MUSIC THERAPY IN PUBLIC SCHOOL SETTINGS:

CURRENT TRENDS AS RELATED TO SERVICE PROVISION MODELS

By

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Submitted to the graduate degree program in Music Education and Music Therapy
and the Graduate Faculty of the University of Kansas
in partial fulfillment of the requirements for the degree of
Master of Music Education (Music Therapy).

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Date Approved: April 11, 2018

Abstract

The purpose of this study was to investigate existing school music therapy service provision, including the role of the therapist and models of service delivery to provide an up-to-date overview of the field as of 2017. Participants included board-certified music therapists working in public school settings (n = 217) who completed an online survey of demographic, job, and caseload characteristics; model(s) of service delivery; and decision-making variables that may impact chosen service delivery model(s). This study expands upon previous surveys by providing an updated and more detailed profile of practicing school music therapists and their caseloads, as well as considering variations from "traditional" service delivery models to provide a more complete picture of the public school music therapist in the 21st century. In comparison to the most recent school music therapy survey data from nearly two decades prior (Smith & Hairston, 1999), participating music therapists in the present study had more master's degrees, were required to have dual certification less often, held more part-time positions, and had worked for less time in schools. Most music therapists provided direct services to whole, self-contained special education classrooms (68.4%). Comparisons of survey results indicate that relationships may exist between the model(s) of service delivery chosen by school music therapists and their (a) number of years employed as a public school music therapist, (b) region of employment, (c) additional certification held, (d) number of music therapists in the district, (e) SPED team model, and (f) how music therapy is listed on the IEP. Further findings and implications for clinicians, administrators, and music therapy educators are discussed. Future studies are warranted to understand the numerous variables related to school music therapy practice, support evidence-based practice, and promote the benefits of music therapy as a related service for students in public school settings.

Acknowledgements

I would first like to express my thanks and appreciation to my committee, Dr. Colwell, Dr. Matney, and Dr. Robinson, for sharing your knowledge and support throughout the thesis process. Your collective wisdom in the fields of education and music therapy has been a guiding light and fuel to my passions, both as a researcher and clinician. Additionally, your attention to detail and seemingly infinite patience has helped me become a stronger writer. I am also grateful to Dr. Hanson-Abromeit and Dr. Dvorak for your leadership as I entered graduate studies, which helped develop my critical thinking skills and confidence. I am forever indebted to the music therapy faculty at The University of Kansas and look forward to learning from them in the future, in whatever capacity that may be.

A very special thank you to Dr. Colwell, my thesis chair: I express my highest possible gratitude for the mentorship and wisdom you have shared with me over the past decade. I feel very fortunate to have worked on this project with such a like-minded champion of the field who also made the thesis process continually stimulating and enjoyable. Thank you so much. You have been such an inspiration and have helped me learn things about myself that I will carry with me from day-to-day. In particular, you have been a compass and model for prioritizing what is truly important in life. I will very much miss our regular office and coffee shop conversations, but look forward to knowing you post-graduation.

To my fellow graduate students, supervision team colleagues, and students: Thank you for your peer mentorship and support. I have enjoyed our collegial conversations and know that you all will bring great contributions to our field. You all make Murphy Hall feel like home. Best wishes to all of you in your endeavors and Rock Chalk!

To Aaron, my husband and confidant: I would like to express all of my love and appreciation for your endless support and faith in me. You helped keep my candle burning and watched it burn at both ends without complaint over the years. Your patience, kindness, honesty, and sacrifices have not gone unnoticed—I owe you so much. Thank you for making me laugh on the hardest days and being my companion on this journey of thesis and life. I cannot wait for our next chapter with Baby Gillespie.

Last but not least, I would like to thank my family: my parents, parents-in-law, sister, and brothers for your love and encouragement throughout my education. You taught me to work hard and follow my dreams, but also helped me to have fun along the way. Much love to all of you!

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Introduction

Music therapists working in public schools have faced the arduous task of responding to educational reform, both in regular and special education. The past two decades in particular have included numerous updates to federal laws and mandates affecting educators and related service providers alike, which have not always been implemented free from contest or repudiation. Concurrently, music therapy as a field has grown rapidly and clinicians have worked to adapt to modern societal needs and changes in other disciplines. How, then, do school music therapists make decisions regarding practice and program design to meet these changes while providing apt services for students? Most research literature detailing the practice of music therapy in schools was published more than a decade ago. Where might the modern school music therapist look for guidance to parallel systemic trends in their work environment? Music therapists might first seek to understand prevailing educational law affecting service provision trends in special education before committing to specific programmatic decisions.

Overview of Public Laws

In the last half-century, a number of mandates have been written into educational law by the federal government. One such law, Public Law 94-142—known as the Education for All Handicapped Children Act (EAHCA), has significantly expanded educational services for students with disabilities when passed in 1975 (Adamek, 2002). There have been several amendments to this original act, though the 1990 amendment, PL 101-476—commonly known as the Individuals with Disabilities Education Act (IDEA)—reflected many changes in language and service provision that are current today (Adamek, 2002; Simpson, 2002). IDEA has had a profound impact upon children with special needs, their families, and educators. As a basic overview, IDEA allows all children to receive a *free and appropriate public education*, within a *least restrictive environment*, including all services students need in order to succeed in reaching their individualized goals. As a result of IDEA, there are more children with special needs receiving services in schools than ever before. By 2013-14, the number of students served under the law

was 6.5 million, or 13% of the total school enrollment (U.S. Department of Education, 2015). Many students with disabilities are now educated for most or all of the school day within the general classroom and related service providers "push in" to classrooms to provide educational support as necessary.

Impacting all students, the No Child Left Behind Act (NCLB) was passed in 2001 as a revision of the Elementary and Secondary Education Act of 1965. Both regular and special educators felt pressure due to high expectations for growth and achievement, particularly in minimizing educational "gaps" between low-achieving students and schools and those meeting proficiency (Klein, 2015b). NCLB required all schools to meet benchmarks, labeled Adequate Yearly Progress (AYP), with a goal of 100% proficiency for *all* students by 2014 (Department of Education, 2001). Schools who do not meet AYP under this law are subject to intervention from the federal government, including funding cuts and personnel loss. Critics argue the bill caused a "teach to the test" mentality and noticed problems when a majority of the schools in the nation were failing to meet AYP even after a decade of implementation.

Acknowledging the failures to close educational gaps under mandates of NCLB, state leaders worked together to create and introduce the Common Core State Standards Initiative (CCSSI) of 2010 (Common Core State Standards Initiative, 2016). These standards include a set of learning goals that outline what a student should be able to demonstrate at the end of each grade level; the demonstrations focus on English-language arts and mathematics. CCSSI was an initiative to create and implement a national educational standard intended to help prepare students for the expectations of college and the workforce. States may choose the option of adopting CCSSI and choose from a number of tailored teaching materials and supports to ensure student success on CCSSI assessments. Critics argue that the standards are inflexible and harsh. Several states have since taken legislative action to re-brand, modify, or revoke adoption of CCSSI assessments (National Conference of State Legislatures, 2016; Ujifusa, 2016).

In December of 2015, President Obama signed the Every Student Succeeds Act (ESSA), a revision of the Elementary and Secondary Education Act of 1965 and replacement of the NCLB Act of 2001 (Department of Education, 2015; National Conference of State Legislatures, n.d.). This law offers

more flexibility in testing administration, remains neutral on Common Core (states may still choose to implement the CCSI standards and benchmarks), and accountability goals are left up to individual states. All students, including those with special needs, are still held to high accountability and testing standards though the educational climate is more temperate as of late (Klein, 2015).

Impact of Public Laws

Special educators, general educators, and related service providers have been directly affected by each of these federal and state laws. In particular, the *least restrictive environment* mandate within IDEA has changed how special education is implemented by these professionals. Whereas special education used to function as a separate division of the school, many departments now function as more of a collection of services provided to support general education teachers either within the regular classroom or as limited services in separate classrooms (Johnson, 2002). Under IDEA mandates, members of the special education team are expected to collaborate to create goals and objectives and to design a plan for each student to achieve maximum potential (Friend & Cook, 2012). This collaboration, aimed at student success, is perhaps more urgent now with additional pressures to help students meet individualized goals and AYP—which may be reflected in test-related teacher evaluations. Collaboration is not only mentioned by special education professionals as "key to their success in meeting the needs of all students" (Friend & Bursick, 2012, p. 66), but collaboration among interdisciplinary team members can help "lighten everyone's workload" (Turnbull et al., 2013, p. 139) and thus reduce the pressure of responsibility that team members may feel to help a student meet their individualized goals and perform to increased testing standards.

The philosophy of *inclusion* has been largely accepted in recent years within the regular and special education community after implementation of IDEA (Turnbull et al., 2013), though debates have ensued for decades as to whether full inclusion or a continuum of placements (from segregation to inclusion) for a child with special needs is best (Jones & Cardinal, 1998; Wilson, 2002). Paramount to inclusion is the preparation of general educators to develop skills and attitudes necessary to successfully include *all* students, which may mean additional training, collaboration, consultation, or co-teaching

within the general classroom. Special educators and related service providers may see an interdisciplinary model as beneficial, in which professionals work together within their respective roles to promote holistic intervention, or a transdisciplinary team model—where all team members engage in roles that cross into other professional fields to meet student goals efficiently (Friend & Cook, 2012). These models may foster inclusion practices more readily than a multidisciplinary model, in which each team member writes and implements goals separately. Music therapists are assets to inter- and transdisciplinary team models due to the malleable nature of the music modality, as well as the transfer across developmental domains and educational subjects (Johnson, 2002; Twyford & Watson, 2008).

Music Therapy

Music therapy has been a service for children in public schools for the last half century (Nordoff & Robbins, 1971). The role of the music therapist shifts and grows with changes in the profession and in special education. A student may be eligible for music therapy as a related-service if assessment reveals that they need music therapy in order to make achievements toward goals on their Individualized Educational Program (IEP). In other models of music therapy, the therapist may provide consultation to another professional who is looking to use music to enhance his or her service provision or may provide preventive services as educational enrichment or positive behavioral support to all students within a given program (Coleman & Brunk, 2003; Gardstrom, 2002; Turnbull, Turnbull, Wehmeyer, & Shogren, 2013).

Recently, music therapists have faced many of the same challenges as other special education professionals in relation to legislation and funding for programs that support children with special needs. According to some researchers, funding can be problematic for music therapists without steadfast administrative support (Ropp et al, 2006). If music therapists are not labeled as "necessary" in helping students achieve individualized goals, which now may include goals related to standardized testing and CCSS, then the music therapist may become an unnecessary link in the special education departmental chain (Ritter-Cantesanu, 2014). Thus, music therapists need relevant and current information on how best to adapt to this educational atmosphere—which has such a weighty emphasis upon achievement and

accountability—and yet provide evidence-based, student-centered services that are in agreement with the special education team's philosophies and models.

