music therapy, and although he was not a music therapist, he used many examples of the benefits of music with the elderly.

This entertainer did not have the training and a clinical understanding in working with a patient with Lewy body dementia, and to this, did not have the necessary clinical skill set to support the needs of this patient, who became rapidly confused and decompensated into violence. Assuming that music calms and soothes, and simply changing to a different song as a method to change behavior was an inappropriate action.

Music therapists know of the risks that play into altered psychological states, and various shifts in comprehension and perception related to dementia. We make sure we have a reasonable and predictive understanding of the influence of music with our patients through assessment methods. A key point that must not be understated: the music therapist (through training and supervision) has a level of vigilance and monitoring of the patient while simultaneously engaging in, and facilitating the music experience. In contrast, musicians and entertainers are commonly focused on the performance and the identity of themselves within the performance. No one is perfect, but in this example, music therapists would not have placed a volatile patient in the setting, and would have recognized very quickly the signals leading up to increased confusion and exacerbated behaviors. This patient loved music, and needed to have a one-to-one individual type of experience.

There is an uncomfortable irony in writing this account, and harm is a real thing. This elderly gentleman was not able to heal, spent his last week in pain, and died in a nursing home in Roanoke, Virginia a few weeks after this incident.

3. If no evidence of actual harm is available, what aspects of the provider group’s practice constitute a potential for harm?

Potential harm to the public includes misrepresentation of the music therapy profession, as these individuals hold themselves out to the public as being able to produce outcomes that are not based upon evidence-based practice; and, these individuals show a substantial lack of supervised clinical training and feedback to promote and ensure ethical practice. This lack of formalized training and credentials pose an unnecessary and sometimes unintended risk to clients. This also has financial implications for consumers which include being overcharged by untrained individuals that are not held accountable to follow or uphold professional standards and ethics, and who are not qualified to provide the service or document measurable outcomes.

4. To what can the harm be attributed? Elaborate as necessary.

- **lack of skills**
- **lack of knowledge**
- **lack of ethics**
- **lack of supervision**
- **practices inherent in the occupation**
- **characteristics of the client/patients being served**
- **characteristics of the practice setting**
- **other (specify)**

Harm can be attributed to all of the above. There are a growing number of unqualified individuals in the state claiming to be music therapists who do not hold a music therapy degree from an accredited institution or carry the national credential of Music Therapist-Board Certified (MT-BC). The current lack of music therapy recognition in the state leaves Virginia residents at-risk for negative social, emotional, medical, and economic consequences due to the inability of an untrained individual having no experience or understanding of the established music therapy standards of clinical practice. In addition, unqualified and non-credentialed individuals hold themselves out to the public as being able to produce outcomes that are not based upon evidence-based practice. Finally, these individuals show a substantial lack of supervised clinical training and feedback to promote and ensure ethical practice. This also puts the consumer at-risk financially; as he or she may be paying untrained individuals for services that do not include documented measurable outcomes and scientifically based treatment.

It can be difficult to understand how music can cause harm, but there are several examples of how the improper use of a music stimulus can be medically and emotionally harmful.

For example, musicians across the state identify themselves as “Music Therapists” and claim to offer music therapy services, yet they are not trained music therapists according to the profession’s nationally established standards. For example, a nurse at a long-term care facility may claim to do “music therapy” by playing the piano for sing-a-longs for the residents. While qualified to address a number of physical issues, she is not trained to select or manipulate particular musical elements to elicit specific desired responses, nor is she trained to handle the social or emotional responses that those individuals may have in response to

musical stimuli; these types of social and emotional responses occur frequently and can be powerful.

The potential for harm could be recognized when a non-qualified individual claiming to be a music therapist does not comply with federal and state statutes and regulations, i.e., HIPAA regulations safeguarding client privacy. The potential for harm could exist if a non-qualified individual provided inappropriate applications of music interventions that could cause physical or emotional harm, or if the individual participated in unethical practice that could be harmful to the public and consumers in general. Without regulation of music therapists by the state, it would be difficult to identify music therapists who are in compliance with state regulations, which is essential for public protection.

As indicated in the examples above, music therapists often work with vulnerable populations (e.g. persons with intellectual or emotional disabilities, or persons coping with physical, mental, or terminal illness). Therefore, it is important to formally recognize the profession to safeguard consumers who may be less able to protect themselves. A person claiming to be a music therapist, but who did not have the nationally accepted academic and clinical training and did not hold the nationally recognized music therapy credential, could potentially cause significant health and/or safety risks. Similar to the requirements of other healthcare professionals, music therapists are responsible for working within AMTA Standards for Education and Clinical Training (attached), AMTA Standards of Clinical Practice (attached), and AMTA Code of Ethics (attached). Board certified music therapists must also abide by the CBMT Code of Professional Practice (attached) and work within the CBMT Board Certification Domains (attached). These standards, codes, and professional documents require that music therapists follow state and institutional laws and mandates for ethical practice.

5. Does a potential for fraud exist because of the inability of the public to make an informed choice in selecting a competent practitioner?

Yes, Virginia music therapists are seeking licensure to mitigate the potential for harm to the public and to increase consumer access to music therapy services. Regulating music therapy practice would provide the public with assurance that they are protected from the misuse of terms and techniques by unqualified individuals and to ensure competent practice. Virginians would be assured that individuals providing music therapy services are qualified clinicians who have met the education, clinical training, and credentialing requirements for the profession.

Potential fraud to the public includes misrepresentation of the music therapy profession, as these individuals hold themselves out to the public as being able to produce outcomes that are not based upon evidence-based practice; and, these individuals show a substantial lack of supervised clinical training and feedback to promote and ensure ethical practice. This lack of formalized training and credentials pose an unnecessary and sometimes unintended risk to clients. This also has financial implications for consumers which include being overcharged by untrained individuals that are not held accountable to follow or uphold professional standards and ethics, and who are not qualified to provide the service or document measurable outcomes.

Additionally, access to medically, behaviorally, or educationally necessary music therapy services would be improved, as Virginians would be able to locate qualified providers

recognized by the state. Access to qualified music therapists would also be made easier for employers. Facilities interested in providing music therapy services would be able to utilize the state system to locate qualified professionals. Regulation will prevent the incidence of unqualified individuals having access to clients' confidential information and potentially compromising clients' health and wellness issues. Furthermore, the current trend in healthcare is consumer choice. Consumers need and want choices in their healthcare treatment options. Licensure for music therapists is a step toward providing Virginians access to another type of service that can improve their health and treatment outcomes.

State regulation would effectively eliminate confusion for those seeking private services, as consumers would have a means to determine competence. There are a large number of non-credentialed individuals claiming to practice music therapy who could cause psychological harm as they do not have the necessary education and clinical training to assess, develop and implement interventions. This is confusing to the general public as these individuals do not always represent themselves accurately. In Virginia, we have seen cases where musicians volunteer by playing music in hospitals under the title of "music therapy." We have been notified that other healthcare professionals, teachers, and paraprofessionals claim to sing to students in order to provide the "music therapy" listed on a child's IEP. These situations demonstrate fraudulent and unethical business practices with no recourse for consumers. Virginia residents deserve transparency concerning the services they receive.

6. Does a potential for fraud exist because of the inability for third party payors to determine Competency?

The potential for fraud does exist because of the inability for third party payers to determine competency. Since music therapy is not currently recognized as a profession in the state of Virginia, there is no standard for competent practice defined by the state. Third party payers could be paying for services by untrained individuals.

7. Is the public seeking regulation or greater accountability of this group?

Yes, the public is seeking regulation.

In June of 2017: The Virginia Music Therapy Association (VMTA) received emails from concerned parents in Loudoun County, stating that Loudoun County Public Schools (LCPS) planned to discontinue contracts with board certified music therapists and replace with existing staff. VMTA communicated with AMTA as well as music therapists involved and supported parents with advocacy materials about U.S. Department of Education's recognition of music therapy as a related service under the federal Individuals with Disabilities Education Act (IDEA). In August 2017, parents received Notification from LCPS that they were using occupational therapists, speech-language pathologists, and teachers to offer "music therapy" instead of board certified music therapists. AMTA forwarded multiple LCPS IEPs received from parents to the U.S. Department of Education Office of Special Education programs. After multiple conversations with the Virginia Department of Education, AMTA was told that the district can determine who provides music therapy when the state does not have a license for the profession.

In summary, The Virginia Department of Education does not formally recognize the profession and its national board certification credential. As a result, some districts in

Virginia are claiming they can determine who is qualified to provide music therapy. This unusual interpretation of the federal special education law is not being done in any other state in our nation. This practice has led to a disruption of student progress, professional ethics questions from staff being asked to provide services they are not qualified to offer, and significant frustration within the many families affected by this interpretation of the law. The American Music Therapy Association (AMTA) has communicated with the VA Department of Education and it appears the only way to resolve this problem is for the VA Legislature to create a music therapy license that recognizes the national board certification credential.

Criterion Two: Specialized Skills and Training. *The practice of the health occupation requires specialized education and training, and the public needs to have benefits by assurance of initial and continuing occupational competence.*

1. What are the educational or training requirements for entry into this occupation? Are these programs accredited? By whom?

- **Are sample curricula available?**
- **Are there training programs in Virginia?**

Those who wish to become music therapists must earn a bachelor's degree or higher in music therapy from one of over 80 American Music Therapy Association (AMTA) approved colleges and universities. These programs require academic coursework and 1,200 hours of clinical training, which includes a supervised internship. The academic institution takes primary responsibility for providing students with the entire continuum of clinical training experiences with a representative range of client populations in diverse settings. Qualified supervision of clinical training is required and coordinated or verified by the academic institution. An academic institution, AMTA, or both may approve internship programs. Clinical supervisors must meet minimum requirements outlined by *AMTA Standards for Education and Clinical Training* (attached). In exceptional cases, a student may have an on-site supervisor or facility coordinator (e.g. OT, nurse, special educator, etc.). Under these circumstances, the student must have a music therapist as a supervisor under the auspices of the university.

At the completion of academic and clinical training, students are eligible to take the national examination administered by the Certification Board for Music Therapists (CBMT), an independent, non-profit certifying agency fully accredited by the National Commission for Certifying Agencies (NCCA). After successful completion of the CBMT examination, graduates are issued the credential necessary for professional practice, Music Therapist-Board Certified (MT-BC). To demonstrate continued competence and to maintain this credential, music therapists are required to complete 100 hours of continuing music therapy education during every five-year recertification cycle.

All board certified music therapists receive education and training in compliance procedures for state, federal and facility regulations and accreditation. They are trained and skilled to conduct music therapy assessments, draft and incorporate goals and objectives into treatment plans, specify procedures and define expected treatment outcomes, evaluate and make appropriate modifications and accommodations, and document the process utilizing standard tools. The skill set and competencies required of music therapists are outlined in the *AMTA Professional Competencies* (attached) and the *CBMT Board Certification Domains* (attached).

Radford University and Shenandoah University are the only universities in Virginia that offer Bachelor's level and Master's level music therapy trainings in the state. The Bachelor of Music in Music Therapy degree is a 4-year program and the Master of Science in Music Therapy degree is a 2-3 year program. Radford University and Shenandoah University are both accredited by the National Association of Schools of Music and approved by the American Music Therapy Association.

Contact information:

Radford University
801 East Main St.
Radford, VA 24142
Director of Music Therapy: Dr. Patricia Winter
pwinter3@radford.edu

Shenandoah University
1460 University Drive
Winchester, VA 22601
Director of Music Therapy Studies: Dr. Tony Meadows
ameadows2@su.edu

Sample curricula for Shenandoah University is attached, and curricula for Radford University can be found at the following links:

Undergraduate:

<https://www.radford.edu/content/dam/colleges/cvpa/forms/checksheets/17-18/music/1718bm-musictherapy.pdf>

Graduate:

http://catalog.radford.edu/preview_degree_planner.php?catoid=39&poid=4305&returnto=1489&print

In addition to the collegiate training curriculum, all board certified music therapists must also complete a six-month clinical training internship in order to be eligible to sit for the board certification exam. An academic institution, AMTA, or both may approve internship programs. Clinical supervisors must meet minimum requirements outlined by the *AMTA Standards for Education and Clinical Training* (attached).

2. **If no programs exist in Virginia, what information is available on programs elsewhere which prepare practitioners for practice in the Commonwealth? What are the minimum competencies (knowledge, skills, and abilities) required for entry into the profession? How were they derived?**

Not applicable. Formal training and education, to include a Bachelor's Degree in Music Therapy, or a Master's Degree in Music Therapy is required, in addition to national board certification as regulated by the *Certification Board for Music Therapists* (CBMT).

3. **Are there national, regional, and/or state examinations available to assess entry-level competency?**
- **Who develops and administers the examination?**

- **What content domains are tested?**
- **Are the examinations psychometrically sound -- in keeping with *The Standards for Educational and Psychological Testing*?**

Yes. All board certified music therapists have either passed an exam developed and administered by the Certification Board for Music Therapists (CBMT) or transitioned into board certification through CBMT. CBMT is an independent, non-profit certifying agency fully accredited by the National Commission for Certifying Agencies (NCAA). This accreditation serves as the means by which CBMT strives to maintain the highest standards possible in the construction and administration of its national examination and re-certification programs, ultimately designed to reflect current music therapy practice for the benefit of the consumer. The CBMT defines the body of knowledge that represents competent practice in the profession of music therapy, creates and administers a program to evaluate initial and continuing competence of this knowledge, and issues the credential of MT-BC to individuals that demonstrate the required level of competence.

The CBMT examination is psychometrically sound. It meets accreditation standards with NCCA and is developed in accordance with the APA standards for Educational and Psychological testing. CBMT programs meet or exceed the same standards for Educational and Psychological testing. CBMT programs meet or exceed the same standards licensing boards use in test development and administration. In accordance with APA standards, a practice analysis is reviewed every five years in cooperation with a team of experts in the field, surveyed certificants, and CBMT's testing firm, Applied Measurement Professionals (AMP). It is from this process that the *CBMT Board Certification Domains* (attached) are updated to reflect current clinical practice and outlines the tasks necessary to practice music therapy completely to ensure consumer protection. The five content domain areas, essentially performance domains, encompass the certificate's scope of practice.

- 4. Are there requirements and mechanisms for ensuring continuing competence? For example, are there mandatory education requirements, re-examination, peer review, practice audits, institutional review, practice simulations, or self-assessment models?**

Yes. At the completion of academic and clinical training, students are eligible to take the national examination administered by CBMT, an independent, non-profit certifying agency fully accredited by the National Commission for Certifying Agencies since 1986. After successful completion of the CBMT examination, graduates are issued the credential necessary for professional practice, Music Therapist-Board Certified (MT-BC). To demonstrate continued competence and to maintain this credential, music therapists are required to complete 100 hours of continuing music therapy education within every five-year recertification cycle. If certification is not maintained, the individual must successfully pass the exam again to obtain the MT-BC credential.

- 5. Why does the public require state assurance of initial and continuing competence? What assurances do the public have already through private credentialing or certification or institutional standards, etc.?**

Establishing a state licensure for music therapists protects the public because licensure would only be granted to those who are credentialed clinicians and have met the stringent education, clinical training, and national board certification requirements established by the American

Music Therapy Association (AMTA) and the Certification Board for Music Therapists (CBMT). State licensure would effectively decrease confusion for those seeking private services, as consumers would have a means to infer competence based on finding a credentialed individual who also meets state licensure requirements. There are a large number of non-credentialed individuals claiming to be music therapists or who use the term music therapy to describe their work who could cause potential psychological and physical harm as they do not have the necessary education and clinical training to assess, develop and implement music interventions as outlined in the *CBMT Board Certification Domains* (attached). These individuals do not always represent themselves accurately and this is confusing to the general public.

Finally, a state license to practice music therapy would provide the public with a well-defined, easily-accessed method of determining qualified practitioners. Licensure would assist potential employers in selecting qualified music therapists as opposed to non-credentialed music professionals, decreasing the incidence of unqualified individuals having access to clients' confidential information, and potentially compromising clients' health and wellness issues.

Currently, complaints against a board certified music therapist can be brought to the attention of CBMT for investigation and possible disciplinary action as defined by the CBMT Code of Professional Practice. Unfortunately, this disciplinary action does not prevent the person from practicing in a state that does not formally recognize the national credential. Although CBMT is charged with setting and enforcing quality practice standards for the profession, if the state does not officially recognize this national certification through licensure, state residents and employers have no system to determine competence. Currently, any person can represent himself or herself as a music therapist in Virginia. Without the oversight provided through state occupational regulation, there are no checks and balances that insure providers have met education, clinical training, or certification requirements for the profession.

6. **Are there currently recognized or emerging specialties (or levels or classifications) within the occupational grouping? If so,**
- **What are these specialties? How are they recognized? (by whom and through what mechanisms – e.g., specialty certification by a national academy, society or other organization)?**
 - **What are the various levels of specialties in terms of the functions or services performed by each?**
 - **How can the public differentiate among these levels or specialties for classification of practitioners?**
 - **Is a “generic” regulatory program appropriate, or should classifications (specialties/levels) be regulated separately (e.g., basic licensure with specialty certification)?**

No. There are advanced trainings available for music therapists to pursue as a part of their continuing education, but no formal specialties are included within the national board certification credential.

Criterion Three: The functions and responsibilities of the practitioner require independent judgment and the members of the occupational group practice autonomously.

1. What is the nature of the judgments and decisions which the practitioner must make in practice?

- **Is the practitioner responsible for making diagnoses?**
- **Does the practitioner design or approve treatment plans?**
- **Does the practitioner direct or supervise patient care?**
- **Does the practitioner use dangerous equipment or substance in performing his functions?**

If the practitioner is not responsible for diagnosis, treatment design or approval, or directing patient care, who is responsible for these functions?

Music therapists do not diagnose.

Music therapists design music therapy treatment plans and collaborate with other health care providers involved in the client's care.

Music therapists direct the music therapy portion of treatment but do not typically direct the overall patient care program unless they serve in a management position within a healthcare or education facility. Music therapists work as treatment team members, alongside physicians, nurses, and allied health professionals.

Music therapists do not use dangerous equipment or substance in practice.

Music therapists access diagnosis information from the referring physician or treatment team within interdisciplinary practice.

2. Which functions typically performed by this practitioner group are unsupervised, i.e., neither directly monitored or routinely checked?

- **What proportion of the practitioner's time is spent in unsupervised activity?**
- **Who is legally accountable/liable for acts performed with no supervision?**

Supervision of music therapy services is determined by the work setting. For example, when employed by a healthcare facility, Therapy Service Department Directors may supervise music therapists, and peers often include physical therapists, occupational therapists, and speech/language pathologists. In educational settings, music therapists are typically supervised by Special Education Administrative Directors with peers in related services as listed above. For clinicians in private practice, supervision opportunities are available through peer supervision groups, paid consultations, as well as through state, regional, and national conferences.

The employer of the music therapist is legally accountable/liable for acts performed with no supervision.

3. Which functions are performed only under supervision?

- **Is the supervision *direct* (i.e., the supervisor is on the premises and responsible) or *general* (i.e., supervisor is responsible but not necessarily on the premises)?**
- **Who provides the supervision? How frequently? Where? For what purpose?**

- **Who is legally accountable/liable for acts performed under supervision?**
- **Is the supervisor a member of a regulated profession (please elaborate)?**
- **What is contained in a typical supervisory or collaborative arrangement protocol?**

Board certified music therapists provide interventions without direct supervision, but typically have access to a supervisor on site or through consultation. AMTA Standards of Clinical Practice state it is the responsibility of the music therapist to seek and participate in supervision on a regular basis.

Supervisors vary by clinical setting and may include: physicians, psychologists, social workers, school administrators, music therapists, and other advanced practice allied health professionals. Most music therapists receive access to periodic supervision meetings as needed or required by a facility, along with an annual performance review.

Supervision is mandatory only for selected advanced practice certifications above and beyond the scope of practice and licensure proposed herein.

Within some facilities, internal policies may require referral from a physician or other advanced practice health professional in order for music therapy to be offered. In some instances, documentation and record audits and reviews are conducted by supervisors of all clinical staff, including music therapists.

4. Does the practitioner of this occupation supervise others? Describe the nature of this supervision (as in #3 above).

Although supervisory responsibilities are not formally outlined within the scope of music therapy practice, many music therapists hold supervisory positions depending upon the clinical setting and level of additional training. Board certified music therapists are qualified to supervise music therapy practicum students and interns, once they meet the requirements outlined within the AMTA Standards for Education and Clinical Training.

5. What is a typical work setting like, including supervisory arrangements and interaction of the practitioner with other regulated/unregulated occupations and professions?

Board certified music therapists work in a variety of work settings, including but not limited to:

- Medical facilities, such as general hospital settings, hospice, oncology, physical rehabilitation, home health agencies, outpatient clinics, VA facilities, partial hospitalization and children's hospitals or units.
- Mental health settings, such as child and adolescent treatment centers, psychiatric hospitals, community mental health centers, drug and alcohol programs, forensic facilities, and inpatient psychiatric units.
- Geriatric facilities, such as adult day care, assisted living, geriatric facilities, geriatric psychiatric units, and nursing homes.
- Developmental centers, such as group homes, intermediate care facilities, community day treatment programs, and state institutions.
- Educational facilities, such as children's day care/preschool settings, early Intervention programs, and schools (K-12).

- Community Centers, such as Senior Centers, recreation centers or community music schools
- Other settings, such as diagnosis-specific support groups, wellness and prevention programs, and work in a music retailer setting.
- Private practice settings, which commonly contract services in any of the facilities mentioned above.

As members of the interdisciplinary team, music therapists interact, collaborate, and sometimes co-treat with a variety of health professionals, including: physical therapists, occupational therapists, speech language pathologists, social workers, counselors, physicians, psychologists, psychiatrists, neurologists, nurses, etc.

Supervision includes observation and feedback, case consultation, and/or mentorship of music therapy practice provided by a clinical supervisor, an advanced colleague, or a graduate educator.

6. Does this occupational group treat or serve a specific consumer/client/patient population?

Music therapists provide healthcare and education support services to individuals of all ages and ability levels, ranging from neonates in the Neonatal Intensive Care Unit (NICU) to older adults in hospice care. Client groups served include those with:

Developmental disabilities

Including Down Syndrome, autism spectrum disorders, Rett syndrome, Fragile X syndrome, cerebral palsy, etc.

Mental illnesses

For example, Post-Traumatic Stress Disorder, schizophrenia, Bipolar Disorder, depression, emotional/behavioral disorders, substance abuse, etc.

Acute or chronic illnesses or pain

Such as HIV/AIDS, cancer, Multiple Sclerosis, burns, surgeries, etc.

Impairments or injuries due to aging or accidents

Including stroke, Alzheimer's disease or other dementias, Traumatic Brain Injury, Parkinson's, etc.

Hearing, visual, or speech impairments

Including multiple impairments

Terminal Illnesses

Such as hospice and palliative care

Learning Disabilities

For example, those related to math difficulties, language difficulties, or motor difficulties

Health and Wellness Issues

Such as cardiac care and well seniors

7. Are clients/consumers/patients referred to this occupational group for care or services? If so, by whom? Describe a typical referral mechanism.

Clients have direct access to music therapy and may be referred by members of another occupational group. This distinction is typically determined by the clinical setting. For example, clients have direct access to music therapists in private practice, sometimes with a referral and sometimes without.

In schools, referrals typically come from the interdisciplinary team: parents; classroom teachers; and other professionals involved in that child's education. Clients may also see a music therapist who is employed in an educational or healthcare setting; whether a client directly accesses music therapy services or is referred for music therapy depends on the setting.

The following practitioners may refer a client to a music therapist (not inclusive):

- Speech-Language Pathologist
- Occupational Therapist
- Physical Therapist
- Educator
- Special Educator
- Social Worker
- Clinical Case Manager
- Psychologist
- Psychotherapist
- Physician
- Neurologist
- Nurse
- Behaviorist
- Counselor
- Another client

The referral mechanism is determined by clinical setting. Examples may include: computer system orders; written consult request; verbal direction from case manager; treatment team recommendations.

8. Are clients/consumers/patients referred from this occupational group for care or services? If so, to what practitioners are such referrals made? Describe a typical referral mechanism. How and on what basis are decisions to refer made?

Yes. The AMTA Standards of Clinical Practice state that when assessment indicates the client's need for other services, the music therapist will make an appropriate referral. The list of practitioners to which these referrals can be made may include (not inclusive):

- Speech-Language Pathologist
- Occupational Therapist
- Physical Therapist
- Educator
- Special Educator
- Social Worker
- Clinical Case Manager

- Psychologist
- Psychotherapist
- Physician
- Neurologist
- Nurse
- Behaviorist
- Counselor

AMTA Standards of Clinical Practice state that the music therapist will document referrals made to other sources and will include plans for music therapy services as appropriate. In addition, the documentation of all referrals will include date of referral, source of referral, and services requested.

Criterion Four: The scope of practice is distinguishable from other licensed, certified and registered occupations, in spite of possible overlapping of professional duties, methods of examination, instrumentation, or therapeutic modalities.

1. Which functions of this occupation are similar to those performed by other health occupational groups?

- Which group(s)?
- Are the other groups regulated by the state?
- If so, why might the applicant group be considered different?

Treating patients based on a referral system, development of treatment team goals, performing assessments, providing treatment, consulting with members of the interdisciplinary team, evaluating response and progress, documenting progress in medical records.

Creative Arts therapists, recreation therapists, speech-language pathologists, occupational therapists, and physical therapists are all closely related groups due to the fact that co-treatment with these disciplines happens frequently in education settings, hospitals, and nursing homes.

Physical Therapy (Virginia Department of Health Professions); Occupational Therapy (licensed since 1998); Speech-Language Pathology (includes a provisional license); Recreational Therapy began seeking licensure in 2012.

Music therapy utilizes all elements of music as therapeutic tools. Music therapists actively interact with clients using music in the moment to achieve functional outcomes.

2. Which functions of this occupation are distinct from other similar health occupational groups?

What distinguishes music therapy from other therapies is the use of music as the therapeutic medium. Music therapy practice requires a unique, specialized skill and knowledge set. Music therapists use their knowledge, skills, training, and experience to facilitate therapeutic, goal-oriented music-based interactions that are meaningful and supportive to the function and health of their clients. Music therapists actively create, apply, and manipulate various music elements through live, improvised, adapted, individualized, or recorded music to address physical, emotional, cognitive, and social needs of individuals of all ages and ability levels.

These components of clinical practice continue to evolve with advances in basic science, translational research, and therapeutic implementation. When other healthcare and education professionals report using music as a part of treatment, it involves specific, isolated techniques, using one pre-arranged aspect of music or playing a music recording to address specific and limited issues. In contrast, the use of live music interventions demands that a music therapist not only possess the knowledge and skills of a trained therapist, but also the unique skill set of a trained musician in order to manipulate the music therapy intervention to fit clients' needs and to address issues across multiple health domains concurrently.

3. How will the regulation of this occupational group affect the scope of practice, marketability, and economic and social status of the other, similar groups (whether regulated or unregulated)?

Regulation of music therapy will not affect the scope, marketability, or economic/social status of the similar groups.

Criterion Five: The economic costs to the public of regulating the occupational group are justified. These costs result from restriction of the supply of practitioner, and the cost of operation of regulatory boards and agencies.

1. What are the range and average incomes of members of this occupational group in the Commonwealth? In adjoining states? Nationally?

According to the 2018 workforce analysis survey conducted by AMTA, the average full-time salary for music therapists in Virginia was \$41,500. When examining the regional (Mid-Atlantic) statistics, the average full-time salary was \$48,495.

The median salary was \$46,000, and the mode was \$50,000. The range was \$20,000-150,000. The average full-time salary for all survey respondents, both inside and outside the United States, was \$48,835.

2. What are the typical current fees for services provided by this group in the Commonwealth? In adjoining states? Nationally?

According to the workforce analysis conducted by AMTA, the average hourly individual rate for the Mid-Atlantic Region is \$83.31. The average hourly group rate per person for the region is \$78.04.

Nationally, the average hourly individual rate is reported as \$68.93. The national average hourly group rate per person is reported as \$77.67.

3. Is there any evidence that cost for services provided by this occupational group will increase if the group becomes state regulated? In other states, have there been any effects on fees/salaries attributable to state regulation?

No. In other states where music therapy is officially recognized, there has not been a reported increase in fees or salaries following occupational regulation.

4. Would state regulation of this occupation restrict other groups from providing care given by this group?

- **Are any of the other groups able to provide similar care at lower costs?**
- **How is it that this lower cost is possible?**

No, other professionals in other disciplines are still able to use music within their scope of practice. However, the use of music by other professionals is not equivalent to music therapy as those professionals do not possess the specific training and knowledge that would allow them to utilize music strategically in accordance with evidence-based practice to make robust gains for their clients.

5. Are there current shortages/oversupplies of practitioners in Virginia? In the region? Nationally?

The profession does not have detailed data on this topic. There are currently 8,172 board certified music therapists in the United States.

6. Are third-party payers in Virginia currently reimbursing services of the occupational group? By whom? For what?

- **If not in Virginia, elsewhere in the country?**
- **Are similar services provided by another occupational group reimbursed by third-party payers in Virginia? Elsewhere? Elaborate.**

We are not aware of private insurance companies directly reimbursing for music therapy in Virginia at this time. Music therapy programs in healthcare facilities are often funded through the daily reimbursement rate provided by private payers and the Medicare Prospective Payment System.

Nationally, AMTA reports that approximately 20% of music therapy services receive third-party reimbursement. Companies like Blue Cross Blue Shield, United Healthcare, Cigna, and Aetna have all paid for music therapy services at some time. Success has occurred on a case-by-case basis when the therapist implements steps within the reimbursement process and receives pre-approval for music therapy services. Approximately 23 states provide funding for music therapy services through Medicaid Waiver programs or state agency funds.

There are not similar services provided by another occupational group that receive third-party reimbursement.

7. If third-party payment does not currently exist, will the occupation seek it subsequent to state regulation?

Third-party reimbursement for music therapy in Virginia will be sought from appropriate payers as it relates to increasing music therapy access and quality of services for consumers.

Criterion Six: There are no alternatives to State regulation of the occupation which adequately protect the public. [Inspections and injunctions, disclosure requirements, and the strengthening of consumer protection laws and regulations are examples of methods of addressing the risk for public harm that do not require regulation of the occupation or profession.]

1. What laws or regulations currently exist to govern:

- **Facilities in which practitioners practice or are employed?**
- **Devices and substances used in the practice?**
- **Standards or practice?**

State laws and regulations do provide guidance to facilities where music therapists may be employed, but these rules often require the facilities to hire individuals that have a state recognized credential or require employment under a different job title/description to match state rules.

Devices and substances: N/A

There are currently no state laws or regulations that govern the standards of practice for music therapy in VA.

2. Does the institution or organization where the practitioners practice set and enforce standards of care? How?

Many institutions or organizations that would employ music therapists are often required to hire providers who have a state recognized credential. The VA Department of Education does not recognize the profession or its credential because the profession is not licensed in the state, and as a result, students in individual school districts are not able to access music therapy services in special education. State requirements for holding a state license or state recognized credential prevents nationally board certified music therapists from working in certain healthcare and education settings in VA, which prevents state residents from accessing services.

3. Does the occupational group participate in a nongovernmental credentialing program, either through a national certifying agency or professional association (e.g., Institute for Credentialing Excellence National Commission for Certifying Agencies).

- **How are the standards set and enforced in the program?**
- **What is the extent of participation of practitioners in the program?**

Yes. Although not legally required unless a state license, registry, certification, or title protection exists in statute, music therapists who have met AMTA education and clinical training requirements are eligible to sit for the national board certification exam administered by CBMT.

When the CBMT was created in 1983 to be the independent credentialing body for Music Therapists, CBMT became a member organization of National Organization of Certifying Agencies. CBMT's certification program was accredited in 1986 upon its initial application to the Commission. The CBMT's accreditation is renewed every five years. Among Institute for Credentialing Excellence (ICE) members, formerly NOCA members, the CBMT is recognized as having a quality certification program that is a leader in the field, particularly among professions with around 6,000 practitioners.

CBMT continues to be involved with ICE and National Commission for Certifying Agencies (NCCA) for a number of important reasons. First, NCCA accreditation is recognition that the CBMT meets the highest standards for national certification programs. Accreditation

demonstrates to certificants, employers, government agencies, payers, courts, and professional organizations that an impartial, objective Commission has reviewed the CBMT's program. This impartial, objective review is particularly important for organizations like the CBMT that are structured to be independent from professional associations and have protection of the public as part of its mission. Accreditation and adherence to NCCA standards are an important check and balance for the CBMT Board of Directors to assure that the CBMT programs reflect the most current principles in the field of credentialing. Accreditation also shows licensure boards that the CBMT programs meet or exceed the same standards to which licensing boards adhere in test development and administration.

All board certified music therapists in Virginia participate with the CBMT certification process. Unfortunately, this participation is not officially recognized by the state, and as a result, anyone in Virginia can call themselves a music therapist, without any of the required education, clinical training, or board certification.

4. Does a Code of Ethics exist for this profession?

- **What is it?**
- **Who established the Code?**
- **How is it enforced?**
- **Is adherence mandatory?**

Yes. AMTA established the Code of Ethics for AMTA members (attached). It is enforced through AMTA Judicial Review Board Procedures. Adherence is mandatory for AMTA members.

CBMT has a Code of Professional Practice for MT-BCs (attached). All board certified music therapists must adhere to this Code. It is enforced through the establishment of CBMT special disciplinary review and disciplinary hearing committees.

5. Does any peer group evaluation mechanism exist in Virginia or elsewhere? Elaborate.

No.

6. How is a practitioner disciplined and for what causes?

- **Violation of standards of care?**
- **Unprofessional conduct?**
- **Other causes?**

There is no official system in Virginia for specifically disciplining music therapists for not following standards of care or for unprofessional conduct. Individual health and education facilities have employment requirements and disciplinary procedures, but they are not specific to the profession of music therapy.

7. Are there specific legal offenses which, upon conviction, preclude a practitioner from practice?

Without state licensure in Virginia, a provider could still practice in the state, despite legal offenses. CBMT can only pull the credential, but cannot legally stop an individual from practicing. The state is the only entity that can stop an individual from practicing as long as there are state laws recognizing the credential and regulating the profession.

8. Does any other means exist within the occupational group to protect the consumer from negligence or incompetence (e.g., malpractice insurance, review boards that handle complaints)?

- **How are challenges to a practitioner's competency handled?**

There is currently no legal recourse available in Virginia to protect consumers from negligence or incompetence. Currently, consumer complaints can be brought to CBMT for possible disciplinary review. As stated previously, CBMT can only pull the credential, but they cannot prevent an individual from practicing. Only official state recognition of the credential in statute provides the legal protection for consumers against negligence and incompetence.

9. What is the most appropriate level of regulation?

A state license would provide the highest level of protection for consumers so that they can be assured music therapy services are being provided by a qualified individual.

A state license is necessary to address the immediate restriction of service access in special education in Virginia.

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VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS

PANEL FOR MUSIC THERAPIST STUDY

JUNE 24, 2019
SECOND FLOOR CONFERENCE ROOM
9960 MAYLAND DRIVE
HENRICO, VIRGINIA 23233
9:00 A.M.

IN RE: MUSIC THERAPIST STUDY

1 APPEARANCES:

2

3 PANEL MEMBERS FOR VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS

4

5 Yetty Shobo, PhD, Deputy Executive Director

6 James Wells, RPh, Citizen Member, Committee Chair

7 Elizabeth Carter, PhD, Executive Director

8 John Salay, MSW, Board of Social Work

9 Louis Jones, Board of Funeral Directors and Embalmers

10 Barbara Allison-Bryan, M.D. Chief Deputy Director

11 Laura Jackson, MSHSA, Operations Manager

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1 James Wells: Good morning ladies and gentlemen I will call
2 to order the meeting of the Board of Health Professions
3 Regulatory Research Committee, June 24th, 2019. Because we don't
4 really have a quorum we will dispense with the approval of
5 minutes, I would move to emergency egress with Dr. Carter.

6 Elizabeth Carter: Yes indeed. In the event of an
7 emergency, fire or emergency, alarms will sound, we will
8 immediately exit the building either through that door there, or
9 the door here, make a right, and there is a door at the end of
10 the hall here, go across the parking lot and you will wait at
11 the fence, staff will get you there, just, and hopefully that
12 doesn't happen, but every once in awhile they will do a run
13 through a mock one and go oh, okay. Thank you.