Most recently published school music therapy references outline and describe defining characteristics of school music therapy service delivery models (Adamek & Darrow, 2005, 2010, 2018; Humpal & Colwell, 2006). Wilson (2002) provides additional detail on this topic by highlighting examples from large, representative school districts. Individual chapters in these resources are written by professors and educators in the field and can provide foundations for future research. However, these references provide limited first-hand experiences and opinions that current practicing school music therapists might be able to offer about particular models. Instead, most chapters describe models of music therapy in relation to certain disability categories in general terms and case examples. Authors rarely articulate how particular models relate to the day-to-day job responsibilities and roles of the music therapist in public schools (see Johnson, 2002), such as caseload size, attendance of IEP meetings, or level of collaboration with other school professionals. Furthermore, authors may be providing suggestions based on a set of limited experiences; the reader is unable to deduce whether certain variables (i.e. therapist training, individual student needs, or philosophical perspective) may influence the author's service delivery decisions.

Need for Study

Researchers have looked globally at school music therapy by surveying therapists to report on what models they use based on the current educational climate (McCormick, 1988, Smith & Hairston, 1999) or by examining opinions regarding inclusion (Jones & Cardinal, 1998). Unfortunately, no studies have been conducted since 1999; therefore, none of these previous surveys include information regarding changes in service provision since NCLB, CCSSI, or the most recent ESSA—let alone changes in the field of music therapy. Early surveys of school music therapists outline therapist demographics and direct music therapy services but do not inquire about philosophical orientations or indirect service delivery models (McCormick, 1988; Smith & Hairston, 1999). Furthermore, these studies give limited consideration to the multiple variables that might impact a therapist's decision or preference to operate

within a particular model of music therapy (such as the therapist's caseload, attitudes of other school professionals toward music therapy, or individual student needs). Therefore, current clinical music therapists, music therapy students, and educators may have difficulty generalizing the findings of these past studies to current practice in public schools.

Since the late 1990s, authors have advocated for an expansion of the traditional school music therapist profile; in particular, international researchers point to consultative music therapy as a successful and practical way to meet inclusion needs (Chester et al., 1999; Rickson, 2010; Twyford & Rickson, 2013). Other authors have introduced innovative school models such as community music therapy in schools (Skewes McFerran & Rickson, 2014a, 2014b), after school programs (Chong & Chung, 2006; Chong & Kim, 2010), inclusive, "push-in" music therapy vs. traditional "pull-out" services (Adamek & Darrow, 2010; Johnson, 2002), and preventive music therapy groups (Gardstrom, 2002). An update to the literature regarding current and prevalent models of school music therapy is timely and should outline options of school music therapy models for practitioners who are interested in working in school settings, developing a new music therapy program in a school, or enhancing their program's evidence-based practices.

Implications also extend beyond school music therapists to music therapy educators as students in higher education who plan to achieve a job in the current school climate need to have an understanding of contemporary practices in school music therapy, as relayed by their professors. Furthermore, an understanding of various service-delivery models and variables impacting clinical decisions may lead to further research regarding the impact of various models on meeting student IEP goals, which could enhance evidence-based practice in school music therapy and intervention fidelity. Therefore, the purpose of this study was to investigate existing school music therapy service provision, including the role of the therapist and models of service delivery to provide an up-to-date overview of the field as of 2017.

Chapter 2

Review of Literature

Special education programs in public schools are among several settings in which board-certified music therapists work with children with special needs. As part of a special education team, music therapists are typically hired to provide related services as part of a student's Individualized Education Program (IEP). The American Music Therapy Association reported that 12% of its 3,957 members worked in children's facilities and schools in 2016, indicating a growth of five percent in the eleven years between 2005 and 2016 (AMTA, 2005, 2016; Ropp, Caldwell, Dixon, Angell, & Vogt, 2006). This growth parallels the increasing number of students served under IDEA each year. By 2013–14, the number of students served under IDEA was 6.5 million, or 13% of total public school enrollment (U.S. Department of Education, 2015). Evidence suggests that this number is gradually increasing, particularly in certain disability categories. Furthermore, additional preventive services may be beneficial to students who may be considered "at risk" for academic failure but do not having an IEP that enables them legal access to academic supports (Gardstrom, 2002). As music therapists work to accommodate growing caseloads and the changing educational climate, a clear look at current trends in school-based music therapy may be warranted.

Music therapy may be considered a related service under the 1997 amendments to the Individuals with Disabilities Education Act (IDEA) (Brunk & Coleman, 2002; Humpal, 2002; Ropp et al., 2006; Simpson, 2002; U.S. Department of Education, 2010), along with physical therapy, occupational therapy, speech-language pathology, and other services that support a child's educational needs. These related services providers, in conjunction with special educators, parents, classroom teachers, and school administrators function as a team to target specific, individualized goals for each student so that he or she may function within the mainstream curriculum. Unlike other related services, which tend to address specific goal or domain areas on a student's IEP, music therapy crosses many domains and can simultaneously address multiple goals (Pellitteri, 2000). Because music therapy is defined by modality

rather than area of functioning, it is a flexible and widely applicable service to children in educational settings.

In the past few decades, public school music therapy has been delivered in special education settings in a variety of service provision models. Common models include direct services, consultation with staff or students, program-based consultation, or collaborative experiences such as inservices and workshops (Johnson, 2002). Multiple variables may determine which model a therapist uses, such as workplace variables (i.e. administrative support and finances), therapist-related variables (i.e. philosophy, education, caseload), and student-related variables (i.e. individual needs, age, level of function). For a student to receive direct music therapy services, the student must meet eligibility, defined as needing music therapy in order to make progress toward his IEP goals (Brunk & Coleman, 2000). Eligibility assessment is a critical element for including music therapy within a student's IEP and thus establishing it as an educational benefit (Pellitteri, 2000). Examples of eligibility assessments used in school music therapy include the Special Education Music Therapy Assessment Process (SEMPTAP), (Coleman & Brunk, 2003) and the Individual Music-Centered Assessment Profile for Neurodevelopmental Disorders (IMCAP-ND), (Carpente, 2014). In some models, however, music therapy is provided to all students, regardless of IEP need. In other cases, a music therapist provides consultation for an educator who may use music in his or her classroom to influence behaviors or educational outcomes.

Little is known about the status of music therapy in school settings since the most recent major publications from AMTA are from the years 1996 to 2006 (Humpal & Colwell, 2006; Wilson, 1996, 2002). Authors also published a few descriptive studies around that same time to gather additional information about current music therapy practice in schools (Jones & Cardinal, 1998; McCormick, 1988; Smith & Hairston, 1999). Meanwhile, education in the United States experienced a number of changes such as standardization of testing, focus on decreasing learning gaps, and greater multicultural diversity. These changes are echoed in special education as more teachers are including all students with disabilities in their general classroom (Turnbull et al., 2013). With these factors in mind, several questions are posed. Has the role of the music therapist changed to acclimate to trends in both regular and special education?

As the number of students with special needs educated in the general setting increases, are music therapists adapting service delivery? In an effort to address these questions and more, a look at the roles and responsibilities of the "modern" school music therapist seems warranted.

This chapter provides an overview of research and literature that outlines music therapy, special education, related-service provision models, and associated trends in school settings. Areas examined in this chapter include (a) laws influencing changes in special and regular education settings, (b) models of service delivery in special education and related services, (c) and the impact that these laws and trends have on both service providers and individual students. In order to understand the educational and environmental contexts within which related services such as music therapy are provided, one must first look at recent trends in special education.

Trends in Special Education

Federal laws and initiatives. The U.S. government plays a significant role in the decision-making processes in which teachers, administrators, and related service providers engage every day. Moreover, the rights and protections of the individual child to receive appropriate education often lie in the hands of federal and state legislators. Since 1990, perhaps some of the biggest changes in the history of disability advocacy have occurred with the reauthorization of IDEA, or Public Law 101-476. According to IDEA principles, students with disabilities have rights to free, public, individualized education and are to be included within the Least Restrictive Environment (LRE). Providing educational services in the LRE requires including the child in the same classrooms as their typically developing peers to the maximum extent possible (Turnbull et al., 2013). While IDEA promoted positive changes for children with special needs, state and federal mandates in the last 15 years have also introduced new challenges for teachers and students alike. The following sections provide a brief overview, as well as benefits and challenges, of some of the most significant laws and changes in the recent history of U.S. education: (a) Public Law 94-142 and IDEA, (b) No Child Left Behind Act of 2001, (c) Common Core State Standard Initiative of 2010, and (d) Every Student Succeeds Act of 2015.

***Public Law 94-142 and IDEA*.** Many changes began in the educational system for children with special needs after the implementation of Public Law No. 94-142 in 1975, and its most recent reauthorization as the Individuals with Disabilities Education Improvement Act (IDEIA) of 2004, or P.L. 108-446. This law is more commonly known and referred to by the 1990 reauthorization of P.L. 94-142 called Individuals with Disabilities Education Act, or IDEA (Adamek, 2002; P.L. 101-476; Turnbull et al., 2013). Perhaps the most notable and innovative change within the *least restrictive environment* mandate of IDEA, was the *mainstreaming* rule*,* which is now known as the principle of *inclusion* (Smith & Hairston, 1999; Turnbull et al., 2013). Inclusion involves educating children with disabilities in the most natural environment possible; ideally with their typically-developing peers. As a result of additional mandates within IDEA, including the zero-reject policy which states that all children are entitled to a Free and Appropriate Education (FAPE), most children with special needs are now educated in public schools, rather than private or segregated institutions (Turnbull et al., 2013; U.S. Department of Education, 2015).

Despite positive changes, some argue that interpretation of language within IDEA makes it difficult to know how to implement individual mandates (Wilson, 2002). For instance, in regard to FAPE, interpretations may differ as to what makes an individual educational experience "appropriate" for a particular child. Wilson (2002) states that an education experience is appropriate when the program is "procedurally developed, individualized, and reasonably expected to provide benefit" (p. 25) unless the student is fully included within the regular classroom, in which case the student may need related services and paraprofessionals. Critics believe, still, that this open language gives children access to some services, but not at a particular level of provision; "appropriate" could mean receiving a 'basic floor of opportunity' to achieve a certain skill rather than maximizing potential (Wilson, 2002, p. 26).

IDEA also mandates that a child must be educated in their Least Restrictive Environment (LRE). As previously mentioned, the *inclusion* initiative was perhaps one of the most important aspects of IDEA that lead to widespread changes in special education and was introduced as an option for a student's LRE. Today, approximately 95% of all children with disabilities who receive services under IDEA are being

educated in regular school buildings, with over 60% being educated in regular classrooms for 80-100% of their school day (U.S. Department of Education, 2015).