14 James Wells: Alright, the next item of business is the
15 Music Therapist Study review of the first draft, Ms. Jackson.

16 Laura Jackson: Good morning everybody, thank you for
17 coming. We are going to start out this morning with the review
18 of the first draft of the music therapist study, the first slide
19 reviews the Code of Virginia which authorizes the Department of
20 Health Professions on matters pertaining to regulation of health
21 professions and occupations and scope of practice issues.
22 Senate Bill 1547 which is located in (Appendix 1) which is in
23 the packet directs the Board of Health Professions to evaluate
24 whether music therapist or the practice of music therapy should

1 be regulated and the degree of regulation to be imposed. The
2 Board of Health Professions (BHP) is required to report the
3 results of its evaluation to the Chairmen of the Senate
4 Committee on Education and Health and to the House Committee on
5 Health, Welfare and Institutions by November 1st of this year.

6 **The Criteria** - The Board of Health Professions has adopted the
7 following criteria and guidelines to evaluate the need to
8 regulate health professions.

9 **Criterion One:** Of course is the top priority, risk for harm to
10 the consumer.

11 **Criterion Two:** Specialized skills and training.

12 **Criterion Three:** Autonomous Practice.

13 **Criterion Four:** Scope of Practice.

14 **Criterion Five:** Economic Impact.

15 **Criterion Six:** Alternatives to Regulation.

16 **Criterion Seven:** Least Restrictive Regulation.

17 **The application of the criteria** - In the process of evaluating
18 the need for regulation, the Board's seven criteria are applied
19 differently, depending upon the level of regulation which
20 appears most appropriate for the occupational group, it includes
21 licensure, statutory certification, and registration.

22 **Licensure** - Confers a monopoly upon a specific profession whose
23 practice is well defined. It is the most restrictive level of
24 occupational regulation. It generally involves the delineation

1 in the statue of a scope of practice which is reserved to a
2 select group based upon their possession of unique,
3 identifiable, minimal competencies for safe practice. In this
4 sense, state licensure typically endows a particular occupation
5 or profession with a monopoly in a specified scope of practice.

6 **Risk** - The risk here has got to be high where high potential,
7 attributable to the nature of the practice.

8 **Skill & Trianing:** Highly specialized accredited post-secondary
9 education required; clinical proficiency is certified by an
10 accredited body.

11 **Autonomy:** Practices independently with a high degree of
12 autonomy; little or no direct supervision.

13 **Scope of Practice:** Definable in enforceable legal terms.

14 **Cost:** High.

15 **Application of the Criteria:** When applying for licensure, the
16 profession must demonstrate that Criteria 1 through 6 are met.

17 **Statutory Certification** - Is the certification by the state is
18 also known as "title protection". No scope of practice is
19 reserved to a particular group, but only those individuals who
20 meet certification standards (defined in terms of education and
21 minimum competencies which can be measured), may title or call
22 themselves by the protected title.

1 **Risk:** Moderate potential, attributable to the nature of the
2 practice, client vulnerability, or practice setting and level of
3 supervision.

4 **Skill & Training:** Specialized; can be differentiated from
5 ordinary work. The candidate must complete education or
6 experience requirements that are certified by a recognized
7 accrediting body.

8 **Autonomy:** Is variable; some independent decision-making;
9 majority of the practice actions directed or supervised by
10 others.

11 **Scope of Practice:** Is definable, but not stipulated in law and
12 the cost is variable

13 **Cost:** Is variable, depending upon the level of restriction of
14 supply of practitioners.

15 **Application of Criteria:** When applying for statutory
16 certification, a group must satisfy Criterion 1, 2, 4, 5, & 6.

17 **Registration:** Registration requires only that an individual
18 file his name, location, and possibly background information
19 with the State. No entry standard is typically established for
20 a registration program.

21 **Risk:** Low potential, but consumers need to know that redress is
22 possible.

23 **Skill & Training:** Variable, but can be differentiated for
24 ordinary work and labor.

1 **Autonomy:** Also variable.

2 **Application of Criteria:** When applying for registration,
3 Criteria 1, 4, 5, & 6 must be met.

4 **What is music therapy?**

5 According to the American Music Therapy Association (AMTA),
6 music therapy is the clinical and evidence-based use of music
7 interventions to accomplish individualized goals within a
8 therapeutic relationship by a credentialed professional who has
9 completed an approved music therapy program. Music therapy is
10 an evidence-based health profession with a strong research
11 foundation.

12 **What do credentialed music therapists do?**

13 Music therapists: Assess emotional well-being, physical health,
14 social functioning, communication abilities, and cognitive
15 skills through musical responses. Music therapists design music
16 sessions for individuals and groups based on client needs using
17 music improvisation, receptive music listening, song writing,
18 lyric discussion, music and imagery, music performance and
19 learning through music. Music therapists participate in
20 interdisciplinary treatment planning, ongoing evaluation, and
21 follow-up.

22 **Criterion One: Risk of Harm**

23 Due to the low number of states that license or utilize title
24 protection for music therapists, and the Credentialing Board for

1 Music Therapists (CBMT) requirement that all MT-CB credential
2 holders self-report any violations of the CVMT Code of
3 Professional Practice, the level of reported cases at this time
4 is very low. The following information regarding disciplinary
5 action against music therapists is provided by CBMT. The data
6 represents the last 20 years since the current Code of
7 Professional Practice and new disciplinary procedures were
8 adopted in 1998. Sorry it's so long. Overall, the Misuse of
9 Credentials was listed as the top reported violation with 27
10 cases, now remember this is over 20 years. Also, falsification
11 of records followed next with 8 reported cases. Over the past
12 20 years Virginia has had one reported case. This case falls
13 under the Sexual Offenders or Sexual Harassment heading. No
14 additional information from the Certification Board of Music
15 Therapists was made available regarding this case, so we are
16 unable to determine if it is a new case or if it was an old
17 case. I'm certainly going to follow-up with them to see if they
18 can help determine a timeline. Table 2 shows disciplinary action
19 by state since 1998. There have been 53 cases. Pennsylvania
20 has had the highest number of reported cases at 7, with
21 California and Texas following at 5 each. The states with
22 existing licensure for music therapists, Connecticut and Oregon
23 with one action taken and Oklahoma has two.

1 Table 3 represents disciplinary action by year since 1998. 2018
2 had the highest number of cases with 13. It is interesting that
3 2016 shows 11, then there was a drop to 7 in 2017, a big
4 increase in 2018, and so far to date in 2019 we are at 4.
5 Music therapists do not utilize dangerous equipment while
6 performing within their practice guidelines and music therapists
7 do not diagnose. They do work with vulnerable populations,
8 individuals with intellectual or emotional disabilities.
9 Persons coping with physical, mental or terminal health
10 diagnosis. The potential for harm exists if a nonqualified
11 individual provides inappropriate application of music therapy
12 interventions that could cause emotional harm. The potential
13 for fraud exists as there are no existing laws or regulations
14 regarding this profession in Virginia. Consumers are not able
15 to determine actual credentialed music therapists from those
16 that claim to be music therapists but have no training. Third
17 party payers could be paying for services provided by untrained
18 individuals.

19 **Moving on to Criterion 2: Specialized Skills and Training**

20 **Education:** A Bachelor's degree or higher in music therapy from
21 an American Music Therapy Association approved program.

22 Coursework in music, music therapy, biology, psychology, social
23 and behavioral sciences, disabilities and general studies. One
24 thousand 200 hours of required field work are necessary.

1 Internship in an approved mental health, special education,
2 education or health care facility. Upon successful completion of
3 the bachelor's degree, individuals may sit for the national
4 certification exam to obtain the Music therapist Board Certified
5 or MT-BC credential. To maintain this credential, 100 hours of
6 continued competence in music therapy education is required
7 every five years. Virginia has two universities: Radford
8 University and Shenandoah University. Both of these colleges
9 have bachelor's and master's degree in music therapy programs.

10 **Credentialing:** The Certification Board for Music Therapist
11 (CBMT) is the only national organization to certify music
12 therapists. Certification provides an objective national
13 standard that can be used as a measure of professionalism and
14 competence. The MT-BC program is fully accredited by the
15 National Commission for Certifying Agencies (NCCA). To maintain
16 this credential, music therapists must complete 100 hours of
17 recertification credits or retake and pass the CBMT exam within
18 the five year recertification cycle. Credentialing allows for
19 easy recognition of individuals who have successfully completed
20 an AMTA program and exam demonstrating competency in the
21 profession. Currently in Virginia there are 227 individuals who
22 hold the MT-BC credential.

1 **Criterion Three: Autonomous Practice**

2 Whether practice is autonomous or not depends on the music
3 therapist's clinical practice setting. Should the music
4 therapist have a private practice all treatment would likely be
5 unsupervised, holding the music therapist accountable for the
6 job they perform. However, when treating patients in a clinical
7 environment or school setting, there would be some level of
8 being both supervised and unsupervised, holding both parties
9 accountable for the job they perform. Virginia currently cannot
10 hold music therapists legally liable for improper conduct or
11 unethical practice, as no standards have been established for
12 this unlicensed profession. Music therapists currently follow
13 the Standards of Clinical Practice which is Appendix 3 in the
14 packet and it is established by the AMTA. In general, music
15 therapists work as a member of a treatment team and often
16 receive referrals from other occupational groups.

17 **Criterion Four: Scope of Practice and Overlap**

18 The practice of music therapy is specific in its scope of
19 practice. Music therapists provide health care and educational
20 support services to individuals of all ages and ability levels.
21 Client groups include: Individuals with developmental
22 disabilities, mental illnesses, acute or chronic illnesses or
23 pain, impairments or injuries due to accidents or aging,
24 hearing, visual or speech impairments, terminal illnesses, the

1 learning disabled, and others with health and wellness issues.
2 Typical work settings for music therapists include: Medical
3 facilities, mental health settings, geriatric facilities,
4 developmental centers, educational facilities and private
5 practice settings. Music therapists often work in conjunction
6 with an interdisciplinary treatment team. There are several
7 professions licensed and unlicensed, that use or may use music
8 as a modality for treatment. Licensed professions that may
9 employ musical modalities include and these licenses or these
10 professions that I am going to list are licensed by the
11 Department of Health Professions currently. Psychologist,
12 occupational therapists, speech and language pathologists,
13 marriage and family therapists, professional counselors, social
14 workers, and massage therapists. Music therapy differs from the
15 professions listed above in that its practice uses music
16 interventions to accomplish individualized goals. This form of
17 therapy involves the development of music therapy treatment
18 plans specific to the needs and strengths of the individual
19 client. Unlicensed professions who may use music include:
20 Hypnotherapists, therapeutic musicians, music practitioners, and
21 healing musicians. The regulation of music therapists could
22 negatively affect other licensed professionals who use music
23 during treatment. Regulation would also negatively affect

1 individuals utilizing the term "music therapy" when they do not
2 hold the necessary credentials to do so.

3 **Criterion Five: Economic Impact - Wages and Salaries**

4 The music therapists in Virginia are grouped under recreational
5 therapists, and available compensation data on the profession is
6 subsumed within a broader behavioral health provider categories,
7 specifically Recreational Therapists. The U.S. Department of
8 Bureau of Labor statistics in May of 2018 showed that the
9 national median salary per year for recreational therapists is
10 \$47,860 with a salary range of \$29,590 up to \$77,050. The
11 Virginia Labor Market Information showed recreational therapists
12 in Virginia have a median annual wage of \$43,180. According to
13 the AMTA, music therapists' salaries vary based on location,
14 setting, population, experience, training, full time or part
15 time employment, as well as a number of other factors. Many
16 music therapists work in private practice and charge an hourly
17 rate for services. In 2014, the average salary reported was
18 \$50,808. The median salary was \$46,000 and the most commonly
19 reported salary was \$40,000. The average hourly individual rate
20 for music therapists in the Mid-Atlantic region is \$83.31 with
21 the average hourly per rate per person being at \$78.04. The
22 national average hourly individual rate is \$68.93 with the
23 average hourly group rate per person at \$77.67.

1 **Workforce Adequacy**

2 According to CBMT, there are 227 music therapists in Virginia
3 with MT-CB credential. Whether there is a shortage or an
4 oversupply of these practitioners in Virginia is unknown. The
5 profession-distinct supply and demand data are not available to
6 make such assessments. It may be said that as mental health
7 providers in Virginia, music therapists do provide care to
8 individuals in need of this unique type of mental health care.
9 Many facilities that would employ music therapists often require
10 providers to have state recognized credentials. The Virginia
11 Department of Education does not recognize music therapists or
12 the MT-CB credential as the profession is not licensed in
13 Virginia.

14 **REIMBURSEMENT**

15 The American Music Therapy Association now estimates that
16 approximately 20% of music therapists receive third party
17 reimbursement for the services they provide. Music therapy is
18 comparable to other allied health professions such as
19 occupational therapy, and physical therapy in that individual
20 assessments are provided for each client, service must be found
21 reasonable and necessary for the individual's illness or injury,
22 and interventions must include a goal-directed documented
23 treatment plan. Medicare since 1994 has been a reimbursable
24 service under benefits for Partial Hospitalization programs.

1 Medicaid approximately 23 states provide funding for music
2 therapy services through Medicaid Waiver programs or state
3 agency funds.

4 **FORMS OF REIMBURSEMENT**

5 Private insurance: Private insurance companies do not directly
6 reimburse for music therapy services. Again nationally 20% of
7 music therapy services received third party reimbursement.
8 Reimbursable when services are pre-approved and deemed medically
9 or behaviorally necessary to reach the individual patient's
10 goals. Other sources: State department of mental health,
11 county boards of developmental disabilities and private pay are
12 forms of reimbursement.

13 **Impact of Licensure:** Here at the Department of Health
14 Professions, some regulated professions lack a sufficient number
15 of individuals to cover their regulatory costs and this places a
16 strain on the board's cash resources.

17 **Criterion Six: Alternatives to Regulation.**

18 **Criterion Seven: Least Restrictive Regulation.**

19 Currently there are nine states that regulate music therapists.
20 Five states license music therapists, one state provides title
21 protection only, one state provides title certification, and two
22 states require registration. You can see under licensure that
23 there are 288 currently that have the CBMT certification and are
24 licensed in the 9 listed. Currently there are 11 states seeking

1 some form of legislation. And that is it, does anyone have any
2 questions.

3 Elizabeth Carter: No this is to them.

4 Laura Jackson: Okay.

5 Elizabeth Carter: You all will have a chance to speak in a
6 moment so. Jim any questions.

7 James Wells: Ms. Jackson, thank you very much, that was a
8 lot of work and a heck of a job. I'm Jim Wells, I'm the Chair
9 of the Regulatory Research Committee, this is a public hearing
10 to receive public comment, on the Board's review of whether
11 music therapy and the practice of music therapy should be
12 regulated and the degree of regulation to be imposed. The Code
13 authorizes the Board of Health Professions to advise the
14 Governor of the General Assembly and the department director on
15 matters related to the regulation of health care occupations and
16 professions. Accordingly the Board is conducting this review to
17 provide recommendations on the competency of the Virginia Music
18 Therapists to practice music therapy. At this time I will call
19 on those persons who signed up to comment. As I call your name
20 please come forward and tell us your name, where you're from and
21 after everybody has been, on the sheet has been called, I'll ask
22 for anybody or anybody may repeat, but not until everyone has
23 spoken. I'm going to fight my way through this. Nicole, is
24 there a Nicole here.

1 Nicole Drozd: Good morning members, thank you for giving
2 us the opportunity to speak in support of music therapist
3 licensure today, this means a lot to us and the work that you've
4 done already means the world to us, thank you. My name is
5 Nicole Drozd and I am a board certified music therapist, and
6 owner of Hearts of Music Therapy, I'm a member of the Virginia
7 State Task Force and President of the Virginia Music Therapy
8 Association. I live in Norfolk and I serve older adults in the
9 nursing home setting, children and teens in temporary
10 residential care, individuals in hospice and palliative care and
11 I also had the privilege of doing my internship and Master's at
12 UVA Medical Center. I got involved working with the Virginia
13 State Task Force when I was still the corresponding secretary
14 the Virginia Music Therapy Association. I chose to get involved
15 after the association received a letter on June 18th, 2017, from
16 a parent of a student who was receiving music therapy as a
17 related service as part of their IEP. She informed us that music
18 therapy services were not provided any longer at the school
19 because the Virginia Department of Education does not "regulate
20 the qualifications for music therapy providers and that there
21 are currently no licensure of registrations for music therapy in
22 Virginia". Instead the school provides these services through
23 their own music teachers and special education providers. Rather
24 than providing music therapy services as a related service as

1 part of their IEP, the students will receive MUSIC services.
2 The acronym music stands for musically based unique services
3 with individualized collaboration. According to a letter sent
4 to parents from the director of special education at Loudoun
5 County Public Schools, Dr. Jaminis [sp] the service will be
6 implemented by music teachers, special education teachers,
7 speech language therapy, occupational therapy, physical therapy,
8 behavioral specialists, resource teachers, and early childhood
9 professionals. Eventually, this is the equivalent of asking an
10 English teacher to provide speech therapy or a Phys. Ed teacher
11 to provide physical therapy. The parent in particular reached
12 out to us stated her concern that this group of professionals
13 listed in the letter do not know how to utilize music therapy
14 intervention with the program to meet her child's academic
15 goals. She also shared her fear that these providers may become
16 subjective in their practice and decide too early that her child
17 no longer qualifies for this service anymore. As a music
18 therapist and representative of the Virginia Music Therapists
19 Association this raises deep concern about client safety and
20 exploitation of services. Since this correspondence our
21 national organization of American Music Therapy Association in
22 collaboration with the task force has attempted many times to
23 educate and collaborate with Loudoun County Public Schools and
24 the Virginia Department of Education in order to ensure that

1 students still receive music therapy as a service and that
2 students are protected from potential harm of nonpotential
3 professionals of music interventions. Again, however it was
4 decided by the Virginia Department of Education in December of
5 2017 that the district could decide to provide music therapy due
6 to Virginia not having a license in our profession. This
7 response from the State has ultimately led us to request support
8 from our legislators to help us resolve this issue and reach a
9 state licensure or state regulation. While many of you already
10 know about the timeline of our communication with Loudoun County
11 Public Schools and the Virginia Department of Education, you may
12 not be aware of how many parents, music therapists, teachers and
13 other non-health professionals who have reached out to each of
14 our organizations to state their concerns about the change in
15 music therapists services in Loudoun County Public Schools and
16 some of them are here today to speak. The following are excerpts
17 of letters received through the Virginia Music Therapy
18 Association and the Task Force in which describe what has been
19 happening at Loudoun County Public Schools since music therapy
20 has been cut. Each individual has asked that their name not be
21 shared for fear of losing their job or their services. The
22 first excerpt is from a parent which I believe you have on
23 record. This county change in music therapy services has
24 impacted my son. He has always reached his IEP goals before

1 Loudoun County Public Schools cut music therapists from
2 servicing instruction. This past year and current year, he has
3 not mastered or progressed in the Math IEP goals that was
4 supported by music therapy. My son has autism. It is hard as a
5 parent when you know your child learns differently and
6 communicates differently. He is supported by different kinds of
7 professionals. This past month the Task Force received a
8 concerned email from this very same parent. She shared that she
9 recently heard that music services may be cut from her son's IEP
10 based on this data. She has been given no indication as to why
11 it came to the task force to help gain insight so that she can
12 advocate for her son's needs. She asks "can you explain how the
13 county or therapist decides to cut services, is it because a
14 child is not benefiting from it, is it because he mastered a
15 goal, is it because they don't want him to become dependent on
16 therapy, or is it because they gave up on him. I would have
17 asked the IEP team but I was so surprised that they wanted to
18 cut it. No one mentioned it during the year". Just to follow-up
19 the answer, really answer on what happened, mostly just...the
20 second excerpt is from a music therapist who was originally
21 employed by Loudoun County Public Schools. "Teachers and speech
22 therapists were told that they were supposed to sing to the
23 students as they walked down the hall and as the student sat on
24 the toilet or while doing occupational speech therapy, so that

1 they could mark that down time as integrative music time and
2 fulfill service clients on their IEP. One kindergarten student
3 with Down's Syndrome was pulled for 30 minutes each week to
4 watch YouTube videos and answer questions about them and the
5 supervisors often wrote integrative music on paper but called it
6 music therapy verbally to the staff. The final excerpt is from
7 a music teacher who still teaches at Loudoun County Public
8 Schools. The music teacher music services are administered and
9 the progress is tracked by members of the IEP team. I, or anyone
10 else on the team who have music therapy experience or
11 certification or training currently I'm the only experienced
12 music educator, or practicing musician on the team and in this
13 particular incident, the IEP services are to be administered by
14 the case manager and related service providers with data
15 collected and tracked to determine if the student showed
16 progress. I have been asked as a consultant for recommending
17 music activities that may be appropriate for working toward the
18 academic goal. My role is strictly as a consultant to the IEP
19 team. My issue in this task is that everything I read in
20 academic periodicals, to research publications, reinforcing the
21 structure, music therapists is an integral part of the team,
22 working collaboratively to meet the student's needs towards
23 showing progress in their academic goals. And invite special,
24 by a special education administrator "music therapy services

1 will be delivered using a collaborative team approach, using
2 musically based strategies toward student learning and IEP
3 goals. A shift is occurring because credentials are not
4 recognized in Virginia and districts can determine how services
5 will be provided. Music therapy services therapy should not be
6 removed because staff are not therapists, but due to the student
7 no longer requiring the service". This teacher continues on to
8 say, I'm aware that the Virginia Department of Education does
9 not regulate music therapy services, I guess I'm having
10 difficulty in understanding the stay of Virginia's definition of
11 music therapy as related service and how this group is choosing
12 to implement IEP services. In closing, music therapists are not
13 the only ones concerned about not having a license in the state.
14 Clients, parents, teachers and other allied health professionals
15 are concerned that without a regulated license for music
16 therapists, possible harm could be done to those receiving music
17 interventions. We are here today to protect our title and our
18 scope of music therapy so that we can protect our clients and
19 their families from harm. Thank you for the opportunity to
20 provide my comments and I will answer any questions you have.

21 John Salay: Thank you for that, I was just wondering are
22 you hearing anything from the other numerous school districts
23 besides Loudoun County.

1 Nicole Drozd: From the standpoint of the Virginia Music
2 Therapy Association, I know there have been one or two, or
3 schools looking for music therapists, but we haven't heard any,
4 from anybody picking, following through with those schools and
5 we haven't heard anything else, and that might be a question for
6 our Task Force Chairman, Tracy since she handles a lot of the
7 emails and phone calls that come in. Tracy do you know, have
8 you heard of any.

9 Tracy Bowdish: Am I allowed to answer that.

10 John Salay: Sure.

11 Tracy Bowdish: I haven't heard any, I think there was one
12 incident in Northern Virginia, but that was before I assumed the
13 position as Co-Chair, so I could check with our national team
14 and see if there have been other incidents, and follow-up on
15 that.

16 Jim Wells: I guess maybe my thought of course to that
17 would be obviously their concern is Loudoun County, but are
18 there other counties who utilize music therapists and music
19 therapy or was Loudoun County the only one that was sort of
20 officially using them.

21 Tracy Bowdish: So there are definitely other school
22 districts who use music therapists and employ them, but Loudoun
23 County was the one where we had a great concern for because they
24 had actually cut the service and they were trying to create

1 something that fulfilled IEP goals for students that really
2 don't fulfill IEP goals given what we have been hearing, so to
3 answer your question, we know Loudoun County Public Schools is
4 like the big one, and we know of the one in Northern Virginia as
5 well, as far as other districts we haven't been hearing anything
6 recently in the State. Now, as far as harm in other places we
7 definitely heard about that, and I've seen some of that as well
8 from other practitioners coming in, who don't always know what
9 they're doing with music as an intervention, that we can speak
10 about as well and, we will be speaking about it. [1:41:22) Thank
11 you.

12 Tom Sweitzer: We also, at our center.

13 Elizabeth Carter: Who are you please.

14 Tom Sweitzer: I'm Tom Sweitzer, from Loudoun County,
15 Virginia. I run a center called A Place To Be, in Loudoun
16 County. I think a lot of our clients come from Fairfax County
17 and we have clients with us now, Fairfax has also taken away
18 music therapy in the last 3 years and we clients who come to us
19 with, parents and families that have been upset that it is no
20 longer available. That's the only other county we are, Fauquier
21 County and Prince William and Prince George's County as well,
22 but Fairfax definitely. I don't know if that's just in specific
23 schools in Fairfax because I think they're a huge county as well

1 and I think there are still some school left in Fairfax that do
2 offer it.

3 Jim Wells: Thank you, is that it. Okay Thank you. Tracy
4 uh.

5 Tracy Bowdish: Thank you committee members, my name is
6 Tracy Bowdish and I am a board certified music therapist. I
7 work in Sentara Neurology Specialists in Norfolk and I also Co-
8 Chair the Music Therapy Task Force along with Shelby Reynolds.
9 Shelby attended the last meeting last month. I'd like to speak
10 to you briefly today from three different perspectives. The
11 first is personally as a Virginia resident, the second is as a
12 clinician and the third is as Task Force Co-Chair. So, on a
13 personal note, I group up in a small town in the rural Midwest.
14 I'm totally blind. I went to a public school, very small town
15 and so I received needed services through an IEP. Not music
16 therapy but Braille, literacy, orientation and mobility. I was
17 really fortunate to have people who advocated for me so that I
18 could receive the most appropriate services to help me thrive
19 from the most qualified individuals. No one tried to cheapen my
20 education. Had they done so, I probably wouldn't be here today.
21 What Nicole described is really the equivalent of someone
22 telling me that a physical therapist was going to work me on
23 white cane news to navigate busy streets instead of a certified
24 orientation and mobility specialist. So, in Loudoun County and

1 as Tom mentioned, even in Fairfax, students no longer have
2 access to music therapy that previously helped them thrive.
3 This is why I'm advocating personally for students in Virginia
4 and it's also why at this time we chose to pursue state
5 licensure because we had situations where students were no
6 longer being, not only being working with qualified music
7 therapists but they were also renaming the service and trying to
8 use that to fill a void on the IEP. As a clinician, my clinical
9 work, as part of my work, I treat patients with strokes,
10 dementia, mild cognitive impairment, Parkinson's disease,
11 traumatic brain injuries and multiple sclerosis. I address goal
12 areas including, but not limited to date, gross and fine motor
13 skills, attention, memory, executive functions, and speech and
14 language. I work on a multi-disciplinary team that includes
15 neurologists, APCs, neuropsychologists, an LCSW as well as
16 physical, occupational and speech language pathologists. To
17 address criteria 2 as a board certified music therapist, my
18 specialized skills and training allow me to use music as a tool
19 to facilitate functional, non-musical outcomes for my patients.
20 So I'd just like to give a couple of examples of that. For
21 example, I use rhythm and other musical elements to provide feed
22 forward queing to improve motor timing resulting in more
23 optimized motor planning and most importantly in improved
24 functional movement for my patients. I can actually lecture

1 about auditory motor synchronization for hours, so if you find
2 that exciting, get with me afterwards, but it is a really great
3 mix of music, science and clinical skills. One other example, I
4 also manipulate musical elements such as rhythm, harmony and
5 melody to facilitate the practice of different types of
6 attention by both changing the task level difficulty and the
7 response demand utilizing multimodal musical stimuli. So, you
8 see, in music therapy, music is not just a motivational tool for
9 patients. Instead, we are trained in our skill set to use
10 musical mechanisms to drive meaningful functional outcomes for
11 our patients. As a side note, the American Congress of
12 Rehabilitation Medicine has several special interest groups and
13 one of those groups does include the Arts and Neuroscience
14 Special Interest Group and it is chaired by a music therapist.
15 Alright, from the Task Force, I would like to conclude with
16 three brief points, the first point is addressing the end of
17 Criteria 5 and we realize that we are a small profession and we
18 have found ways to offer cost effective regulation in other
19 states by creating an advisory board, an advisory committee
20 under existing board structure which you are already aware of
21 and I know in those states those advisory committees do
22 teleconference in order to minimize expenses. We do ask that
23 should you ultimately deem licensure is needed in Virginia that
24 you would respectfully consider the possibility of placing us an

1 advisory committee under an existing board. For example, as you
2 already know Oklahoma houses music therapy as an advisory
3 committee under the Board of Medicines. Second, to address the
4 end of Criteria 4, we do want to emphasize that we are in no
5 way, no way wish to restrict the use of music by other
6 professionals. In fact, if you look at the exemption language
7 that was proposed in our original licensure bill before all of
8 the amendments it was a specific example of the protection for
9 those other professions and it's a result of successful
10 communications with those professions to ensure that their
11 practices do not present, that their practices are not
12 preventing a restriction of the use of music as long as they are
13 operating and working within their scope of practices. We
14 actually had language in the bill to specify that. And, then
15 finally, just on behalf of the Task Force and on behalf of the
16 Board of Certified Music Therapists across the State, we just
17 cannot thank you enough. We know that this is a shorter timeline
18 to complete the study which is taxing on all of you and evident
19 from the work study draft, that you all have done an incredible
20 amount of work and we just want to thank you, no matter, no
21 matter what you ultimately decide, just the time that you are
22 taking for our profession, is very meaningful to use and to our
23 patients and clients. I welcome any questions you have.

24 Jim Wells: That's all. Thank you.

1 Tracy Bowdish: Thanks for saving them for Nicole.

2 Jim Wells: Okay, Taylor Farland.

3 Taylor Farland: Good morning, my name is Taylor Farland
4 and I'm a music therapy intern at Sentara Neurology Specialists
5 and the Children's Hospital of the Kings Daughters in Norfolk,
6 Virginia. I want to thank you for allowing me to speak in
7 support of licensure for music therapists in Virginia. This is
8 a topic that is increasingly important to me, as I have almost
9 completed my clinical hours and soon I will be taking my
10 certification exam to become a board certified music therapist.
11 Now that I'm coming into the end of my internship, finally, I am
12 naturally beginning to look for a job. One of the factors that
13 is influencing that search is my desire to work in a state that
14 cares about protecting patients like I have been trained to do.
15 I grew up in Virginia and left the state to do my music therapy
16 coursework at the University of Evansville, in Evansville,
17 Indiana and I was so excited to be able to come back to the
18 state to complete my internship and to work with such excellent
19 clinicians as I have been privileged to do. It has been me an
20 opportunity to give to the community that has built me. Now
21 that I'm looking for a position, I am looking for jobs in the
22 state to stay in the area that I love, one of the jobs though
23 that comes up during the search is for a volunteer music
24 therapist and the description of the position, they are asking

1 for a volunteer to help trigger memories and emotions, provide
2 social interactions and influence breathing for patients in
3 hospice. All that is required is volunteer training and a TB
4 test. This stunned me. Not because I believe that it is outside
5 of the ability of music therapy, but because it is asking for a
6 volunteer to do things that I have worked for through years of
7 education and months of supervised hands on training and I can't
8 imagine going to work with those patients without the training
9 that I am still going through in my last month and through my
10 exam. As a music therapy intern I observed and learned and had
11 experiences that I know will make me a better and more effective
12 clinician in the future and I like so many other interns that I
13 know in this state and in others, we cannot imagine working with
14 patients without the ability to have those experiences and make
15 those learning connections. Every patient, client, resident,
16 student deserves to know that the person that is working with
17 them is the person who is best equipped to achieve their
18 therapeutic goals. Thank you for your time and your attention
19 to this study and it really does mean so much to us.

20 Louis Jones: In your internship you are interfacing with
21 patients I assume.

22 Taylor Farland: Uh huh.

1 Louis Jones: And, is there a supervisor with you when you
2 are doing that or just something that you are doing separate and
3 apart.

4 Taylor Farland: Yeah, so, I've been lucky that my
5 internship is split between two hospitals, so I'm working with
6 Tracy at Sentara Neurology and it's a little bit different in
7 both places, so for both places I started out with complete
8 supervision and there is, it's hands on, it's observing first
9 and making sure, learning, you know style and understand the
10 patient and the population and the specific needs of people that
11 I'm working with, and it gradually you know, baby steps into,
12 into more and more work, where, for instance, now coming into my
13 last month, while I'm doing a lot of the interacting with the
14 clients, Tracy is there and making sure, she is still the
15 supervisor and making sure the patients are getting the optimal
16 level of services. Does that answer your question.

17 Louis Jones: Yes.

18 Taylor Farland: Good.

19 Louis Jones: Thank you.

20 John Salay: So I saw standards, is there certain hours.

21 Taylor Farland: It's 1,200 hours.

22 John Salay: 1,200 hours, so that, give me an idea like for
23 social work it would be 2 to 4 years to complete, you know
24 thousands of hours, and 100 of that is direct time with your

1 supervisor behind closed doors supervision, so how much of it is
2 actual practice and how much of it is actual supervision as
3 opposed to...

4 Taylor Farland: Yeah, so part of it there's an amount
5 that's done, I know we've got several professors who can correct
6 me if I'm wrong, but, there is a portion of it that you do
7 during your coursework, through practicum, but the bulk of it is
8 the section that I'm in now with my internship where I have now
9 completed all of my coursework through my university and I think
10 I am at 1,020 hours that I have now been working on, roughly it
11 is about 6 months full time that I have been working for my
12 internship.

13 John Salay: Do you get your degree after that or.

14 Taylor Farland: Yes.

15 John Salay: Okay.

16 Taylor Farland: So, I'm while my coursework is completed,
17 I do not get, I'm not graduated, I'm not done with the music
18 therapy program to receive a Bachelor's in Music Therapy until I
19 have completed all of my clinical hours.

20 James Wells: Is that it. Thank you.

21 Louis Jones: How many schools have this program.

22 Taylor Farland: I think it's about 80 that have the AMTA
23 degreeable certification or whatever but that, governing and so

1 there is two in Virginia and they are kind of all spread out
2 across the country.

3 Louis Jones: Now in the program that you've taken, I guess
4 at the, you were at Evansville you said.

5 Taylor Farland: Uh huh.

6 Louis Jones: I'm very familiar with that.

7 Taylor Farland: Oh really.

8 Louis Jones: But, how many students were in the program.

9 Taylor Farland: Hum, I think there were about, I want to
10 say 20 who graduated with me and probably maybe a little bit
11 more in other years, it just kind of depends on the year. I
12 don't know exactly the number that was in our program.

13 Louis Jones: Thank you.

14 Taylor Farland: Uh huh.

15 Jim Wells: Yes sir.

16 Tony Meadows: I'm Tony Meadows, I direct the music therapy
17 program at Shenandoah University, I just had a couple of points
18 to clear up academically. So students, that is correct,
19 students complete 1,200 hours of clinical practice, all 1,200
20 hours are supervised. Students receive an internship and
21 practicum placements weekly, supervision, practicum is weekly,
22 onsite clinical and academic supervision and an internship is
23 ongoing weekly, clinical supervision and academic supervision
24 varies from university to university from 2 hours weekly to

1 periodic check-ins depending on the nature of the internship.
2 The internship itself, the guideline is roughly 50/50, so at
3 least 50% of the students time is direct clinical experience,
4 and the rest is documentation, case meetings, supervision and
5 other related kinds of experiences that are directly related to
6 the internship. What we are talking about now in the later
7 stage of an internship is, of course internship as a kind of a
8 process in which the student learns to be independent as a
9 professional and begins with closely supervised clinical work
10 and what ends with what we would call independently supervised
11 clinical work where the student has their own caseload but is
12 monitored very carefully by the music therapist. So there is a
13 whole, there is a process moving from strongly supervised,
14 strongly monitored, though to independent professional practice.

15 Louis Jones: May I ask another question. The educational
16 program at these colleges, are they all Bachelor's degrees or
17 what are they.

18 Tony Meadows: The minimum entry requirement for music
19 therapy is a Bachelor's degree. We have Bachelor's and Master's
20 equivalency, a Master's and PhD training programs throughout the
21 country. There are 86 currently accredited music therapy
22 programs but that is growing every year.

23 John Salay: In 6 months how are they able to go through
24 the full transition of music therapy treatment. I know for a

1 lot of internships you want the student to be exposed to the
2 beginning phase and the developmental phases and transition to
3 some level of care or is 6 months how long music therapy
4 treatment lasts.