Considerable debate has ensued over the educational placement of individuals with disabilities. Much like the debates regarding FAPE, the interpretation of what constitutes the "least restrictive environment" may be unclear to those implementing policies. While some support the inclusion of all students, others believe that full inclusion is restrictive and fails to individualize educational needs for each specific child (Wilson, 2002). Opponents are often concerned that immediate placement in a general education classroom might actually *limit* many students' growth in certain areas and may be unrealistic, or even harmful. In backing the opposing philosophy, those supporters maintain that it is the right of all students to be educated with their peers and, thus, achieve their potential within society (Jones & Cardinal, 1998). Authors and researchers seem to agree that inclusion—which may perhaps occur on a spectrum—is the present and future standard for children in special education.

No Child Left Behind Act (NCLB) of 2001. While IDEA mandates allow services for students with special needs on IEPs, President George W. Bush implemented the No Child Left Behind (NCLB) Act of 2001 to improve educational outcomes for all students. By singing this Act into legislation, President Bush amended the Elementary and Secondary Education Act (ESEA) of 1965. This law has greatly impacted regular and special educators; some consider NCLB to be the impetus for an era of "standardization" in education. NCLB significantly raised expectations for states, districts, and schools. The law required schools to meet Adequate Yearly Progress (AYP), a method of accountability that compelled states to set benchmarks and make progress toward goals of 100% proficiency for *all* students by the year 2014 (Department of Education, 2001). To meet AYP requirements, 95% of students in each subgroup (such as special education or English-language learners) and 95% of students in the school as a whole must meet or exceed annual objectives in reading and math set by the state for each year on state tests (Department of Education, 2001). A school that does not meet AYP for two consecutive years are given a "needs improvement" status and may be subject to repercussions such as staff or administration

dismissal, conversion to a charter school, lengthening of school day or year, or school closure (Education Week, 2015).

By 2011, 38% of schools failed to make AYP; the Secretary of Education, Arne Duncan, predicted the number to reach 82% by the end of the year if the law was not rewritten (Editorial Projects in Education Research Center, 2011; McNeil, 2011). Consequently, the NCLB amendments to ESEA became largely unpopular among educational professionals. While the goal of the law was to take an aggressive role to raise achievement and close the gaps between achieving and struggling schools, many felt that the 100% proficiency goal would be extremely difficult and expensive, setting schools up for failure. Critics also noted that NCLB caused a "teach to the test" mentality among teachers and administrators who were under stress to keep their schools afloat (Ritter-Cantesanu, 2014). Because of these factors, efforts were made to reauthorize the previous ESEA.

Common Core State Standards Initiative of 2010. After years of struggle under the NCLB of 2001, the state leaders including governors and state commissioners of education led development of the Common Core State Standards (CCSS) as an initiative to create and implement a national education standard (Common Core State Standards Initiative, 2016). The CCSS is a set of quality standards in mathematics and English-language arts/literacy (ELA) that states may choose to adopt as accountability standards. As of 2013, forty-two states had adopted the CCSS (CCSSI, 2016). While federal law does not mandate the CCSS, districts are supported by federal government grants if their state has "opted in" to CCSS. These standards serve as learning goals, which outline what a student should know and be able to do at the end of each grade.

The CCSS initiative, which is often viewed as a natural extension of NCLB, enables collaboration between states on developing teaching materials and comprehensive assessments. It also shifts accountability from the school to the teacher; test results are considered part of teacher evaluations. Critics of CCSS argue that the initiative is inflexible and harsh. Immense pressure is placed upon teachers and administrators to ensure students receive high test scores, which encourages the "teaching to the test" mentality, much like NCLB. Educators may have difficulty supporting this mentality—particularly

because the CCSS were created by a private organization, with limited public review or teacher input. Several states have since taken a legislative action to re-brand or revoke adoption of CCSSI assessments (National Conference of State Legislatures, 2016; Ujifusa, 2016).

***Every Student Succeeds Act of 2015*.** In December of 2015, changes occurred when President Obama signed the Every Student Succeeds Act, which replaced NCLB of 2001. The new law offers schools additional flexibility in test administration, remains neutral on state choices to implement CCSSI, and leaves accountability goals to states. States must submit accountability plans including their own goals to the Department of Education, starting with the 2017-18 school year. These goals must still address gaps in subgroups that are furthest behind, as in NCLB. Additionally, ESSA requires states to assess students for success indicators as a supplement to math and English-language arts state assessments, such as student and educator engagement, postsecondary readiness, or school safety. While there are some positive changes that accompany ESSA, such as testing flexibility, Common Core still has significant impact in many states and 90% of students with disabilities are still to be included in standard testing requirements for making AYP (Samuels, 2015; U.S. Department of Education, 2015).

Implementing laws: Obstacles for school professionals. General educators are still facing challenges related to IDEA—particularly with successful inclusion of children with special needs into their classrooms. Evidence suggests that there have been positive changes in teacher attitudes regarding inclusion but that many teachers still feel the need for additional training or classroom support to effectively include all students (Jellison, 2000, 2015). NCLB and CCSS requirements have imposed upon teachers a need to "teach to the test" rather than individualize instruction (Ritter-Cantesanu, 2014). Students are spending an inordinate number of hours preparing for, and taking, state and Common Core assessments, which leads to student and teacher stress, as well as teacher burnout. Additionally, teachers are often building entirely new curricula to align with goals under CCSS. Teachers therefore find themselves driven by state assessments rather than the individual needs of the student or the classroom's collective culture, interests, and needs.

A current reality faced by many states and districts, which affects teachers and students directly, is the limitation of funding for additional supports to general educators such as paraprofessionals or consultants. The Great Recession of 2008 resulted in a multitude of negative outcomes in public schools, including sharp cuts in state education funding, mass job losses in teachers and teacher aids, inequality in school spending, and increased vulnerability due to the ups and downs of the economy (Evans, Schwab, & Wagner, 2014). These changes put even more pressure on teachers hoping to retain jobs.

Special education teachers face many of the same challenges as their general education peers. Providing services in a more inclusive environment means limited one-on-one time with students to target individualized goals on the IEP. This puts the special education personnel at the mercy of the teacher to have time to collaborate or provide consultation on strategies for inclusion and then to implement accommodations appropriately. Additionally, testing and AYP requirements since NCLB have put an immense pressure on special educators and related service providers (Ritter-Cantesanu, 2014). Students with special needs are often held to the same accountability standards as typically developing peers in meeting AYP, which may or may not be an attainable goal. The most recent educational law, ESSA of 2015, only allows for 1% of the school population, or approximately 10% of students in special education, to qualify for alternative assessments such as portfolios of student progress, IEP-linked content data, and checklist data (Turnbull et al., 2013; U.S. Department of Education, 2015). Advocates have fought to lift this requirement (Samuels, 2015), arguing that the law lacks clarity or reasonable assessment in determining whether many students with special needs are making "adequate" progress. Although state by state dependent, CCSS may drive what is taught in the classroom and as such there are direct implications for what goal areas special educators must support. Goals, benchmarks, and plans within a child's Individual Education Program (IEP) need revision if his or her state chooses to adopt CCSS. How do special educators manage this and also help students achieve goals in all domain areas and all academic subjects?

Finally, the concerns for meeting AYP resulting from the current laws can be problematic for related service providers who are assessing students for service eligibility (Coleman & Brunk, 2003;

Ritter-Cantesanu, 2014). Special educators work to demonstrate that students with special needs are making "adequate" progress so they and their school are not in jeopardy under AYP requirements. This decision may decrease the referral for assessments for related service eligibility. If funding is limited in a school district, a genuine concern is that funds may be allocated to those services that best support testing rather than related services for functional goals. While the number of students with special education services is increasing, federal funding is not (National Center for Educational Statistics, 2012; Ritter-Cantesanu, 2014). Despite the authorization within Part B of IDEA that the federal government would pay 40% of excess cost of providing special education services for students with special needs (which is estimated as nearly double the cost of educating typically-developing peers), actual federal funding covered 16% of the excess cost in 2014—approximately $17.7 billion less than full funding mandated under IDEA Part B (McCann, n.d.). The shortfall is left to state and local school districts to fund, which may be greatly impacted by budgeting allocations and availability of funds. This can make it difficult for special education administration and service providers to advocate for their services and, thus, meet student needs through the appropriate means.

Inclusion. Most recent literature in special education and related services suggests that inclusion is the current model of service-provision. Contemporary educational pedagogy emphasizes inclusion and teamwork so that students with diverse abilities are supported to remain within a single classroom (Skewes McFerran & Rickson, 2014; Turnbull et al., 2013). Perhaps one reason for this shift from "pull-out" or segregated education of students with special needs to a mainstreamed or inclusive environment is because inclusion is more than just a model; it represents a change in societal thinking and general philosophy (Turnbull et al., 2013). As trends in modern society include progression toward more diverse, accepting, and global thinking, a comparable alignment in the school system would follow this societal model. Debate has continued over the appropriate educational setting for students with disabilities since the initial implementation of IDEA (Jones & Cardinal, 1998; Wilson, 2002), particularly in relation to how inclusion is implemented.

Full inclusion means that all services are provided in the general classroom and support services are "brought into the room only as absolutely necessary" (Wilson, 2002, p. 28). Proponents of full inclusion believe that this will reduce the stigma surrounding students with disabilities and provide all students with a more meaningful educational experience and positive social experiences. Opponents, however, still argue the appropriateness of this model. They worry about the impact on other students if students with special needs require an inordinate amount of the teacher's time. Additionally, critics ask how one can truly identify the LRE for each student; they argue that LRE must be secondary to a primary objective of *appropriate* education. They see full inclusion of students with disabilities as more of a 'dumping' into the regular classroom and see it as the removal of special education services entirely (Wilson, 2002, p. 29). Some worry that inclusion will, in fact, lead to further stigmatization of individuals with disabilities because differences may be accentuated if students with special needs are compared side-by-side to their typically developing peers or receiving services within the classroom setting (Petch-Hogan & Haggard, 1999; Wilson, 2002).

While inclusion "conservationists" and "abolitionists" (Wilson, 2002) both provide valid arguments regarding inclusion, others argue that inclusion can be defined as somewhere between full inclusion and "pull-out" special education services. Position statements released in 1997 by 15 national associations representing children with disabilities support a full continuum of placements rather than a single option of inclusion is best (Sandler, 1997). In the past decade, the philosophy of inclusion has been embraced internationally (Skewes McFerran & Rickson, 2014). Pedagogical resources in special education have shifted from a more generalized, norm-oriented curriculum to a more universal design that can account for individual needs of all students (see Turnbull et al., 2013). According to Turnbull et al. (2013), universal design for learning (UDL) refers to the "design of instructional materials and activities to make the content information accessible to all children" (p. 35), which may include curriculum modifications achieved through technology, multiple means of representation of content, and multiple means of engagement. UDL focuses on student strengths and learning capacities, allowing children with disabilities full opportunity to benefit from the general education.

Inclusion research. Teachers and school administrations widely support inclusion as a philosophy (Turnbull et al., 2013). However, an important question deserves further exploration: is inclusion empirically demonstrated as most appropriate for children with special needs? Evidence has supported some benefits of inclusion, especially in regard to social skills (Kehagias, 1998; Snell, 1991). In contrast, a meta-analysis by Carlberg and Kavale (1980) indicated benefits of special or segregated classrooms in the late 1970s and found that students with mild learning disabilities have most success with inclusion. Kehagias (1998) found that school-based occupational therapists and classroom teachers perceived the "pull-out" model of occupational therapy to be more effective in terms of academic abilities. Otherwise, research that empirically compares one service delivery model to another (i.e. inclusion vs. pull-out services) appears limited in all related service fields. Many challenges to studying these models exist, such as eliminating teacher bias, finding equivalent teachers and students, varying degrees of support services, and lack of valid sources of measurement (Darrow, Colwell, & Kim, 2002). Some research supports full inclusion as a successful model of service-delivery for students with special needs, while other research supports partial inclusion to the degree most beneficial for the student. However, additional empirical studies are warranted that attempt to nullify some of the considerations presented above and look at inclusion within current laws and educational environment.

Trends in Related Services

Related services are those considered necessary to assist the student in benefiting from special education (Turnbull et al., 2013). Related services may include assistive technology and services, audiology, counseling services, interpreting services, family services, health and medical services, specific therapies, psychological services, transportation and more. Educational law and trends in both special and regular education have led to growth in the number of related services included in public schools. These laws and trends have also accounted for a number of changes in these related services. To meet unique student needs, individualized instruction may not be enough and educators may need to supplement instruction with additional, related services.

IDEA and related services. Within mandates of IDEA including a free and appropriate public education, all students with special needs have the right to receive related services which may help them meet educational objectives within their IEP. IDEA states that a related service must be *necessary* for the student to make progress toward individualized goals and objectives, and thus eligibility assessments within each related service must demonstrate that a student needs the service in order to make further progress (Ritter-Cantesanu, 2014). If the service is deemed necessary for the student, the service must be listed on the student's IEP as a related service. As the nature of service delivery changes to include more students with disabilities in the general education classes it becomes necessary to consider any issues regarding the delivery of related services in less restrictive environments.

SPED department models and related services. Whether a special education department operates as a multi-, inter-, or transdisciplinary team model can impact related service provision (Ritter-Cantesanu, 2014). In a multidisciplinary team, special education and related service professionals work separately; each team member writes and implements only goals specific to their area (i.e. physical goals in physical therapy). Goals are often duplicated or overlapped, though transfer of skills from one environment to another may be limited. In an interdisciplinary team, professionals work together to write and implement a student's IEP through shared goals and implementation plans. Though information is shared readily, each specialist works within his or her own area of expertise. This model allows for transfer and repetition of skill development and effective communication among professionals. Finally, transdisciplinary models blur discipline boundaries and identities in order to coordinate efforts to meet student needs. All service providers plan, implement, and evaluate IEP goals together. In some circumstances, this may mimic a medical co-treatment model. Overall, the team model in which related services function could impact how goals are written on the student's IEP and the amount of communication or collaboration between team members. Within a particular *team* model, the related service professional must use clinical reasoning processes to decide which *service delivery* model and program intensity (Brandel & Frome Loeb, 2011).

Service delivery models for related services. Following changes in special education such as inclusion, service delivery models for related services have been similarly impacted. Researchers in certain related service disciplines have recently focused on models of service delivery and program intensity, as well as the clinical reasoning process for determining these factors (Brandel & Frome Loeb, 2011). Authors in the fields of physical therapy (APTA, 1990; Sandler, 1997), occupational therapy (AOTA, 1987; Brown & Montivero, 2001; Dunn, 1988, 1990; Kehagias & Rothner, 1998), speech-language pathology (ASHA, 2000, 2003; Law, et al., 2002), and music therapy (Darrow, 1999; Jellison, 2015; Jones & Cardinal, 1998) generally regard inclusion as the common and preferred option, in an effort to align with trends in special education. Potential barriers to facilitating inclusive education are unique to each discipline. For example, a physical therapist may need specialized equipment that can only be accessed outside of a classroom. A music therapist may struggle to provide individual services within a classroom due to inherent noises involved in making music. Related service providers must decide whether they will provide direct or consultative services, depending on the needs and philosophies of the special education department in which they work and the process of clinical reasoning.

Direct service delivery in related services. In a direct service delivery model, a therapist within a particular related service typically works one-on-one with an individual student or with a group of students (Brown & Montivero, 2001). A student's individual needs may be addressed directly through targeted therapeutic experiences. According to Dunn (1988), the most critical feature in choosing direct service is the identification of an educational need that can be met only by direct interaction between the student and the therapist. Direct service delivery may be called the "pull-out" model if students are removed from their natural environment with peers to receive services in an isolated therapy environment, either individually or in a group of learners. Little collaboration occurs between the related service provider and teachers or parents in this model. This "traditional" model of service focuses on targeted need areas and assumes that the student will be able to somewhat independently transfer or generalize skills to the classroom environment and academic tasks. Additional drawbacks include fragmented services and poor communication among team members.

On the other hand, direct services may be provided within the inclusive general classroom or special education classroom and may be referred to as the "push-in" model (Brown & Montivero, 2001). This model of service may be delivered to an individual, group, or whole class. Brown and Montivero (2001) label 'push-in' direct services or "integrated therapy" (p. 24) as the most common model for service delivery in occupational therapy and note that inclusive models focus on the student's strengths and academic achievement, rather than developmental deficits. This form of direct service delivery aligns with the IDEA requirement that a student should be educated within their LRE and allows for immediate use of a learned skill within the natural, classroom context. Because the therapist may only be with the student for a limited amount of time and may be at the mercy of the teacher's lesson plans, generalization of skills is still limited. Recognition of limitations of the "pull-out" and "push-in" direct services approaches has led to an increase in interest toward consultative therapy in related services in the past few decades (Sandler, 1997).

Consultative service delivery in related services. Within consultative therapy services, a child's general education teacher (or parents) provides the direct services to a child under the direction of and consultation with the related service provider. The therapist, or related service provider, consults with a teacher to solve a particular problem rather than for evaluation or general suggestions (Brown & Montivero, 2001; Dunn, 1990). The primary role of the therapist is as consultant (Sandler, 1997). Dunn (1988) states that the critical factor in choosing consultation is identification of an educational need that may be met most effectively through a supportive environment that offers opportunities to generalize skills to different environments.

Consultation in related services can be oriented to the needs of the student (case consultation), the professionals (colleague consultation), or the system (system consultation) (Dunn, 1988). In some forms of consultation, the therapist designs an intervention program, which is then demonstrated to teachers and parents within training (Sandler, 1997). Sandler suggests that this allows the people who have the most contact with the student to deliver therapeutic input. If the student is evaluated and then the teacher implements techniques, this form of consultation is called monitoring (Brown & Montivero, 2001).

Consultation or monitoring allows the classroom teacher or other related service professionals to work more effectively toward specific IEP goals for their students.

While consultation in related services seems to be a popular and growing area of interest, especially within a transdisciplinary model (Sandler, 1997), authors suggest that this should not be the only service provision model (Brown & Montivero, 2001; Sandler, 1997). These authors caution that consultation should not preclude ongoing, direct therapy when required by a student to succeed on IEP goals. Consultation is effective for providing ongoing environmental support but may require special skills to implement properly. Law et al. (2002) noted that speech-language pathologists (SLP's) with fewer years of experience are more likely to engage in direct services and argued for specialist recognition for more experienced practitioners looking to provide consultation services. Additional problems exist such as the large number of students on a therapist caseload, shortage of financial resources for consultant services, and questions about whether needs would actually be met through consultation (AOTA, 1987; Dunn, 1988). For instance, will the teacher receive enough training to fulfill the role? Do they have time to implement strategies gathered from consultation within their daily classroom interactions? Is the student's health and safety protected when someone other than the related service provider implements strategies?

Each model and submodel presented above has benefits and limitations. Direct service is time consuming and, thus, costs a school district more money. This model, however, can address individualized needs effectively through flexibility and adaptation. Consultation provides more generalizable and ongoing support for a child but may require special skills (Dunn, 1988). Results of a pilot study by Dunn (1990) comparing effects of direct and consultative services suggested that level of goal attainment was similar between the two models. Furthermore, relationships developed between related service providers (OTs) and teachers led to more positive views of the general classroom and of the related service's contribution to the environment. A meta-analysis conducted in 1985 suggests that the largest outcomes of consultation are actually within the person with whom the consultant meets rather than student functioning (Medway & Updyke, 1985). Additionally, Kehagias (1998) found that "push-in"

or inclusive, direct service models were perceived as more effective in terms of societal benefits, but that "pull-out" direct services were more effective for academic abilities. While neither method is empirically demonstrated as more effective than another, "pull-out" direct services are found to be the most common throughout the past few decades (Brandel & Frome Loeb, 2011; Kehagias, 1998). So how do related service providers determine which service delivery model to implement? A closer look at influential variables and clinical-decision factors may be warranted.

Variables impacting service delivery models. In recent years, researchers have engaged school therapists in reflection to determine which factors influence decisions to use a particular model of service delivery (ASHA, 2003; Brandel & Frome Loeb, 2011). In particular Brandel and Frome Loeb (2011) conducted a survey in which nearly 2,000 speech-language pathologists rated the effects of various therapist, student, and workplace factors on their decisions to choose a service-delivery model and program intensity. The researchers designed a school-based intervention decision-making model (SIDM) based on previous research and clinical experience to use as a framework (p. 462). The SIDM is also based on ASHA's (2000) 14 factors to be considered when determining appropriate program intensity and service delivery model.

The SIDM indicates the following factors to be potentially influential in decision-making, within the domains of therapist, student, and workplace: (a) *Therapist factors* may include clinical training (type of experiences, year of graduation), professional development (type of activities, years in schools), and relationships with school personnel, (b) *Student factors* include strengths, needs and current abilities; peer modeling; impact on general education curriculum; severity and type of disability; motivation and attitude; and grade or developmental level, (c) *Workplace factors* include workload size (including caseload), administrative support, and team input. This model may neither be inclusive of every variable that may influence decision-making nor provide a hierarchy of importance each variable plays in decision-making. However, it does provide a starting point for future studies in additional related services and a thought-provoking look at variables that may impact models and clinical reasoning.