5 Tony Meadows: It's hard for me to answer that question in
6 one way because clinical practice is so varied. So in a
7 children's hospital music therapy student or a music therapist
8 may see a child once for procedural support or for the full 6
9 months if they are receiving cancer care. So the length of
10 treatment varies considerably from place to place. The design
11 of an internship is that students have experience with the
12 assessment phase with the treatment and documentation phase and
13 with the termination phase of treatment. And within that 6
14 month experience they are going to have varying degrees of those
15 three kinds of experiences.

16 John Salay: Maybe just not with the same client.

17 Tony Meadows: Not at the same time, yeah, they are not
18 tracking, in typical internship they will, they may not track
19 the same patients throughout the same 6 months, just depends on
20 the internships that they are working in.

21 Taylor Farland: I don't know if it helps clarify, so for
22 my internship for example, I work for both a children's hospital
23 and for Neurology Specialists and the children's hospital I
24 might see a patient a couple of times because of discharge and

1 you just never know how long they are going to be there, but
2 with neurology some of the patients, the patients have been
3 there before, I, I was there, but we have also had new referrals
4 so I have seen both sides you know, like he was saying the whole
5 process, it just really depends on how, on the site and what it
6 looks like.

7 Elizabeth Carter: I'm putting you on the spot. The
8 state's role in regulating any profession is to establish what
9 minimal competency is, so that safe practice that a patient will
10 be encountering. Is a Bachelor level minimal competency and if
11 so, what are we gaining by going to Master's. I'm sorry.

12 Tony Meadows: The, our professional association has deemed
13 the Bachelor's level entry as the minimal competency to practice
14 as a music therapist. The Master's level provides what AMTA
15 calls advanced competencies that improve upon a person's
16 capacity to practice with greater depth. PhD trainings
17 typically have two focus areas, one is the training of music
18 therapy educators and the second is to develop researchers.

19 John Salay: I was looking through some of the standards
20 and curriculum for the Bachelor's level, how much exposure do
21 you have with neuro anatomy and neurology and brain function.

22 Tony Meadows: There are a number of ways students have
23 those learning experiences. Psychology of music courses that
24 are specifically taught by music therapists, anatomy and

1 physiology courses, yeah is a requirement of a training program
2 as well as course specific as Tracy was describing earlier,
3 course specific and orientations specific trainings, for example
4 neurologic music therapy is a different approach to music
5 therapy practice and that includes a lot of this kind of work.

6 Tracy Bowdish: Could I answer as well. A lot of where I
7 went to school it was, like integrated into my music therapy
8 courses but I also had to take human functional anatomy to
9 dissect things, but in addition that is also why we have our 100
10 hours of continuing education. Because I was in a neuro setting
11 those are things that I seek out in order to ensure that I am
12 practicing evidence based practice and staying abreast of the
13 things that are researched after graduation.

14 James Wells: Any questions.

15 Louis Jones: All of you who identify and work and
16 mentioned Sentara in Norfolk are the other possibilities in the
17 state.

18 Taylor Farland: You just happen to catch the first people
19 that came in carpooled together. So, you'll get some more
20 variety. Unfortunately it was just we all came in at once.
21 There are some music therapists in Chippenham, working in
22 pediatrics, and all the Bon Secours Hospitals, so St. Mary's,
23 I'm totally blanking on the rest of them, but we do have music
24 therapists. Yes VCU Medical Center we have multiple music

1 therapists working there as well. You'll get to the Richmond
2 folks after the Hampton Roads folks.

3 John Salay: Are the residential settings still doing it, I
4 was a commission in residential for years, I'm not sure if you
5 still have.

6 Taylor Farland: Residential behavioral health facilities.

7 John Salay: Yes.

8 Taylor Farland: Yes, that was actually my first position.

9 John Salay: Okay.

10 Patricia Winters: Hi I'm Trish Winters, I'm down at
11 Radford University, I was going to say that Crillerion Hospital
12 has music therapists for their hospice and their adolescent
13 psychiatric facility.

14 Tom Switzer: An outside of Washington, D.C. we supply all
15 the NOVA Hospitals with music therapy as well as children in
16 Washington, D.C. Which I know D.C. is not much...

17 James Wells: Okay, Becky Watson.

18 Becky Watson: Good morning, committee members. Thank you
19 for the opportunity to speak this morning for music therapy
20 licensure in Virginia. My name is Becky Watson, a board
21 certified music therapist and owner of Music For Wellness and a
22 retired Navy Supply Corp. Captain with 25 years of Naval
23 service. I'm smiling from ear to ear because I love what I do
24 now. I live in Norfolk, Virginia and I have my own private

1 practice, Music For Wellness. My company serves older adults
2 with dementia and their care partners with cognitive impairments
3 and also mental health facilities including post traumatic
4 stress, traumatic brain injury in Southern Southeast Virginia,
5 using evidence based music therapy services. I would like to
6 provide one example of how music can be harmful when a
7 nonqualified provider attempts to offer music therapy services
8 to the veteran population. As you are all well aware, our
9 veteran population in the Commonwealth of Virginia is about 10%.
10 The third highest capita in the United States. Many of my male
11 clients in retirement communities are veterans and many have
12 dementia or PTSD. Music therapy interventions improve the
13 overall physical and mental wellbeing of my clients and promote
14 social interaction, improved mood and decreased perception of
15 pain and provide a sense of control. It is important to note
16 that my clients diagnosis require a trained and credentialed
17 professional that knows how to assess, develop and conduct
18 clinical music therapy interventions to make a positive impact
19 with their illnesses. The use of music can potentially be
20 harmful to these vulnerable populations if not directed and
21 implemented by a board certified music therapist professional
22 who understands the clinical applications and evidence related
23 to physical and emotional responses to music. For example, the
24 inappropriate use of music can elicit negative quiet behaviors

1 such as physical aggression, emotional distress, disorientation
2 and combativeness. Music is made of many elements, one being
3 rhythm. There are many benefits of using rhythm as a
4 therapeutic intervention specifically using drumming, however,
5 when drumming with veterans or individuals with PTSD, the loud,
6 abrupt, steady beat, and noise level can trigger memories of
7 past trauma. Music also has the potential to be harmful by
8 causing extreme anger and irritability with others inducing
9 physical violence and depression as the selected music may be
10 conducted with or a reminder of a traumatic event. It is also
11 important to note that the American Music Therapy Association is
12 thrilled to announce a newly published qualification standard
13 for the general schedule of recreational and creative arts
14 therapist for the Veteran Health Administration. As of June 9th,
15 2019, all new music therapy hires for the Veteran's
16 Administration must be a board certified music therapist
17 approved by the certification board of music therapists.
18 Specific knowledge, skills and abilities have been defined for
19 GS7-GS14. As noted music has the potential to be harmful and
20 leave a veteran in distress if a board certified music therapist
21 is not there to help process these emotions, feelings, and
22 adverse reactions. The creation of a music therapy license in
23 Virginia would ensure these individuals providing music therapy
24 have an education, clinical training and board certification

1 required of the profession, providing that public protection
2 needed for our residents of our state. Thank you for the
3 opportunity to provide comments and I welcome any questions that
4 you have at this time.

5 John Salay: It was stated earlier or suggested that
6 regulation advisory also under the Board of Medicine.

7 Becky Watson: I'm not sure I understood the question.

8 John Salay:

9 Elizabeth Carter: ...the bureaucratic way is easier. No he
10 was asking would it satisfy you to be under an advisory board
11 under the Board of Medicine, Virginia Medicine Therapy, is that
12 a consensus among all of the folks, not only here, but.

13 Becky Watson: Yes.

14 James Wells: Just walk me back on the Veteran's
15 Administration, that came about in June, it requires a board
16 certified and take me back, board certification is by the.

17 Becky Watson: National level.

18 James Wells: Okay.

19 Becky Watson: ...certification.

20 James Wells: Take me one step back further a Bachelor's is
21 the minimum requirement to obtain that certification.

22 Becky Watson: Correct.

23 James Wells: Alright thank you.

1 Elizabeth Carter: Are you or anyone else here aware of any
2 employers, hospitals, health care systems, heard on the
3 educational issues of hiring people who call themselves music
4 therapists but do not have certification. Is that going on
5 anywhere that you know of.

6 Kerry Cassie Byers: I was actually going to address that..

7 Elizabeth Carter: Okay, I'll let you do that when
8 you...thank you.

9 James Wells: Cassie Byers.

10 Elizabeth Carter: That was she.

11 James Wells: Do we run a good show or what.

12 Kerry Cassie Byers: It's all coming into place. Thank you
13 so much for giving us this time to speak so much to all of us in
14 our profession, and thank you for letting us speak in support of
15 music therapy licensure. So, my name is Cassandra Byers, I am a
16 board certified music therapist, I actually completed my
17 training in 2016 at Eastern Michigan University and I am
18 currently working for my Master's in music therapy at Shenandoah
19 Conservatory with Dr. Meadows who spoke earlier. I work full
20 time in hospice care. Sorry, I should just read what I wrote.
21 I work full time in hospital care, most often serving
22 individuals with a terminal Alzheimer's diagnosis, as well as
23 their families who are preparing for the loss of their loved
24 one. In fact, my office is literally across the street. It is

1 quite literally across Broad Street and I have served clients in
2 more than a dozen senior living communities within 10 miles of
3 this room as well as dozens more in surrounding communities such
4 as Mechanicsville, Chesterfield County and Fredericksburg
5 County. The issue we are here to discuss today is particularly
6 pertinent with older adults and particularly urgent as you were
7 saying there are people being hired as music therapists who do
8 not meet our competencies. I do think some of that is a lack of
9 understanding sort of, as was talked about earlier with
10 volunteer music therapists and I'm happy to provide direct
11 examples now or after I read what I wrote.

12 Elizabeth Cater: Whichever you are more comfortable with.

13 Kerry Cassie Byers: Great, so I'll just give them now, for
14 example I reached out to Hospice of Virginia, because I
15 specifically get Indeed alerts to my phone although I have no
16 intention of leaving my position to filter out these requests
17 for untrained music therapists. Hospice of Virginia had
18 wonderful intentions, they wanted a music therapist, they
19 understood the power of music and it said plus be able to read
20 music. We would love if you can play an instrument. So I just
21 very kindly reached out to them and informed them of our
22 qualifications, our scope of practice and said I'd love to
23 schedule a meeting to let you know about all the work I'm doing
24 as a board certified music therapist at a, at a competing

1 hospice but really that my intentions are to ensure the safety
2 of our patients. As we know the power of music can go both ways.
3 It can be incredibly powerful in a positive way and it can cause
4 harm as well. My other examples are written down. So this is
5 particularly pertinent and urgent issue with our older adults.
6 I've witnessed firsthand the rampant incident of lay musicians
7 and music enthusiasts in the community calling themselves music
8 therapists and claiming to work within our scope of practice
9 with no regard for patient's musical preferences, culture,
10 religion or medical or behavioral needs. Often I hear these
11 individuals playing recorded music intended for small children,
12 music which is too fast or too loud. I often only see them
13 engaging the highest functioning residents or only utilizing
14 happy music. Not only does this last example insinuate that our
15 seniors are not capable of or should not feel complex or
16 negative emotions, these are all opportunities for causing
17 unnecessary harm to our patients. Just this past Friday, one of
18 our nurse's aides who is incredibly supportive of my program
19 told me that one of the residents was at breakfast that morning,
20 a new staff member observed being announced, it's time for music
21 therapy and began to play just the fastest most deafening loud
22 70's disco music, while shouting the lyrics in their faces
23 trying to get them to sing along. I don't know why she needed
24 them to sing along, they were trying to eat breakfast. As you

1 can imagine this was not conducive to a calm breakfast
2 consumption. Many of the residents became severely agitated and
3 really causing the opposite effect the staff intended, they were
4 so taken by how much it was calming the residents down. So, all
5 these intentions were genuine in caring for their residents and
6 from seeing the positive benefits such as with me, this incident
7 demonstrates the need for education and I will be providing them
8 service next week. But in hospice care families are not trained
9 or licensed in the death of their loved one. They expect the
10 individuals and trusted them with the care of themselves and
11 their loved ones during the end of live process to have a formal
12 education recognized by a regulatory board. This population is
13 so highly vulnerable. They're experiencing the loss of a mother,
14 father, husband, a wife, a sister or a brother and I have held
15 more crying adults in my arms three times my age than I can
16 count. They're relying on us to be the expert in the room,
17 competent at the goal and knowledgeable about this inevitable
18 but nonetheless unimaginable time in their life. That being
19 said I wanted to share a story from one of my interns, she is
20 finishing her 4 years of classroom education and 6 months of
21 full time unpaid internship on Wednesday. Just last week she
22 had the opportunity to conduct her first solo transitional
23 visit. This is when a patient is actively dying. We received a
24 referral for music therapy because the patient came to us

1 already on transition, he had declined rapidly and his wife of
2 over 60 years was sitting vigil in his room for days. She
3 needed some emotional support. When we debriefed this session
4 in supervision immediately following, she expressed that if she
5 had been given this task before her internship she would have
6 been terrified. She had no idea what to do. After all, none of
7 us routinely sit vigil with dying people. That's not a very
8 common occurrence. For 5 months prior she had attended these
9 vigils with me to take notes on how to facilitate the dying
10 process through music, how to uncover the most relevant music to
11 the patient and their family and to facilitate a meaningful end
12 of life process where words do not remain unsaid, and families
13 are able to come together to celebrate their time with this
14 person. In this session she conducted there were tears but also
15 laughter, joyful songs and songs which resonated the wife's
16 profound sense of loss, she sang to him, she caressed his hand
17 and she kissed him and they had this experience together. All
18 of this was guided by my interns clinical knowledge. The patient
19 himself remained calm and was constantly monitored should the
20 music cause any pain or distress and the wife was able to grieve
21 and explore these complex emotions in a safe environment. I
22 imagine that if this was your loved one you would only want to
23 allow family or a trained and competent professional in this
24 sacred space as you say goodbye. A qualified trained

1 professional with the skills to guide you through this journey
2 who will also ensure the safety and comfort of you and your
3 loved one as you transition from this life. So thank you so
4 much for allowing me to provide these comments, which were also
5 kind of an answer to a question, but I am happy to field more
6 questions.

7 John Salay: I'm not sure if you know the answer but I'm
8 gonna put it out there, so from a title protection standpoint in
9 other states are related to music therapy does this start to
10 make a difference or you don't have, indeed it is coming up all
11 the time to therapy jobs.

12 Kerry Cassie Byers: I think it helps with the education
13 and perhaps Tracy will be able to give you some harder numbers.
14 It certainly helps with the education aspect because as soon as
15 I am informed, these places, again very kindly, you know I would
16 like to create more music therapy positions, I just want to make
17 sure you are hiring the people that are capable of what you are
18 asking for. It has helped significantly to provide that
19 information and inform them that they need to get the education,
20 pass the test and I think a license would definitely ensure more
21 credibility.

22 Tracy Bowdish: I do also know that, and I don't know the
23 specifics states, but I do know that it has increased music
24 therapy that is stated funded programs because of what was

1 discussed earlier music therapy not being employed because they
2 are not regulated state, so it has actually increased access of
3 music therapy services for states.

4 Kerry Cassie Byers: There have also been a number of
5 positions unfortunately the music therapist who have experienced
6 that couldn't be here today where she just so happened to have a
7 teaching license from a previous life and career and she now has
8 a professional counseling license and her job when she left was
9 actually never filled again because none of the rest of the
10 music therapists were not going to take out, you know get
11 another degree in counseling or obtain a teaching license, but
12 if she had had a specific music therapy license that would have
13 been a requirement, so often times these positions are just
14 being lost because the one person who happened to hold those
15 credentials left for another position.

16 John Salay: The credentialing, is it similar to the..

17 Elizabeth Carter: ...it's not.

18 John Salay: So the person that you are talking about the
19 LPC they didn't use that as a basis for their LPC requirements.
20 I was wondering if there is a lot of LPCs out there that can get
21 this license.

22 Elizabeth Carter: We would research that. The question
23 he's got is the difference between a licensed professional
24 counselor, educational, they are all licensed.

1 Tracy Bowdish: Yes.

2 Elizabeth Carter: I think it's got more standardized with
3 K Craft. If you don't know what job you have to further, but
4 that is what he is referring to, you know and we are not asking
5 you to distinguish yourself from licensed professional
6 counselors.

7 Tracy Bowdish: Uh huh. Yeah. They pretty much just told
8 her we want someone with any type of license so that we can make
9 sure that you are an ethical person, you're not allowed to
10 practice anymore. So it was just the perfect storm that she
11 wound up fitting those requirements and of course I'm getting my
12 Master's Degree in music therapy I'm not going to go get a
13 teaching license as well.

14 Yetty Shobo: Thank you for your presentation. You may
15 assess the patient, you are looking at the culture, and
16 experience everything with the family, do you have multiple
17 instruments you play, do you have multiple recorded, like what
18 does the real process look like, the real question I have is
19 since you are quite trained in this already, does what you are
20 paid correspond to what we see in other states and what impact
21 does that have on the salary in the state here. Do you have any
22 idea of what the impact of licensure or registration or
23 application what they have as far as the salary or payment,
24 etc., Do you have any idea.

1 Kerry Cassie Byers: Yeah I'm happy to turn to Tracy for
2 the second but happy to answer the first, as she is the numbers
3 keeper. So yes, and Dr. Meadows is welcome to speak to some of
4 the culture humility training, this has been a huge topic of
5 conversation as a profession which is predominantly undertaken
6 by white females, we have huge cultural humility training. I
7 personally was required to take a bunch of intercultural
8 communications courses in my degree. I didn't get to chose my
9 general education courses, they made me take specific ones and
10 we are required in our AMTA competencies to be proficient and
11 that is expanded upon in the document in voice, so singing,
12 guitar and piano. Many of us picked up a primary instrument
13 when we were younger and I just also happen to play violin which
14 we are also trained how to use clinically, perhaps someone who
15 plays trombone, there is not as many applications with that. So
16 we are all, we do all meet musical standards and are taught many
17 different styles of playing, music from many different cultures
18 and countries so that we can meet those needs and where to find
19 those resources when we are you know totally out of our element
20 for whatever reason. So we are taking into consideration
21 someone's culture, someone's religion and familiarizing ourself
22 with all of those things, so I know Baptist music, I know Jewish
23 music, I know music that is more relevant to Presbyterian,
24 modern worship music but also I'm from Detroit so I know a lot

1 of Motown, and that is maybe not as relevant down here where
2 it's more Patsy Cline, so we are taking all of those things into
3 consideration especially when you have a patients like mine who
4 have severe cognitive impairment such as dementia and maybe
5 couldn't tell me those things on their own. So Tracy do you
6 want to talk about salaries.

7 Tracy Bowdish: I can try. The only data that we have with
8 salaries is like all over the Mid Atlantic region, versus
9 nationally and that is also certain factors for example, New
10 York, they charge more than what they would, but as far as
11 salaries and fees for service increasing incredibly, like
12 license and title protection I don't believe we've seen that in
13 other states and I will research it and get back, just so that I
14 don't give you misinformation. But we haven't seen that because
15 we really do try to keep the cost low so if you are interested
16 in what other states charge for the licensing fees, we have that
17 information if you'd like that, but you always seem one step
18 ahead of us and you might have that already. But because we are
19 trying to keep costs low, that it doesn't trickle over to
20 increased fees which would create barriers for patients.

21 James Wells: Thank you.

22 Tracy Bowdish: Are there any other questions.

23 James Wells: Thank you. Dr. Meadows.

1 Anthony Meadows: Thank you all again for giving me the
2 opportunity to speak to you today and thank you again for all of
3 your work. Again, my name is Tony Meadows, I direct the music
4 therapy program at Shenandoah University where we have both
5 undergraduate and graduate programs, we serve just under 100
6 music therapy students and so this will be our 45th year as a
7 program. In our graduate programs we place a strong emphasis on
8 research and this includes a focus on how music can be helpful
9 and also harmful to a client's physical and mental wellbeing.
10 We are currently in the first stage of a research project that
11 directly addresses how music therapy can be harmful to clients.
12 I'd like to share some of our preliminary findings from this
13 study which is led by one of our graduate students, Valerie
14 Jackson. In this study Miss Jackson interviewed experienced
15 music therapists and asked them about times in their own
16 clinical work where they thought something potentially harmful
17 happened. The therapists she interviewed had a combined 187
18 years of clinical experience with an average of 15.6 years.
19 These music therapists described a total of 47 clinical events
20 that they defined as either harmful, potentially harmful to the
21 clients that they worked with. Two categories stand out. The
22 first category is music experiences that are potentially
23 physiologically harmful. In this category where experiences as
24 described by music therapists in which their patients responded

1 physiologically in unanticipated ways to music. For example, an
2 ICU patient receiving intervention to decrease pain and anxiety
3 with the therapist monitoring heart rate, respiration and blood
4 pressure and noticing these vital signs increasing during the
5 music intervention rather than decreasing, with the music
6 therapist then responding immediately and carefully adapt the
7 music intervention to the patient and monitoring their
8 responsiveness to ensure that the intervention was
9 therapeutically beneficial. The second category is the
10 potential for music to be emotionally harmful to patients. In
11 this category music therapists described the ways in which
12 clients had strong unanticipated emotional responses to music.
13 For example, a patient hospitalized for cancer treatment asked a
14 music therapist for one of her favorite songs, Moon River, made
15 famous by Frank Sinatra. She started singing with the music
16 therapist right away and soon began weeping, continuing to sing
17 the song with great passion through her tears and at the end of
18 the song she shared that this was one of her wedding songs and
19 that she missed her husband who had recently passed away. This
20 kind of deeply emotional experience can be very helpful to
21 patients when handled by clinicians trained to meet the
22 psychological needs of patients, to help the patient transition,
23 so they can be prepared for their cancer treatment, and then to
24 be able to come back the next day and reconnect with the patient

1 to be able to provide the next level of support. This is what
2 we do as music therapists. These categories and these
3 experienced music therapists perspectives may additionally be
4 important for you as a committee because musicians who provide
5 music for vulnerable people without any training often start
6 with client preferred music without knowing what to do when a
7 client responds in an unexpected way. According to the music
8 therapists interviewed for this study this is potentially
9 harmful. Finally, when this group of music therapists was asked
10 about the percentage of harmful or potentially harmful events
11 they perceived in their clinical work overall, none answered
12 zero. On average these music therapists estimated that 5% or
13 less of client experiences had harmful potential. But this
14 varied widely from setting to setting with music therapists in
15 medical settings suggesting as much as 10% of their work had the
16 potential to be harmful if the clinician was not appropriately
17 trained. This kind of training in which we as educators teach
18 students how to safely use music interventions is at the core of
19 music therapy. The creation of a music therapy license in
20 Virginia is therefore essential to protect the public and
21 ensuring that music interventions are used safely with our most
22 vulnerable citizens. Thank you.

23 James Wells: Thank you. Lauren DiMayo.

1 Lauren DiMayo: Thank you for letting me come and speak to
2 you today, and I obviously speak in support of licensure. I am
3 Lauren Mayo, I have my undergraduate degree in music therapy
4 from Berkley College of music and my Master's and Doctorate from
5 Temple University in Philadelphia, I did my internship in
6 hospice in North Carolina where I lived for 19 years, so I moved
7 to Virginia to become a professor at Radford University and so I
8 moved to this beautiful state last summer for music therapy.
9 One of the things I did in my career as a clinician was I worked
10 at a hospice for 12 years and for the last 6 of those years I
11 was head of the bereavement department. One of the others things
12 I have been doing is in the last 7 years, I have been Co-Chair
13 of the ASCA which is an internship committee so we approve our
14 internships as a process and I am here to speak about that. So
15 the internship committee for AMTA approves through applications
16 for internship programs, we make recommendations for guidelines,
17 we manage the current internship program, we enforce the
18 guidelines, we mediate problems that may occur and we facilitate
19 training to be an internship. There are 179 internships across
20 the United States and five in the State of Virginia. One in
21 Salem, at the VA, one at the Blue Ridge Hospice in Winchester,
22 one in Fairfax County Public Schools, Sentara Neurological
23 Specialists, Children's Hospital of the Kings Daughters, and one
24 at Shenandoah Valley Westminster Canterbury which is a

1 retirement community. So as you all know there 1,200 clinically
2 supervised hours which was a minimum when I was an internship
3 director. Most sites were 6 months full time and I said no-no,
4 it'll be 7 here, hospice is tricky and the mountains of North
5 Carolina are tricky also, so let's spend a little bit more time
6 together so it is a minimum, and some sites are 9 months. As an
7 internship director we are in charge of facilitating an
8 agreement that creates a plan between the university and the
9 site so every intern is a little different and it has to be
10 based on our competencies which I'll get to next. My job was to
11 plan, implement and monitor programs, communicate with the
12 faculty, monitor and act upon any noncompliance issues,
13 establish policies to dismissal interns and ultimately
14 responsible for their work while they were under my watch. So
15 everything they did, everything they wrote, I had to sign off on
16 and make sure it was correct because not only was it our site,
17 and my name but these were clients that I love and adore and
18 wanted the best for. So internships are based completely around
19 the professional competencies in music therapy and there are
20 116. I printed it out and highlighted some of my favorites in
21 case you were wondering, what does Lauren love to teach in
22 internship. So there are things like music foundations, music
23 theory, music history, composing and arranging functional
24 skills, being proficient on piano, voice, guitar and percussion,

1 conducting movement to music. So for example, being able to
2 transpose several compositions, I may have one client who has a
3 very high soprano voice, I need to be able to create a song that
4 is in that key that makes her beautiful high soprano voice sound
5 good and I may see the next client who has a very low voice and
6 guess what our voices change as we age and so I need to be able
7 to play a song that makes that person specifically restful and
8 in the key that is right for them. Since I was a hospice person
9 you may be surprised to hear that often I would facilitate
10 Amazing Grace eight times a day. And every time I did it, it
11 was different. I knew I was doing my job wrong or my interns
12 weren't doing their work correctly if this sounded the same so
13 everything needed to very personally centered around what's best
14 for them to be successful. Other professional competencies
15 include clinical foundations, therapeutic applications,
16 principals and the fun thing of having a therapeutic
17 relationship. When I was an internship director, we would go
18 into people's homes which is always the safest facility so being
19 able to set boundaries and say no is an important aspect as a
20 music therapist, knowing when to disclose information and not is
21 also important. So complex issues that I can tell you don't say
22 this, but when it happens its different so being able to process
23 that with students was a core part of the supervision. We also
24 cover things within music therapy foundations of principals,

1 assessments, treatment planning, implementation, how to
2 evaluate, how to document, termination and discharge planning,
3 professional roles ethics, inner professional collaboration,
4 supervision, administration and research are all also part of
5 our 116 professional competencies. And at the end of an
6 internship, if the internship director decides that yes, which
7 is no surprise because we do a final evaluation, we do evaluate
8 them halfway through and at the end point and then they have to
9 evaluate themselves and this all goes to the academic person
10 also, so we write a letter to CMBC saying yes this person has
11 demonstrated their competency on entry level of 116 competencies
12 that is part of becoming a music therapist. Any questions.

13 Louis Jones: You say writing a letter, who are you writing
14 a letter to.

15 Lauren DiMayo: It is the certification board of music
16 therapists. The people where we take the test, so you know you
17 get 4 years education and get your internship, I write a letter
18 saying you did your internship, they get it, then you can sit
19 and take the test.

20 Louis Jones: I see, do you do that periodically throughout
21 the internship.

22 Lauren DiMayo: Only after they have completed it.

23 Louis Jones: Only after they've completed.

24 Lauren DiMayo: Yes.

1 Louis Jones: And the internship is for a number of hours
2 or a number of months or what.

3 Lauren Mayo: It is by hours, but most people look at it
4 months, so it 1,200 hours minimum total, but you can look at it
5 as 6 months full time. So in my internship students would move
6 to Asheville, North Carolina, and live there for 7 months to do
7 their internship with me and then go elsewhere or stay in the
8 area. Which is similar in Virginia also.

9 John Salay: So it's a lot like the doctor internship where
10 they get matched all across the country like social work people
11 pretty much stay, they have to stay in the states they, we have
12 a lot of people coming from across the country to a lot of
13 sites.

14 Lauren Mayo: Yes.

15 John Salay: How many internships do they sponsor.

16 Lauren Mayo: I don't understand the question.

17 John Salay: So, Kings Daughters.

18 Lauren Mayo: Yes.

19 John Salay: How many interns would they have.

20 Lauren Mayo: We regulate how many they are allowed, so for
21 one full time music therapist you can have two full time
22 interns.

23 Yetto Shobo: The pass rates for the exam and are people
24 allowed to retake.

1 Lauren Mayo: They are allowed to retake, I know Radford
2 University's pass rates are great. The pass rates across the
3 nation are like 52%, 72%.

4 John Salay: Is that a practicum test or written.

5 Lauren Mayo: It is at a computer, written. So yes, think
6 about the internship is we have to make sure that they can do
7 all these music skills. That is one of the jobs as the
8 internship director saying yes you have demonstrated competency
9 in these music areas, singing a tune, to playing all of these
10 different cultural styles, otherwise you have to stay longer or
11 go back and take some more courses.

12 Louis Jones: Is that standardized within the profession
13 for all of the certifications, schools in other words.

14 Lauren Mayo: Yes, all of the education is based on these
15 116 competencies. My classes I'm teaching at Radford I know
16 which ones are in the, my soloist, we're in the internship
17 because we have to evaluate in the midterm and final and that's
18 the list that is documented with all of them on there and you
19 are rating the intern and how they are doing. Does that answer
20 the question.

21 John Salay: Yes.

22 Elizabeth Carter: I know one of the competencies is your
23 ability to do assessments and to diagnose, and okay, that's
24 good, yeah so in terms of assessment it is based upon progress

1 of the treatment plan, and those kinds of milestones for a
2 patient.

3 Lauren Mayo: Yes, it's a complex process assessing and
4 walking into, I was at Carillion and I walk into the peds room
5 and the baby is crying and I need to figure out why so I am
6 looking at the context, I'm looking at the diagnosis, I looked
7 at before I walked into the room. I am looking at their
8 breathing rate, like the tone, you know what is mom doing to,
9 the assessment is complex which is why there are actually
10 several competencies that look at it from different points of
11 view, then what do you do and so you try something and see if
12 that works, if that is not working then we need to intervene
13 immediately.

14 Elizabeth Carter: At what point do you feel the need, if
15 you do, is there a point where you refer the patient back to say
16 a physician, I mean are there limits where you feel like here is
17 where I have to check off and hand this off to...

18 Lauren Mayo: Yes, I have, so, that's my answer, there have
19 been clients I have, I said I will refuse to come back to, one
20 because they were dealing illegal drugs in the home, one because
21 of sexual harassment that occurred to me in the house, only one
22 because a person had zero relationship to music and I asked when
23 I was doing my assessment I said why did I drive 20 minutes to
24 your home to do music therapy with you when you don't like

1 music, you don't listen to it, you never play, there is no music
2 in your house, you don't have a song list, you don't care what
3 the last sound is that you listen to when you die, what am I
4 doing here and they just said I just wanted to know what a music
5 therapist looked like and so I said...and I never came back. That
6 was a waste of my time.

7 John Malay: So it was mentioned earlier that with folks
8 with PTSD illness, I've got two questions, first is there a
9 competency for being well informed approach or does that go
10 through all the competencies and the second is it's kind of
11 related, are there competencies related to transfers and counter
12 transfers.

13 Lauren Mayo: Yes and those are the best ones. What do you
14 do when a client can't speak or answer, do you play when you
15 don't know anything about them, that's a blank slate for counter
16 transference right. Yeah we definitely go into that as related
17 to specific populations. Off the AMT website there are 38
18 different populations that we work with, of course we work with
19 a lot of different more, our competencies are not based on
20 population or theoretical how you assess complex issues. There
21 is trauma informed music therapy, articles and letters of
22 training to go to if that's that area you want to specialize in.
23 But there are scopes of practice about not providing services to
24 someone you don't know anything about. Right, so, if I don't

1 have that training I would not go to someone with PTSD for music
2 therapy until I got that education because that would be
3 unethical.

4 Louis Jones: Give me a synopsis of why you think licensure
5 would be beneficial to the public.

6 Lauren Mayo: So I have only lived in Virginia for 1 year,
7 but in my career I have met many people who said they were music
8 therapists and are not in my definition. My favorite is I was
9 at my daughter's 4 year birthday, where a man informed me that
10 he was using music therapy by drumming to people and heals them
11 with cancer and in fact in my hospice work I met a social worker
12 who was very frustrated because a 38 year old woman was dying
13 with cancer in great pain and the social worker knew that I was
14 really good at helping people with that and she refused to have
15 music therapy referral because she already worked with a music
16 therapist at her work and we came to find out that she worked
17 with this man, the drummer who said he cured cancer with
18 drumming and she paid him and it didn't work, so that was her
19 experience with music therapy.

20 James Wells: Obviously you do, your internships are very
21 focused at the site, do you feel like that covers the gamut
22 because there is a good chance that I did an internship at a
23 hospice but the position I can get is with the school system, do
24 you think that internship structure sets folks up properly.

1 Lauren Mayo: I am a little biased, I think there is a lot
2 to be said about the strength of it, no system is perfect, I'm
3 aware of our weaknesses. The strength of it is, it is based
4 around the competencies. If you are a music therapist and
5 wanted to be an internship director it would probably take you a
6 year to get through the application and be approved and there is
7 absolutely guarantee that you would be approved as we do reject
8 and deny people. So one, we have quality assurance that your
9 site be focused on these 116 professionals competencies and also
10 look at the development of learning these skills like say begin
11 with observing and at what point do you actually have any
12 leadership role, the minimum hours of being supervision of
13 formal and unformal supervision, and the thing too is that
14 debate do you teach to population or a theory and if you look at
15 the theory of assessment, treatment, and evaluation that can be
16 transferred to any population and that is what the competencies
17 are around which is why it doesn't focus on population instead
18 focuses on a more theoretical intervention and specific
19 techniques.

20 James Wells: Yes sir.

21 Anthony Meadows: Lauren has beautifully outlined the
22 national roster sites and the importance of national roster
23 sites, I'd also like the committee to know that there are also
24 university affiliated internships so there is actually two types

1 of internship sites, they seem as equivalent, but one is
2 nationally credential and the other is university managed or
3 university credentialed so at Shenandoah University we have 45
4 internship sites and these come from the gamut of school
5 settings, to mental health placements to private practice to
6 hospital to hospice and that Lauren is talking about the
7 competencies is really really important is another component
8 that we see in our students as well and that is that they tend
9 to self select because they look at a particular kind of career
10 path so those clinicians who are really interested in working
11 with children with disabilities are more likely to take an
12 internship at a site in working with children with disabilities
13 and that preps them for their professional brawl, so that while
14 it does happen that students will transfer from hospital to a
15 medical setting or hospice to even work with children, it's more
16 commonly experienced professionally that people will get a
17 longer tract and that will help them prepare the competencies
18 they want based upon the path they choose as students.

19 Lauren Di Mayo: My internship was in hospice but my job
20 was for the State of North Carolina at a residential facility
21 for adults with severe and profound developmental delays. Very
22 different populations, but because of my internship training I
23 knew how to do a research and literature review, well let me
24 read everything about this, let me understand, let me see

1 supervisions that have such a positive experience with that. I
2 wasn't starting from scratch it was just the people were
3 different. Was I as good as when I started my first day of work
4 there, as when I left 2 years later, no, you grow and get better
5 and learn things. Just to clarify the university related
6 internships have to follow the same guidelines as the ones that
7 I was talking about too. Thank you.