Clinical reasoning processes in related services. A related service provider must make a decision about what setting is most appropriate for a student based on clinical expertise and individual needs of the student. This process is known as *clinical reasoning* (Brown & Montivero, 2001). Therapists should now only know how to implement a particular strategy, but should also know under what conditions the strategy would most likely be effective (Dunn, 1990), for "excellent techniques that are applied within an inappropriate context may prove to be ineffective" (p. 301). Once the therapist or IEP team determines the appropriate, least restrictive environment for a particular student, the LRE is included within the student's IEP and considered when determining appropriate models of service delivery for the child's strengths and needs.

Brown and Montivero (2001) designed a study to delineate the clinical reasoning process school therapists use to determine service delivery models, and to determine the level of self-satisfaction occupational therapists have in their reasoning abilities. The authors argue that while all therapists use a form of clinical reasoning, the OT "might not realize that she or he is using a clinical reasoning process and might not be able to articulate their reasoning process" (p. 6-7). Additionally, the authors state that inability to explain methods of decision-making appears "unprofessional" and might cause the OT to doubt his or her expertise and clinical wisdom (p. 7). While literature describes different treatment settings and models, there remains little study of the therapists' clinical reasoning process used to determine their choice of treatment in a school-based setting. Brown and Montivero (2001) contend that articulating the process can help put abstract mental processes in terms that can be understood by other disciplines.

National organizations for multiple related service providers have compiled lists of parameters that may help a therapist in using clinical reasoning to determine the best model for a student. For instance, the American Occupational Therapy Association (AOTA) provided a list of 10 parameters that help a therapist choose a best model (AOTA, 1987; Dunn, 1988). Similarly, the American Speech-Language-Hearing Association (ASHA) (2000) listed 14 factors to be considered when determining appropriate program intensity and service delivery model and the American Physical Therapy Association

(APTA) (1990) provided a similar list. No such list has been provided within national music therapy organizations. These organizations generally agree that service model decisions should be determined on a case-by-case basis which should consider health and safety of the student, necessity for external communication, necessity for environmental modification, age of the student, severity of the student's disability, expertise of the staff involved, and more. Additionally, these organizations agree that consultation is not a substitute for direct services and that adherence to the guidelines is consistent with professional standards in OT, PT, and SLP and the rights of students under IDEA. Some of these organizations, including AOTA, recognize that specialized skill may be required to provide school-based services and, therefore, provide additional and specific training related to clinical decision-making (Dunn, 1988). Many clinicians, however, likely struggle to navigate clinical reasoning processes due to lack of research-based guidance and national guidelines, or outdated information that predates current educational laws and trends.

Music Therapy as a Related Service

While music therapists have worked in settings with school-aged children for nearly 70 years, P.L. 94-142 was the primary factor in driving music therapy services into public schools in the 1970's (Humpal, 2006; Smith & Hairston, 1999). Authors since the 1970's have outlined the roles of music therapists in school settings, which have included direct service delivery (Alley, 1977; Nordoff & Robbins, 1971) and consultation (Steele, 1977). Alley (1979) described music therapists as teachers of academic, social, motor, and language objectives through the use of music, providers of materials for special educators, and members of an Individualized Educational Plan (IEP) team.

Today, music therapy is recognized as a related service under IDEA and, thus, must be included on a student's IEP if the student meets eligibility for services. While not listed in the Part B regulations of IDEA, the U.S. Department of Education (2010) clarifies the role of music therapy as a related service in a list of questions and answers regarding regulations for Part B of IDEA, stating that "members of the child's IEP Team… must make individual determinations in light of each child's unique abilities and needs about whether an artistic or cultural service such as music therapy is required to assist the child to

benefit from special education" (p. 25). Additionally, "if the child's IEP specifies that an artistic or cultural service such as music therapy is a related service for the child, that related service must be provided at public expense and at no cost to the parents" (p. 25-26).

Music therapy and the IEP. If music therapy is seen as the way to achieve IEP goals via formal assessment, schools are obligated by law to provide music therapy services (Johnson, 2002). If music therapy is seen as *one of* the ways in which a student might achieve goals, music therapy may or may not be listed on the IEP and the school may choose from a number of related services. How music therapy is mentioned on the IEP may also be related to the special education team model (multi-, inter-, or transdisciplinary) and model(s) of music therapy in which the therapist provides services. If music therapy is listed as a related service on the IEP, the therapist will likely provide direct services to address IEP goals. If the music therapist consults with a student, professional, or parent (and not directly with the student), music therapy may be listed on the IEP under "supplementary aides and services" (Johnson, 2002). A therapist that delivers consultation to a program or provides eligibility assessment services will likely not be listed on the IEP (Chester et al., 1999; Coleman & Brunk, 2003).

Whether the music therapist works within a multi-, inter-, or transdisciplinary team will determine whether they will write music therapy-specific IEP goals. If the music therapist is working within an inter- or trans-disciplinary team, goals and objectives will likely be linked to Common Core or state assessment-based standards (Ritter-Cantesanu, 2014). Ritter-Cantesanu (2014) implores the school-based music therapist to have a good understanding of the IEP, how it is composed, how it relates to music therapy, and how laws in both general and special education relate to and affect music therapy. This will enable the music therapist to overcome potential barriers to being included on the IEP and to be an essential member of the special education IEP team.

In determining whether a student is eligible for music therapy within their IEP, the music therapist must be concerned with one thing according to Brunk and Coleman (2002) and that is "the impact of specific music therapy interventions on that student's ability to achieve the goals set in his or her Individual Education Program" (p. 70). To be included as a related service on an IEP, a music

therapist must demonstrate through assessment, implementation, and documentation, that music therapy is *required* or *necessary* for the student to achieve his or her goals and objectives (Brunk & Coleman, 2002, 2003; Johnson, 2002). The school music therapist may use the Special Education Music Therapy Assessment Process (SEMTAP) (Coleman & Brunk, 2003) and the Individual Music-Centered Assessment Profile for Neurodevelopmental Disorders (IMCAP-ND), (Carpente, 2014) to assess a student's eligibility for services. However, before the IDEA 1997 Amendments, music therapy may have been considered as a separate program or may have even been viewed as a support program to music education, or perhaps a replacement program in lieu of music education (sometimes known as "special music education"). In the past, music therapy as a related service may have been provided in self-contained classrooms, in one-on-one direct therapy, or as a combination of therapy and education (Johnson, 2002). Music therapy is now often seen as a partner to regular education, rather than a separate "pull-out" program, though a variety of models of music therapy exist today.

Models of Music Therapy in Schools

As with the process in special education and other related services, a school-based music therapist must rely upon clinical reasoning and administrator support to determine the best service delivery model for an individual student once eligibility has been determined (Coleman, 2002). While the American Music Therapy Association (AMTA) has not provided a list of suggested factors in making this decision such as that from AOTA (1987), ASHA (2000), or APTA (1990), literature published by music therapists working in school settings may serve as a rudimentary guide to clinical decision-making. Literature supports that music therapists primarily contribute to special education teams by providing direct services, or by serving as consultants to teachers and other specialists—as well as variations of these models (Coleman, 1996; Johnson, 2002; Pellitiri, 2000; Wilson, 1996, 2002). Most literature in recent years, however, indicates that music therapists are moving to models that facilitate inclusion such as inclusive direct services, expanded models of consultation, collaboration, inservices, and community music therapy models in schools.

Johnson (2002) states that music therapy is evolving to a more inclusive model of service delivery to align with changes in special education. Similarly, Smith and Hairston (1999) claim that inclusive practices are the "latest impetus for change in music therapy conducted in school settings" (p. 275). Rickson (2010) of New Zealand agrees and adds that inclusive education has changed the range of music therapy service delivery worldwide. She also specifies that collaboration and consultation models are increasing due to the move toward the inclusive "ecological approach" in which therapy is integrated into the naturally occurring school routines (p. 60). These researchers seem to agree that school music therapists should remain sensitive to and flexible within the changing landscape of education services. Music therapists may then be considered an effective and valued part of the IEP team, which may include a continuum of direct and consultative music therapy.

Direct services in music therapy. Traditional direct services in music therapy are often called "pull-out" therapy, comparable to other related services (Adamek & Darrow, 2018; Johnson, 2002). Within this model, a student is removed from their general classroom or a school activity and taken to another location for services (such as a therapy room or special education classroom) before being returned to their classroom. Traditionally, direct services are provided as one-on-one—one student and one therapist—though direct services may also be provided in a group environment. Groups may contain a number of students with special needs or, in some cases, a student or students with special needs and peer models (sometimes known as *reverse inclusion*). In all direct service delivery models, the primary role of the therapist is to provide direct, individualized intervention to meet student IEP goals.

Traditional direct music therapy services have benefits such as interpersonal rapport between child and therapist, individualization of interventions, and focused work time in which the student may be working on multiple goals simultaneously. In contrast to these benefits, direct services may reduce communication among the special education team, including not having ongoing opportunity to relay growth and accomplishments of the students to the team. Additionally, students may be set further apart from their peers, potentially increasing stigmatization of disabilities; there may be limited opportunity for "real-life" or generalized practice; and someone observing music therapy, such as an administrator, may

see music therapy as a "music lesson" or an opportunity to support primarily *music education* goals rather than IEP goals pertaining to any functional need or academic area (Johnson, 2002, p. 89). Inclusive direct services, however, may balance some of these strengths and weaknesses of direct services and align with special education trends.

Inclusive direct services. As mentioned previously, inclusion refers to a model of special education in which students with disabilities are educated in the same environment as their typically-developing peers. Supports or services are provided for the student within the regular classroom rather than a separate, segregated setting. The music therapist may be working with one student or a small group of students who have music therapy listed on their IEPs. Sometimes, the music therapist may work with the whole group—designing interventions based on the objectives of the student with disabilities while also choosing academic-related material that would benefit the entire class—in order to model strategies for the classroom teacher. Related service and special education professionals may work with teachers to design and provide "appropriate educational interventions" for children in their natural, inclusive environments (Adamek & Darrow, 2010, p. 106). Delivering services in the "traditional 'pull-out' model is increasingly challenged" by inclusion advocates (Johnson, 2002, p. 90).

While inclusion has received a great deal of attention in music therapy literature and research, a limited number of studies look at inclusive practice empirically—a majority of music therapy services and research studies have been conducted in segregated therapy settings. Jones and Cardinal (1998) found some evidence that music can facilitate interaction between children with and without disabilities and decrease inappropriate behavior in inclusive settings. In addition, they found that even though music therapists know about and express willingness to provide services in inclusive classrooms, the majority of work remains in segregated "pull-out" models.

Johnson (2002) suggests that music therapists may want to deliver inclusive music therapy services within music education classes. Within this method, the student may receive direct services in an environment that already embraces musical sounds. Additionally, this method provides music educators with consultation or collaboration opportunities with music therapists. Johnson (2002) states that the

"purpose of the music therapist in the class is to meet needs of a diverse group of students" (including those without special needs) and "help frustration felt by many music educators" (p. 91). When considering that research suggests that music educators are looking for opportunities to collaborate and consult with specialists such as music therapists (Darrow, 1999; Jellison & Draper, 2015; VanWeelden & Whipple, 2014), inclusive services within the music classroom may be mutually beneficial to the therapist, teacher, and student.

Benefits of inclusive direct services include (a) establishment of positive peer friendships; (b) increase in self-esteem and social skills; (c) change in peer attitudes and development of interpersonal skills among a diverse group of students; (d) increase in successful inclusion in music education; (e) diminished isolation; and (f) a potential "spill-over" effect, or preventive therapeutic experience where typically-developing students or those at-risk of academic delays benefit from music therapy in the environment. Some difficulties arise related to individualization and focused work on goal areas. For example, sound may become a distraction in most classroom environments if the music therapist is not working with the whole class (Johnson, 2002). Additionally, the therapist may need to navigate the classroom schedule when designing intervention experiences for the individual student or small group. Inclusive services can also be facilitated in an ongoing manner when delivered through a consultative model.

Consultation services in music therapy. Music therapy consultation aligns with the inclusive philosophy; it aims to increase a teacher's capacity for supporting diverse learning needs and individuals in his or her classroom, rather than a focus on the individual student's needs. This model allows children to receive maximum opportunities to learn alongside their peers. According to Rickson (2010), an international leader in advocating for school-based music therapy consultation, this model of music therapy is likely to become a large part of the music therapist's role in schools. In the last major study that surveyed music therapists regarding their model and role in the school (Smith & Hairston, 1999), only 13 percent of the music therapist's time was spent providing consultation services, though the authors suspected this number to be increasing.

There are multiple definitions and interpretations of consultation (Chester et al., 1999; Coleman, 2002; Johnson, 2002, Jones & Cardinal, 1998; Pellitteri, 2000; Register, 2002; Smith & Hairston, 1999; Wilson, 2002), many of which are conflicting, unclear, and rarely describe the process. Overall, the emphasis of consultation is "changing attitudes, modifying teaching and therapy practices, and creating a supportive learning environment rather than on highlighting specific needs of students" (Rickson, 2011, p. 63). To define music therapy consultation, one must look at all areas of consultation: consult to student, consult to staff, consult to program, and consult to music educators.

Consult to student. This sub-category of consultation typically involves weekly or bi-weekly individual or group sessions for a set period of time (such as 6-10 weeks). During this time the teacher observes the sessions as a form of training in order to carry out a designed program for the student or group of students (Adamek & Darrow, 2018; Coleman, 2002). Once the teacher begins to implement the music therapy program, the music therapist *monitors* the teacher on a monthly basis; Coleman states monitoring is a requirement of the consult-to-student process. In this model, goals, objectives, and assessment are the same as in direct services, though limited information is provided as to how this would be included in an IEP.

Consult to staff. While various definitions exist for this sub-category of consultation, the researcher found Rickson's definition of consultation to staff to be most clear and based on extensive literature review (2010), research, and experience. Rickson (2010) set to develop and describe a Music Therapy School Consultation Protocol, which draws upon the social learning model. This model suggests student learning is impacted by complex interaction between student, adult, and their learning environment (Twyford & Rickson, 2013). Rickson suggests that the consultant work with a singular consultee, with a focus on one student, which will have a ripple effect to additional students on the consultee's current or future caseload. Between 2010-2013, Rickson developed the model of Music Therapy School Consultation and sought to pilot-test the model before developing an eventual protocol.

To pilot the original model, Rickson engaged four teachers in music therapy consultation and interviewed them afterward to determine their impressions of the service. Rickson (2011) noted that

teachers were encouraged about the process and recognized the potential for music to support student learning and development. Factors such as time constraints and limited teacher confidence in musical abilities, however, prohibited continued use of modeled music strategies. Thus, Rickson believes that more formal opportunities for modeling and discussion such as workshops or inservices may be helpful in conjunction with consultation experiences. Additionally, findings indicated that consultation may need to be adapted depending on the number of consultees and students, student abilities, and culture of the school (Rickson, 2011).

Limited information exists as to whether the IEP is part of this program, as Rickson's studies took place in New Zealand (2010, 2011). In a seminal chapter on school consultation published by the AMTA, Coleman (2002) describes that consultation does *not* involve an IEP committee referral or formal assessment, though the music therapist should review all IEP's within the group to determine skills to be addressed. Music therapy services are designed to support the overall program and involve weekly services where teachers and paraprofessionals observe so that they may continue the music program throughout the week. Coleman describes self-contained autism and life skills classes. Therefore, it seems that this chapter needs updates to reflect current special education practice and additional clarity regarding school consultation-to-staff practice.

Consult to program. Chester, Holmberg, Lawrence, and Thurmond (1999) describe a program-based consultative music therapy model in which the therapist provides weekly sessions in classrooms to groups. In this model, teachers are present, actively engaged, and working with students to learn skills for independent facilitation of strategies during the modeled music therapy sessions. The music therapist helps design strategies for individual students on an ongoing basis and serves as a resource to all teachers within the program. The authors describe this model as a curriculum for primarily language, communication, and leisure-based skills that also aligns with IEP objective domains. This model is a *combination* of direct and consultative work; combining the interaction between the music therapist and student for direct service model and teacher training from the consultation model. In this model, the IEP does not contain music therapy, as music therapy is not considered a related service. Rather, music

therapy is an "educational resource" (p. 83) and uses informal assessment based on specific documentation. In a similar model, the Integrated Music Therapy Service Model (Snell, 2002), the author mentions that all or most students in the program receive music therapy. The therapist may document music therapy as a related service on a student's IEP if deemed "necessary for the student to realize their educational goals" (p. 213). Other names for this model may include "district-wide program" (Adamek & Darrow, 2018), or music therapy as "enrichment" or "programmatic" services (Brunk & Coleman, 2003; Ritter-Cantesanu, 2014). Authors note a major benefit of consult-to-program models; it allows a maximum number of students to benefit from music therapy intervention. This maximization increases cost-effectiveness, which is likely a major factor in deciding to implement this model. Furthermore, the approach minimizes travel in a large geographic area (Chester et al., 1999; Snell, 2002). Rickson (2012) argues that consultative music therapy should not be viewed as merely an option for the therapist to see maximum amounts of children.

Consultation to music education. Perhaps the most frequent reference to music therapy consultation available to clinicians is in relation to music education consultation. Many authors have pursued the issue of including children with diverse needs into an inclusive music classroom (Adamek & Darrow, 2002, 2010, 2018; Jellison, 1979; Johnson, 2002; VanWeelden & Whipple, 2014). In a survey of individuals in the music education field, Darrow (1999) found that nearly all participants identified need for collaboration or consultation with special education personnel such as music therapists. In some cases, the boundaries between music education and music therapy are blurred (Darrow, Colwell, & Kim, 2002; Johnson, 2002). If music therapists who work with music educators are also versed in the current national standards for music education, their consultaations with music educators could benefit both music educators and their students (Adamek & Darrow, 2018; Darrow, 1999). When choosing consultation as a model of service delivery (whether for students, staff, program, or music educators), music therapists may wish to consider factors such as: the possibility of controversy, training or experience required, and benefits and limitations of consultative models.

Consultation controversy. Some music therapists oppose the idea that music therapy consultation is considered "music therapy" if the therapist never works directly with the student or if someone other than a board-certified music therapist is implementing music strategies. In his work *Defining Music Therapy,* Bruscia (2015) raises the dilemma that situations in which non-music therapists utilize music in a therapeutic manner may not be music therapy, per se (p. 72). Some feel that music is more of an ancillary function rather than the central role in such models (Bruscia, 2015; Pellitteri, 2000). The AMTA Standards of Practice (2009) state that music therapists may provide consultation services to other music therapists or those in related disciplines, and to others directly involved with the client (including parents); provide resource information regarding techniques and materials; and/or design programs for clients in various settings.

Rickson (2012) notes issues related to a music therapists' professional identity and consultation. She firmly believes and states that consultants should convey to their consultees that they are *not* practicing therapy but also states that "it is not clear that the music therapy consultant is engaged in music therapy either" (p. 276). She claims that some music therapists may struggle to "move away from psychotherapeutic models of music therapy" to a more inclusive, collaborative form of therapy because they may feel as if they are "losing clear frameworks and boundaries" that differentiate the music therapist, other related service providers, and the special educator (p. 276). As music therapists expand and refine definitions of music therapy to meet an evolving society and educational system, changes may likely be viewed as controversial. Consultative approaches, however, may also open up new pathways for students to access music in multiple forms, which may strengthen the connection between music and the IEP or functional outcomes.

Training and expertise needed for consultation. While AMTA (2009) notes that music therapists are able to provide consultation services guided by the professions' *Standards of Practice,* others believe that advanced training for experienced consultation may be more appropriate (Johnson, 2002; Rickson, 2010). Johnson (2002) states that "the music therapist is qualified by credentials and background to address the unique role music plays in the education of students with disabilities" (p. 94), but that a dual

certification in an educational field will be an asset to inclusion and enhance the music therapists' credibility with special and regular education personnel. Rickson also suggests that consultation as a unique practice brings professional and ethical issues that many—particularly, entry level—therapists may not be prepared for (Rickson, 2012). She suggests that a therapist "knows the limits of one's competence" (p. 273) and that development of formal practice standards for consultation may be necessary. For example, she suggests that informed consent within a contractual agreement, prepared before the consultation relationship, can help a consultee understand the boundaries and expected outcomes of consultation work (Rickson, 2012). As consultation models grow within the field of school-based music therapy, there may be a need for expanded training and standards of practice.

Benefits and limitations of consultative models. Consultation can offer a wide range of benefits. Empowering consultees with strategies that they may use can help ensure ongoing music-based educational experiences for students with special needs in their classrooms. Additionally, consultation may provide more students access to music that may not have opportunity such as in geographically isolated locations (Rickson, 2010). Consultations with PT, OT, and SLP providers can also lead to the use of music within these clinical services (Pellitiri, 2000). Coleman (2002) claims that a benefit of consultation is minimized paperwork and increased time for planning, as well as increased changes for repetition if teachers and paraprofessionals are involved in sessions.