8 James Wells: Trish Winter.

9 Patricia Winters: Good morning, I'm Trish Winters, I'm the
10 Director of Music Therapy Program at Radford University. Thank
11 you so much for your time and your willingness to listen to our
12 statements today about support of licensure for music therapy.
13 I'm a board certified music therapist and I have been for 21
14 years, Radford University offers the Bachelor Degree in Music
15 Therapy and a Master's of Science Degree in Music Therapy. We
16 have anywhere from 55 and 60 students between our undergraduate
17 and graduate programs. My clinical background has been very
18 diverse and I have served clients across the developmental
19 continuum from very young children and early intervention,
20 children in Head Start Preschool and K-12 school based settings,
21 adults in psychiatric settings, community based programs,
22 hospitals, continuing care, to retirement care and hospice and
23 end of life care. Since 2012, I have been co-facilitating an
24 inner professional speech language pathology and speech therapy

1 clinic for young children ages 18 months to 16 years of age with
2 speech and language disorders as a results of autism spectrum
3 disorder, Down's syndrome, cerebral palsy, global developmental
4 delay, or otherwise nonspecified. The preschool language lab is
5 a continual reminder of the incredible importance of our music
6 therapy training program. The need for our students to have
7 opportunities to work with other professionals and the
8 importance of our individual scopes of practice, our work in the
9 preschool language lab has emphasized the value of cotreatment
10 and the efficacy of service delivery when professions from
11 different people from different professions work together
12 collaboratively to meet the individual needs of the clients we
13 serve. This powerful collaboration changes the lives of our
14 children and our families, so imagine the very first day of a
15 clinic we have children who are 18 months of age, they have no
16 communication, they have never been away from their caregiver,
17 and they are entering a room with six other children and there
18 is a lot of crying and screaming and otherwise general bedlam.
19 It's a beautiful thing and our music therapy students begin to
20 sing. Silence ensues, I'm telling you, it will blow your mind,
21 silence and the little children tears streaming down their faces
22 stop and look and smile and breathe, and then we move on and
23 we're able to offer more music and the speech language
24 pathologists are able to offer speech language interventions and

1 we do change the lives of the children and the families that we
2 serve. The powerful collaboration helps us to clearly delineate
3 the difference between music therapy and speech language
4 pathology and to highlight the need for us to be very clear and
5 confident about what it is that we do and do not do in a
6 clinical setting. Each summer for 4 weeks our music therapy
7 students and speech pathology students serve as interventionists
8 who work side by side, plan side by side, get supervision side
9 by side to work together in a professional manner. The music
10 therapy students learn how to cue speech and the SLP students
11 learn how to sing to children, but that does not make us speech
12 language pathologists, nor does it make SLPs music therapists.
13 When you hear both groups sing you would understand why the SLPs
14 are not music therapists. It also helps us understand where our
15 scopes of practice do overlap which is also a really important
16 part of our education and training. The preschool language lab
17 solidifies that the music therapy standards of education and
18 training which you have been hearing about are essential for the
19 development of music therapists and that that 1200 hours of
20 supervised clinical work is essential. This requirement
21 supports the development of very strong musicians and client
22 focused clinicians, ethical practice that depends and relies on
23 the best evidence in our profession. Our training facilitates
24 clear and concise articulation of the service we provide so that

1 we can inform the public about the difference between music
2 therapy and other therapy, the difference between music
3 therapists and well meaning musicians who are not trained as we
4 are. As you review the statements today and in the documents
5 for this review, we want you to understand that professional
6 protection for music therapy is not just about music therapists,
7 it's about protecting the most vulnerable members of our
8 community. Eighteen month old children, 98 year olds who are
9 transitioning at the end of their life and every other client in
10 between. To assure that people that claim to provide music
11 therapy services are in fact actually music therapists with a
12 degree with the clinical training hours. In 2017 a Cochrane
13 review was completed by a few of our music therapy researchers
14 and they evaluated a bunch of literature about music therapy and
15 stroke. It is meta analysis of the research that is available.
16 They identified that using rhythm or tapping a beat or a
17 metronome did improve people's ability to walk and their gait
18 after having a stroke. However, they also reported that when
19 that rhythm was embedded in music it was more effective than
20 just tapping a beat or using a metronome. But what's also very
21 important is that the analysis revealed that people trained as
22 music therapist had better results than other practitioners who
23 tried to do the same thing using just a beat or even using some
24 recorded music. So in summary, we ask for your support for

1 state licensure to ensure that music therapists in the
2 Commonwealth are appropriately trained and to protect our
3 vulnerable populations and the people who are making decisions
4 about health care in the Commonwealth. I welcome any questions
5 at this time.

6 James Wells: Tom Switzer.

7 Tom Switzer: Hi, Tom Switzer from Loudoun County Virginia.
8 Thank you so much and the study that you showed us was
9 exhaustive and I'm sure that took a lot of work and we
10 appreciate your doing that. I'm the cofounder and head of music
11 therapy at a place to be. We're located in Loudoun County,
12 Virginia, I'm also adjunct faculty at Shenandoah University. We
13 are going into our 10th year. We are a nonprofit organization
14 and our mission is we help people face and navigate and overcome
15 life's challenges through the therapeutic arts. We right now
16 see close to 400 families per week. We have 18 people on staff
17 and 9 full time music therapists. I'm going to change this up a
18 little bit because I'm more toward the end here and so, so much
19 has already been covered. One of my missions is not only to be
20 a great music therapist but also to help educate, inform and
21 enlighten people about what music therapy is. This goes back to
22 a plane ride that I had down to Florida where somebody sat
23 beside me and it was that awkward moment and you don't know what
24 to say so you ask what do you do for a living and I said I'm a

1 music therapist and she said that is really cute. My job is
2 head of music therapy, I work six to seven days a week. My
3 population I work with right now is young men between the ages
4 of 14 and 23 who have suicide ideation. I work very closely
5 with their psychiatrist and psychologist. Something that we
6 all, somebody brought this up earlier, we do not claim to be
7 what we're not. We work great with other disciplines. My best
8 success has been with speech therapists, the fact that I am also
9 very honored and lucky to be a part of a young man's life with
10 traumatic brain injury, he was in a snowboarding accident where
11 he split his head in half and was in a coma for a year and a
12 half and an amazing thing happened, a camera started following
13 us and we are going to be, we are in a documentary that will be
14 released this fall and I'm also very honored that it will be an
15 MGM motion picture in a year and a half from now, 15 years, we
16 just know we have an 88 page contracts with them, but the reason
17 that I signed that contract with MGM is because I am desperate
18 for people to understand what music therapy does. But I worked
19 right beside his physical therapist, his speech therapist, his
20 occupational therapist for 6½ years, and we're really proud to
21 say that he is a sophomore at George Mason University in the
22 life program. Yeah, he is a true hero. Just less than 3 months
23 ago I was in the NICU there at NOVA Hospital and we were with an
24 8-day old baby, she was only alive for 8 days, and we knew that

1 she was going to pass in the new few hours, as music therapist,
2 we sat there, we watched the heart rate, we delivered music with
3 the same rhythm as the heart rate, and then when she did pass,
4 we used music to uplift the family. The beauty of music is its
5 universal, it is nonthreatening. I'll tell you this story
6 really quickly too, a young man came to our office a year and a
7 half ago, a 16 year old who looked really angry and I came out
8 to the hallway and the mom said good luck, he's not going to
9 stay in your room more than 2 minutes. He's been through 10
10 psychiatrists, 10 psychologists, and just thank you, thank you
11 for trying. He's a drummer by the way, so he came into my
12 office, he was on the couch and I'm on the chair, and I have a
13 guitar and I have music ready, a piano and a speaker and we
14 looked at each other for a good 2 minutes without a word and I
15 said, what is your favorite kind of music, and he said, you
16 wouldn't like it and I said give me a try, Metallica. I don't
17 like Metallica but, I pretended I did, I put it on and we
18 listened to an entire song of Metallica and then we listened to
19 another, I had this kid now for 12 minutes, then another, then
20 another, then we started looking at each other and we are
21 building rapport, the last song 50 minutes. He is starting to
22 cry, why are you crying, what's wrong, I don't want to be the
23 next school shooter. He's been with me a year and a half and he
24 is now going to be drumming in one of our camps coming up called

1 Pop Rocks for developmentally disabled individuals and be a
2 mentor, right away obviously I called the psychiatrist up, had a
3 family meeting and now I work very closely with that family. We
4 want to work beside other disciplines, that is very important.
5 Lastly, I have a different perspective on all of this because I
6 graduated from Shenandoah as a music theatre major in 94, and
7 then I worked for a school who taught music and theater and I
8 thought I was being therapeutic and then I also had the amazing
9 privilege of working with very special arts through the Kennedy
10 Center and I thought I'm doing music therapy, I wasn't. It
11 wasn't until a day that I had a voice lesson with a young man,
12 this was now 13 years ago and from Loudoun County, he came in
13 with a poem called falling from the moon and was about his
14 father taking his life. Unfortunately this gentleman took his
15 life in front of his son's eyes and I found myself out of my, I
16 was not trained, I wrote the beautiful song with him, but I went
17 home that night and I remember music therapy from Shenandoah
18 University was there and I thought this is what I need to become
19 and it is different than just being a musician. It is different
20 than being a music teacher and I have had amazing experiences
21 with the NIH, Renee Fleming working at the Kennedy Center with
22 Sound Health where we were trying to bring the neurology and how
23 the brain is connected to music out into the public. So if this
24 licensure could help us so that wonderful lady on the plane

1 doesn't have to say it's a cute job, I saw we are just in the
2 beginning of a journey. When we were looking at the numbers I do
3 notice there isn't 80,000 of us, that this is one of, my mission
4 in this world right now is to be a good music therapist, and my
5 second mission is to make sure that music therapy gets into the
6 masses in a way that keeps its integrity, its value, and also
7 its clinical structure. Thank you.

8 John Salay: Many of those other professions you mentioned
9 working shoulder to shoulder with are able to build commercial
10 and Medicare and Medicaid and have you had anyone whatsoever,
11 any of that.

12 Tom Switzer: We don't have much luck, we have a few
13 families that get reimbursed, it depends on what your insurance
14 is and actually if it's okay, I brought the Executive Director
15 here and he can talk about that. You've been in the field of
16 insurance.

17 John Tong: Yeah, my name is John Tong, I'm the Executive
18 Director for A Place To Be. I think we have done some informal
19 surveys of the parents that we serve and approximately 30% of
20 them have had some success at getting some type of insurance
21 reimbursement, but not a significant amount. Generally they
22 might get back something like half of what they are paying us,
23 so the reason why we are organized as a nonprofit organization
24 is to make our services accessible, we actually relay on 50% of

1 our revenue coming in through philanthropy in order to be able
2 to keep our prices low and on top of that we have financial aid
3 program available to individuals that can't even afford the
4 reduced prices.

5 Tom Switzer: I should have said that I have three
6 missions. My third mission is I spend more time than I'd like
7 to confess that I raise money. I raise money to make sure that
8 a family is never turned away from us. There are people that
9 come to us after perhaps that we've met them perhaps in a NOVA
10 Hospital in the mental unit, in the psychiatric unit, and I know
11 that this one individual pays \$10.00 each session. So all the
12 parties, and all the things I have to go to to ask for money for
13 music therapy, so if we could get insurance to understand and to
14 back up some of these special medically fragile families, I have
15 so many families with children with autism that have spent so
16 much money already and that's why we do what we do.

17 John Tong: I'd also like to add that it is a very
18 difficult field to enter into because they are given a lot of
19 standardization and success in getting that insurance
20 reimbursement worked out and so there aren't as many practices
21 of our size. I think we are one of the largest nonprofit music
22 therapy practices in the country and it is because of the fact
23 that it is so difficult to organize. It is so difficult to work
24 out the reimbursement and there is so much of it being provided

1 by private pay. And so, I think that contributes to the fact
2 that there aren't as many providers and that so many providers
3 enter the field or don't stay in it as long as other professions
4 so in order to develop the field and in order to keep getting
5 more and more growth in the field, I think it's going to become
6 increasingly important that it get recognition like things like
7 licensure so that insurance companies will starting to
8 reimburse. That has been one of I think the biggest barriers and
9 in fact in our organization right now we are implementing an
10 entire electronic health record data base, totally HIPPA
11 compliant that is based off of the hope one day that we will be
12 able to work our reimbursement with the insurance companies,
13 negotiate with them rates, negotiate things like you know how
14 many sessions they will allow our clients to see and all those
15 sorts of things. So those are where we are trying to push the
16 field, but you know, without support I think for something like
17 licensure it is going to be harder to make that case. Any other
18 questions.

19 Elizabeth Carter: You are referral driven correct.

20 John Tang: Correct.

21 Elizabeth Carter: So the client would not necessarily know
22 to contact you directly, and you are getting that, you are
23 getting that now without having to have a license so, how would
24 that relationship would it change.

1 Tom Switzer: Yeah I think, that because we are also
2 in the NOVA Hospitals I think it will change, you know sometimes
3 this is semantics, like outside of the health profession world a
4 lot of people like to say, or ask is she licensed and I don't
5 even if they really know what that means, but there are things
6 that we can do beside an occupational therapist and then there
7 are sometimes things that they don't do or can't do and when
8 they hear that that occupation is licensed, and we're not, it's,
9 especially I think the medical field, it would make a very large
10 difference. Anybody else. Thank you so much.

11 James Wells: Thank you. Amy Stone

12 Amy Stone: Well, moving things along here, I'm sorry. Good
13 morning. So I don't know if you can hear me.

14 Elizabeth Carter: I can.

15 Amy Stone: Thank you for letting me know because honestly
16 I can't see if the microphone is on, so, I come from a unique
17 perspective here, because I am not a music therapist, I am in
18 fact a music therapy client, and I have been receiving music
19 therapy along with other therapeutic disciplines and therapeutic
20 interventions since I was basically a child, so when I was born,
21 I was a little one, I was 11 weeks early, I was only 3 pounds.
22 So, the doc--, when my parents first took me to the doctor, the
23 doctor said I would never talk, walk, or have any cognitive
24 ability, they were right with one of those things, which is why

1 I sit in this little thing called a wheelchair. Basically if I
2 didn't have any cognitive ability I probably wouldn't be able to
3 speak in front of you today, so when my mom and I were planning
4 for this trip, I ended up basically telling her if I could walk
5 that would help, but I said wait, hold that thought, because if
6 I could walk I wouldn't even know, chances are I wouldn't even
7 know music therapy exists. That's why I wouldn't even know the
8 place existed and my life would be completely different and when
9 I was in school I ended up being pulled, my music therapy class
10 sessions, which ironically when I was younger, I wanted to go to
11 music classes more than music therapy basically because I was so
12 tired of going from therapy to therapy that my parents basically
13 ended up tricking me into thinking, okay it's just class but
14 really what music therapy does, is it, because they are so good
15 at working as a team with other therapists, other therapy is
16 kind of in disguise, so if someone says hey Amy I'm gonna
17 stretch you out, I'm gonna say please don't hurt me, but if
18 someone says hey Amy dance with me, my hands all the way out,
19 outside of your range of motion, I'm going to go okay, let me
20 try because guess what I am increasing my range of motion,
21 without knowing that I'm going it and sometimes, music can be
22 used as a tool as almost the therapist and the professional
23 competencies that would help to kind of help bridge that gap
24 between things that I don't want to do and things I do want to

1 do because well not, my family worked really hard to find
2 nontraditional means of therapeutic intervention, however, me, I
3 just didn't quite understand because me, I'm like is this going
4 to fix me, am I broken, so I think a lot of people no longer
5 understand that when you are on a journey to increase your
6 independence and increase your ability to what we call in my
7 life, ADL's which are like activities of daily living, we have a
8 lot of passion for understanding hello I am a person, I am human
9 and it goes back to that person first or people first mentality,
10 hi my name is Amy, I have CP, not I have CP and my name is Amy,
11 so I think a lot of it is understanding hey, everything's going
12 to be okay, we'll figure it out, I am going to sing a song that
13 I've written 15 songs based on, they come out of music therapy
14 sessions and creative sessions with people studying to get
15 their, to become CBMT's, I have the gift of working alongside
16 The Place to Be and sometimes when people are done with their
17 internship they send people over to me just to teach them how to
18 do the hand by hand stuff so they are picking me up and putting
19 me down and making sure I have what I need and making sure that
20 music therapists also understand the physical ramifications of
21 what it's like to take care of someone with a physical
22 limitation so that they have deeper respects when they get into
23 the field. I hope some of that made sense. You guys have any
24 questions, I will be happy to answer them.

1 John Salay: Thank you for that Amy, it made a lot of
2 sense, I don't know if you can answer this, you may have or
3 maybe somebody else has talked about this, do you think
4 movement, does dance therapy a subset of music therapy or does
5 that come into the competencies.

6 Amy Stone: As just the client, sometimes that's where the
7 music therapists in my world have to kind of, I might not know
8 that, but that's because they are just trying to relate to me
9 and create improvement so.

10 Elizabeth Carter: Thank you for that answer.

11 Patricia Winters: There are two competencies related to
12 movement, just like there are competencies related to words and
13 speech. There are two competencies related to movement which is
14 specifically related to expression in music, just like there are
15 other competencies related to speech with the use of words with
16 music and processing, but we would never say we are a social
17 worker, we would never say we are a dance therapist, but we do
18 speak and sometimes we do move with movements with music as the
19 primary ingredient in that mixture. Sorry.

20 Lauren DiMayo: I actually know several dance therapists
21 and it's a separate degree program, I'm not intimately familiar
22 with it, but it is a separate program and I know some people
23 pursuing that at the PhD level. I can ask them if you'd like
24 that information.

1 John Salay: Yeah, that's that cleared that up.

2 Lauren DiMayo: Okay great.

3 Amy Stone: Like I said, sorry I'm just a client, I don't
4 know all the logistics of it.

5 John Salay: Don't be sorry for us.

6 James Wells: Thank you Amy. Is there anyone else that
7 would like to speak or to respeak. If not, I want to thank all
8 of you. I, I don't know about my fellow committee members but it
9 certainly was enlightening and it certainly was an educational
10 experience for us, when we think we know what something is, we
11 sometimes don't and I have a very strong feeling that regardless
12 of how this committee votes, one of your problems is that behind
13 the scenes you make it look so easy that everybody else thinks
14 they can do it too, so I thank you all for coming today. We will
15 receive written comments through July 15th, 2019 at 2:00 p.m. and
16 let's see we do have one bit of business because we need to
17 approve the minutes of the May 14th meeting, you have them now
18 and we do now have a quorum.

19 John Salay: Move approved.

20 Louis Jones: Second.

21 James Wells: And all in favor "I". And with that I will
22 conclude the public hearing and is there anything, I tell you
23 what Ms. Jackson, could you give everybody a timeline of what
24 happens next, please.

1 Laura Jackson: The next meeting will be July 31st and it is
2 to review the next draft so the public comment that is received
3 will be incorporated into the study and so the things we have
4 discussed and brought to our attention today will be added to
5 the study. The committee will meet to have any more questions
6 answered if they have any, then any edits or changes from the
7 July 31st meeting will be brought over to August 20th. That will
8 be the final report, which will be given to the board to vote on
9 and the committee will make a decision on what type of license
10 or registrations or certification at that time and, so there
11 will be a decision made August 20.

12 Elizabeth Carter: It will still go to the director of the
13 department.

14 Laura Jackson: Yeah August 20th.

15 Elizabeth Carter: And also once the board recommendations..

16 Tracy Bowdish: ...just a quick question, are there things
17 that you would like us to follow-up on, questions that either we
18 didn't answer or that you want us to clarify and then again we
19 want to maintain that balance of equipping you with the
20 information that you need to make an informed decision but also
21 not overstepping our role.

22 John Salay: I said this earlier, social worker and I
23 worked with music therapist for years and I ask under the board
24 of social work. Looking at the other states they seem to be the

1 under broad categories, so if you could add some comments as to
2 why it should under the advisory board of medicine versus
3 another that would be helpful to me at least.

4 Tracy Bowdish: Okay.

5 James Wells: Ms. Jackson is there anything else you would
6 like to say. Okay. Alright if there is nothing else then our
7 next committee meeting will be on July 31, 2019 and I will take
8 the motion to adjourn.

9 Louis Jones: Second.

10 James Wells: All in favor say "I".

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12 Recording ends

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1 I, Sandra Hall, do hereby certify that the foregoing audio was duly
2 transcribed by me, and further, that the transcript is, to the best
3 of my ability, a true and correct transcription of the audio.

4 *Sandra Hall*

5 Sandra Hall

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Music Therapist Public Comment

APPENDIX 12

File Number	Name	Date Received	Support	Opposed
MT PC 1	Liz Wong, MT-BC	6/17/2019	X	
MT PC 2	Joseph Umstead	6/21/2019	X	
MT PC 3	Anonymous	6/21/2019	X	
MT PC 4	Daniel Cohen, MD	6/21/2019	X	
MT PC 5	Lisa Shaw	6/23/2019	X	
MT PC 6	Linda Platt	6/24/2019	X	
MT PC 7	Judith Washburn	6/24/2019	X	
MT PC 8	Pamela Steuart	6/24/2019	X	
MT PC 9	Susan Westfall	6/24/2019	X	
MT PC 10	Michelle Westfall	6/24/2019	X	
MT PC 11	Natalie	6/25/2019	X	
MT PC 12	Hua Wang, MD	6/25/2019	X	
MT PC 13	Kimberly Griffin	6/26/2019	X	
MT PC 14	Talmage Oneal	6/26/2019	X	
MT PC 15	Noel Anderson, MMT, MT-BC	6/26/2019	X	
MT PC 16	Dorothy Shumate	6/27/2019	X	
MT PC 17	Melissa Owens, NMT, MT-BC	6/27/2019	X	
MT PC 18	Steve Vaughan, Chaplain	6/28/2019	X	
MT PC 19	Raymond Leone, MMT, MT-BC	6/30/2019	X	
MT PC 20	Shelby Reynolds, MT-BC	6/30/2019	X	
MT PC 21	Anna McChesney, MS, LPC, MT-BC	7/1/2019	X	
MT PC 22	Gabriel Villarreal, PPC	7/1/2019	X	
MT PC 23	Sarah Wardle Jones	7/1/2019	X	
MT PC 24	Dolores Heidenthal	7/1/2019	X	
MT PC 25	Patrick Heidenthal	7/1/2019	X	
MT PC 26	Catherine Backus	7/1/2019	X	
MT PC 27	Miriam Smith	7/2/2019	X	
MT PC 28	Becky Sowers, MT-BC	7/2/2019	X	
MT PC 29	Heather Lipscomb, RN	7/3/2019	X	
MT PC 30	Brenda Clarkson	7/3/2019	X	
MT PC 31	Mariagracia Rivas Berger, MT-BC	7/3/2019	X	
MT PC 32	Teresa Welter	7/5/2019	X	
MT PC 33	Kim Gilbert, MT-BC	7/7/2019	X	
MT PC 34	Lucy Cardon	7/7/2019	X	
MT PC 35	Jesse "Jay" Forbes, MMT, MT-BC	7/9/2019	X	
MT PC 36	Kelly Sweeney, MS, MT-BC	7/11/2019	X	
MT PC 37	Grace Jordan, PA-C	7/11/2019	X	
MT PC 38	Leigh Dymond	7/11/2019	X	
MT PC 39	Stacey Sheppard	7/11/2019	X	
MT PC 40	Leslie Magee, MT-BC	7/11/2019	X	

File Number	Name	Date Received	Support	Opposed
MT PC 41	Jamie Grace, MBA	7/11/2019	X	
MT PC 42	Armando Castro, RN	7/11/2019	X	
MT PC 43	Cassie Smith, MT-BC	7/11/2019	X	
MT PC 44	Louise Dillon	7/12/2019	X	
MT PC 45	Anonymous	7/12/2019	X	
MT PC 46	Kristen Schaible, MSN, FNP-BC, CNRN	7/12/2019	X	
MT PC 47	Sandra Rodriguez	7/12/2019	X	
MT PC 48	Maria Kokkinaki	7/12/2019	X	
MT PC 49	Margel Edmondsom, MMed, MT-BC	7/12/2019	X	
MT PC 50	Raymond Cobb	7/12/2019	X	
MT PC 51	Becky Watson, MBA	7/12/2019	X	
MT PC 52	Leighton Rogers	7/13/2019	X	
MT PC 53	Terri Flud	7/13/2019	X	
MT PC 54	Elizabeth Rogers	7/14/2019	X	
MT PC 55	Gregory Ulmer, RpH	7/14/2019	X	
MT PC 56	Eugene Knezevich	7/14/2019	X	
MT PC 57	Kelli Maddock, MMT, MT-BC	7/14/2019	X	
MT PC 58	Paul O'Leary	7/14/2019	X	
MT PC 59	Lily Bowers, MT-BC	7/14/2019	X	
MT PC 60	Stephanie Suber, MT-BC	7/15/2019	X	
MT PC 61	Kelsi Yingling, MT-BC, NMT	7/15/2019	X	
MT PC 62	Paul Horwitz	7/15/2019	X	
MT PC 63	Lisbeth Woodward, MT-BC	7/15/2019	X	
MT PC 64	Cindie Wolfe, MT-BC	7/15/2019	X	

Laura Jackson

From: Liz Wong
Sent: Monday, June 17, 2019 6:56 PM
To: laura.jackson@dhp.virginia.gov
Subject: In support for Music Therapy Licensure in VA
Attachments: Dr Jiminez's letter to parents 2017.jpeg

Hello

I have been a Board Certified Music Therapist for over 20 years. I was contracting with LCPS for over 9 years when the new Director of Special Education Services came in and started making changes.

Music Therapy uses music as a tool to achieve a non-musical goal. To qualify for Music Therapy in the schools, as per IDEA, a student must have an educational need. In Loudoun County, if a student was not making progress on their IEP goals and responded significantly to music in the classroom during break times, circle time, etc., the IEP team would request a Music Therapy assessment. After the Music Therapist performed the SEMTAP Assessment, data would be compared/contrasted on goals using Music Therapy to the teacher or other therapists' data on said goal without musical intervention. Some students respond significantly to music, are able to learn and retain facts and concepts better and are more attentive and motivated to learn overall when music is used as a tool to address goals.

Music Therapists are required to have a degree in Music Therapy and pass a National Board Certification, which up until now has been sufficient to practice MT in Virginia. However, two years ago Loudoun County Schools found a loophole/ interpreted the law in a new way, and was able to suddenly cut Music Therapy from students' IEPs (LCPS had contracted Music Therapists for over 13 years). Dr Jiminez (the new director at the time) stated teachers could perform these services equally or better because there was no State Licensure or Certification for Music Therapy, but there was State Licensure for teachers. So LCPS changed the name from Music Therapy to Integrative Music, and told teachers to sing to the kids. The Music Teachers immediately were given permission to refuse by their Director because they are not therapists. Teachers and Speech Therapists were told that they were supposed to sing to the students as they walked down the hall, as the students sat on the toilet, or while doing OT or Speech Therapy so that they could mark that down time as Integrative Music time and fulfill services times on the IEP. Therapists were worried about double billing and were told not to worry about it. Some therapists were observed to ensure they were cooperating. One Speech therapist told me, "She can come observe me as many times as she likes, but I'm still going to do the same 3 songs because that's all I know." Some teachers have attempted set music times and sang songs like "Old MacDonald" or other familiar songs because they lacked the knowledge or confidence to sing any other songs. However if a song or activity is not a goal-directed activity, it is simply music group or even Adapted Music, not Music Therapy. One kindergarten student with Down Syndrome was pulled for 30 minutes each week to watch You Tube videos and answer questions about them. THAT was his Music Therapy/Integrative Music time. And the supervisors often wrote Integrative Music on paper but called it Music Therapy verbally to the staff.

When parents and Music Therapists complained to VDOE, VDOE stated LCPS interpreted the law correctly.

Attached is the letter she sent out to parents describing the change in services. Notice how she simultaneously discredits the Music Therapy contractors for not having state licensure, while describing how the LCPS staff will do a great job fulling the Music

Therapy components of the IEPs. Then she continues to elaborate upon the fact that we do not have state licensure.

Not only is this a HUGE injustice to these students and their families, we are worried it may set a precedent for other agencies in the state.

Please support Music Therapy State Licensure in VA!!
Thank you for your time!

--

Liz Wong, MT-BC

Music Therapist-Board Certified

c 703-505-2968

<https://uachieve.wixsite.com/lizwongmt>



LOUDOUN COUNTY PUBLIC SCHOOLS
DEPARTMENT OF PUPIL SERVICES
Office of Special Education
Administration Building
21000 Education Court, 4th Floor
Ashburn, VA 20148
Telephone: 571-252-1011
FAX: 571-252-1244

June 14, 2017

Dear Parent,

The purpose of this communication is to advise you of a transition in service providers for music therapy for the 2017-18 school year. There are no proposed changes to IEP services, only to the providers who deliver the instruction included in the IEP. There will be a collaboration of music teachers, special education teachers, and related services staff. I believe that this collaboration will be a great benefit to our students. I am anticipating that parents and school staff will concur as we move toward the introduction of MUSIC (Musically Based, Unique Services with Individualized Collaboration) for eligible students with disabilities in our schools.

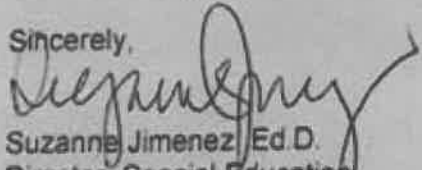
All students have access to music education and opportunities in our schools. In addition to the music education provided in schools, some students with disabilities receive music therapy as a related service as part of their IEP. Contracted music therapy providers, who are not part of the licensed and endorsed LCPS staff, have been coming to school sites to work with students providing services to support identified goals. These individuals are expected to collaborate with teachers and provide ongoing data to support communication about student progress. The change in providers will allow all services to be provided by LCPS staff, strengthening communication among IEP team members, expanding the implementation of strategies across the day and enhancing our ability to collect and use data for instruction. As we implement MUSIC in our programs, music educators and special education teachers will work together to design strategies which may incorporate rhythm, voice, instrumentation, and other components of music education to support IEP goals. Frequently this service includes supporting communication/language development, attention, memory and motor memory. We are very pleased to provide specially designed music education for qualifying students to meet the needs of our students in this collaborative initiative.

Educational services are required to be delivered by providers who meet the qualification standards set forth by the Virginia Department of Education (VDOE). Loudoun County Public Schools (LCPS) staff meet the rigorous requirements for licensure and are required to participate in ongoing professional learning and recertification to maintain high professional standards and as a condition of employment. The VDOE does not regulate the qualifications for music therapy providers. There is no licensure or registration for music therapy providers in Virginia through the VDOE or the Department of Health Professions. According to the VDOE, when there are no requirements, the school division determines the qualifications for providers. In order to provide quality services, with consistent accountability with staff who are licensed, qualified teachers in the school division, we will provide music and music therapy services with the collaborative work of our music educators and special education teachers. This model will apply for students who have music and/or music therapy in their IEP. LCPS will not continue to employ outside private providers for this service and instead will implement a systematic approach for service delivery with the music and special education staff collaborating on the strategies, goals, and communication of outcomes.

I am looking forward to working with a team this summer representing music, special education, speech/language therapy, occupational therapy, physical therapy, behavior specialists/resource teachers, and special education early childhood professionals as we plan the provision of these services through this integrative model. We will ensure that all students receive services in accordance with their IEPs and with high professional standards. Please plan to attend an open house in August to learn more about the MUSIC services that will be provided in your child's school! Information about the exact date and other details will be forthcoming.

All the best to your family for a wonderful summer.

Sincerely,


Suzanne Jimenez, Ed.D.
Director, Special Education

Laura Jackson

From: Joseph Umstead
Sent: Friday, June 21, 2019 1:33 PM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professions,

My name is Joseph Umstead, and I am a patient of Sentara Music Therapist Tracy Bowdish. I started seeing Ms. Bowdish in January 2019 for memory issues related to mitral valve replacement surgery at Norfolk Heart Hospital in October 2018, and prior concussions. My Sentara neurologist made the referral. My therapy with Ms. Bowdish is ongoing and involves complicated exercises that I can also practice at home. ***My therapy with Ms. Bowdish has improved significantly my short and long term memory.***

As a former licensed K-12 music teacher for 40 years in several states in the US, I enjoyed directing choruses, bands and orchestras, as well as teaching general music to 3000 children. However, I would never have considered practicing music therapy with any of these children.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians. Thank you!

Sincerely,
Joseph Umstead
35 Sinton Road
Newport News, VA 23601

919.616.6203

Laura Jackson

From: VA Music Therapy Task Force
Sent: Friday, June 21, 2019 11:52 AM
To: Jackson, Laura
Subject: Fwd: For the June 24 meeting: written response

Hi Laura,

I am forwarding this from a Loudon County parent. Sorry for the delay.

at first we had thought she had sent this to you as well but later realized she wanted us to pass it along to you. She asks in the email for her last name not to be used but later asked for me to remove her complete name. I did so, and also removed her email address, replacing anything I deleted with ____

Thank you,
Tracy

----- Forwarded message -----

From: ____
Date: Fri, 7 Jun 2019 17:04:37 +0000 (UTC)
Subject: For the June 24 meeting: written response
To: VA Music Therapy Task Force <vastfmt@gmail.com>

Subject: 54.1-2957.23

My child's school system, LCPS (Loudoun County Public Schools) cut music therapists from servicing students who were screened and qualified from music therapy. Now the music therapy service is provided by the special education teacher who is not qualified/licensed for music therapy. This county change in music therapy service impacted my son. He has always reached his IEP goals before LCPS cut music therapists from servicing the instruction; this past year and current year he has not mastered or progressed in the math IEP goals that were supported by music therapy. In the past he always reached and mastered his IEP goals. By cutting the music therapist, our son had direct impact in reaching his math IEP goals.

My son has autism. It is hard as a parent when you know your child learns differently and communicates differently; he has needs that can be supported by different trained professionals. Please support the music therapy program. Some kids learn differently and are reached by different techniques. Applying music therapy into instruction helps children with acquiring language and accessing instruction. My family is advocating on behalf of student protection and access to services.

(Please don't use my last name as LCPS has been challenging me)

Thank you for your time,
____ (mom)

--

Tracy Bowdish, MM, MT-BC & Shelby Reynolds, MT-BC Co-Chairs, Virginia State Task Force

Laura Jackson

From: DANIEL A COHEN
Sent: Friday, June 21, 2019 8:48 AM
To: 'laura.jackson@dhp.virginia.gov'
Subject: Support for Music Therapy state licensure

Dear Board of Health Professions,

I am writing to ask for your support for state licensure of Music Therapy. I am the Chief of Neurology for Sentara Medical Group and the Chair of Neurology for Eastern Virginia Medical School. My sub-specialty focus is in Cognitive Disorders. As the Director of the Sentara Cognitive Neurology Program, I can voice from our entire multi-disciplinary team the great fortune we have by having a dedicated Neurological Music Therapist to provide cognitive rehabilitation services to our patients. We have seen tremendous benefits for our patients in the realms of language fluency, attention, memory, and mood stabilization.

Neurological music therapy uses music as a tool for achieving non-musical functional goals, allowing individuals to capitalize on brain networks that support music perception/generation so that those networks can facilitate function previously served by damaged/diseased neural networks. We support increased access to this treatment modality, and we also support regulation to ensure that only appropriately trained and certified therapists can claim this title in their credentials. Unfortunately, we see many self-proclaimed experts in medical fields that may not provide the best service for our patients.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Respectfully,
Dan

Daniel Cohen, MD
Clinical Chief of Neurology, Sentara Medical Group
Chair and Associate Professor of Neurology, Eastern Virginia Medical School

Disclaimer:

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Laura Jackson

From: lls6495@aol.com
Sent: Sunday, June 23, 2019 11:05 PM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professions -

My name is Lisa Shaw and I am the mother of a 14 year old girl named Phoebe. Phoebe has suffered with depression, anxiety, and panic disorder since about the age of seven. She was formally diagnosed at age eight. Her anxiety levels were so high that we had to pull her from public school. She has been in traditional therapy since her diagnosis, so for six years. She has been on various meds for her conditions, and has seen numerous doctors, two different psychiatrists, and about a half dozen different therapists. There would be minor improvements, but nothing seemed to help her. At around age 10, she first began having suicidal ideation. She began to self-harm. We were desperate to find her the help she needed, but nothing was really making that much difference.

*That is, until we found music therapy. We began going to a place in Middleburg, VA called **A Place To Be** two years ago, and it was the miracle we had been looking for! Phoebe started with one of their summer camps to see how she liked it, and soon she was having private music therapy sessions, as well as participating in their Immersion Program one day a week. We saw improvement right away. She still had many of her same issues, but she was able to express herself through music in a way that she hadn't been able to do before. She was able to perform on stage in their summer musical theatre camp in 2018, and that's when we really saw a change in her. She was then asked to be in APTB's "Same Sky Project," a touring ensemble that goes around to area schools and performs at assemblies to promote empathy, inclusion, and self-advocacy. She became even more self-confident and was able to make many new friends. She was even able to perform at the very schools she had once attended, with kids she's known all her life, some of whom were her bullies.*

Because of music therapy, she has been able to reduce her anxiety and panic attacks. She still has those mental illnesses, but the difference is that now she has the tools to help her reduce those episodes. The people at APTB are all caring and loving people who have helped so many kids. The music therapists there have done more to help Phoebe's mental health issues than any other form of therapy she has had.

I will go so far as to say that Music Therapy has saved her life.

Phoebe doesn't want to die anymore. She wants to live and keep performing and making music. She has learned so much and we're thrilled that she is currently in another summer musical camp right now. She is also slated to be in the next production of the "Same Sky Project" for the 2019-2020 school year.

It is very important to our family that Music Therapy be given licensure in the state of Virginia.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Thank you for taking the time to read my email.

***Blessings,
Lisa Shaw
Phoebe's Mom***

Laura Jackson

From: Alan Platt
Sent: Monday, June 24, 2019 4:44 PM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure

To Whom It May Concern:

I have been a career teacher and have taught a number of students at Heritage High School for the past twelve years. During this period, there have been dramatic changes in a number of these autistic, OCD, cerebral palsy, chronic Lyme's disease. and numerous other life challenges. What is more rewarding, is that I have been on the board of directors of A Place to Be in Middleburg, Virginia, for almost 6 years, and have seen these same students in performances of all kinds, all seasons of the year. It has been a remarkable experience for the past six years, and I have been personally and professionally rewarded to see the growth in our number of clients and the quality of the therapy. At the high school level, there have been many students in other classes who have taken note of the empathy demonstrated in our performances in the Same Sky project ("Behind the Label") and "Will to Survive", both of which have now been seen by thousands of Loudoun, Fauquier and Fairfax County middle and high school students.

I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained healthcare providers and patients/families seeking Music Therapy services and increase consumer access to appropriately trained clinicians.

Sincerely,
Linda B. Platt

Laura Jackson

From: Judith Washburn
Sent: Monday, June 24, 2019 5:47 PM
To: laura.jackson@dhp.virginia.gov
Subject: Support Music Therapy Licensure in VA

Dear Board of Health Professions:

My name is Judy Washburn and I have a granddaughter with autism who has benefited tremendously from highly trained music therapists. For several years I brought her every Friday afternoon from Washington DC to Middleburg, Virginia, where I live, to work with very skilled music therapists who are with the organization, A Place To Be. I am now on the Board of this entity and over my several years on this Board I have learned the importance of having only very well trained therapists working with this very vulnerable group of people. There must be established accreditation for these clinicians. The need for more appropriately trained therapists is only going to grow and it is important that the State of Virginia take action as soon as possible.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Most sincerely,

Judith Washburn

Laura Jackson

From: pamelasteuart
Sent: Monday, June 24, 2019 6:05 PM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professions,

My name is Pamela Steuart. I am the Mother of a child with multiple challenges (Down syndrome, Sensory processing disorder, Apraxia of speech...). We have been doing music therapy since our son was two years old, through the public school system.

Four years ago, we began private therapy (with a therapist named Ashley Gant) at A Place To Be in Middleburg, Virginia. We have seen our son's speech, language and enunciation improve. He is now speaking in complete sentences and answering questions appropriately. He has gained social skills and strengthened his handwriting skills. He is now able to follow multi-step directions and has learned how to calm and organize himself, pay attention, deal with anxiety and participate more effectively in therapy as well as life.

All this has been accomplished through "playing and singing" with the help of a therapist who applies her education and clinically based practices of music therapy. I would NEVER take my child to a speech therapist or occupational therapist that wasn't board certified and licensed.

I consider music therapy the broadest, most vital and effective form of therapy that my son receives. Please safeguard the uniformity of practice, quality of education and expertise these therapists will bring to the table by supporting state licensure of music therapy.

We parents do not have the time or resources to do a trial and error search for effective therapists. Please increase consumer access to appropriately trained clinicians and ensure that only appropriately trained individuals may practice.

Thank you,
Pamela, Scott and Riley Steuart



PAMELA STEUART
fine art



703.728.7582

Laura Jackson

From: Susan Westfall
Sent: Monday, June 24, 2019 1:26 PM
To: laura.jackson@dhp.virginia.gov
Subject: Client testimony for Licensing Music Therapists

Dear members of the Board of Health Professions,

I am writing to request that Virginia music therapists require a license to practice because I received private music therapy services for my own mental health treatment. My mother also received music therapy to help with her agitation related to the advanced stages of dementia. When talk therapy and medications weren't working for me, I tried music therapy. My insurance did not cover music therapy, but did cover counseling from a licensed counselor. Because there was no board certified music therapist with a counseling license in Southwest Virginia, I had to go to one in Tennessee. During music therapy sessions, I learned how to calm my thoughts and my body and was able to learn how to use music as a way of coping with everything going on in my life, especially my chronic pain disorder. My mother received music therapy to help her with agitation due to dementia when she lived in assisted living and skilled nursing facilities. I could not find a board certified music therapist in the area, but I found a music therapist who had finished her schooling but had not yet completed her internship and board certification requirements. We determined that some training in music therapy was better than none, as there were volunteer musicians who did not have the training to deal with the level of agitation my mother had. I would only trust someone with training on how to respond to significant agitation. I paid for this out-of-pocket because music therapy was so important to help my mother. Also, you should know that her Medicare insurance would not cover music therapy, even though it significantly improved her quality of life. After her music therapy sessions, she was calmer and had an improved overall mood. She sometimes even sang along, remembering the words! On one occasion when the music therapist was playing and singing for my mother, one of the other residents of the memory care unit came into her room and sat down to listen. As the music therapist played a song he recognized, he stood up, extended his hands to mine and danced with me. This man was also suffering from dementia. He had been an orthopedic surgeon and had actually operated on my knee years ago. It was so sad to see such a brilliant mind deteriorate to the point where he could/would communicate with no one. Yet, he spoke to me through this experience with music.

I learned about the value of music therapy from my daughter, who received her master's degree in music therapy from Radford University in Radford, Virginia. She currently practices music therapy as a board certified music therapist in a public school district in the state of Virginia. As an allied health profession, recognized by the National Institutes of Health, music therapists must earn a bachelor's degree or higher in music therapy from one of over 70 American Music Therapy Association (AMTA) approved colleges and universities which includes 1,200 hours of clinical training. At the completion of academic and clinical training, students are eligible to take the national examination administered by the Certification Board for Music Therapists (CBMT), an independent, non-profit certifying agency fully accredited by the

National Commission for Certifying Agencies. After successful completion of the CBMT examination, graduates are issued the credential necessary for professional practice, Music Therapist-Board Certified (MT-BC).

Sincerely,

Susan Westfall

12075 Goose Creek Road

Bristol, VA 24202

276-669-9159

ogmare@ecansol.com

Laura Jackson

From: Michelle W
Sent: Monday, June 24, 2019 1:15 PM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure

Dear Board of Health Professions,

I am writing in support of a license for music therapists to practice in the state of Virginia. I live in Virginia and work in a public school district as a Music Therapist - Board Certified (MT-BC), providing music therapy as a related service as part of students' Individualized Education Plans (IEPs). I received my Masters of Science in Music Therapy from Radford University in Radford, VA and my Bachelor of Music in Music Therapy from Berklee College of Music in Boston, MA. In this testimony, I will speak to the criteria enumerated in "Invitation for Public Comment on the Review of the Need for Regulation of the Practice of Music Therapy in Virginia," sharing my perspective having worked with children in private practice and public school settings for over ten years.

The risk of harm: Parents entrust school employees and private therapists with their child's physical and emotional safety. There are inherent risks when working 1:1 with children in a therapeutic context, which often involves emotionally sensitive content, physical contact, and using musical instruments to make music. Children who are referred to music therapy services usually demonstrate a significant lack of progress in school and struggle with regulating their emotions and using fundamental communication and social interaction skills. Many students I have served present physically aggressive behaviors or self-injurious behaviors that require careful consideration and skillful responses.

Specifically designed music therapy interventions can assist the child with regulation, appropriate emotional expression, and effective communication. The music used serves as a therapeutic agent of change, and only a trained music therapist has the in-depth understanding of how to employ musical elements of rhythm, melody, harmony, dynamics, and tempo effectively to meet these goals. Most music therapy interventions in my practice involve live interactive music making where the child is interacting with me, musical instruments, and sometimes with their peers. I rarely use pre-recorded music or play a song just for the child to hear. Every musical experience has a purpose to meet the child's needs in the moment and to address the goals that the IEP team has agreed to. Through live musical experiences, I may slow down the musical experience if it is too overstimulating for the child. I may change the tonality of the music to match the child's mood. I may sing or play an instrument louder to gain their attention or increase their energy. I may avoid using certain instruments or playing certain songs because the child becomes upset or begins displaying agitation. The ability to adapt musically, in real time, based on observations of the child's subtle affective responses and

overt behavior, is what makes a music therapist's skill set unique and what provides the emotional and physical safety for the child.

Many of these children have a history of trauma and need careful assessment of their strengths and preferences, but also their emotional triggers, which can include music or sound. A music therapist is trained to assess aversive responses to music, even in children who are nonverbal and cannot communicate that a particular instrument, song, or sound bothers them. In fact, sometimes IEP teams refer a child to music therapy because the child is demonstrating aversive responses, including fight/flight behaviors, to music or sound, leading the team of professionals to seek expert advice from a music therapist on how to understand or manage these responses.

It is often recommended or may even be required in some settings, for a music therapist to hold a professional liability insurance policy. A musician hired by a family or school district, who does not have adequate training in the application of music to change behavior, could inadvertently trigger a trauma response or cause a child's behavioral pattern to worsen. Furthermore, someone without the specialized skills in using musical interaction to meet individualized goals would not be able to sufficiently meet the treatment goals agreed upon by the child's IEP team, preventing the child from making adequate progress.

Specialized skills and training: Music therapy is a truly unique set of therapeutic skills, as we prescribe specific musical elements to cue behavioral responses and promote clinical change throughout the music therapy treatment process. School professionals often request the unique skill set offered by music therapists for children who seem to respond highly to music when verbal, visual, and kinesthetic teaching techniques do not work.

While other professionals often use music in educational and therapeutic activities, many of them are not trained musicians and do not have the in-depth and complex understanding of the musical elements and their effects on human psychology or physiology. Furthermore, given that music is a nonverbal form of expression, music therapists, have extensive experience communicating through nonverbal-musical means and interpreting nonverbal behaviors.

As with any helping profession, trends in healthcare and education are constantly transforming and quality continuing education is imperative. New music therapy techniques are studied and published in our professional peer-reviewed research journals, and new programs are designed across the globe in the field of music therapy. Since clinical musical skills are critical to the practice of music therapy, the music therapist is required to continue development of instrumental and vocal competencies and repertoire throughout his or her career. Furthermore, since music therapy practice is dynamic and complex, we often need connection with other music therapists for mentorship and support so that we can maintain clinical objectivity and ethical practice.

Autonomous practice: I began my career in music therapy running an independent private practice. I had just finished my internship in April 2009 in a public school district in Georgia. Due to the shortage of jobs in

the area, I started a private practice. As an entry level professional, there was a lot for me to learn and I had no supervisor. Because I was trained in an American Music Therapy Association (AMTA) approved program and had sat for the Certification Board for Music Therapists (CBMT) exam, I knew that those were the official resources for professional practice. I read, in depth, the CBMT Scope of Practice (now referred to as the Board Certification Domains), the AMTA Code of Ethics, listened to the professional advice podcasts provided by the AMTA, and connected with other like-minded professionals. Through this professional network, I gained access to professional development programs designed for private practice music therapists. If a board certified music therapist in private practice does anything deemed as inappropriate or unethical, a parent's only option would be to contact the Certification Board for Music Therapists, where corrective action or removal of the certification could occur. In such a case, there would be absolutely nothing to prevent a non-certified music therapist for continuing to practice, serving children and other vulnerable populations. This is a troubling and potentially harmful consequence of no regulation for a therapeutic profession.

Currently, I work in the public school system with a certain degree of autonomy, given that I am the only music therapist in the school district. I choose to collaborate on a regular basis with other professionals, following best practice to meet the unique needs of each student with whom I work. I often work with students 1:1 in a separate classroom and report progress to the child's IEP team. I am accountable to both the IEP teams and the school district's administration for collecting data, reporting progress, and ensuring that I provide effective evidence-based music therapy services. I serve 12-18 schools each year, traveling between schools to see a caseload of students who qualify for music therapy as a related service. Additionally, I work with other professionals as a consultant on the use of music in their practice.

The scope of practice is distinguishable from other regulated professions: for some children with disabilities, music is one of the few ways to reach them so that they can learn communication, social regulation, emotional regulation, academics, and other important life skills. While teachers, occupational therapists, counselors, speech-language pathologists, and other helping professionals work on these skills, sometimes the traditional therapeutic models alone do not work for particular children. One of the best ways to illustrate that the music therapist's scope of practice is distinguishable from other therapeutic practices is to describe why other professionals refer students to music therapy services in the school setting. Our school social workers and counselors refer students to music therapy when talk therapy doesn't work for the student, but the student shows a strong interest in music and will increase engagement or express their feelings in response to music. Our occupational therapists refer students to music therapy when they have observed that music helps the student de-escalate after a behavioral crisis or helps the student attend to and complete non-preferred fine motor tasks when the task is structured with a specially written song and sung live. Speech-language pathologists refer students to music therapy when the child will sing the words to their favorite songs when they can't yet use functional speech to communicate basic wants and needs. The music therapist can write songs to help cue the child's use of important phrases, such as "I want it" or "no, thank you." The physical

therapists refer students to music therapy when they notice that music helps a child engage in challenging physical activities. Often physical therapists notice that the child needs more musical support than they have the skills to provide. The music therapist can use rhythm, harmony, and melody to cue motor responses so that the child can make progress on their physical skills. Teachers, parents, and administrators also make referrals to music therapy services, and in most cases it is because the child is not responding to other interventions and the child demonstrates a strong motivation from music.

The economic cost to the public: When I ran a private practice in Georgia (a state which now regulates music therapy with a license), one of the greatest challenges to the families I served was that music therapy was not covered by insurance. One family told me that they stopped all other therapies and kept music therapy because it was the only one that was helping their daughter and they couldn't afford all of them. As with many other therapeutic interventions, insurance companies began to cover evidence-based therapies that were recognized by the state. One of the reasons I left private practice and began working through public school districts is because I knew that the public school system would be able to provide music therapy to those children who really needed the services, but who would not be able to afford it privately. Not all children who need music therapy services will qualify through the rigorous standards of the educational system, especially if the need is medically necessary but not educationally necessary. By being recognized by the state, and increasing reimbursement, more Virginians could access quality music therapy services.

I have recently become aware that without state recognition of music therapy practice, even public school students are not guaranteed access to quality music therapy services even if the IEP team determines that it is educationally necessary. There is no better example of this than what happened in Loudoun County in recent years where the district determined that since the Local Education Agency (LEA) was allowed to determine the qualifications of a music therapist, they could completely cut music therapy programming and task teachers with providing music therapy services. In my informed opinion this was highly unfair to teachers, who already buried in requirements, and a trivialization of the skills and training possessed by music therapists to meet the unique needs of students served in the county. If music therapy had been a licensed profession, then this would not have happened because the school district would have been required to abide by the state's licensure requirements.

Many related professionals such as therapists and teachers have verbally expressed concern and confusion over the fact that music therapists currently do not need a license to practice in Virginia, even though we work with the same vulnerable individuals. Music therapists go through extensive training to earn a degree in music therapy, complete training through field placement and internships, and take a national board certification exam to demonstrate competence in the unique music therapy scope of practice.

I am asking the state of Virginia to regulate the practice of music therapy with full licensure and to recognize that the MT-BC (Music Therapist - Board Certified), awarded by the Certification Board for Music

Therapists, denotes the appropriate level of education and training for a music therapist. Thank you for your attention to this important issue.

Sincerely,

Michelle Westfall
203 Mahone Court
Spotsylvania, VA 22551
(770) 891-6516
drumamare@gmail.com

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Laura Jackson

From: Natalie Riddick
Sent: Tuesday, June 25, 2019 3:59 PM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professions:

Subject: Support for Music Therapy Licensure in VA

My child's school system, LCPS (Loudoun County Public Schools) cut music therapists from servicing students who were screened and qualified for music therapy. Now the music therapy service is provided by the special education teacher who is not qualified/licensed for music therapy. This county change in music therapy service impacted my son. He has always reached his IEP goals before LCPS cut music therapists from servicing the instruction; this past year and current year he has not mastered or progressed in the math IEP goals that were supported by music therapy. In the past he always reached and mastered his IEP goals when he had a trained and licensed music therapist. By cutting the music therapist, our son had direct impact in reaching his math IEP goals. My son has autism. It is hard as a parent when you know your child learns differently and communicates differently; he has needs that can be supported by different trained professionals. Please support the music therapy program with the importance of seeking appropriately trained music therapists while instructing children in the public school system. As a parent, I am asking for licensure. Some kids learn differently and are reached by different techniques. Applying music therapy into instruction helps children with acquiring language and accessing instruction. My family is advocating on behalf of student protection and access to services.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Thank you for your time,
Natalie (mom)

Laura Jackson

From: HUA WANG
Sent: Tuesday, June 25, 2019 1:21 PM
To: laura.jackson@dhp.virginia.gov
Cc: vastfmt@gmail.com
Subject: Support for Music Therapy state licensure

Dear Board of Health Professions,

I'm writing to ask for your support for Music Therapy licensure in Virginia. As a neurologist, I work with patients who are extremely vulnerable. Therefore, when I make referrals to therapy, it is important for me to know that therapists have the proper training, adhere to a clinical scope of practice, and possess standard competencies in their fields. It is also important that therapists maintain their credentials via continuing education in order to continually provide the most evidence-based treatments for my patients. Music Therapy is no exception. I personally have observed the benefits of music therapy for patients in our practice.

Please support state licensure for music therapists in order to protect our patients and to provide clarity and transparency to healthcare providers when we seek music therapy for our patients.

Sincerely,

Hua Wang MD
Disclaimer:

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Laura Jackson

From: Kimberly Griffin
Sent: Wednesday, June 26, 2019 5:30 PM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professions:

My name is Kimberly Griffin. I am the daughter of Virginia Griffin, whom receives music therapy through a licensed music therapist named Cassie. My mother is elderly, with chronic depression, mild cognitive impairment and suffers from severe chronic pain and a deteriorating spine. After my father died over two years ago, mom's depression worsened with the enormous grief. Her psychiatrists have tweaked her antidepressant medication over the years and we were concerned that further adjusting could throw her into a tailspin. Mom didn't want to speak with a therapist. Her geriatric psychiatrist's RN strongly urged me to contact Anderson Music Therapy because many of her patients had been helped greatly through music therapy.

I eagerly made contact with Anderson Music Therapy and the lovely, warm, talented and gentle Cassie came to meet my Mom. She was so kind with my mom and learned what kind of music my mother enjoys (old hymns). Cassie played some of her songs and it really touched her heart, and helped her feel the pain and loss of my dad and simply be with her grief. I think that the music therapy has helped my mom move through her grief process. I also know that the music brings my mother a lot of joy. Cassie has mom play some of her instruments and mom even asked me to get her a small keyboard like Cassie's that she could hold on her lap!

My mom lives in an assisted living community and I take care of all her other matters beyond her day to day. Bringing in Cassie to help mom has provided many positive things to her world – aside from me and my son, Cassie is the only other person who routinely sees my mom. I know that I can trust Cassie alone with my mom, and that is because she is licensed and a trained professional in music therapy. Mom is safe with her! Were she not licensed, I would not be confident nor comfortable with my vulnerable mother being alone with her.

The Commonwealth of Virginia provides an important function by safeguarding the public through its licensing power of music therapist. I am indebted to the Commonwealth of Virginia for providing this because it assures the public – me – that Cassie is who she says she is and is regulated at the state level. Your licensing also allows medical professionals, such as the RN, to recommend to medical patients music therapy as a complimentary therapy to the traditional pharmaceutical options for folks like my mother. I don't believe a nurse would have recommended Anderson Music Therapy were their therapist not licensed professionals.

Also, aside from Cassie communicating with me directly when I have had questions and being very transparent in her work with my mother, I really appreciate her coming once a week and being with my mom, and helping my mom. I am grateful that she is in the mix of mom's support network.

My mom had a health crisis about 1.5 years ago. Multiple falls landed her with two broken wrists and another severe compression fracture in her spine. Cassie kept up with mom and would go to her rehab facility for the 2.5 months that mom was there! As before, I was confident that this was appropriate because Cassie was licensed.

The licensing requirement is critical for this field. Were Cassie not licensed, I would not feel comfortable with my mother being alone with her.

I ask that you support state license of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Sincerely,

Kimberly Griffin

Roanoke, VA

Laura Jackson

From: RAY ONEAL
Sent: Wednesday, June 26, 2019 2:07 PM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in Va.

Dear Board of Health Professions,

My Name is Talmage O'Neal, I am the Husband and primary caregiver for my Wife of 50 years who had a pretty significant Stroke in December of 2017. She had a left side Stroke which left her Right side Hand, Arm, and Leg basically none functional and her speech was impaired to the point she could only say Yes as her default answer or response to a question. After about 6 to 8 months of Physical, Occupational, and Speech Therapy things did improve with motion and communications. The Neurology Dept. of Sentara suggested Music Therapy which is not covered by insurance but is offered to patients for a simple \$40 copay per session. We have been going to Music Therapy once a week for about a year now. My wife responded very well to Music Therapy and her Therapist Tracey Bowdish. My wife now has made tremendous improvements in her communication skills and abilities to initiate a conversation. This is noticed by our immediate family and friends she comes in contact with.

Having seen first hand how fragile the human mind is, I personally agree that Music Therapists should be properly educated and licensed to be able to work with patients that have suffered Brain related injuries or diseases creating an inability to communicate with Family and loved ones.

In conclusion I do support the State of Virginia to have Music Therapist properly Educated and Licensed in order to protect the Vulnerable population, and insure transparency for other Healthcare providers and Patients/Families searching for Music Therapy services and increase consumer access to properly trained and licensed Music Therapist.

Thank You for the chance to voice my opinions on this matter,

Talmage O'Neal

Laura Jackson

From: Noel Anderson
Sent: Wednesday, June 26, 2019 11:49 AM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA
Attachments: MT State licensure letter.pdf

Dear Laura,

Please see my attached letter in support of music therapy licensure in the state of Virginia. I have also copied it below for your convenience.

Dear Board of Health Professions,

As a board certified music therapist in Roanoke, Virginia I have had a number of experiences where parents, therapists, teachers, and mental health professionals have noticed the unique positive results their client or child received from music under the guidance of a board certified music therapist, verses someone who is not qualified to support clinical goals.

I have been a board certified music therapist for over a decade, previously working in a private school for individuals with developmental disabilities and presently running a private practice that serves hundreds of clients.

Most of the parents that come to my clinic state their child loves music. However, they weren't able to connect the use of music to meeting clinical goals before music therapy. Now they are gaining independence in talking, using their hands to manipulate objects, and expressing their emotions in a safe way.

"Anderson Music Therapy has helped my daughter find joy in something she already loved, just in a new way! She is **working hard on goals** and doesn't even realize it!" – A Proud Mom

Community organizations such as Goodwill and Mental Health America have also commented on the unique impact music therapy has had with their clients:

"Anderson Music Therapy has been an integral part of Forgotten Victims curriculum this past year. We saw several of the **children blossom from shy and introverted to actively participating**. It was also wonderful to see how their **communication and listening skills improved** as Catherine had them first listen and then play. Our **group became cohesive** and we had a group song by Bruno Mars, that truly summed up our experience as well as our group "Count on Me". Thank you, Anderson Music Therapy and especially Catherine." - Alicia Baxter, Office and Family Programs Coordinator for Mental Health America of Roanoke Valley

"I had to share with you how amazing our class was today. Catherine is amazing and was able to get so many of our guys interacting and participating **more than we could have ever imagined**. It brought tears to our eyes. I told her she would typically not have the entire team in there with her but **we were so in awe and couldn't leave**." - Laura Dickerson, Regional Coordinator, Foundational Services Goodwill Industries of the Valleys

Likewise, assisted living administrators did not realize the true impact music could have on their residents before a board certified music therapist began leading music groups. This demonstrates the **clear difference between music as entertainment and clinical music therapy.**

“I have nothing but good things to say. Contracting with Anderson Music Therapy has **made a huge difference in the lives of our residents and the overall program** at Brandon Oaks. I would highly recommend Anderson Music Therapy to anyone who provides care for others.” - Esteban Duran-Ballen, Administrator

“**Music therapy has been a huge help at our facility**, enriching the lives of our seniors.” - Stephen Davies, Activity Director

The individuals we work with are often part of a vulnerable population, such as those with developmental disabilities or dementia. Given the complex nature of these neurologic states, there is potential for harm if someone without the proper background attempts to address clinical goals through music. As a board certified music therapist, I have both my undergraduate and graduate degrees in music therapy. I had over 1200 supervised clinical hours face to face with clients before sitting for my board certification test.

It's important that we continue to help the community understand the difference between clinical music therapy and other types of music experiences. Both are valuable, we simply want to keep our clients safe from those who would claim to be a music therapist without the proper training.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Sincerely,



Noel Anderson, MMT, MT-BC

Director
Board Certified Music Therapist

Anderson Music Therapy Services

m: (540) 384-1677

f: (540) 808-1582

a: Hollins: 8231 Williamson Road, Roanoke, VA 24019
Old Southwest: 1217 Maple Avenue, Roanoke, VA 24016
Mail: PO Box 20736, Roanoke, VA 24018

w: www.amusictherapy.com



How can music help? Schedule [a call with me.](#)

Need help getting your child to sleep?

Laura Jackson

From: Dorothy Shumate
Sent: Thursday, June 27, 2019 7:40 PM
To: laura.jackson@dhp.virginia.gov
Cc: Dorothy Shumate
Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professions,

My name is Dorothy Shumate. I am a registered pharmacist and mother of an autistic son who has benefited from Music Therapy. As a pharmacist, I am aware of the importance of maintaining my license each year. By doing so, I am qualified to do my job as I must complete 15 hours of CE . This enables me to stay qualified for my profession. By fulfilling these requirements yearly, one can easily see that I have done so by my display of a license at my place of employment.

Likewise, in Music Therapy , similar transparency of a therapist's abilities should be determined by state licensure.

My son John has benefited greatly from Music Therapy. His therapist is qualified to bring skills out of him by appropriate choice of musical instruments and songs. She has brought out his interest in guitar, piano and various percussion instruments. She has the training to bring him out. State licensure will bring her training to the light of those seeking Music Therapy.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/ families seeking Music Therapy services, and increase access to appropriately trained clinicians.

Sincerely,
Dorothy Shumate

Sent from my iPhone

Laura Jackson

From: Melissa Owens
Sent: Thursday, June 27, 2019 11:54 PM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in Virginia

Dear Board of Health Professions,

My name is Melissa Owens, and I am a board-certified music therapist at VCU Health in Richmond, where I have provided full-time medical music therapy services since 2001. In order to become a board-certified music therapist, I followed a rigorous course of study at Shenandoah University in Winchester, Virginia, followed by a 6-month music therapy internship in Delaware. Only after successfully completing my 1200-hour clinical internship program did I become eligible to sit for the music therapy board-certification exam, after which time I became credentialed as a board-certified music therapist. As many of my colleagues, I have chosen to pursue additional training in order to continue my education and remain current with research and study. My particular areas of additional study include Neonatal Intensive Care Music Therapy, Neurologic Music Therapy, and Music Therapy Assisted Childbirth. Board-certified music therapists are required to complete recertification every 5 years in order to assure that the services we are providing are in keeping with best practices in music therapy.

During my 26 years as a board-certified music therapist, I have witnessed hundreds of medical patients reaching their treatment goals through music therapy. In my private practice, many children and adults with autism spectrum disorder have benefitted from music therapy to address goals related to communication, self-expression, and social and emotional development. Unfortunately, because music therapists do not currently have state licensure in Virginia, some consumers are facing potential harm by receiving services by those who claim to be providing music therapy, but are not trained or credentialed. One such example is the Loudoun County Public School System, where non-credentialed support staff and teachers provide the IEP service of music therapy to approximately 60 students. State licensure will not only protect those students and other consumers, but will also help create easier access to music therapy for Virginia residents. It is for this reason that I believe state licensure for music therapists is critical in Virginia. It is my sincere hope that Virginia will recognize music therapy and the Music Therapist-Board Certified (MT-BC) credential to ensure that consumers receive services by competent practitioners.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that *only* appropriately trained individuals may practice, in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians. Thank you so much for your time and consideration of this important matter.

Sincerely,
Melissa L. Owens NMT, MT-BC

Laura Jackson

From: Steve Vaughan
Sent: Friday, June 28, 2019 7:58 PM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professions,

Please allow me to introduce myself. I am Rev. C. Steven Vaughan, former pastor of 30 years and now Chaplain and Bereavement Coordinator with Hospice Community Care located in Glen Allen, VA since September 2015. Our Glen Allen office currently provides hospice services for just under 100 individuals who utilize our services of a Nurse, Nursing Assistant, Social Worker, Chaplain, and fortunately for our office, a Board Certified Music Therapist.

As pastor, I witnessed firsthand how a trained musician could effectively lead a congregation in a positive and meaningful worship experience. Also as pastor, I have seen the negative and lasting impact when those who are not trained, nor skilled, are attempting to lead a congregation in the worship experience. It does not work.

Now as a Hospice Chaplain, I work closely – even side by side at times – with our Board Certified Music Therapist and have witnessed first hand how someone specifically trained in this unique work improves the overall physical and mental well being of the clients we serve. It is oftentimes a remarkable transformation that takes place in the mind of our clients.

Under the direction of our Board Certified Music Therapist, I have witnessed patients raise their heads to make eye contact when previously they would make eye contact with no one. I have seen them begin to listen with an intentionality that was not there previously. I have seen their mood change from sadness to gladness and from being withdrawn to becoming more outgoing. I have heard them sing songs, correctly, when previously their thoughts were confused and disconnected. A Board Certified Music Therapist is specifically trained to recognize where a patient is emotionally, and then take that patient to a different and more engaging, more alert, level.

I wish there was a way that each of you could witness for yourself the moving and positive influence that someone clinically trained can make in a hospice patient's life. Our hospice population is too fragile to allow just anyone to have formal access and use music in a way that could potentially harm patients (and negatively impact their loved ones with them).

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

I would be glad for you to contact me with any questions you have or to clarify any of my statements. Thank you so much for your consideration of this very important step in the overall emotional health and wellbeing of our citizens in the Commonwealth of Virginia, and specifically, the many hospice patients I(we) serve.

Rev. C. Steven Vaughan, Chaplain/Bereavement Coordinator
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Laura Jackson

From: Ray Leone
Sent: Sunday, June 30, 2019 8:05 PM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA
Attachments: 2019 AJCC - Active Music Therapy.pdf

Dear Board of Health Professions

My name is Raymond Leone and I am the Head of Medical Music Therapy at A Place To Be (Middleburg, VA) and the Inova Health System. For the past 4 years I've initiated and grown our medical music therapy program within the Inova Hospitals Network. Four years ago we introduced music therapy at Inova Loudoun hospital as a pilot program, two days per week for eight weeks. We now have 4 music therapists working at 3 of the Inova hospitals as we have become a valued practice and part of care at Inova. We are currently working on further expansion into all 5 hospitals within their network. We work directly with patients in all units of the hospital including the ICU, oncology units, telemetry, post surgical and pediatrics.

Music therapy in a medical setting addresses both physiological (helping to reduce pain and anxiety) and psychological (emotional support, sense of self, coping) needs for patients in the hospital with various diagnoses and needs. Inova, and now many hospitals across the country, is utilizing music therapy as a valued non-pharmacological method in helping patients as part of overall care. Music therapy is an evidence-based practice with research showing that music therapy may help reduce the need for powerful medication and opioids in addressing stressors, pain and anxiety in acute care. Music therapy has become just as important at Inova as physical therapy, occupational therapy and speech therapy. Music therapists at Inova also work on helping cancer patients cope with new diagnoses and grueling treatment and we also support patients transiting at the end of life. Music therapy has become a vital part of patient care at Inova.

As a music therapist, I am a trained and board-certified clinician. I am using music as a clinical means of addressing various areas of need within acute care. My training is crucial in working directly with patients and staff, relying on our research and practices. Music is a very powerful medium, especially when being used clinically in a critical care environment. When working with patients on mechanical ventilation, it is crucial that I rely on my training, as a clinician designing and utilizing music interventions in, say, helping to reduce anxiety, or by knowing a patient is hypotensive, where using music improperly can have critical ramifications (using music as a means of relaxation could reduce blood pressure even more). I use music to entrain with patients' heart rates, to create tension and release in working with pain and when working with patients in the oncology unit, I am trained to help them process their feelings regarding a new cancer diagnosis. I am not simply a musician providing music to make people happy. I am a trained clinician, working directly within the hospital system.

At Inova Loudoun hospital we are currently working on a research project tracking the benefits of music therapy on agitation and pain in mechanically ventilated patients. Last year we did a research project that looked at the effects of music therapy on vital signs and self-reported pain and anxiety on patients in the ICU. Our findings showed that music therapy may be very beneficial as a non-pharmacological means of reducing pain and anxiety. Our research was published in the January 2019 issue of *The American Journal of Critical Care*. The first music therapy article published in this esteemed medical journal (a copy of the article is

attached). Our research is crucial in showing the music therapy is a legitimate practice. A practice that requires trained clinicians working within evidence based methodology.

In summary, I ask that you support state licensure of Music Therapy to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families sensing Music Therapy services, and increase consumer access to appropriately trained clinicians.

Sincerely,

Raymond Leone, MMT, MT-BC
Board Certified Music Therapist/Head of Medical Music Therapy
A Place To Be
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IMPACT OF AN ACTIVE MUSIC THERAPY INTERVENTION ON INTENSIVE CARE PATIENTS

By Amanda J. Golino, MSN, RN, RN-BC, CCRN, CCNS, Raymond Leone, MMT, MT-BC, Audra Gollenberg, PhD, Catherine Christopher, MEd, CCC-SLP, Debra Stanger, MSN, RN, NEA-BC, Theresa M. Davis, PhD, RN, NE-BC, CHTP, Anthony Meadows, PhD, MT-BC, LPC, Zhiwei Zhang, PhD, and Mary Ann Friesen, PhD, RN, CPHQ

Background Nonpharmacological interventions appear to benefit many patients and do not have the side effects commonly associated with medications. Music-based experiences may benefit critical care patients.

Objective To examine the effect of an active music therapy intervention on physiological parameters and self-reported pain and anxiety levels of patients in the intensive care unit.

Methods A study was conducted using a pretest-posttest, within-subject, single-group design. The study population consisted of a convenience sample of 52 patients. Study participants received a 30-minute music therapy session consisting of either a relaxation intervention or a “song choice” intervention. The music therapist recorded the patients’ vital signs before and after the intervention, and patients completed self-assessments of their pain and anxiety levels before and after the intervention.

Results After the intervention, significant decreases (all $P < .001$) were found in respiratory rate (mean difference, 3.7 [95% CI, 2.6-4.7] breaths per minute), heart rate (5.9 [4.0-7.8] beats per minute), and self-reported pain (1.2 [0.8-1.6] points) and anxiety levels (2.7 [2.2-3.3] points). No significant change in oxygen saturation level was observed. Outcomes differed between the 2 intervention groups: patients receiving the relaxation intervention often fell asleep.

Conclusions The results of this study support active music therapy as a nonpharmacological intervention in intensive care units. This study may lay the groundwork for future research on music therapy in critical care units using larger, more diverse samples. (*American Journal of Critical Care*. 2019;28:48-55)

The critical care unit is one of the most anxiety-producing medical environments for patients and their caregivers.¹ Critically ill patients often experience anxiety, depression, posttraumatic stress disorder, cognitive impairment, and a general decline in their overall well-being.² Physiological distress can lead to increased respiratory and heart rates, elevated blood glucose levels, hyperlactatemia, and lowered blood pressure, all of which can affect treatment outcomes.³

The psychological stress of critical illness also may have lasting effects after discharge. An estimated 15% of intensive care unit (ICU) patients experience posttraumatic stress disorder.⁴ Chahraoui and colleagues⁵ reported that approximately 25% of ICU patients experience at least 1 psychiatric comorbidity within the first year after hospitalization, and that anxiety affects roughly 70% to 80% of all critical care patients, especially those receiving mechanical ventilation.