In contrast, teachers sometimes express frustration that music therapy will not be provided directly to students on an ongoing basis (Twyford & Rickson, 2013). Twyford and Rickson (2013) admit that additional considerations as to how student needs can be met are required when designing consultative experiences and that music therapists "may continue to provide direct intervention as well as to develop a range of indirect service models" (p. 133). Additionally, in Rickson's case studies used to develop the Music Therapy School Consultation Protocol (Rickson, 2010, 2011), she found that strategies modeled for the teacher in a separate therapy setting for assessment may not transfer to the inclusive classroom readily and that the music therapist should model in the natural environment when possible (Twyford & Rickson, 2013). The therapist may benefit from the development of multiple sub-categories

of consultation to meet different staff and student needs. Additionally, the therapist may also benefit from a clear understanding of clinical decision-making strategies, as appropriate to the contexts in which they provide consultative services.

Inservices and workshops on music therapy. Both inservices and workshops provide music therapists with opportunities to share how music can be used to benefit student needs. Smith and Hairston (1999) state that the introduction of music therapy as an inservice option signified an increasingly diverse role for music therapists in school settings. From 1970-1982, the National Association for Music Therapy was awarded a grant through the Office of Special Education, entitled "Special Project: A National Inservice Training Model for Educational Personnel Providing Music Education/Therapy for Severely/Profoundly Handicapped Children" (Smith & Hairston, 1999). This grant not only increased the role of the music therapist as an inservice provider, but also resulted in an increase in related materials within music therapy literature.

Culton, in Wilson's 2002 monograph describing music therapy models in school settings, outlines inservice delivery models in music therapy. These inservice models might include short- and long-term workshops, statewide inservice opportunities, graduate and extension courses, or yearlong school-based inservice programs—often aimed at helping music educators include students with special needs in their music classrooms appropriately. Culton suggests training booklets, field observations, audiovisual, and experiential components as part of an inservice experience. While inservices have grown in popularity, only "descriptive information and limited empirical data exist to substantiate the relative benefits of delivery for music education inservice" (Culton, 2002, p. 117). This model of music therapy services may be even further removed from music therapy than consultative services. The inservice provider never works directly with the student and someone other than a board-certified music therapist is implementing music strategies—with little to no supervision past the inservice training experience.

Collaboration as a model of music therapy. There are various types of collaboration; from day-to-day communication and interaction with teams, to fully integrated work—such as working simultaneously and combining treatments with other professionals (Twyford and Watson, 2008). As an

example, in a medical model of music therapy a fully integrated form of collaboration might be called *co-treatment,* which may fit well within a transdisciplinary special education department model. Consultation itself may be collaborative, as consultant and consultee share expertise to solve a problem. For example, music therapists and music educators may collaborate to determine appropriate music experiences that include the student with disabilities and meet both music and non-music goals and objectives (Adamek & Darrow, 2018). Additionally, collaboration is an integral part of membership of both interdisciplinary and transdisciplinary special education departments; special education, related service, music therapy, and support personnel—as well as parents and sometimes students themselves—work together and share diverse knowledge and expertise to provide services (Dettmer, Thurston, Knackendoffel, & Dyck, 2005). This approach to student services can provide all team members with increased insights into student abilities and needs. Collaborative approaches can also help to increase requests for music therapy support from others who see benefits of music and want to increase the use of music in their work (Allgood, 2006; Register, 2002; Twyford, 2007).

Community music therapy in schools. Recent literature introduces the philosophical components of community music therapy within the school system (Skewes McFerran & Rickson, 2014a, 2014b). These authors propose that traditional theories still frame the work in school contexts, despite changes in relation to inclusion. They also propose that community music therapy provides a "congruent theoretical framework for current practice, with an emphasis on equality, resource orientation, collaboration, and acknowledgement of the systems that shape music therapists' work" (Skewes McFerran & Rickson, 2014a, p. 75). Community music therapy involves a transition from focus on the individual student or teacher to the musical culture in the whole school system. Music therapy groups with whole classes, as in inclusive direct services, are often thought to be driven by economic factors, though current pedagogy on a global scale does emphasize teamwork and inclusion within the natural, general classroom.

Advocates of community music therapy suggest that this model offers a new, "anti-oppressive" approach to therapy that could foster growth within an entire school community and expand traditional

practices to align with contemporary approaches to education (Skewes McFerran & Rickson, 2014a, p. 79). These authors suggest that traditional music therapy models described music therapy using language that puts power in the hand of expert professionals (i.e. terms such as referral, assessment, treatment, evaluation). In contrast, these authors state that community music therapy in schools is largely "exploratory and collaborative in nature" and "seeks to include the systems that can support… development of healthy musical communities in schools" (p. 79). Due to limited research and publication on this model of music therapy within the United States, little is known about logistics of community music therapy in schools such as the relationship to the special education team and IEP, employer of the music therapist, potential for success within the current United States' school systems.

After school programs. Some music therapists provide school-based music therapy services solely as after school programs for students with behavioral needs. After school programs, in general, have been noted to reduce "negative behaviors including juvenile delinquency, substance abuse, school dropout, and other counterproductive outcomes often related to absence of parental supervision" (Chong & Chung, 2006; Chong & Kim, 2010; Gottfredson, Gerstenblith, Soule, Wormer, & Lu, 2004). Chong and Chung (2006) developed a music therapy approach for after school programming called Education-Oriented Music Therapy, based on literature supporting the use of structured music therapy applications in after school programs to improve emotional and behavior functioning. The goal of this approach is to transfer skills learned in these after school music therapy sessions to academic areas, though academic transfer has not yet been demonstrated (Chong & Kim, 2010).

Self-contained classrooms and special schools. Music therapists may provide direct services within self-contained classrooms and special schools, though this model may be less common today with the movement toward inclusion. This was described by Johnson (2002) as one of the primary models of music therapy—even after the introduction of IDEA 1990 and emphasis on inclusion. For some students, self-contained classrooms or schools where students spend a substantial percentage of the day may be the LRE until the student is able to transfer skills to the general classroom. Self-contained classrooms or schools for students with special needs often meet severe and multiple needs. Music therapy may occur in

individual or small group formats within the classroom, or as a whole-class intervention. According to Johnson (2002), one major purpose or benefit of this model is to allow classroom staff to practice techniques for regular implementation of music interventions in a "nonthreatening" manner (Johnson, 2002). Updated information is needed to determine whether this is still a model in which many music therapists practice though, overall, this model is of similar design to inclusive direct services in music therapy.

Preventive music therapy in schools. Some music therapists provide services to students who do not qualify for an IEP or coverage under IDEA but are considered at-risk, as part of a "Section 504 team" (Johnson, 2002, p. 106; Turnbull et al., 2013). Music therapy may be provided for juvenile offenders in residential treatment settings (Gardstrom, 2002) or to those students who may be at-risk of future criminal behavior. In some cases, music therapists may provide services within an alternative high school within a school district, to expectant teenage mothers or other sensitive populations with behavioral and emotional needs, or even in hospitalization or homebound situations where students may be at-risk for academic declines due to health concerns and subsequent absence or removal from general education. The therapist may collaborate with community-based organizations to help students become involved in "positive music experiences" and social interaction upon discharge from treatment settings or alternative schools (Gardstrom, 2002, p. 193). More research is needed regarding preventive music therapy and its role in modern school systems.

Additional models of music therapy. While the models of music therapy defined above are most frequently described in literature regarding school-based music therapy, they are certainly not all-encompassing. Some music therapists believe that there are as many models of music therapy as there are school districts (Chester et al., 1999, p. 83). In some areas of the United States, music therapists may face the reality of working in a multi-district system with multiple team models and philosophical orientations. Some music therapists are employed by private schools or private service providers and contracted for part-time work through one or many school districts. Additionally, some authors mention that the international focus on inclusive education suggest that it will be necessary for music therapists to develop

new approaches to music therapy to have a place within modern school environments (Twyford & Rickson, 2013). With the number of options for music therapy models expanding and evolving to meet modern needs, how does a music therapist make or recommend a service delivery model?

Deciding on a Model of Music Therapy: Variables

Music therapists who are developing a new music therapy program in a school district or looking to expand or adapt current practice to align with evidence or current philosophy in special education may struggle to navigate available literature. Because each school has its own culture impacted by administrative styles, demographics, geographic location, range of student needs and disabilities, etc., a therapist should select a model appropriate to the situation rather than rely on the "status quo" or settle for a model based upon tradition. Brandel and Frome Loeb (2011) suggest that a therapist must look at certain variables related to the district, therapist, and students in making clinical decisions regarding service delivery model and program intensity. The researcher of this study chose to expand upon and transfer Brandel and Frome Loeb's decision-making model to the music therapy context; looking at district and workplace, therapist, and student variables that may impact the chosen model of music therapy. These variables are described below.

District and workplace variables. Administrative support, preference, and attitudes may be some of the most influential factors in determining a music therapy program model since administrators are responsible for distributing funds and making hiring decisions (Ropp et al, 2006). A regular or special education administrator determines the special education department model in which a music therapist functions. The administrator may or may not have a central role in deciding the music therapist's service delivery model. Researchers suggest that administrator perceptions of music therapy are critical to development and ongoing support of music therapy (Ropp et al., 2006). Ropp (2008) conducted a survey of 529 administrators and discovered that personal or professional experience with music therapy significantly influenced perceptions of the profession and role of music therapy within special education. She suggests that music therapists provide services on a trial period basis to increase an administrator's exposure to music therapy or provide experiential workshops. Additionally, Chester and colleagues

(1999) suggest that music therapists make options known and available for district administrators to determine the "most effective system of delivery for their particular needs" (p. 82).

School location can also have an impact on models of music therapy chosen. School-based music therapists in New Zealand describe that consultation models may better meet the needs of children in rural districts or those with a large geographic spread due to music therapists' travel time (Rickson, 2010, 2011; Twyford & Rickson, 2013). School location can also have an impact on a music therapist's caseload; music therapists in larger, urban or suburban districts may have difficulty providing direct services due to a large caseload. Finally, school location may impact social factors, including community knowledge of and attitudes toward related services such as music therapy. No known studies to date have compared differences between models used by music therapists in suburban, rural, and urban school districts.

The special education department or district model in which a music therapist is employed may impact how the music therapist functions in relation to the IEP and how the therapist communicates, collaborates, or consults with other therapists and educators. A music therapist who works in a multidisciplinary model may feel isolated from other therapists and have more limited administrative awareness and support. On the other hand, music plays a large role in transdisciplinary teams due to its multi-sensory nature and its ability to cross multiple domains and academic areas (Johnson, 2002). Some school districts mandate the length of service delivery and consultation for all related services (Brownell, Weldon-Stephens, & Lazar, 2002).

Teacher support, preferences, and attitudes in relation to music therapy may have an impact, most notably on whether music therapy is provided within or outside of the classroom. Some teachers may see music as a distraction, while others may perceive music therapy as a valuable resource in modeling additional strategies for meeting educational objectives and individual needs. Perceptions of teachers regarding the role of music therapy in education can play a significant role in clinical decisions regarding intervention (Ropp et al., 2006). Choi (1997) found that staff members who observed music therapy groups indicated on attitudinal questionnaires that they valued music therapy more highly than staff who

had not; however, research regarding the perceptions of music therapy by other professionals other than administrators is limited. Additional research is necessary to determine whether these perceptions affect decision-making in school music therapy.