Although treatment teams recognize the physiological and psychological impact of an ICU stay, they have limited interventions available to address patients' experiences, as the patients are often unconscious or otherwise unable to engage in self-care.⁶ Medications have thus become the primary intervention with which to address patients' clinical needs.⁷ Medications can be beneficial in mitigating or masking primary psychological distress, but they can have marked adverse effects that may impede recovery.

In response to these psychophysiological concerns, nonpharmacological interventions have become more widely accepted and implemented, as they appear to benefit many patients without the risks of adverse effects associated with medications.⁸ Some nonpharmacological interventions currently being used in critical care are massage, mindfulness-based stress reduction, Reiki therapy, integrative energetic

medicine, healing touch, music listening, and music therapy, all of which offer low-risk, low-cost alternatives to standard care.^{8,9}

Music listening interventions are among the most widely used nonpharmacological interventions and have been shown to reduce stress and anxiety, pain, depression, and feelings of isolation in critical care patients.^{7,10} For example, Bradt and Dileo¹¹ found that music listening in patients receiving mechanical ventilation reduced anxiety, respiratory rate, and systolic blood pressure, and Chlan and colleagues¹² found that music listening reduced the frequency of sedative administration. However, the impact of music listening experiences is equivocal. Chlan et al¹³ concluded that while music listening decreased stress responses in patients undergoing mechanical ventilation, the findings were not significant. Hetland and colleagues¹⁴ found that music listening did not have an impact on duration of weaning trials in patients receiving mechanical ventilation. Cooke and colleagues¹⁵ found that music listening did not significantly affect discomfort or anxiety among postoperative ICU patients during turning procedures.

Incorporating active music therapy involving live music into the ICU may clarify the effectiveness of these music-based interventions. Hunter and colleagues¹⁶ reported that active music therapy was effective in managing anxiety associated with weaning from mechanical ventilation. In their study, a music therapist provided multiple live music therapy sessions while participants were undergoing weaning trials from mechanical ventilation. After assessing the patient's ability to actively participate, the music therapist extemporaneously modified the volume and tempo of the music according to the patient's respiration and/or heart rate. The authors found significant differences in heart and respiratory rates after music therapy sessions, along with lower reported anxiety.¹⁶

Nonpharmacological interventions are becoming more widely accepted and are low-risk, low-cost alternatives.

About the Authors

Amanda J. Golino is a clinical nurse specialist, **Catherine Christopher** is director of physical medicine and rehabilitation, and **Debra Stanger** is the Magnet program director, Inova Loudoun Hospital, Leesburg, Virginia. **Raymond Leone** is director of medical music therapy, A Place to Be, Middleburg, Virginia. **Audra Gollenberg** is an associate professor of public health and **Anthony Meadows** is an associate professor of music therapy, Shenandoah University, Winchester, Virginia. **Theresa M. Davis** is clinical operations director of enVision eICU, INOVA Telemedicine, and **Mary Ann Friesen** is nursing research and evidence-based practice coordinator, Inova Health System, Falls Church, Virginia. **Zhiwei Zhang** is an associate professor and director of the Statistical Collaboratory, University of California, Riverside, California.

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Table 1
Music therapy vs music listening in health care

Definition of music therapy: "Music therapy is the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program." (American Music Therapy Association)¹⁸

Music therapy	Music listening
Requires a board-certified music therapist who has been trained to use very specific individualized, live music interventions that match the patient's in-the-moment needs.	Involves a nurse or other practitioner offering patients prerecorded music for listening that will be selected by the nurse, practitioner, or patient, or the patient may be given a list of options from which to choose.
Always involves a therapeutic process in which both the music and the therapeutic relationship serve as healing components in treatment.	Always uses prerecorded music and involves passive listening.
Involves active music making and active listening.	

When examined as a whole, the literature suggests that music-based experiences may be beneficial for patients in the ICU, with the potential to address both physiological and psychological concerns. Variations in reported benefits, however, warrant further examination. In particular, differential effectiveness of music listening experiences, specifically those that use recorded music, may be accounted for by their lack of adaptability to the patient's immediate needs, as well as the absence of an interventionist who can respond "in the moment" to the patient.^{1,17} Thus, music-based experiences in which a board-certified therapist uses live music in an attempt to alter the

physiological and/or psychological state of the patient, adjusting the activity in response to changes in the patient, may provide additional benefits over music listening experiences alone. Music therapy is a clinical approach in which a

licensed music therapist implements music-based interventions to reach a clinical goal (Table 1).¹⁸

Music therapy also encompasses the dynamic relationship between the therapist and the patient and includes verbal processing of the music experience. Little research has been published on active music therapy individualized for critical care patients. Therefore, this study was designed to explore the value of active music therapy in the ICU.

Methods

This study was approved by the Inova Health System institutional review board, and all participants provided informed consent.

Sample

The setting of this study was an American Association of Critical-Care Nurses Beacon Award-winning,

12-bed adult medical-surgical ICU in a Magnet-designated community hospital in the Washington, DC, suburbs. The intervention took place during daytime hours, primarily between 10 AM and 3 PM. A total of 52 English-speaking adults who had been admitted to the ICU were recruited to participate in the study as a convenience sample. The most common diagnoses were ST-elevation myocardial infarction, cardiac arrest, gastrointestinal bleeding, respiratory failure, renal failure, and stroke. There were no restrictions based on the patient's sex, race, or ethnic origin. Exclusion criteria were as follows: (1) being in airborne or special contact isolation, (2) being non-English-speaking, (3) being decisionally impaired, (4) receiving mechanical ventilation, (5) pregnancy, (6) current prisoner status, (7) having been pronounced brain dead, (8) unstable hypotension or bradycardia, (9) having been referred to music therapy with a goal of stimulation (eg, comatose patients), (10) enrollment in another research study, and (11) inability to provide consent. Fifty-four patients declined to participate, and 129 patients were deemed ineligible as a result of meeting exclusion criteria.

Study Design

The study used a pretest-posttest, within-subject, single-group design. Participants were offered a single, 30-minute music therapy session with a board-certified music therapist. Before the session, the music therapist recorded the patient's vital signs (heart rate, respiratory rate, and oxygen saturation level) and self-assessed pain and anxiety levels on a Likert scale ranging from 0 to 10. After assessing the patient's needs, the music therapist selected 1 of 2 music therapy interventions: a relaxation/guided imagery intervention or a "song choice" intervention. At the conclusion of the music therapy session, the patient's vital signs were again recorded, along with self-assessed pain and anxiety levels, for comparison with preintervention data.

The music therapy intervention was either a relaxation/guided imagery experience or a song choice experience.

Intervention

The intervention consisted of either a relaxation/guided imagery experience with live music or a "song choice" experience with live music, in which the participant discussed the lyrics of a favorite song or songs after either listening to or singing the song or songs with the music therapist. The music therapist assessed the immediate needs of the patient and selected 1 of the following 2 interventions:

Relaxation/Guided Imagery. The music therapist and patient chose music or a musical style, to be presented live (on guitar) by the music therapist, for a relaxation experience. The patient was instructed in relaxation techniques, such as focused breathing and/or simple imagery. The music therapist would initiate the music's tempo, volume, and intensity on the basis of the patient's current heart rate and/or respiratory rate, and then alter the music to facilitate a relaxation response. In this process, the tempo of the music, or beats per minute, is initially matched with the patient's heart rate or respiratory rate; then, the tempo (as well as the volume and intensity) is gradually decreased in an attempt to synchronize the heart rate (or respiratory rate) with the music. This concept is known as "entrainment," in which the rhythms of the body coordinate with the rhythms and intensity of the music. This can be accomplished only with the use of live music, provided "in the moment" by a music therapist. The goal of this intervention is to reduce anxiety and/or pain perception and promote relaxation through a focus on the music and the relaxation techniques.

Song Choice. The music therapist and the patient discussed the patient's current physical and emotional states. The music therapist facilitated a conversation about the use of music or songs to help with the expression of feelings or thoughts. The patient was offered the opportunity to either choose a song or songs or have the music therapist choose a song or songs on the basis of their conversation that would either be meaningful to the patient or reflect how the patient was feeling at the moment. The music therapist presented the song or songs and encouraged the patient to participate by either singing along or actively listening to the lyrics. The patient was encouraged to discuss the song lyrics, the feelings the song elicited, or what the song meant to him or her. The goals of this intervention are to create a positive and empathic interaction between the music therapist and the patient, reduce anxiety and/or pain perception, and encourage self-expression and the use of music and songs to cope with hospitalization, treatment, and recovery.

Measurements

The physiological measures of heart rate, respiratory rate, and oxygen saturation level were recorded by the music therapist directly from the patient's bedside monitor before and immediately after the music therapy session. Psychological measures, including pain and anxiety, were self-reported by the patient before and immediately after the music therapy session on a Likert scale ranging from 0 to 10. The physiological data as well as the patient's self-reported anxiety and pain were recorded on a data collection form that was developed by the research team.

Procedures

The research team collaborated with the ICU nurses and charge nurse to identify potential study participants. After the patient's consent was obtained, a single music therapy session was scheduled. Once the baseline demographic data were collected, the music therapist entered the participant's room, introduced himself, and explained what the music therapy session would entail. The music therapist then presented a pain and anxiety assessment tool and asked the participant to self-report his or her current pain and anxiety levels on a scale of 0 to 10. The music therapist then collected the physiological data for heart rate, respiratory rate, and oxygen saturation level from the bedside monitor. Concurrently, the music therapist assessed the patient's current needs and desired level of participation. With this information, the music therapist decided which music therapy intervention to use. The music therapist then conducted the music therapy intervention. Afterward, in accordance with standard music therapy practice, the music therapist spent 3 to 4 minutes discussing the experience with the patient (verbal processing). At the conclusion of the session, the music therapist again asked the participant to report his or her pain and anxiety levels on the data collection tool. Concurrently, the music therapist collected postsession physiological data from the in-room monitor.

Statistical Analyses

Statistical analyses were performed using the SAS and R programs. A paired *t* test was used to determine differences between preintervention and postintervention pain and physiological stress scores. The data were analyzed first as a single-group design

Entrainment is when the rhythms of the body coordinate with the rhythm and intensity of the music.

Table 2
Summary of participants' demographic and medical information (N=52)

Characteristic	Value ^a
Age, median (range), y	62 (20-89)
Sex	
Women	33 (63)
Men	19 (37)
Race	
White	40 (77)
Black	5 (10)
Asian	2 (4)
Hispanic	1 (2)
Other	4 (8)
Days in intensive care unit	
1	25 (48)
2	18 (35)
3	4 (8)
4-8	5 (10)
Intravenous infusion	
Analgesia	10 (19)
Vasopressor	5 (10)

^a Value is number (percentage) unless otherwise indicated in the first column.

for the primary analysis. Several secondary analyses were then conducted, with stratification by type of treatment, presence of family members in the room (yes or no), age (split into groups at the median value of 62 years), and sex. Patients who fell asleep during the intervention were unable to provide self-reported postintervention values for pain and anxiety. These missing data were analyzed in 3 ways. First, the missing values were excluded from the sample and the *t* test was performed using available values. Second, single imputation was employed for the missing values using 0 (as suggested by the patient's ability to fall asleep), the lowest point on the scale. Third, multiple imputation analyses were performed, in which missing data were imputed according to regression models relating the missing data to the observed data,

A music therapist can respond "in the moment" to the patient's needs.

selected using a stepwise regression procedure. The imputation was repeated 1000 times, and the results were summarized using the method developed by Rubin.¹⁹ Power calculations suggested that a sample of 50 participants would have more than 80% power to detect a mean change of 0.4 SDs with an α of .05.

Results

A total of 52 adult patients consented to participate in the study. Most of the patients were white ($n = 40$, 77%) and female ($n = 33$, 63%), and the

median age was 62 years (range, 20-89 years). Nearly half of the participants ($n = 25$, 48%) had been in the ICU for only 1 day when they received the intervention, with the average length of stay at the time of the intervention being 2.4 days (Table 2). Fifteen patients were receiving intravenous infusions: 10 were receiving analgesia for pain, and 5 were receiving a vasopressor for hypotension. When self-reported pain and anxiety were compared between the 2 interventions, no significant differences were detected. Of note, more patients fell asleep during the relaxation intervention than during the song choice intervention (10 vs 2 patients, respectively). Therefore, the imputed values in the secondary analysis for sleeping patients on self-reported measures are closer to those in the primary analysis for the song choice intervention than for the relaxation intervention. The results for each analysis are presented in Tables 3 and 4.

Having observed significant differences in pretest-posttest respiratory and heart rates, we examined these differences according to patient sex and age. No differences were found between men and women, with the exception of a larger effect size in women for heart rate, with a mean decrease of 6.91 beats per minute (95% CI, 4.12-9.70; $P < .001$). The mean decrease for men was 4.16 beats per minute (95% CI, 2.08-6.24; $P < .001$). The results as stratified by patients' age (above and below the median of 62 years) showed no significant differences between younger and older patient groups.

Although it was unanticipated in the study design, family members were often present when the intervention was conducted. Consistent with the family-centered philosophy of the hospital, family members were invited to stay for the session or take a break, as they preferred. Given this option, we examined the impact of the presence of a family member during the intervention. No differences were detected between presence and nonpresence of family members. The mean decrease in self-reported pain with family members present was 1.18 points (95% CI, 0.49-1.86; $P < .001$), and the mean decrease in self-reported anxiety with family members present was 3.06 points (95% CI, 1.99-4.13; $P < .001$). The mean decrease in self-reported pain without family members present was 1.17 points (95% CI, 0.63-1.72; $P < .001$), and the mean decrease in self-reported anxiety without family members present was 2.48 points (95% CI, 1.83-3.13; $P < .001$).

Discussion

The purpose of this study was to investigate the effects of 2 music therapy interventions on 3

Table 3
Primary and secondary analyses of physical and self-reported measures

Variable	Mean (95% CI)		Mean difference ^a (95% CI)	P value ^b
	Before	After		
Primary analyses				
Respiratory rate, breaths per minute (n=52)	21.23 (19.8-22.67)	17.58 (16.42-18.73)	3.65 (2.59-4.72)	<.001
Heart rate, beats per minute (n=52)	89.31 (84.13-94.48)	83.40 (78.06-88.75)	5.90 (3.99-7.81)	<.001
Oxygen saturation level, % (n=52)	97.25 (96.66-97.84)	97.12 (96.37-97.85)	0.13 (-0.32-0.59)	.56
Self-reported pain, points (n=40)	3.27 (2.52-4.02)	1.73 (1.11-2.34)	1.18 (0.77-1.58)	<.001
Self-reported anxiety, points (n=40)	4.90 (4.23-5.58)	2.10 (1.5-2.7)	2.73 (2.16-3.29)	<.001
Secondary analyses with imputations (n=52)				
Self-reported pain, points (SI)	3.27 (2.52-4.02)	1.33 (0.82-1.83)	1.94 (1.30-2.59)	<.001
Self-reported pain, points (MI)	3.27 (2.52-4.02)	1.95 (1.40-2.51)	1.31 (0.92-1.71)	<.001
Self-reported anxiety, points (SI)	4.90 (4.23-5.58)	1.62 (1.10-2.13)	3.29 (2.64-3.93)	<.001
Self-reported anxiety, points (MI)	4.90 (4.23-5.58)	2.09 (1.59-2.60)	2.81 (2.31-3.31)	<.001

Abbreviations: MI, multiple imputation; SI, single imputation.
^a Before value minus after value.
^b From paired t test.

Table 4
Primary and secondary analyses of physical and self-reported measures presented by intervention type

Variable	Relaxation/imagery intervention (n=28)				Song choice intervention (n=24)			
	Mean (95% CI)		Mean difference ^a (95% CI)	P value ^b	Mean (95% CI)		Mean difference ^a (95% CI)	P value ^b
	Before	After			Before	After		
Primary analyses								
Respiratory rate, breaths per minute	20.25 (18.53-21.97)	16.61 (15.30-17.91)	3.64 (2.14-5.15)	<.001	22.38 (19.96-24.80)	18.71 (16.70-20.71)	3.67 (2.04-5.30)	<.001
Heart rate, beats per minute	89.96 (84.16-95.77)	81.54 (75.39-87.68)	8.40 (5.33-11.52)	<.001	88.54 (83.08-94.00)	85.58 (76.01-95.16)	2.96 (1.46-4.46)	<.001
Oxygen saturation level, %	96.89 (96.02-97.76)	96.661 (95.51-97.71)	0.29 (-0.47 to 1.05)	.45	97.67 (96.83-98.50)	97.71 (96.72-98.70)	-0.04 (-0.55 to 0.46)	.87
Self-reported pain, points	3.79 (2.64-4.93)	1.89 (0.78-2.99)	1.06 (0.48-1.63)	.001	2.67 (1.76-3.58)	1.59 (0.86-2.32)	1.27 (0.66-1.89)	<.001
Self-reported anxiety, points	5.43 (4.51-6.35)	2.28 (1.24-3.31)	3.06 (2.18-3.93)	<.001	4.29 (3.29-5.29)	1.95 (1.20-2.71)	2.45 (1.67-3.24)	<.001
Secondary analyses with imputations								
Self-reported pain, points (SI)	3.79 (2.64-4.93)	1.21 (0.44-1.99)	2.57 (1.49-3.65)	<.001	2.67 (1.76-3.58)	1.46 (0.76-2.15)	1.21 (0.64-1.78)	<.001
Self-reported pain, points (MI)	3.79 (2.64-4.93)	2.38 (1.54-3.22)	1.40 (0.84-1.97)	<.001	2.67 (1.76-3.58)	1.46 (0.78-2.13)	1.21 (0.65-1.77)	<.001
Self-reported anxiety, points (SI)	5.43 (4.51-6.35)	1.46 (0.69-2.24)	3.96 (2.97-4.96)	<.001	4.29 (3.29-5.29)	1.79 (1.07-2.52)	2.5 (1.77-3.20)	<.001
Self-reported anxiety, points (MI)	5.43 (4.51-6.35)	2.29 (1.52-3.06)	3.14 (2.43-3.84)	<.001	4.29 (3.34-5.24)	1.86 (1.23-2.50)	2.43 (1.73-3.12)	<.001

Abbreviations: MI, multiple imputation; SI, single imputation.
^a Before value minus after value.
^b From paired t test.

physiological measures (heart rate, respiratory rate, and oxygen saturation level) and self-reported pain and anxiety among patients in an ICU. After participating in a single music therapy session, patients reported lower pain and anxiety and had decreases in both heart rate and respiratory rate, with no changes in oxygen saturation level detected. Examining each intervention individually, a similar responsiveness profile emerged, with the only difference being in heart rate: participants who received the relaxation intervention had a greater decrease in heart rate than did those who received the song choice intervention.

The positive findings related to heart rate and respiratory rate in patients receiving the relaxation intervention may reflect the presence of a music therapist, who could respond to the patient “in the moment,” in 2 interrelated ways. First, the therapist could select the intervention in response to the patient’s current needs. Second, the therapist could modify the elements of the music—tempo, timbre, and modal elements—during the intervention in an attempt to guide the patient into a more relaxed state. When the tempo and intensity of the music are matched to the patient’s heart rate or respiratory rate and then adjusted, the patient may “entrain,” with heart rate and respiratory rate synchronizing with the music.¹ This process can promote changes in the patient’s physiology.

Although both interventions appeared to have a positive impact on patients’ physiological measures, some differences were noted. Patients receiving the relaxation intervention had a greater decrease in heart rate (8.40 beats per minute; 95% CI, 5.33-11.52; $P < .001$) than did those receiving the song choice intervention (2.96 beats per minute; 95% CI, 1.46-4.46; $P < .001$). Additionally, more patients fell asleep during the relaxation intervention (10) than during the song choice intervention (2). This finding may indicate that patients receiving the song choice intervention took a more active role during the session (actively listening, singing) than those receiving the relaxation intervention, affecting the type of relaxation experienced during the session. However, as respiratory rates decreased at similar levels in the 2 interventions, moderators of this benefit are not yet known.

Changes in self-reported anxiety and pain perception further support the presence of a music therapist and adaptability of the interventions. With the flexibility to select the music intervention, as well as the manner in which the musical elements were presented, the therapist could tailor the intervention to the patient’s current needs. Whereas some patients

found the song choice intervention to be especially beneficial (either listening to or singing along with meaningful songs) as a means of addressing psychological distress, other patients preferred the relaxation intervention, allowing the music to guide them into a more relaxed and comfortable physical and psychological state.

The findings from this study also showed no significant differences in responsiveness to the interventions based on the patient’s age (median, 62 years), the patient’s sex, or the presence of a family member. These findings suggest that the benefits of these music therapy interventions are not age- or gender-specific, further supporting the presence of a music therapist who can tailor the music intervention to the patient’s preferences.

Limitations

Although these findings suggest benefits from participation in a single music therapy session, the study had some limitations. The lack of a control or comparison group limits the intervention outcomes and prevents direct examination of the differential treatment effects of a music therapy intervention versus a music listening intervention. Direct comparison of these interventions, including moderators of intervention effectiveness, is essential to clarify differences and identify conditions under which each intervention may benefit a patient. In addition, the single postintervention measurement limits our understanding of the duration of each intervention’s impact. There was potential for bias in the patient’s self-report of pain and anxiety, as these data were collected by the music therapist. Another limitation is that the study was conducted in a single critical care environment in a community hospital. The study was originally intended to include patients receiving mechanical ventilation; however, limited resources prevented the involvement of critical care nurses, which would have enabled evaluation of patients before and after the intervention using validated nursing assessment tools.

Conclusion

As ICU treatment teams seek to reduce reliance on medications to address patients’ needs,⁸ non-pharmacological interventions, including music-based interventions, are being more widely implemented. Although findings from studies of music-based interventions in the ICU are mixed, the results of this study indicate that reductions in pain, anxiety, heart rate, and respiratory rate can be achieved after a single music therapy session. The presence of a

music therapist, who can tailor an intervention to the patient's immediate physiological and psychological needs, may be an important variable in the differential effects of these interventions.

Future research should address the timing and quantity of music therapy sessions in the ICU and whether additional sessions, scheduled at specific times of day, might improve patients' medical or psychological outcomes. Similarly, following up with patients after they leave the ICU and addressing any psychological distress they experience may also affect long-term health outcomes after an ICU stay.^{20,21} The promising results from this study underscore the value of nonpharmacological interventions and the need for larger, multisite studies in the highly technical environment of critical care.

ACKNOWLEDGMENTS

The authors gratefully acknowledge the ICU and nursing leadership at Inova Loudoun Hospital, Leesburg, Virginia, for its support. This abstract was presented at the International Congress of Integrative Medicine and Health Conference in Baltimore, Maryland, May 9-10, 2018. The study was also presented at the ANCC National Magnet Conference in Denver, Colorado, October 26, 2018.

FINANCIAL DISCLOSURES

Raymond Leone is an employee of A Place to Be, which provides contracted services to Inova Loudoun Hospital.

SEE ALSO

For more about music therapy, visit the *Critical Care Nurse* website, www.ccnonline.org, and read the article by Supnet et al, "Music as Medicine: The Therapeutic Potential of Music for Acute Stroke Patients" (April 2016).

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Laura Jackson

From: Shelby Reynolds
Sent: Sunday, June 30, 2019 10:46 AM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professions,

My name is Shelby Reynolds and I am a Board Certified Music Therapist working at Piedmont Geriatric Hospital. Piedmont is a state psychiatric facility for those 65 and older located in Burkeville, VA. I am writing to you today to express my support for licensure for Music Therapy in the commonwealth.

My colleagues and I recently presented a workshop at my place of work on Music Therapy and specialized trainings specific to the profession. This was an opportunity to provide education on the profession to the public and how the patients at Piedmont can benefit from Music Therapy services. Unfortunately, most of those in attendance were non-music therapists with the intent to implement “music therapy” in their places of work. While other professionals use music in their practice, it is imperative that one remains within their scope of practice. Music therapists work with vulnerable populations after becoming board certified, which requires a four year degree, multiple clinical placements, a 6 month internship, and passing of the certification exam. This is the equivalent of if I went to a physical therapy workshop with the expectation of implementing “physical therapy” in my own work afterwards. That would be outside of my scope of practice. While I may be able to improve my own practice and clinical skills, I certainly wouldn't claim to be using physical therapy techniques. The opportunity for harm of the public is too great to continue without occupational regulation.

I was fortunate enough to be able to intern with Blue Ridge Hospice in Winchester, VA, a nonprofit that saw the emotional, monetary, and physical value of Music Therapy. I saw patients with a variety of diagnoses with a variety of time left on earth. In my role as Music Therapy intern, I was able to provide services to patients, under supervision, who were in great deals of pain. It is through Music Therapy that I was able to help people decrease their pain during our sessions without the use of pharmaceuticals. Music Therapy allows for patients to decrease their need for pain medication and to maximize their quality of life by providing increased meaningful interactions with loved ones.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase access to appropriately trained clinicians.

Thank you,

Shelby Reynolds

--

Shelby A. Reynolds, MT-BC
Music Therapist - Board Certified

VASTF Co-Chair - vastfmt@gmail.com
(540)222-9627
shelby.a.reynolds@gmail.com

Laura Jackson

From: Anna McChesney (via Google Docs)
Sent: Monday, July 1, 2019 8:18 AM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA
Attachments: MT License Testimony 6-2019.pdf

anna@healingsoundsrva.com has attached the following document:



MT License Testimony 6-2019



Please see the attached letter regarding licensure of music therapy in Virginia.

Anna McChesney, MS, LPC, MT-BC

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July 1, 2019

Dear Board of Health Professions,

I am writing in support of a license for music therapists to practice in the state of Virginia. I was born and raised in Virginia, and choose to raise my family and have a thriving business in Midlothian, Virginia. My first “real job” was through Henrico County Public Schools in the greater Richmond area. I received my Masters of Science in Rehabilitation Counseling from Virginia Commonwealth University and have two Bachelor of Music degrees from East Carolina University. In this testimony, I will speak to the criteria enumerated in “Invitation for Public Comment on the Review of the Need for Regulation of the Practice of Music Therapy in Virginia,” sharing my perspective having worked with people of all ages and abilities in private practice and within the Department of Education for over ten years.

Music therapy is an allied health profession rooted in deep history. Music therapy became an official profession with true collegiate degrees after the successful use of music therapy interventions during World War II. Music therapy is the use of individualized music interventions based on client preference to reach non-musical goals within the emotional, social, behavioral, spiritual, and cognitive domains. A music therapist is board certified only after completing coursework at an approved music therapy program, completing a 6 month internship and passing the board exam.

Music therapy is a truly unique set of therapeutic skills, as we prescribe specific musical elements to cue behavioral responses and promote clinical change throughout the music therapy treatment process. While other professionals often use music in educational and therapeutic activities, many of them are not trained musicians and do not have the in-depth and complex understanding of the musical elements and their effects on human psychology or physiology. Furthermore, given that music is a nonverbal form of expression, music therapists, have extensive experience communicating through nonverbal-musical means and interpreting nonverbal behaviors.

As with any helping profession, trends in healthcare and education are constantly transforming and quality continuing education is imperative. New music therapy techniques are studied and published in our professional peer-reviewed research journals, and new programs are designed across the globe in the field of music therapy. Since clinical musical skills are critical to the practice of music therapy, the music therapist is required to continue development of instrumental and vocal competencies and repertoire throughout his or her career. Furthermore, since music therapy practice is dynamic and complex, we often need connection

with other music therapists for mentorship and support so that we can maintain clinical objectivity and ethical practice.

After completing all of my music therapy requirements, I moved back to Richmond, VA for a job with Henrico County Public Schools. During my 12 years in my music therapy position, I worked within the scope of the Virginia Department of Education, State Operated Programs (SOP) at three juvenile detention centers in the area. Although a music therapist, I was part of the traditional school day; meaning, all students received music therapy services while in detention. These students were the areas most at-risk children. Many had traumatic histories at home, inconsistent parenting, failure at school, and illegal behavior. The Virginia Department of Education realized that music therapy was necessary for these children to achieve academic and personal success.

During my time with the Virginia Department of Education I co-authored an art and music therapy curriculum to formalize our scope of practice and outline the standards of learning for therapists working in this setting across the state. This document is available on the state's website. The curriculum was used during the orientation of all art and music therapists through SOP and all therapists were expected to document their interactions with the students using the standards and objectives created based on best practice. In addition, the curriculum was used to explain to the leadership of each school and facility what we do on a day to day basis. The curriculum was so fruitful in advocating for our work, that I have utilized it's contents in several presentations, workshops, and continuing education events throughout the country. The curriculum is still used today and is living proof of what music therapy in its purest form looks like.

I left that position not because I wasn't passionate about working with these children, because I was. I left because during the time I worked there, I went back to school for my Master's degree and attained my License as a Professional Counselor and wanted to work closer with these children on an individual basis. Through my new LPC I could continue to find new ways to help them thrive in the community. So, I began my own private practice providing both music therapy and counseling services in the greater Richmond area.

Over the last 7 years, I have also partnered with Virginia Commonwealth University, school of music, to develop a curriculum for a Bachelor's of Music Therapy program. A team of higher education leaders, educators, and music therapists were asked to develop the program in hopes that the program would fill a void with the school of music. Graduates were reporting that they could not find a job in composition, performance, or education and were longing for a position that put helping and music together. Other students were leaving due to desiring music therapy as a career. Although the degree program has not begun, I began teaching a course, Introduction to Music Therapy open to all students from the University interested in learning

more about the profession whether it be for a career choice or for future advocacy or collaboration. I am no longer teaching this course, another colleague is, and she has begun a secondary service-oriented course for students that are interested in furthering their knowledge. However, it is important to note that these students are not doing music therapy. They are not in school for music therapy and do not have the skills to do such an intensive program.

My private practice is now a team of four music therapists, an administrative assistant and at times, an intern. My private practice is one that now serves over 250 people per week in over 20 locations in Richmond. We work in schools, hospitals, behavioral health units, adult day care, and memory support. The people we serve are of all ages and abilities. We exist to help people facilitate growth. The people of Richmond understand the benefit of true music therapy services. We consistently educate community on the differences between music therapy, music education and entertainment. Advocating for our profession is a huge part of our business.

Additionally, I have been providing professional development and training to music educators in Chesterfield County over the last two years. More and more teachers are being asked to provide a music class to kids with severe disabilities. They are expected to have knowledge of these disabilities and adapt their music education curriculum to their needs. These teachers were trained to become general music teachers, band leaders, and choral directors; not special needs music teachers. While some are able to bend the curriculum to meet the students needs, others are struggling. They believe they are not skilled enough to give the students what they need, which many of them say are not music education skills. These students are not receiving the depth of services that they need, music therapy, and are possibly being harmed by under-trained teachers in the process.

I have recently become aware that without state recognition of music therapy practice, even public school students are not guaranteed access to quality music therapy services even if the IEP team determines that it is educationally necessary. There is no better example of this than what happened in Loudoun County in recent years where the district determined that since the Local Education Agency (LEA) was allowed to determine the qualifications of a music therapist, they could completely cut music therapy programming and task teachers with providing music therapy services. In my informed opinion this was highly unfair to teachers, who already buried in requirements, and a trivialization of the skills and training possessed by music therapists to meet the unique needs of students served in the county. Had music therapy been a licensed profession, this would not have happened because the school district would have been required to abide by the state's licensure requirements.

Many related professionals such as therapists and teachers have verbally expressed concern and confusion over the fact that music therapists currently do not need a license to practice in Virginia, even though we work with the same vulnerable individuals. Music

Therapists go through extensive training to earn a degree in music therapy, complete training through field placement and internships, and take a national board certification exam to demonstrate competence in the unique music therapy scope of practice.

I am asking the state of Virginia to regulate the practice of music therapy and to recognize that the MT-BC (Music Therapist - Board Certified), awarded by the Certification Board for Music Therapists, denotes the appropriate level of education and training for a music therapist. Thank you for your attention to this important issue.

Sincerely,

Anna McChesney, MS, LPC, MT-BC
Director, Healing Sounds, LLC
2530 Olde Queen Ter.
Midlothian VA 23113
804.651.1393
anna@healingsoundsrva.com

Laura Jackson

From: Gabriel
Sent: Monday, July 1, 2019 8:00 AM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA

To whom in concerns,

My name is Gabriel Villarreal, LPC. I own and operate within my private practice "ADHD Counseling in the Roanoke Valley" and I have recently been made aware of a push for state licensure of music therapists. This is a must; I work with the best music therapists in the area because I have done my due diligence with connecting with them, but also when referring my clients appropriately. The general public doesn't have this luxury, nor time, when their needs are immediate. So I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Best,

--

Gabriel Villarreal, LPC
Counselor of [ADHD Counseling in the Roanoke Valley](#)
Host of [Informed Consent Podcast](#)
Gabriel@roanokeADHD.com

"The moment you doubt whether you can fly, you cease for ever to be able to do it." ~ J.M. Barrie, Peter Pan

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Laura Jackson

From: Sarah Wardle Jones
Sent: Monday, July 1, 2019 10:26 AM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professions:

My name is Sarah Wardle Jones and I'm the Community Engagement & Education Director for the Roanoke Symphony Orchestra. I facilitate an RSO program called Wellness Arts that provides therapeutic music to people suffering from Alzheimer's and dementia. We have had the pleasure of working with a certified music therapist in designing our program and training our musicians and facilitators. I have personally witnessed both the power of music to heal--particularly in the hands of a well-trained, medically informed therapist. We are experts in music and know anecdotally how music can move people. We are not, however, experts in therapy and do not claim to be. Our musicians have been trained to use music to soothe, energize and stimulate because our music therapist understands deeply how music interacts with the brain and the body and has designed our programs with razor-sharp specificity. The guidance of our music therapist was invaluable. We have been able to confidently use music to help people suffering with memory related diseases because our music therapist uses her clinical experience, and research-based practices to ensure our program is safe & helpful, not inadvertently harmful or upsetting.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Sincerely,

Sarah Wardle Jones
Community Engagement & Education Director
Roanoke Symphony Orchestra

128 E. Campbell Ave.
Roanoke, VA 24011
direct: 540-682-8317
office: 540-343-6221

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Laura Jackson

From: Dolores Heidenthal
Sent: Monday, July 1, 2019 9:32 AM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in Virginia

Dear Board of Health Professions,

I am the grandmother of a 13 year old boy with multiple disabilities that include: blindness; autism; and intellectual special needs. He has received professional Music Therapy been at A Place to Be for six years. Each quarter we receive an assessment of progress and list of goals for the future. My grandson loves his teacher and lessons and never wants to miss.

The therapy has greatly improved his ability to speak. He is able to ask and answer simple questions. He has also been taught to sing in a concert setting, which he does four times a year. We could never have discovered this ability without A Place to Be. They offer many additional opportunities to move students forward and graciously include my grandson. Please feel free to contact me if you have any questions or concerns.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients and families seeking Music Therapy services and increase consumer access to appropriately trained clinicians.

I

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Dolores Heidenthal,
42825 Ridgeway Dr, Broadlands, VA 20148

Cell: 703-217-5001 (Text friendly)

Laura Jackson

From: Patrick Heidenthal
Sent: Monday, July 1, 2019 11:02 PM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in Virginia

Dear Board of Health Professions,

For the past six years I have been taking my grandson to Music Therapy lessons at A Place to Be (APTB.) The highly educated, caring music therapists and programs are very well planned and executed. We have seen benefits from the sessions in many different areas. He now speaks more, sings more, and has overcome many tactile phobias playing drums and piano. He can use a microphone, introduce his song and take a bow at the end. This is done before a crowd of up to 300 people. Only a professional could achieve this kind of results from a boy almost speechless with Autism.

In 2014, we did not know what to expect, but now see how beneficial these sessions are that have given confidence and skills to a young man.

I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Whenever APTB

--

Patrick Heidenthal
Cell: (703) 328-6136

Laura Jackson

From: Catherine Backus
Sent: Monday, July 1, 2019 11:54 AM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professionals,

My name is Catherine Backus, MT-BC, and I am a board certified music therapist currently working in private practice and serving clients throughout the Roanoke and New River valleys. I work in a variety of settings including public schools, skilled nursing facilities, and contracted pre-employment training groups through the Department of Aging and Rehabilitative Services.

In my work, I have unfortunately come across unqualified persons claiming to provide music therapy. They have not completed the requisite 1200 hours of supervised clinical training, earned a Bachelor's Degree from an accredited university, and most importantly, are not able to be held accountable to the Certification Board for Music Therapists in the event that they practice outside of our professional scope of practice. These unqualified persons are not trained to deal with possible contraindications of music, or to navigate the ethical quandaries of our profession (MT-BCs must maintain continuing education in the field, including mandated Ethics training, for 100 credit hours every 5 years).

Music Therapy is an incredibly effective, research supported modality when provided by qualified professionals. State licensure, reflecting the existing MT-BC credential will protect clients and patients from harm, and provide an avenue for accountability in the event of malpractice.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.



Catherine Backus, MT-BC

Board Certified Music Therapist

Anderson Music Therapy Services

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Old Southwest: 1217 Maple Avenue, Roanoke, VA 24016

Mail: PO Box 20736, Roanoke, VA 24018

w: www.amusictherapy.com



Laura Jackson

From: Miriam Smith
Sent: Tuesday, July 2, 2019 7:48 AM
To: laura.jackson@dhp.virginia.gov
Subject: Support of Music Therapy Licensure in Virginia

Dear Board of Health Professionals,

My name is Miriam Smith and I'm a Board-Certified Music Therapist and business owner in our Commonwealth. I'm writing to you to express my support for the need of licensure for music therapy. I know how incredibly important quality services are to the clients and families that we serve on a daily basis. Music therapy is an effective method of treatment often for those that feel they have nowhere else to turn.

I work with pediatric hospice patients and get the privilege of seeing the impacts that music therapy can have first hand. When implemented by a trained professional, music therapy can allow for clients to access physical and emotional growth beyond traditional methods. I cannot describe the feeling of seeing a family interact with their child for the first time verbally through music or when they can grasp an object or make a decision on their own that their family can completely understand. It is more rewarding than I could have ever imagined.

I have also had the unfortunate experience to see the impact that music implemented by untrained professionals can have on families and individuals. As music therapists, we undergo extensive training in mental health, physical, emotional and social domains. We are trained to assist clients work through issues that may arise during musical exposures. We can help them work through sudden emotional responses to music. This is not something that a normal musician is trained to help with. Music is intrinsically therapeutic and can help many people, but when implemented by a trained professional it can not only provide a more significant impact, it can also provide healing and growth in times of need. Please help me to continue to do this work in confidence knowing that trained professionals are not a luxury, but a necessity. Thank you for your time and consideration!

Miriam Smith, MT-BC
Executive Director, [Commonwealth Music Therapy](#)
Virginia Music Therapy Association Past-President

"Where words fail, music speaks" ~H. C. Anderson

Laura Jackson

From: Becky Sowers
Sent: Tuesday, July 2, 2019 11:13 AM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professions,

I am a board-certified music therapist in Fairfax County Public Schools. I have worked in FCPS for 15 years and am the FCPS Music Therapy Internship Director. I mainly work with students from preschool through 4th grade with autism and other developmental disabilities. I have also supervised over 20 music therapy interns through our highly qualified internship program. Our internship program has been active for over 30 years! So this letter is not only advocating for the safety of our school aged students but also our college aged students who are about to begin their music therapy career.

I am hoping this letter will bring awareness to a situation that is potentially harmful for our students. Music Therapy is a related service and can appear on a students IEP. Under the current legislation, any person that teaches music can service these needs. Although these music teachers may be very talented, they are not trained in music therapy. I have heard from numerous parents over the frustration they have due to insufficient services. If a student receives music therapy services, it just seems obvious that a board-certified music therapist should provide these services. But this is currently not the case.

In summary, I ask that you **support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.**

Thank you so much for your attention to this important matter!

Becky Sowers, MT-BC, MEd

Laura Jackson

From: Heather Lipscomb
Sent: Wednesday, July 3, 2019 9:08 AM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA

Good Morning!

My name is Heather Lipscomb. I am a Registered Nurse at Inova Loudoun Hospital on an Oncology Unit. I would like to share my experience with you regarding our amazing Music Therapy department and the importance of this licensure.

Music therapy is essential in the specialty I work. Patients are struggling with intense chemotherapy regimens, their lives have been forever changed due to the diagnosis. There are extreme levels of emotion (sadness, anger, denial, anxiety, fear) and physical symptoms (pain, nausea/vomiting). And unfortunately being in an Oncology Unit, I see quite a few deaths. Music therapy provides support for all. It brings life to those struggling to find the strength. It brings peace to those facing the death of a loved one. It provides distraction from the physical symptoms, requiring less medication management. A simple "Happy Birthday" song can make a difference to someone spending the Birthday in a hospital.

A bit of selfishness if I could. Oncology Nurses experience the "emotional symptoms" as this patient and family. Our levels of anxiety, sadness and anger are comparable. Listening to our amazing Music Therapists can quiet a tense unit. We all will stop, take a deep breath, re-focus, allowing us to continue providing exceptional care to our patients and families.

Licensure should be required. The therapists are with our patients. There is a level of trust. There are multiple legal concerns in healthcare, all with the patient in mind. We require a license for our nurses, physicians, physical therapists... on and on.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Sincerely

Heather Lipscomb, RN

Sent from my Sprint Samsung Galaxy S7.

Laura Jackson

From: Brenda Clarkson
Sent: Wednesday, July 3, 2019 10:39 AM
To: laura.jackson@dhp.virginia.gov
Subject: Comments
Attachments: FinalCommentsMusicTherapy2019Signed.docx

Laura, Please find attached our comments about licensure of music therapy/therapists.
Many thanks for this opportunity.



Brenda Clarkson
Executive Director
The Virginia Association for Hospices & Palliative Care
www.virginiahospices.org



(804) 740 1344

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July 2, 2019

Thank you for the opportunity to comment about to The Department of Health Professional about the licensure of music therapists.

The Virginia Association for Hospices and Palliative Care is composed of hospices and individuals supporting the mission of hospice and palliative care. Quality, compassionate care for people facing a life-limiting illness or injury is the hallmark of hospice and palliative care. Each hospice and palliative care organization is staffed by a multi- and inter-disciplinary team of health professionals and trained volunteers. These include at a minimum physicians, nurses, clergy/counselors, social workers, and hospice aides. Some of our member hospices also employ credentialed music therapists because of the unique services they provide to their clients. As well, hospices may employ health professionals who employ the incidental use of music in their work with clients, such as one hospice member whose chaplain uses a ukulele in his ministry.

Our association supports, at a minimum, title protection for music therapists, because we believe music therapy is a specialized health profession. We are not opposed to licensure for music therapists so long as the incidental use of music in hospice by other disciplines is not inadvertently prohibited. Our concern with the bill is that the definition does not do a clear enough job of carving out the use or incorporation of music *incidental* to other clinical, therapeutic, spiritual, or volunteer interventions. This leaves the exact interpretation up to individual regulators, making it highly subjective and unpredictable. We recommend the following addition at the end of the definition -

"Notwithstanding anything in this section, the foregoing shall not be interpreted to prohibit an individual who is not a licensed music therapist from engaging in unstructured musical activities with a client or from documenting and implementing general music-related preferences expressed by the client or a client's representative."

Thank you so much for this opportunity to provide comment.

Sincerely,

Brenda Clarkson, Executive Director.

Natasha Walsh, Board President.

Laura Jackson

From: Rivas Berger, Mariagracia Estrella.
Sent: Wednesday, July 3, 2019 11:16 AM
To: laura.jackson@dhp.virginia.gov
Cc: vastfmt@gmail.com
Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professions,

My name is Mariagracia Rivas Berger and I am a board-certified music therapist working in the Center for Cancer & Blood Disorders at Children's National. I am also a current full-time supervisor for music therapy students which has provided me with an additional insight into the importance of clinical training and would like to speak on the importance and need for licensure in VA, which is where I reside.

I focus on a wide range of goals in my setting but have listed a few of them below:

- Individualize interventions for pain management
- Utilize singing (being careful with the lyrics and music elements I use) to allow patients to self-express or cope during their diagnoses.
- Assist with rehabilitation when appropriate as music therapy has shown to regain speech and form new neuropathways in the brain.
- Use music-making to increase autonomy and socialization.
- And utilize interventions to reduce anxiety and aid our medical staff during procedural support.
- Provide heartbeat recordings as legacy-making for patients nearing end of life.

As you may know, music therapists work with vulnerable populations, targeting specific goals, and music when not used intentionally or appropriately can cause emotional and even physical harm:

- Because rhythm entrains (syncs) the body and brain, if the tempo of music (live or recorded) does not compliment a patient's movement, muscles can work against each other.
- Music can also increase stress and anxiety or have a negative emotional impact if a patient has a specific association with a song, which is why we are trained therapists that can provide verbal processing after music interventions.
- Stress can raise a patient's heart rate and oxygen saturation, which can be fatal for some patients, and that stress may stem from being triggered by misuse of music.

Additionally, when working with children or in the neonatal intensive care unit, the wrong use of instruments can actually harm a child's development and brain.

There are people in this country claiming to be music therapists without the education or credentials and this is incredibly alarming to me. To claim to be a psychologist or doctor without the training is illegal, so why should the field of music therapy be any different? I want to acknowledge a particular circumstance we had in a setting I worked in. A musician, claiming to be a music therapist, came to perform for children. Her music was not only inappropriate in lyrics, but the context she presented them in could have caused a negative emotional impact on the young children present.

Since then, I have reached out to this woman (who is now working with veterans with PTSD) educating her on the difference between a music therapist and a musician, and the sensitivity in falsifying a profession, but there was nothing that could be done due to the lack of state licensure.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Sincerely,

Mariagracia (MG) Rivas Berger, MT-BC
Music Therapist, Board-Certified

Children's National Health Systems
111 Michigan Avenue, NW
Washington, DC 20010
Phone: 202-476-3554



Laura Jackson

From: Teresa Welter
Sent: Friday, July 5, 2019 8:28 PM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in Virginia

Dear Virginia Board of Health Professionals,

I am the parent of 4 year old twins with Autism, Cerebral Palsy, Hemiplegia, Periventricular Leukomalacia, Global Apraxia, Global developmental delay... and many many more diagnosis. With all of these labels we have been through quite a bit of prescribed therapy since nine months of age to include ABA, Speech, OT, and PT - or the 'traditional' regimen. After exhausting these 'traditional' interventions with little to no progress we started to branch out to Music therapy. Our twins have been in music therapy for about about two years. The changes are stark. I first felt it was silly, but my nonverbal child can sing a song whereas years of speech therapy did nothing. A song doesn't sound that important, but a song made up to have the mom's full name, phone number, and start of address is a huge safety measure. We have worked with our music therapists, and due to results did more research to find how to best harness the power of this therapy to benefit our children.

As the singing center separate from talking location in the brain our nonverbal child, and our child with visual and auditory processing handicaps can not only learn safety supports such as mom's name, telephone, and address, but can help stroke or hemiplegic cerebral palsy patients like our daughters to learn to sing their needs if not speak. Our more affected child can sing the ABCs, but is still considered non-verbal. Communication is a key need in our world no matter what form it takes, and language is the most accepted method in mainstream society. So our children learning these skills helps them in this way, and in the social/emotional aspects of being able to better interact with others even if we are still in the very beginning of language acquisition. Nothing makes us parents and our children happier than going to an event with other children and my children can actually engage in a positive way singing with the others and doing movements like 'head, shoulder, knees, and toes; or wheels on the bus.'

In addition to Communication, safety, and social emotional improvements that communication provide, our children are learning to imitated which is another skill hard won for them. Where ABA, considered the "gold standard" of therapy not only did not work for our children, but caused their more undesirable behaviors to skyrocket including self harm, destructive towards property and others. With the ending of this therapy and the introduction of music therapy we can sing a waiting song and have positive and appropriate responses to everyday activities, and all the harmful behaviors have stopped... regulation and soothing has increased - again hugely contributing to our quality of life.

Another basic life skill that may seem trite is imitation, the social emotional benefits of imitation with the music/noise providing a direct cause and effect for our children is another sensory, emotional, and cognitive win for our children in their journey of learning and improving. Our family has been very thankful of all the progress and gains our children have made and continue to make. Our Music therapists have had extensive training in the deficits and challenges our children's diagnosis' can cause, and as healthcare providers are always looking to learn more to provide our children the best supports - I am concerned that if licensure and appropriate training was not required there would be people who thought simply playing instruments for disabled people would provide the same support and benefits. Our music therapists understand the results or deficits caused by medical labels such as apraxia. They understand it's a regulation problem and one day can present completely different than the next day. Without having the medical training component which can be

regulated through licensure I do not believe we would have the same support, results, and safety in our sessions.

As a result of our experiences, we ask that the board support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients and families like ours seeking Music Therapy services. We hope this will increase access to appropriately trained clinicians and provide the best possible outcomes to their patients.

Sincerely,

The Welter family
703-731-2501
6210 Glen Wood Loop
Manassas, VA 20112

Laura Jackson

From: Kim Gilbert
Sent: Sunday, July 7, 2019 3:03 PM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professions

I am a board-certified music therapist currently working in Henrico County. I am in private practice and contract with Noah's Children out of Bon Secours Hospital, which is a non-profit organization for children in hospice/palliative care, as well as Hiram Davis Medical Center in Petersburg. I have seen the benefits of music therapy in so many ways that I could give you story after story. It is extremely important that a person practicing music therapy is specially trained and qualified to do so. We are seeking licensure because music therapy is unfortunately not always readily available to the public or is being asked to be provided by non-qualified individuals.

I would like to give you an example in which a child was unable to receive services due to limited access. This young girl was a client of mine through Noah's Children who had a condition that limited the use of her left arm. She was resistant to therapies she was receiving at school and not making progress toward the use of her arm. During music therapy, she was motivated to move her arm and stretch overhead. This led to her willingness to grasp instruments with her left hand, strengthen her fine motor skills and increase mobility in her arm. In addition, she began to vocalize and sing some simple words. She was discharged from Noah's because her medical needs stabilized and she no longer qualified as a hospice/palliative care client. Her parents wanted to continue music therapy services, but were unable to do so due to limited access of services.

I would also like to give you another example in which harm has been done due to improper use of music. This individual is an older woman at Hiram Davis who is suffering from dementia. She is easily overstimulated which leads to agitation. When presented with recorded music that is too rhythmically active or too busy, she begins to cry and tries to leave the room. As a board certified music therapist, I am able to use live music that can be adjusted to meet her needs of stimulation appropriate arousal levels and thereby improve her quality of care.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Thank you for your consideration.
Sincerely
Kim Gilbert, MT-BC
Richmond, VA

Laura Jackson

From: Lucy Cardon
Sent: Sunday, July 7, 2019 8:44 PM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professions,

My name is Lucy Cardon, my husband Larry has been receiving music therapy for approximately six months after a stroke on April 9, 2018. He has made tremendous strides in his speech since his therapy started. I have personally observed the benefits of music therapy, under Tracy's tutelage. My husband's speech has slowed down and enunciation has improved tremendously. We were lucky to be referred to Tracy Bowdish from our doctor, who we have complete confidence. Unfortunately, not all therapists are alike, which is why I feel music therapy should require a license to assure patients are receiving quality services from appropriately trained clinicians.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Sincerely,
Lucy and Larry

Cardon
Sent from my iPad

Laura Jackson

From: Forbes, Jesse
Sent: Tuesday, July 9, 2019 12:31 PM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professions,

My name is Jesse Forbes, and I am a board certified music therapist living and working in Virginia for the past five years. After graduating with my bachelors degree in music therapy in 2015, I have had the pleasure of working with many different types of clients include children and adults with intellectual disabilities, adults with emotional disturbance, and older adults diagnosed with dementia. In addition to my work experience, I also went back to school and recently graduated last may with a masters degree in music therapy where I learned advanced clinical practice and research skills.

At this time, the music therapy profession is being harmed by individuals claiming to practice music therapy without proper training or qualifications, who thus bring to potential to inflict harm. I had a position as a music therapist workin within a school system in Northern Virginia where music therapists were cut from the yearly budget and replaced with music educators for some students, and for other students with music therapy in their IEP, music therapy services were not provided due to the lack of state protection of the MT-BC certification. As a result, students within the school system were denied music therapy services, or provided music therapy services by an individual who was not qualified to practice music therapy who may cause harm to students. Additionally, many music therapists were cut from the budget and were left scrambling for employment at the last minute.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Jesse "Jay" Forbes MMT MT-BC

Laura Jackson

To: Sweeney, Kelly
Subject: RE: Support for Music Therapy Licensure in VA

-----Original Message-----

From: Sweeney, Kelly <kjsweeney@RADFORD.EDU>
Sent: Thursday, July 11, 2019 10:19 AM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professions,

My name is Kelly Sweeney, I am a board-certified Music Therapist living in Radford, VA. I am a supporter of Licensure for Music Therapy. I work with hospice patients from 8 months old to 105 years old. My patients have many different diagnosis and come from many different backgrounds. Some of the typical goals I address for patients and family are decreasing agitation, decreasing anxiety, providing emotional support, promoting communication, promoting meaningful reminiscence, life review, facilitating coping, emotional expression, pain management, and promoting relaxation. Prior to my current position, I have worked with Veterans in adult day services, health and rehabilitation, and geriatric psych. I have also worked with children who have experienced sexual assault, day treatment, and intensive in-home therapy as a QMHP. I have been board-certified for more than 11 years.

As a board-certified Music Therapist, I have received specialized training which includes a Masters in Music Therapy from Radford University that has been approved through the American Music Therapy Association. My training also included a minimum of 1200 clinical hours that was completed under a board-certified music therapist at the Salem VAMC in Salem, VA. My education and clinical training prepared me to sit for and pass the certification exam through CBMT; this certification signifies that I possess the professional competencies to practice Music Therapy. In addition, I maintain the MT-BC credential by completing continuing education in order to ensure that I provide the most evidence-based treatment based on current research. Some examples of the continuing education I have completed are the Hospice and Palliative Music Therapy Institute and Adult and Seniors Grief & Loss Therapy Institute. These are 2 of the 4 courses required to become certified in Hospice and Palliative Music Therapy (HPMT). I am also trained in other psychotherapeutic techniques that utilize music to reach therapeutic goals. Every re-certification period also has a required ethics component.

Unfortunately, we have seen cases in Virginia where "Music Therapy" has been provided by individuals who do not hold the MT-BC credential, resulting in ineffective services as well as safety risks for patients/clients.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Sincerely,
Kelly J. Sweeney, MS, MT-BC

Laura Jackson

From: GRACE A JORDAN
Sent: Thursday, July 11, 2019 1:51 PM
To: laura.jackson@dhp.virginia.gov
Cc: vastfmt@gmail.com
Subject: FW: email language

To: laura.jackson@dhp.virginia.gov

CC or BCC: vastfmt@gmail.com

Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professions,

I am writing to ask for your support for state licensure of Music Therapy.

As a Physician Assistant working with patients who have critical health issues, I would like to know that when I refer to music therapy, they are fully qualified and held to a standard of quality my patients will benefit from.

I have worked with a terrific music therapist professional at Sentara, and I have seen the benefits for our patients; it is my hope consistent music therapy benefits would be extended to other patient populations via a state licensure that recognizes the national board credential for all music therapists in Virginia. This would protect my patients and give me peace of mind when I make the referral.

Sincerely,

Grace A. Jordan PA-C

SMG Neurology Specialists

(757)252-9015

.*

Laura Jackson

From: Dymond, Leigh E.
Sent: Thursday, July 11, 2019 2:27 PM
To: laura.jackson@dhp.virginia.gov
Cc: Noel Anderson
Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professions,

My name is Leigh Dymond, I am an LPN of 49 years and a grandmother of 15 years, living in Roanoke, Va. I am a supporter of Licensure for Music Therapy.

As a grandparent and Health Care professional, I have seen board certified music therapist's work and they have been invaluable to the ongoing progress and support of my autistic grandchildren.

Board certified music therapists receive specialized training (which includes a degree from a college/university with a Music Therapy program that has been approved through the American Music Therapy Association). Their training also included a minimum of 1200 clinical hours. Their education and clinical training prepare them to sit for and pass the certification exam through CBMT; this certification signifies that they possess the professional competencies to practice Music Therapy. In addition, they maintain the MT-BC credential by completing continuing education in order to ensure that they provide the most evidence-based treatment based on current research.

Unfortunately, there have been cases in Virginia where "Music Therapy" has been provided by individuals who do not hold the MT-BC credential, resulting in ineffective services as well as safety risks for patients/clients.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Sincerely,

Leigh E. Dymond

Roanoke, Va.

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Laura Jackson

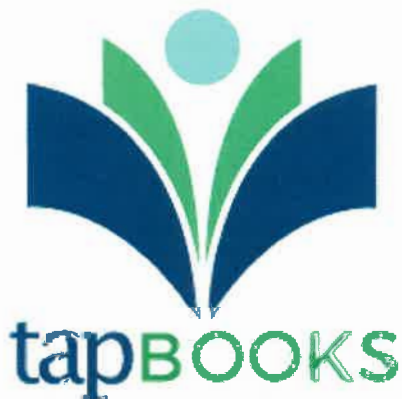
From: Stacey Sheppard
Sent: Thursday, July 11, 2019 3:24 PM
To: laura.jackson@dhp.virginia.gov
Subject: SUPPORT FOR MUSIC THERAPY LICENSURE IN VA
Attachments: music therapy.pdf

Importance: High

Good afternoon,
As a parent and professional, please see my attached letter in support of state licensing for Music Therapist.
Thanks
Stacey

*Stacey L. Sheppard
Director of Housing & Human Services
TAP (Total Action for Progress)
302 2nd St. SW Roanoke, VA 24011*

*~No one is useless in this world who lightens the burden of another
Charles Dickens*



RECYCLE YOUR BOOKS! DONATE TO TAP!

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To: laura.jackson@dhp.virginia.gov

Subject: Support for Music Therapy Licensure in VA
7-11-19

Dear Board of Health Professions,

My name is Stacey Sheppard, I am parent of three special needs adopted children living in Roanoke County Virginia. I am a supporter of Licensure for Music Therapy.

I work as the Director of Human Services for Total Action for Progress (TAP) in Roanoke Virginia. I am retired from 21 years of Law Enforcement and have a degree in Criminal Justice. I also specialize in trauma informed care and childhood trauma. My three adopted boys all have trauma and special issues from the severe neglect and abuse they endured prior to being removed from their mother's care in 2013.

As a parent and human service Advocate, I have seen board certified music therapist's work and my children have attended licensed music therapy. This gave them great comfort and joy while working on calming and sensory needs.

Board certified music therapists receive specialized training (which includes a degree from a college/university with a Music Therapy program that has been approved through the American Music Therapy Association). Their training also included a minimum of 1200 clinical hours. Their education and clinical training prepare them to sit for and pass the certification exam through CBMT; this certification signifies that they possess the professional competencies to practice Music Therapy. In addition, they maintain the MT-BC credential by completing continuing education in order to ensure that they provide the most evidence-based treatment based on current research.

Unfortunately, there have been cases in Virginia where "Music Therapy" has been provided by individuals who do not hold the MT-BC credential, resulting in ineffective services as well as safety risks for patients/clients. I also feel that this is somewhat of an injustice to the clients as they are not always getting a licensed individual. It would be the same with speech or occupational therapy. We, as parents would never send our children to individuals who are not certified or licensed to practice these areas of service or expertise. It simply is ridiculous. Would we ask uncertified police officers to answer calls or drive police cars? The state certifies them just as they should music therapist or any therapist for the integrity of service and clients.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to

protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Sincerely,

A handwritten signature in black ink, appearing to read "Stacey Sheppard", with a long horizontal flourish extending to the right.

Stacey Sheppard
Parent, Advocate & Professional
PO BOX 368
Salem VA 24153

Laura Jackson

From: Magee, Leslie E
Sent: Thursday, July 11, 2019 4:11 PM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professions,

My name is Leslie Magee. I am a board-certified Music Therapist living in Virginia Beach, VA. I am a supporter of Licensure for Music Therapy. I work full-time with the Hospital School Program at Children's Hospital of the King's Daughters in Norfolk, VA. I facilitate group and individual music therapy sessions with children in inpatient and outpatient settings at CHKD. We focus on psycho-educational goals such as social interaction, emotional expression, cognitive functioning, and mobility.

As a board-certified Music Therapist, I have received specialized training from Radford University's Music Therapy program which has been approved through the American Music Therapy Association. My training also included a minimum of 1200 clinical hours. My education and clinical training prepared me to sit for and pass the certification exam through CBMT; this certification signifies that I possess the professional competencies to practice Music Therapy responsibly. In addition, I maintain the MT-BC credential by completing continuing education to ensure I provide the most evidence-based treatment based on current research.

Unfortunately, we have seen cases in Virginia where "Music Therapy" has been provided by individuals who do not hold the MT-BC credential, resulting in ineffective services as well as safety risks for patients/clients. Individuals not certified to practice Music Therapy have also been awarded advertised Music Therapy positions even when board-certified Music Therapists applied and were interviewed for the positions. This places patients in harms way. Patients believe they are receiving Music Therapy, but the transparency regarding the clinician's credentials does not exist. Without state licensure, some facilities will not understand or recognize the need for proper training and certification. This poses significant potential for harm for many patient populations. Based on my experience, medically fragile children and infants are at the top of that list.

I was recently asked by well-meaning students at EVMS to lead a 4-hour training to assist medical students in providing therapeutic music and movement to patients. Ethically this falls outside of a Music Therapist's scope of practice. Individuals cannot be trained in 4 hours or even in 6 months to provide "music for healing". Music therapists do not own the rights to individuals using music to aid in their own healing, but the use of music in a therapeutic relationship (like what was described to me) to assist others in healing should be reserved for Music Therapists with specialized training. The intent was not to harm, but music is a powerful tool and can bring about intense emotional experiences for many individuals with very subtle, or no warning. It is best practice that a therapist be present for these experiences to assist individuals in processing through them in a healthy, safe manner. State licensure of Music Therapy would validate this reality and raise cognizance for medical and psychiatric providers who are currently unaware.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Sincerely,

Leslie Magee

Leslie Magee, MT-BC
Music Therapist
CHKD Hospital School Program
601 Children's Lane
Norfolk, VA 23507
Phone: (757) 668-8521

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Laura Jackson

From: Jamie Grace
Sent: Thursday, July 11, 2019 4:45 PM
To: laura.jackson@dhp.virginia.gov
Cc: vastfmt@gmail.com
Subject: SUPPORT FOR MUSIC THERAPY
Attachments: Music Therapy Support.docx

Good Day!
Please review letter in support for music therapy.
Thank you.
Jamie Grace

To: Board of Health Professions

From: Jamie Grace c/o Anthony Bradford

RE: RQUEST TO SUPPORT MUSIC THERAPY/MUSIC THERAPY SAVES LIVES

Dear Board of Health Professions,

My name is Jamie Grace. I am the parent of Anthony Bradford. My son was diagnosed with Autism at the age of 3. He has not spoken since then. I moved to the Virginia area about a year ago to help Anthony enhance in his communication and I am a strong supporter of Licensure for Music Therapy. When I moved to this area and signed Anthony up for Anderson Music Therapy Services. This changed his life. I have dealt with Autistic children and adults most of my life and the first time I heard of Music Therapy was about 2 years ago.

My son only responds to music. He loves music. There were times where he would stay up all night, he has suffered seizures and he has had tremendous mood swings daily. For any parent this is some sad and upsetting to experience. There have been times I have had to turn down positions because my son could not attend after school programs. He has been turned down due to his condition. I am a single mother with a master's degree and working on doctoral degree, but I had to put a halt on it due to his condition. Just because you are educated it means nothing when your child suffers from a condition. To know that you have worked most of your life to position yourself to have positive career and your child gets a diagnosis that changes your life forever. My son is getting older now and it is more of a struggle to handle him.

Please put yourself for one second in the shoes of a parent with a child with autism. You have been up all night, you cannot sleep. Your child is crying, running, screaming and nothing is working. You want to try to calm/him or her down so he/she will not have a seizure that could cause a coma. But then they hear music and it stops everything. This is happening to a lot of parents, myself and others all over the world. When I moved to Virginia, I was referred to Music Therapy and I never was aware of how amazing it was.

My son has made a tremendous change overnight. He is not on any medication to calm him, he is not stimulated as much, he is happy, and it gives him something to enjoy. He cannot ride a bike, he cannot swim, he does not play with games like his peers, he cannot speak like others or at all, he cannot be left alone but when he hears music, he comes alive. I beg of you to help not only my son but help all that are struggling. Give them a sense of peace. Music helps to soothe the soul, the mind and can save a life.

Board certified music therapists receive specialized training (which includes a degree from a college/university with a Music Therapy program that has been approved through the American Music Therapy Association). Their training also included a minimum of 1200 clinical hours. Their education and clinical training prepare them to sit for and pass the certification exam through CBMT; this certification signifies that they possess the professional competencies to practice Music Therapy. In addition, they maintain the MT-BC credential by completing continuing education in order to ensure that they provide the most evidence-based treatment based on current research.

Unfortunately, there have been cases in Virginia where “Music Therapy” has been provided by individuals who do not hold the MT-BC credential, resulting in ineffective services as well as safety risks for patients/clients. In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

I thank you for your time and concern regarding this issue. I pray you make the right decision and help music therapy be a thing or today, tomorrow and in the future.

Sincerely,

Jamie Grace, MBA

Laura Jackson

From: Castro, Armando A. at MFA
Sent: Thursday, July 11, 2019 5:01 PM
To: laura.jackson@dhp.virginia.gov
Cc: vastfmt@gmail.com
Subject: Support For Music Therapy(NOPHI)
Attachments: Support for Music Therapy_.docx

I certainly support registered and licensed music therapist. Have seen this type of therapy work extremely well with hospice patients, long term care patients.

Thanks,

Armando

To: laura.jackson@dhp.virginia.gov

BCC: vastfmt@gmail.com

Subject: Support for Music Therapy Licensure in VA

Body:

Dear Board of Health Professions,

My name is Armando Castro, I am (Former Director of Nursing, Currently Regional Nurse Consultant) living in (Roanoke, VA). I am a supporter of Licensure for Music Therapy.

I work (In geriatric care and adults in a long term care and skilled nursing services and therapy facilities). My (Patients, and long term care Residents).

As a (Director of Nursing), I have seen board certified music therapist's work and (help residents, patients even in the area of loneliness, depression, dementia).

Board certified music therapists receive specialized training (which includes a degree from a college/university with a Music Therapy program that has been approved through the American Music Therapy Association). Their training also included a minimum of 1200 clinical hours. Their education and clinical training prepare them to sit for and pass the certification exam through CBMT; this certification signifies that they possess the professional competencies to practice Music Therapy. In addition, they maintain the MT-BC credential by completing continuing education in order to ensure that they provide the most evidence-based treatment based on current research.

Unfortunately, there have been cases in Virginia where "Music Therapy" has been provided by individuals who do not hold the MT-BC credential, resulting in ineffective services as well as safety risks for patients/clients.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Sincerely,

(Armando Castro, RN)

Laura Jackson

From: Cassie Smith
Sent: Thursday, July 11, 2019 8:23 PM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professions,

My name is Cassie Smith, I am a board certified music therapist living in Roanoke, VA. I am a supporter of Licensure for Music Therapy.

I work for Anderson Music Therapy Services, a private practice that serves clients all over the Roanoke Valley. I primarily work with children and adults with developmental disabilities. Most of my sessions are a 1:1, but I do have a couple groups (one group is adults and the other is kids age 1-4). Some goal areas that are addressed during these sessions are social skills, expressive communication, receptive communication, impulse control, leadership skills, and decision making skills.

As a music therapist, I have seen growth in the stated above goal areas with the use of music therapy interventions. Some of my clients' parents have stated they have seen more growth in their child during their music therapy sessions than in their other therapies, such as Speech Therapy and Occupational Therapy. Music is our tool to motivate our clients to address their areas of need.

Board certified music therapists receive specialized training (which includes a degree from a college/university with a Music Therapy program that has been approved through the American Music Therapy Association). Their training also included a minimum of 1200 clinical hours. Their education and clinical training prepare them to sit for and pass the certification exam through CBMT; this certification signifies that they possess the professional competencies to practice Music Therapy. In addition, they maintain the MT-BC credential by completing continuing education in order to ensure that they provide the most evidence-based treatment based on current research.

Unfortunately, there have been cases in Virginia where "Music Therapy" has been provided by individuals who do not hold the MT-BC credential, resulting in ineffective services as well as safety risks for patients/clients.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Sincerely,



Cassie Smith, MT-BC

Board Certified Music Therapist

Anderson Music Therapy Services

m: [\(540\) 391-0763](tel:5403910763)

f: [\(540\) 808-1582](tel:5408081582)

a: Hollins: 8231 Williamson Road, Roanoke, VA 24019

Old Southwest: 1217 Maple Avenue, Roanoke VA 24016

Mail: PO Box 20736, Roanoke, VA 24018

w: www.amusictherapy.com



Laura Jackson

From: Louise Dillon
Sent: Friday, July 12, 2019 6:37 AM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professions,

My name is Louise Dillon , I am a guardian and grandmother of a 22 year old adult child with autism and a retired teacher. We live in Salem, VA. I am a supporter of Licensure for Music Therapy.

My granddaughter benefits greatly from music therapy weekly. She is learning how to verbalize her emotions and how to use what she learns in music therapy to calm down during a stressful situation. For my family, this is a major accomplishment.

As a retired teacher, I remember how beneficial music therapy was to a few of my students. Returning to the classroom after a therapy session, they would be much more able to concentrate.

As a guardian, I have seen our board certified music therapist's work and heard from my granddaughter the amazing way she is benefitted from the expertise of this therapist. The therapist is understanding, respectful, but most of all she is very skilled as she makes the most of every minute she spends with my granddaughter.

Board certified music therapists receive specialized training (which includes a degree from a college/university with a Music Therapy program that has been approved through the American Music Therapy Association). Their training also included a minimum of 1200 clinical hours. Their education and clinical training prepare them to sit for and pass the certification exam through CBMT; this certification signifies that they possess the professional competencies to practice Music Therapy. In addition, they maintain the MT-BC credential by completing continuing education in order to ensure that they provide the most evidence-based treatment based on current research.

Unfortunately, there have been cases in Virginia where "Music Therapy" has been provided by individuals who do not hold the MT-BC credential, resulting in ineffective services as well as safety risks for patients/clients.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Sincerely,

Louise Dillon

Laura Jackson

From: VA Music Therapy Task Force
Sent: Friday, July 12, 2019 10:22 AM
To: laura.jackson@dhp.virginia.gov
Subject: Fwd: Support for Music Therapy Licensure - please forward to Board of Health Professions

Hi Laura,

Please see the email below. I deleted the name and email address per the request below, and I replaced with "..."

Many thanks,
Tracy

----- Forwarded message -----

From: ... <...>
Date: Fri, 12 Jul 2019 07:49:09 -0400
Subject: Support for Music Therapy Licensure - please forward to Board of Health Professions
To: VA Music Therapy Task Force <vastfmt@gmail.com>

Dear Tracy and Shelby,

I hope you both are doing well. Will you please forward the following to the Board of Health Professions, deleting my name and email address?

Thank you,

...

--

Dear Board of Health Professions,

Please support state licensure for board-certified music therapists.

I am a board-certified music therapist (MT-BC) working in a medical facility in Virginia.

During my employment, my facility had added another music therapy position. Several candidates applied, most of whom held the MT-BC credential. My facility ended up hiring an individual who did not hold the MT-BC credential; in fact, this person did not have any credentials. I had voiced my concern during the hiring process, but the decision was not mine to make.

My concern was that I had no idea if this individual possessed the professional competencies necessary to practice music therapy safely and effectively. In addition, because this person had no credentials, there was no requirement to maintain them through continuing education. I cannot imagine a scenario where patients received care from doctors, nurses, and therapists who weren't licensed, who weren't required to demonstrate competency, and who weren't required to pursue continuing education. However, this is exactly what happened at my facility concerning music therapy.

This person no longer works at my facility, and administration has chosen not to refill the position. This situation is so sad to me. Not only did this take a job away from an appropriately trained individual, but now, patients are missing out on music therapy services because someone who was not qualified had previously attained the position and could not produce evidence of results effective enough to make a case to refill the position.

Even though I had voiced my concern to multiple individuals, the decision to hire this person had been made. Furthermore, what my facility did was legal because Virginia does not recognize the MT-BC credential and does not

regulate the practice of music therapy. I have heard of this happening at other facilities but wanted to share my experience.

Our patients deserve transparency; they also deserve the best possible care. Please support state licensure of music therapy.

Thank you,

A concerned MT-BC

Laura Jackson

From: KRISTEN M SCHAIBLE
Sent: Friday, July 12, 2019 12:20 PM
To: laura.jackson@dhp.virginia.gov
Cc: vastfmt@gmail.com
Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professions,

I am writing to ask for your support for state licensure of Music Therapy. I am a nurse practitioner in neurology and many of my patients are stroke survivors. Some stroke survivors have expressive aphasia, trouble with speaking. As you can imagine, the inability to communicate with others, including friends and family, is debilitating and has a significant impact on their quality of life. Music therapy is an effective mode of therapy that helps patients speak again. Unfortunately, music therapy is currently unregulated and there are no licensing requirements which would assist providers like myself from identifying qualified music therapist. In addition, patients who are desperate to speak again could unwittingly seek help from an unqualified "music therapist".

Please support state licensure for Music Therapy.

Kristen Schaible, MSN, FNP-BC, CNRN
Sentara Neurology Specialists
301 Riverview Ave, Suite 202
Norfolk, VA 23510
Tel: 757 252-9015
kmschaib@sentara.com

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Laura Jackson

From: Sandra rodriguez
Sent: Friday, July 12, 2019 12:43 PM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA
Attachments: Document (8).docx; Untitled attachment 00117.txt

Dear Board of Health Professions,

My name is Sandra Rodriguez and my husband James is a stroke patient with severe aphasia. He has been in music therapy for the past several years and has gone from only being able to say his name to communicating with many words and sometimes complete sentences. It has opened a whole new world for both of us. Because his therapist is trained in her profession, I believe that she has made a tremendous effect on his ability to communicate with his family and others.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Thank you for your support,

Sandra W. Rodriguez

From: Maria Kokkinaki
Sent: Friday, July 12, 2019 1:09 PM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professions,

My name is Maria Kokkinaki, I am a mother of a 4 year old son living in Salem VA. I am a supporter of Licensure for Music Therapy.

My son is a sweet little boy who can easily talk for hours at home about his cars and his dinosaurs with me or with his Daddy, but in most social settings (i.e., school, playground) he seems to be extremely 'shy' and would not initiate any interaction with or respond to other people, including his peers. I understand this is not a life threatening or extremely debilitating condition, and that he will probably outgrow it with time. However, as a parent I want him to have the most benefit from each stage of his life and this social anxiety limits his possibilities to interact with other people, make friends etc. Therefore, I first inquired a speech therapist for help and she recommended Music Therapy.

We soon signed up for small group Music Therapy sessions. It was the first time I had experienced Music Therapy and I was impressed on the impact that just a single 45 minute session had on my son. After about 10 minutes into the session he switched from hiding his face to avoid unfamiliar faces, to listening to the music and actually raising his hand to ask for a turn to play the xylophone! That was such a huge achievement against his social anxiety and is something he had never done before in school. I am sure his teachers at school sing a lot of songs and play music for him and his friends, almost every day for the last two years that he joined preschool, however it required a board certified music therapist's work for just 45 minutes to see this positive effect in his social behavior!

Board certified music therapists receive specialized training (which includes a degree from a college/university with a Music Therapy program that has been approved through the American Music Therapy Association). Their training also includes a minimum of 1200 clinical hours. Their education and clinical training prepare them to sit for and pass the certification exam through CBMT; this certification signifies that they possess the professional competencies to practice Music Therapy. In addition, they maintain the MT-BC credential by completing continuing education in order to ensure that they provide the most evidence-based treatment based on current research.

Unfortunately, there have been cases in Virginia where "Music Therapy" has been provided by individuals who do not hold the MT-BC credential, resulting in ineffective services as well as safety risks for patients/clients.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Sincerely,

Maria Kokkinaki

Laura Jackson

From: Edmondson, Margel
Sent: Friday, July 12, 2019 2:14 PM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professions,

My name is Margel Edmondson, I am a board-certified Music Therapist living in Arlington, VA. I am a supporter of Licensure for Music Therapy. I am an employee of Northern Virginia Mental Health Institute (NVMHI) in Falls Church, VA where I provided music therapy services to adults with serious and chronic mental illness. I have been serving this population for over twelve years. We use music to address a variety of needs with this population. Music is an excellent vehicle for self expression in individuals that are suffering from psychotic symptoms. Our individuals learn a variety of safe and effective coping skills through their engagement in music therapy. We regularly receive positive feedback from individuals that have received music therapy at NVMHI. They often identify music therapy as improving their quality of life, helping them engage in difficult discussions/life transitions, helping them connect with others and identifying ways to use music for wellness in their daily life.

As a board-certified Music Therapist, I have received specialized training which includes a degree from the University of Georgia with a Music Therapy program that has been approved through the American Music Therapy Association. My training also included a minimum of 1200 clinical hours, including a six month internship at the Virginia Treatment Center for Children. My education and clinical training prepared me to sit for and pass the certification exam through CBMT; this certification signifies that I possess the professional competencies to practice Music Therapy. In addition, I maintain the MT-BC credential by completing continuing education in order to ensure that I provide the most evidence-based treatment based on current research.

Unfortunately, we have seen cases in Virginia where "Music Therapy" has been provided by individuals who do not hold the MT-BC credential, resulting in ineffective services as well as safety risks for patients/clients.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Sincerely,

Margel Edmondson, MEd, MT-BC
Lead Expressive Therapist/Music Therapist
Fellow of the Association for Music & Imagery
Northern Virginia Mental Health Institute
[✉margel.edmondson@dbhds.virginia.gov](mailto:margel.edmondson@dbhds.virginia.gov)
☎(703) 207 7425

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Laura Jackson

From: Raymond Cobb
Sent: Friday, July 12, 2019 3:03 PM
To: laura.jackson@dhp.virginia.gov
Subject: Please License Music Therapist

Dear Board of Health Professions,

My name is Raymond G. Cobb. I am the grandfather and guardian of a granddaughter, let's call her Christy. Indeed, now at age 20, she lived with me from age 4. I live in Roanoke as a retired banker of 30 years. Based on my experience with Christy and her licensed Music Therapy professional, I am a supporter of Licensure for Music Therapy.

I retired as Executive Vice President of a major regional bank and during my career, had to judge the character and professionalism of many individuals. Based on my early judgment and subsequent engagement of Christy's therapist, it provided confirmation of my selection to help my granddaughter. Christy is on the Autism Spectrum and also has some level of cognitive disability.

In my early roles, it was my goal to find help to "fix" her limitations. Though I eventually learned these limitations could not be fixed, one of my early successes in trying was to discover a Licensed Music Therapist. For the next 7 - 8 years I have been so appreciative of all the support, social and personal coaching overheard by me and results witnessed with music as the setting through this Music Therapist. Her licence has always been displayed and continuing education known as she needed to miss some weekly sessions in that pursuit. Following all sessions, I received a detailed account of the major area to be addressed and a description of approaches with an assessment of results. I would pass some of these memos to Christy's Psychiatrist and School Teacher professionals to help create a focused approach to help Christy.

I am aware that Board certified music therapists receive specialized training (which includes a degree from a college/university with a Music Therapy program that has been approved through the American Music Therapy Association). Their training also includes a minimum of 1200 clinical hours. Their education and clinical training prepare them to sit for and pass the certification exam through CBMT; this certification signifies that they possess the professional competencies to practice Music Therapy. In addition, they maintain the MT-BC credential by completing continuing education in order to ensure that they provide the most evidence-based treatment based on current research.

Unfortunately, I have heard of cases in Virginia where "Music Therapy" has been provided by individuals who do not hold the MT-BC credential, resulting in ineffective services as well as safety risks for patients/clients.

In summary and based on my experience, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations like my granddaughter. Hopefully this will ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Sincerely,

Raymond G. Cobb

Laura Jackson

From: becky@music4wellness.net
Sent: Friday, July 12, 2019 6:38 PM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professions,

Please allow me to introduce myself, I'm Becky Watson, MBA, Board Certified Music Therapist and owner of Music for Wellness, LLC in Norfolk, VA. My company serves adults, older adults and their care partners living with cognitive impairments (i.e. Post-Traumatic Stress, Traumatic Brain Injury, dementia, etc) in the Hampton Roads community through evidenced based music therapy services.

As a board-certified Music Therapist, I have received specialized training (which includes a degree from a college/university with a Music Therapy program that has been approved through the American Music Therapy Association). My training also included a minimum of 1200 clinical hours. My education and clinical training prepared me to sit for and pass the certification exam through CBMT; this certification signifies that I possess the professional competencies to practice Music Therapy. In addition, I maintain the MT-BC credential by completing continuing education in order to ensure that I provide the most evidence-based treatment based on current research.

Music therapy improves the overall physical and mental well being of my clients in the following ways:

- memory recall;
- positive changes in moods and emotional states;
- a sense of control over life;
- non-pharmacological management of pain and discomfort;
- stimulation that promotes interest even when other approaches are ineffective;
- structure that promotes rhythmic and continuous movement or vocal fluency as an adjunct to physical rehabilitation; and
- opportunities to interact socially with others.

It is also important to note that my clients' diagnoses require a trained and credential professional that assess, develop and conduct clinical music therapy interventions to make a positive impact with their mental illnesses. Music can be a risk and potentially harmful to these vulnerable populations if not conducted by an experienced, trained and credential professional (client may become physically aggressive, emotionally distraught, disoriented, combative, etc) Unfortunately, we have seen cases in Virginia where "Music Therapy" has been provided by individuals who do not hold the MT-BC credential, resulting in ineffective services as well as safety risks for patients/clients.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Many thanks for your time and attention in the matter impacting the safety and protection of vulnerable populations in the Commonwealth of Virginia.

Becky Watson, MBA, Board Certified Music Therapist Owner, Music for Wellness, LLC Retired Navy Supply Corps Captain
Positive Approach to Care (Teepa Snow) Certified Consultant, Trainer, Engagement Leader, Coach Veteran Owned,
Family Operated Enriching the Mind, Body and Spirit with MUSIC!
(757) 563-3488
email: becky@music4wellness.net
PO Box 9372
Norfolk, VA 23505
email: becky@music4wellness.net
Website: music4wellness.net
Facebook: <https://www.facebook.com/MusicForWellness>

Laura Jackson

From: Virgil Rogers
Sent: Saturday, July 13, 2019 3:57 PM
To: laura.jackson@dhp.virginia.gov
Subject: Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professions,

My name is Leighton Rogers , I am a father living in Roanoke, VA, I am a supporter of Licensure for Music Therapy.

I am a retired deputy sheriff, my daughter attends music therapy to help control her RSD/CRPS which is a nerve pain disease.

As her father I have seen board certified music therapist's work help her to control her pain through music, their work has helped relieve her suffering and lead a more productive life. Words don't describe the great work they have done.

Board certified music therapists receive specialized training (which includes a degree from a college/university with a Music Therapy program that has been approved through the American Music Therapy Association). Their training also included a minimum of 1200 clinical hours. Their education and clinical training prepare them to sit for and pass the certification exam through CBMT; this certification signifies that they possess the professional competencies to practice Music Therapy. In addition, they maintain the MT-BC credential by completing continuing education in order to ensure that they provide the most evidence-based treatment based on current research.

Unfortunately, there have been cases in Virginia where "Music Therapy" has been provided by individuals who do not hold the MT-BC credential, resulting in ineffective services as well as safety risks for patients/clients.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Sincerely,

Leighton Rogers



Virus-free. www.avast.com

Laura Jackson

From: Terri Flud
Sent: Saturday, July 13, 2019 11:14 PM
To: laura.jackson@dhp.virginia.gov
Subject: Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professions,

My name is Terri Flud I am a caretaker living in New Jersey. I am a supporter of Licensure for Music Therapy.

My sister attended music therapy for help with her dementia.

As a caretaker, I have seen board certified music therapist's work and when using music for my sisters dementia.

Board certified music therapists receive specialized training (which includes a degree from a college/university with a Music Therapy program that has been approved through the American Music Therapy Association). Their training also included a minimum of 1200 clinical hours. Their education and clinical training prepare them to sit for and pass the certification exam through CBMT; this certification signifies that they possess the professional competencies to practice Music Therapy. In addition, they maintain the MT-BC credential by completing continuing education in order to ensure that they provide the most evidence-based treatment based on current research.

Unfortunately, there have been cases in Virginia where "Music Therapy" has been provided by individuals who do not hold the MT-BC credential, resulting in ineffective services as well as safety risks for patients/clients.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Sincerely,

Terri Flud

Laura Jackson

From: Virgil Rogers
Sent: Sunday, July 14, 2019 12:45 AM
To: laura.jackson@dhp.virginia.gov
Subject: Subject: Support for Music Therapy Licensure in VA

My name is Elizabeth Rogers, I take music therapy weekly with Anderson Music Therapy here in Roanoke, VA. I am a supporter of Licensure for Music Therapy.

As a client, I have seen board certified music therapist's work and what it's done for me.

I am college student with Cerebral Palsy , Chronic Regional Pain Syndrome, Post Traumatic stress disorder and Depression . Over the years I have tried many of the well known treatments used to help people overcome the major issues of these disabilities with little or no success.

The treatments include Physical therapy , Occupational Therapy ,speech Therapy ,as well as psychological therapy and so called designer drugs

These designer drugs are man made versions of the chemicals made naturally by the brain. Most people do well with types of treatments but there is always an exception to every rule and I think I am it.

Since I started taking Music Therapy three years ago I have improved physically, emotionally, and psychologically. I think this type of therapy has been so successful for me is because when a person sings the whole brain is being used and feel good chemicals such as Dopamine are increased slowly melting the pain away. Unlike the other types of therapy which only focuses on one part of the brain.

Music Therapy may not work for everyone but it has made my speech easier to understand on the phone and when I am out and about. With that being said I hope Music Therapy can continue in Virginia

Board certified music therapists receive specialized training (which includes a degree from a college/university with a Music Therapy program that has been approved through the American Music Therapy Association). Their training also included a minimum of 1200 clinical hours. Their education and clinical training prepare them to sit for and pass the certification exam through CBMT; this certification signifies that they possess the professional competencies to practice Music Therapy. In addition, they maintain the MT-BC credential by completing continuing education in order to ensure that they provide the most evidence-based treatment based on current research.

Unfortunately, there have been cases in Virginia where "Music Therapy" has been provided by individuals who do not hold the MT-BC credential, resulting in ineffective services as well as safety risks for patients/clients.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Sincerely,

Elizabeth Rogers



Virus-free. www.avast.com

Laura Jackson

From: Greg Ulmer
Sent: Sunday, July 14, 2019 7:48 AM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA

To: laura.jackson@dhp.virginia.gov

BCC: vastfmt@gmail.com

Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professions,

My name is Gregory Ulmer, I am Pharmacist, Parent, Power of Attorney and Guardian living in Botetourt County, Roanoke, VA. I am a supporter of Licensure for Music Therapy as it has beneficial effects on anxiety, fatigue, depression, pain, and quality of life for patients with cancer and reduces the need for pain medication after surgery. It calms the ADD/ADHD child, helps with memory restoration in the Alzheimer population, and assists in the mental health of the autistic population as well

I work as a registered pharmacist in a closed pharmacist in a retail setting dealing with mental health patients. My son Brian Ulmer has been receiving Music Therapy for many years. Music therapy helps with his cerebral palsy with the weak muscles and strengthen his other muscles as well.

As a pharmacist, I have seen board certified music therapist's work and Music therapy helps with his cerebral palsy with the weak muscles and strengthen his other muscles as well. It aids in gait training through walking to the music, the singing calms him and the use of his hands helps in preventing Dupuytren's contracture.

Board certified music therapists receive specialized training which includes a degree from a college/university with a Music Therapy program that has been approved through the American Music Therapy Association. Their training also included a minimum of 1200 clinical hours. Their education and clinical training prepare them to sit for and pass the certification exam through CBMT; this certification signifies that they possess the professional competencies to practice Music Therapy. In addition, they maintain the MT-BC credential by completing continuing education in order to ensure that they provide the most evidence-based treatment based on current research.

Unfortunately, there have been cases in Virginia where “Music Therapy” has been provided by individuals who do not hold the MT-BC credential, resulting in ineffective services as well as safety risks for patients/clients.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians. Truly they provide many beneficial services and have earned the right to be licensed.

Sincerely,

Gregory M. Ulmer RPH

Laura Jackson

From: Eugene Knezevich
Sent: Sunday, July 14, 2019 11:22 AM
To: laura.jackson@dhp.virginia.gov
Subject: Music Therapy Call to Action

Dear Board of Health Professions,

My name is Eugene Knezevich, I am a board-certified Music Therapist living in Virginia. I am a supporter of Licensure for Music Therapy. I work at the Northern Virginia Mental Health Institute and treat patients with chronic/severe mental illness.

As a board-certified Music Therapist, I have received specialized training (which includes a degree from a college/university with a Music Therapy program that has been approved through the American Music Therapy Association). My training also included a minimum of 1200 clinical hours. My education and clinical training prepared me to sit for and pass the certification exam through CBMT; this certification signifies that I possess the professional competencies to practice Music Therapy. In addition, I maintain the MT-BC credential by completing continuing education in order to ensure that I provide the most evidence-based treatment based on current research.

Unfortunately, we have seen cases in Virginia where "Music Therapy" has been provided by individuals who do not hold the MT-BC credential, resulting in ineffective services as well as safety risks for patients/clients.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Sincerely,

Eugene (Alex) Knezevich

Laura Jackson

From: Kelli Maddock, MMT, MT-BC
Sent: Sunday, July 14, 2019 1:05 PM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA by a Returned Peace Corps Volunteer

Dear Board of Health Professions,

My name is Kelli Maddock, I am a board-certified Music Therapist living in Arlington. I am a supporter of Licensure for Music Therapy. I work as a Development Officer at a humanitarian organization currently. I am also a Returned Peace Corps Volunteer, where I spent three years using music therapy techniques to teach holistic wellness education in the Fiji Islands. As a music therapist, my primary experience lies within trauma, community development, women's empowerment, youth empowerment and mental health. I have seen children, who refuse to talk to other therapists, open up after our music-making interventions together. I have seen music sooth PTSD symptoms. I have seen music help my clients become the best versions of themselves.

As a board-certified Music Therapist, I have received specialized training (which includes a degree from a college/university with a Music Therapy program that has been approved through the American Music Therapy Association). My training also included a minimum of 1200 clinical hours. My education and clinical training prepared me to sit for and pass the certification exam through CBMT; this certification signifies that I possess the professional competencies to practice Music Therapy. In addition, I maintain the MT-BC credential by completing continuing education in order to ensure that I provide the most evidence-based treatment based on current research.

Unfortunately, we have seen cases in Virginia where "Music Therapy" has been provided by individuals who do not hold the MT-BC credential, resulting in ineffective services as well as safety risks for patients/clients. I have seen my trauma clients be triggered by a song, but because I was trained to work within this population as a music therapist, I could help them process the song. An untrained musician, may be able to provide rapport and emotional release, but there is a specific nuance to using music within trauma and mental health. Music can cause people to dissociate and it takes a trained professional to recognize that.

There is also another side of licensure – because I was in a field that was not licensed, I was finding a hard time finding work in the trauma population. I had to leave the state of Missouri and I left for Peace Corps. Coming back to the states, I knew that I could not return to Missouri. I look forward to the day when I will be able to approach a non-profit organization and say that we have the same rights as all the other therapists. I look forward to returning to my profession.

Work in trauma is primarily with non-profit organizations, practitioners either must find grants or use licensure to process insurance payments. Music is not the only key, but often music allows us to open doors that other therapies cannot. Every specialty has their own unique perspective and benefit. In an ideal world, every therapy organization would have every kind of therapy so that each client can find what is right for them.

Music therapists are not here to take over other professions, but to work in tandem with them to help our clients reach the same goals – using a medium that develops instant rapport and allows for things that words cannot explain to be processed. We have our own code of ethics and our own scope of profession. We are asking that you help us allow clients to find the therapist that works for them, without having to worry about the financial implications paying out of pocket. As a grant writer, I know there are other ways, but that system is inherently flawed, as well. Asking people to decide between which need is higher so billionaires can choose who to fund, is also inherently flawed. The easiest and least oppressive system, is to allow music therapists to gain licensure.

When music therapists aren't licensed, you are asking clients to pay out-of-pocket for their own healing. This means that only the most privileged gain access to our services. Please don't be party to systematic oppression. Sometimes this opens the door for volunteer musicians, who are untrained to come in and offer services as "music therapy." We are not saying they don't have a place, together we can accomplish more than we can separately. Dissolve the barriers that keep clients from accessing our services and protect the vulnerable. In addition, not licensing music therapy will create a brain drain of qualified music therapists moving to states where music therapy is licensed – leaving our state with a deficit.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Much Appreciated,

Kelli Maddock, MMT, MT-BC

Development Officer

Returned Peace Corps Volunteer | Music Therapist-Board Certified | Master of Music Therapy

Laura Jackson

From: pauloleary@cox.net
Sent: Sunday, July 14, 2019 2:44 PM
To: laura.jackson@dhp.virginia.gov
Subject: SUPPORT FOR MUSIC THERAPY LICENSURE IN THE COMMONWEALTH OF VIRGINIA

Your time is valuable and I won't repeat what you hopefully have been hearing from Music Therapy Licensure advocates. Let me simply add one sentence:

IT IS THE RIGHT THING TO DO – PERIOD.

Sincerely,

PAUL O'LEARY
3229 Galberry Road
Chesapeake, VA 23323
H: 757-487-3663
C: 757-676-1009

Laura Jackson

From: Bowers, Lily
Sent: Sunday, July 14, 2019 10:17 PM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professions,

My name is Lily Bowers, I am a board-certified Music Therapist living in Richmond, Virginia. I am a supporter of Licensure for Music Therapy. I work at The Virginia Home, a residential facility for adults diagnosed with irreversible physical disabilities. We serve 130 residents diagnosed with, cerebral palsy, multiple sclerosis, traumatic brain injuries, and more. The residents who live at the home range from their 20's, to their 80's, and many have lived there for 30 years or more. Music Therapy is an established health profession that uses music to address specific, non-musical goals. At the Home, these goals often include increasing quality of life, socialization, self-expression, fine-motor skills, and end-of life support. I see clients both individually and in group settings. When working with residents, musical interventions include songwriting, recording, adapted instrument playing, music discussion, singing, performing, and music and relaxation.

As a board-certified Music Therapist, I have received specialized training (which includes a degree from a college/university with a Music Therapy program that has been approved through the American Music Therapy Association). My training also included a minimum of 1200 clinical hours. My education and clinical training prepared me to sit for and pass the certification exam through CBMT; this certification signifies that I possess the professional competencies to practice Music Therapy. In addition, I maintain the MT-BC credential by completing continuing education in order to ensure that I provide the most evidence-based treatment based on current research.

Unfortunately, we have seen cases in Virginia where "Music Therapy" has been provided by individuals who do not hold the MT-BC credential, resulting in ineffective services as well as safety risks for patients/clients. In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Sincerely,
Lily Bowers, MT-BC

--

*Lily Bowers, MT-BC
Bachelor of Music Therapy
Piano Performance Certificate
Summa Cum Laude
Shenandoah University*

Laura Jackson

From: Stephanie Surber
Sent: Monday, July 15, 2019 8:57 AM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professions,

My name is Stephanie Surber, and I am a board-certified Music Therapist living in Richmond, VA. I am a supporter of Licensure for Music Therapy. I work at Bon Secours Mercy Health System providing music therapy to inpatients, specifically at St. Mary's Hospital, Memorial Regional Medical Center, and St. Francis Medical Center. I work with patients throughout these hospitals, including infants in the Neonatal Intensive Care Unit, patients with cancer, with neurological issues like stroke and traumatic brain injury, with dementia, pre- and post-surgery patients, to name a few. I use research-backed music interventions to work toward physical goals, like alleviating pain, emotional goals, like supporting healthy coping, social goals, like decreasing loneliness, and spiritual goals, like supporting meaning and purpose.

As a board-certified Music Therapist, I have received specialized training (which includes a degree from a college/university, in my case Shenandoah University, with a Music Therapy program that has been approved through the American Music Therapy Association). My training also included a minimum of 1200 clinical hours. My education and clinical training prepared me to sit for and pass the certification exam through CBMT; this certification signifies that I possess the professional competencies to practice Music Therapy. In addition, I maintain the MT-BC credential by completing continuing education in order to ensure that I provide evidence-based treatment based on the most current research.

Unfortunately, we have seen cases in Virginia where "Music Therapy" has been provided by individuals who do not hold the MT-BC credential, resulting in ineffective services as well as safety risks for patients/clients.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Sincerely,

Stephanie Surber

--

Stephanie L. Surber, MT-BC | Music Therapist-Board Certified

Music Therapy Clinical Supervisor

Bon Secours Mercy Richmond Health System

St. Mary's Hospital

5801 Bremo Road | Richmond, VA | 23226

W: 804/281-8393 (SMH)

C: 304/282-4947

stephanie_surber@bshsi.org

Good Help to Those in Need®

Laura Jackson

From: Kelsi Yingling-Tafaro
Sent: Monday, July 15, 2019 10:31 AM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professions,

My name is Kelsi Yingling, and I am a board-certified Music Therapist living in Haymarket, VA. I am a supporter of Licensure for Music Therapy. I own a music therapy private practice in Northern Virginia where I work with a wide range of individuals and groups, including but not limited to, children, adolescents and adults with developmental disabilities, mental health disorders, neurological diseases, and age-related disorders. I also work for a school division that has chosen to remove music therapists as the service provider for music therapy services.

As a board-certified Music Therapist, I have received specialized training from Shenandoah University, which includes a degree from a college/university with a Music Therapy program that has been approved through the American Music Therapy Association. My training also included a minimum of 1200 clinical hours. My education and clinical training prepared me to sit for and pass the certification exam through CBMT; this certification signifies that I possess the professional competencies to practice Music Therapy. In addition, I maintain the MT-BC credential by completing continuing education in order to ensure that I provide the most evidence-based treatment based on current research.

Unfortunately, I have personally seen cases in Virginia where "Music Therapy" has been provided by individuals who do not hold the MT-BC credential, resulting in ineffective services as well as safety risks for patients/clients. School divisions in Virginia have tasked special education teachers to provide music therapy services. These teachers have reported that they do not feel that have adequate training or skills to provide these services. On a few occasions, it has been reported that teacher assistants/paraprofessionals were providing these services rather than a licensed professional due to special education teachers' many responsibilities and demands. Many of the students receiving services are medically fragile and vulnerable and require specialized support from a credentialed music therapist.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Sincerely,

Kelsi Yingling, M.Ed, MT-BC, NMT
Administrative Director | Music Therapist
NeuroSound Music Therapy, LLC.
10355-B Democracy Lane
Fairfax, VA 22030

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Warm Regards,

Kelsi Yingling, M.Ed., MT-BC, NMT
Clinical Director | Music Therapist
NeuroSound Music Therapy, LLC.
10355-B Democracy Lane
Fairfax, VA 22030
Phone: 571-367-9951
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Laura Jackson

From: magrice@aol.com
Sent: Monday, July 15, 2019 12:23 PM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professions,

My name is Paul Horwitz and I am writing on behalf of my family (which includes my wife Margaret Rice and my son Jeremy Horwitz) in support of licensing music therapists.

As parents of an autistic child, my wife and I have seen, first hand, the pitches of “snake oil” salesmen saying that they had the right therapy or drug, or antidote to cure his autism. Unfortunately, because we would do anything to help our kids, we are vulnerable to such pitches. Without licensure of professionals, it is impossible for desperate parents to make a clear headed judgement on how to spend our limited resources to help our children. We believe licensing of Music Therapists would provide the transparency necessary to help us make that choice in a safer, more thoughtful manner.

For the past 5 years, our son has been working with professionally trained music therapists at A Place to Be in Middleburg, Va, and it has made a profound difference in his life. It is clear that under the guidance of trained professionals, using music to stimulate different neural pathways in his brain has proved an effective way to enable him to learn things that he otherwise would not have been able to learn. It takes professionals to be able to know the appropriate techniques to get positive results. The absence of licensing makes it much more difficult for parents to determine whether they should invest in these therapies.

Finally, because there is no formal licensing, the music therapy that we get is not covered by our insurance (maybe it is covered by some but it is not covered by ours). In that regard it seems as if the current, unregulated system is designed to make it harder for parents of autistic children to cover related costs, rather than easier.

For those reason, we urge you to support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, increase consumer access to appropriately trained clinicians, and provide more impetus to insurance companies to cover such a vital successful therapy.

Paul Horwitz 571-213-4275
Margaret Rice 703-772-6754

Laura Jackson

From: Woodward, Lisbeth A SAMVAMC
Sent: Monday, July 15, 2019 12:24 PM
To: laura.jackson@dhp.virginia.gov
Cc: Woodward, Lisbeth A SAMVAMC
Subject: Support for Music Therapy Licensure in VA
Attachments: Letter to the Board of Health Professions.docx

Dear Ms. Jackson,

Please find attached my testimony in support for Music Therapy Licensure in VA. Please do not hesitate to contact me with any questions or request for further information.

Sincerely,
Lisbeth Woodward, MT-BC

Lisbeth A. Woodward, MT-BC
Music Therapy Internship Director
Veterans Affairs Medical Center
Salem, VA
Lisbeth.Woodward@va.gov
(540) 982-2463 ext. 2781

July 15, 2019

Dear Board of Health Professions,

My name is Lisbeth Woodward, MT-BC, and I am a board-certified Music Therapist living in Roanoke, VA. I have had the honor of working as a professional Music Therapist at the Veterans Affairs Medical Center in Salem, VA, for twenty-eight years. I continue to work with Veterans of all ages (19-105) suffering from a variety of diagnoses ranging from Post-Traumatic Stress Disorder (PTSD), Anxiety Disorders, Substance Abuse Disorders, Depressive Disorders, Traumatic Brain Injuries, Cerebral Vascular Accidents, communication disorders, various dementias including Parkinson's and Alzheimer's Disease, Schizophrenia, amputees, Chronic Obstructive Pulmonary Disease, various cancers, Visual Impairments, acute medical conditions, as well as, provide treatment for veterans in our hospice care program related to terminal diagnoses. I am also a Music Therapy Internship Director and have held a National Internship Program through the American Music Therapy Association, for approximately twenty-six years and have supervised/mentored over 35 music therapy interns for 1,040 hours per intern. Throughout my 28 years' experience, I have had numerous opportunities to witness the extreme importance of proper training for our profession, therefore, I am in adamant support of Licensure for Music Therapy.

I can not stress the importance of proper clinical knowledge and training within our field. Considering the wide range of diagnoses music therapists treat on a daily basis, as well as, the comprehensive effect music and musical components elicit, it is imperative to be properly educated and maintain our scope of practice and high ethical standards within the Music Therapy profession. The potential to "harm" through improper use of music and/or music interventions is significant. It is no different than the potential to harm by other untrained providers, portraying to possess knowledge and skills related to medical/mental health professionals. Music has the power to "trigger" acute PTSD symptoms through inappropriate use of instrumentation and music that may project flash backs thus increasing fight or flight responses through a surge of various neurotransmitters. Improper use of music (as treatment) can cause a depressed individual to become more depressed and/or a manic individual to become hyper manic. Music can aid a dying individual to be more calm and comfortable, improve breath regulation, or increase irritation and irritability, thus negatively affecting "a good death." Music and music interventions have the potential to decrease psychiatric medications, decrease wandering behavior, decrease irritability and other negative behaviors in those with dementia. Without proper training, music/music interventions have the potential to increase these same behavioral characteristics in a negative manor. The application of neurological music therapy interventions can improve motor control of the upper extremities and or improve lower extremities through pre-gait and gait training of those with various neurological disorders. Implementation of these techniques by an untrained individual can lead to falls, fractures, soft tissue damage, rotator cuff tears, or at minimum, pose no improvement at all. These are just a few instances of opportunities for potential harm with improper use of music and/or music related interventions by an untrained provider.

As a board-certified Music Therapist, I have received specialized training which includes a degree from an accredited university through a Music Therapy program approved by the American Music Therapy Association. My training included a minimum of 1200 clinical and internship hours. My education and clinical training prepared me to take and pass the certification exam through the Certification Board of Music Therapy. This certification affirms that I possess the professional competencies/clinical skills to practice Music Therapy. In addition, I maintain the MT-BC credential by completing continuing education in order to ensure that I provide the most up-to date evidence-based treatment derived from current research. Unfortunately, we have seen cases in Virginia where “Music Therapy” has been provided by individuals who do not hold the MT-BC credential, resulting in ineffective services as well as safety risks for patients/clients.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer awareness and access to appropriately trained clinicians.

Most Sincerely,

Lisbeth A. Woodward, MT-BC

Lisbeth A. Woodward, MT-BC
Music Therapy Internship Director
Veterans Affairs Medical Center
Salem, VA
Lisbeth.Woodward@va.gov
(540) 982-2463 ext. 2781

Laura Jackson

From: Cindie Wolfe
Sent: Monday, July 15, 2019 2:32 PM
To: laura.jackson@dhp.virginia.gov
Subject: Support for Music Therapy Licensure in VA

Dear Board of Health Professions,

I am writing to you today as a supporter of Licensure for Music Therapy. I am a board-certified Music Therapist living in Blacksburg where I have a private practice, Music Therapy of the New River Valley, LLC.

Music therapists are trained both as professional musicians and as therapists and learn how to use the two together. As a board-certified Music Therapist (MT-BC), I have received specialized training (which includes a degree from a college/university with a Music Therapy program that has been approved through the American Music Therapy Association) - a bachelor's degree in music therapy from Radford University. My training also included a minimum of 1200 clinical hours, most of which I accumulated during an internship at the Salem Veterans Affairs Medical Center. My education and clinical training prepared me to sit for and pass the certification exam through the Certification Board for Music Therapists (CBMT); this certification signifies that I possess the professional competencies to practice Music Therapy. In addition, I maintain the MT-BC credential by completing continuing education in order to ensure that I provide the most evidence-based treatment based on current research. CBMT is accredited by the National Commission for Certifying Agencies (NCCA). Other programs accredited by NCCA include the American Academy of Nurse Practitioners, the National Board for Certification in Occupational Therapy, and the National Board for Certified Counselors.

Licensure for music therapists is important for consumer protection. Music can be a powerful force (e.g. evoking strong memories or emotions) and there is potential for patient harm, especially when used with vulnerable populations. Additionally, consumers may not get the services they are paying for because many people claim to provide "music therapy" even though they are not trained in music therapy. A music therapy license for board certified music therapists would help consumers know if they are paying for Music Therapy or music-based activities.

Unfortunately, we have seen cases in Virginia where "Music Therapy" has been provided by individuals who do not hold the MT-BC credential, resulting in ineffective services as well as safety risks for patients/clients. "Sue", a young Jewish woman related an upsetting story to me. After having cardiac surgery a woman came to her hospital room, stated she was a music therapist, and asked if she could play some music for the patient. The visitor also said the only music she had with her was Christian. Sue was outraged. Her strong emotional and physiological response could have posed a danger to her physical health so soon after surgery. A board-certified music therapist would 1) be

able to provide a wide range of musical styles, 2) only use religious music acceptable to the patient and only when there was a therapeutic reason to do so.

In summary, I ask that you support state licensure of Music Therapy in order to ensure that only appropriately trained individuals may practice in an effort to protect vulnerable populations, ensure transparency for other healthcare providers and patients/families seeking Music Therapy services, and increase consumer access to appropriately trained clinicians.

Regards,

Cindie L. Wolfe, MT-BC

Board Certified Music Therapist

Director, Music Therapy of the New River Valley, LLC

Clinical practicum supervisor

SWVA Regional Coordinator, Virginia Music Therapy Association

Music Therapy of the New River Valley, LLC

PO Box 10565

Blacksburg, VA 24062

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Follow us on Facebook! <https://www.facebook.com/MusicTherapyNRV1>

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