Finally, district finances may play a role in determining the music therapist's role and model of service delivery within a school or district. As public schools face financial constraints, the development or maintenance of music therapy positions may even be jeopardized (Ropp et al., 2006). In particular, schools facing budget cuts due to limited state funding and those who do not meet AYP and have to make critical personnel decisions may increase pressure to limit direct services and provide consultation or whole-class inclusive music therapy to provide services to a maximum number of students. The music therapist may be able to present a number of direct service models options to the administrator facing budget cuts, though models in which music therapy is tied to the IEP can legally bind the school to continue employment of the music therapist (if deemed necessary for achievement of student IEP goals) (U.S. Department of Education, 2010). Ideally, an administrator or music therapist would make decisions based on individual student needs to align with IDEA and IEP goals, rather than budget concerns. However, researchers should explore the financial realities of services, since cost-effectiveness is a factor mentioned in various school music therapy studies (Brownell, Weldon-Stephens, & Lazar, 2002; Pellitteri, 2000; Rickson, 2012; Ropp et al., 2006).

Music therapist variables. Perhaps the most impactful variable in determining which service-delivery model a music therapist employs is the therapist caseload, which may include number of students, number of schools or classrooms in which services are provided, additional job requirements, and travel time between sites. The number of music therapists or music therapy interns within a district will impact a therapist's caseload. Brandel and Frome Loeb's (2011) school-based intervention decision-making model (SIDM) for speech-language pathologists suggests therapist variables including clinical training (type of experiences, year of graduation), professional development (type of activities, years in schools), and relationships with school personnel may also be influential in practice decisions.

In Wilson's (2002) monograph regarding models of music therapy in school settings, Huges, Rice, DeBedout, and Hightower authored a chapter outlining three varying district-wide music therapy models that highlight potential caseload variables. Within the Leon County School System of Tallahassee, Florida, music therapists see up to 1,000 students of the 8,500 requiring special services and work with nearly 100 teachers. About half of the therapist caseload is spent providing direct services with emphasis on IEP goals and inclusion, and the other half is spent supervising interns, traveling, providing consultation and training, advising IEP committees, conducting research, pursuing grants, and more. Four music therapists and up to four interns in Clayton County Public Schools, part of the metro area of Atlanta, Georgia, provide services to nearly 700 students of the 5,000 in special education and in more than 85 classrooms. Service delivery is offered primarily in groups with emphasis on inclusion and is not primarily provided through assessment and IEP processes, but rather assumed by administration to be beneficial to all students with moderate disabilities. The third district-wide model described is from Fulton County Schools, also from the Atlanta metro area. The five music therapists in this district work within the music *education* department and primarily serve students in large group settings within the inclusive music classroom. Fulton County music therapists are required to also hold music education licensure. Within their programming model, Fulton County music therapists also provide consultation and inservices regularly, and music is typically not a part of a student's IEP. While these case studies of individual programs represent public school music therapy in the early 2000's and their programs may have changed dramatically since this time, they provide insight into possible caseload and workload department factors that impact service delivery.

Specific demographic characteristics of the music therapist may also impact the service delivery model, such as gender, race, political orientation, philosophical orientation, social identity, and more. Demographic considerations might also include the number of years in practice and professional experience, as well as educational factors. Education may impact philosophical orientation, specific training received, and comfort with specific models of music therapy. While most music therapists practicing in public schools today are board-certified by the Certification Board for Music Therapy

(CBMT) and many are members of AMTA, therapists may also hold additional certification or membership in other national organizations. Many school districts actually require a therapist to be dual-certified as a music or general educator (Hughes et al., 2002; Skewes McFerran & Rickson, 2014; Smith & Hairston, 1999). No studies to date have attempted to determine relationships between therapist demographic variables and clinical decisions in school music therapy.

The role of the music therapist within the special education department may be a variable related to both the district (i.e. the perceptions others have of music therapy) and the therapist as an individual. The therapist may see oneself as a welcome part of an integrated, interdisciplinary team that makes decisions as a group to best-serve students. On the other hand, the therapist may feel isolated due to either lack of knowledge or negative perceptions of music therapy held by staff or perceived by the music therapist. Because music therapy is perhaps less common than PT, OT, and SLP in today's special education teams, the therapist may need to increase opportunities for advocacy, inservices, and exposure of music therapy services in order to build strong relationships with other members of the special education team. A music therapist providing services in inclusive classrooms may be perceived much differently, and perhaps embraced more as a peer and a support, than a music therapist that removes students from their classroom environment and provides services in a therapeutic environment. As mentioned previously, some staff may even see this as an adapted music lesson rather than a therapeutic means to meet IEP objectives. The impact of perceived and actual roles on the team, as well as professional relationships, upon a chosen service delivery model has yet to be studied.

A final major variable that may impact the service delivery chosen in school music therapy is the philosophical approach and attitude of the therapist. Different therapists approach clinical work with different backgrounds, experiences, skills, and philosophies (Darrow, 2008), which may be developed through clinical experience, learned through education and training, or decided based on personal preference. Some of the common music therapy approaches used in schools, as outlined in Darrow's (2008) *Introduction to Approaches in Music Therapy, 2nd Edition* include (a) approaches adapted from music education such as Orff, Kodaly, and Dalcroze; (b) Nordoff-Robbins Music Therapy;

(c) psychodynamic approaches; (d) behavioral approaches; and (e) medically-based approaches, such as Neurologic Music Therapy. "Traditional" music therapy in American schools is often related to behavioral and music education-based approaches, since many music therapists were also licensed as general and music educators (Darrow, 2008; Smith & Hairston, 1999). Modern approaches may be different, embracing newer models such as community music therapy. In a recent book published in the United Kingdom regarding music therapy in schools (Tomlinson, Derrington & Oldfield, 2012), the authors provide vignettes that describe Nordoff-Robbins, community-based music therapy, developmental theories, psychodynamic, and music-centered approaches. Readers may find that descriptions of school music therapy within these approaches differ from U.S.-based approaches described above. Both philosophical approach and attitudinal differences among therapists may impact wiliness to implement or adjust to new models in order to meet trends in special education. Overall, the approach chosen by the therapist will likely impact how the therapist interacts with the clients, which interventions are chosen, and—potentially—which model of service delivery the therapist provides.

Student related variables. According to Brandel and Frome Loeb (2011), student variables that may impact service delivery models include student strengths, needs and emerging abilities; peer modeling available to the student; general education curriculum within which the student is learning; severity and type of disability; motivation and attitude; and grade or developmental level. Though these variables are described within an SLP context, the same variables may impact music therapy services within the special education context. Student variables could also include student age, gender, race, socio-economic status, and other personal or cultural considerations. Additional variables specific to music therapy include student preference for and response to music. Requirements for IEP eligibility note that the child must *need* music therapy to meet goals and objectives (Coleman & Brunk, 2003) and thus students receiving direct services are often highly responsive to music. Therefore, non-IEP-based services such as whole-class and inclusive direct therapy may be impacted by overall student response and preference.

Overall, limited literature exists for music therapists to use as guides for making clinical decisions and recommendations for student services. Brunk and Coleman (2002) describe factors that may determine music therapy services such as "music as the primary learning modality" as a factor determining "pull-out," direct services (p. 76), though these factors are limited and describe only those related to the student. These workplace, therapist, and student variables described above are found in current literature in music therapy, guided by Brandel and Frome Loeb's (2001) SIDM model, and supplemented from the researcher's clinical and education-based experience in school settings. These variables are not all-inclusive; yet, they may serve as a potential guide or framework for studies or surveys that inquire as to whether certain variables influence service delivery models of music therapy and clinical decisions.

Preferred Models of Music Therapy in Schools: Surveys of the Field

While some literature regarding music therapy models and guidelines for making clinical decisions for children with special needs in schools is available to music therapists (see Wilson, 1996; 2002), this literature is now 15 to 20 years old and provides little insight into preferences and realities of current practitioners. Many chapters in Wilson's two monographs, published in 1996 and 2002, were written by professors in higher education. The experience and expertise of these authors is unquestioned by the researcher, though a clinician seeking information and advice about current practice in public school music therapy may choose to look for supplemental research, such as surveys from the field and studies from other practitioners that are facing changes and variables mentioned above on a first-hand basis.

In the past 20 years, authors have published three seminal articles describing current practice in school-based music therapy, each based on survey input from practicing music therapists (Jones & Cardinal, 1998; McCormick, 1988; Smith & Hairston, 1999). McCormick (1988) investigated the current status of music therapists employed by public school systems in the United States five years after the "inservice thrust" (p. 73). For this study, McCormick designed a survey for gathering therapist demographic information, basic employment information, caseload, therapy schedule, job responsibilities,

student populations, referral information, goals and objectives, interventions, and the hiring process. McCormick received 54 returned surveys and determined that the greatest number of music therapists were employed in states that did not require an additional teaching certificate and that full-time school music therapists served a caseload of less than 200 students per week, often in groups of 5 to 10 students, at an interval of twice weekly. Therapists spent time providing direct services to students, scheduling group and individual therapy, developing goals, serving on IEP teams, and documenting student progress. While this investigation provided a look into clinical practice in the 1980's, McCormick (1988) hoped the study would serve as a baseline for future studies.

In 1998, Jones and Cardinal conducted a related survey of the school music therapy field to determine the perceptions and attitudes of music therapists toward inclusion. The survey tool, designed by these authors, included questions regarding therapist demographic information, caseload, years and settings in which the therapist had worked, and twelve statements that sought to determine respondent familiarity with and opinions regarding inclusion. The authors received survey data from 373 respondents and found that the majority of music therapists were providing services in segregated settings (nearly 90% of clients served received music therapy in segregated settings). Notwithstanding this finding, the respondents indicated overwhelming knowledge about inclusion (90.9% indicated a clear understanding) and willingness to provide services in an inclusive setting (85.2% indicated willingness). Only 25% of respondents felt that clients were better served in inclusive, rather than segregated, settings, and 58.5% indicated no strong preference for either setting. Many respondents felt that inclusion provides social and academic benefits to all students and that they would be willing to work in inclusive, heterogeneous student groups. Interestingly, though the survey did not include opportunity for comments or follow-up interviews, 42 of the respondents felt compelled to write in the margins of the paper survey to clarify and expand upon responses. The authors note the importance of the dissonance between the willingness to work in inclusive settings and predominant delivery of services in segregated settings—indicating that therapists may not be the decision-makers in determining service delivery models.

Following and expanding upon McCormick's (1988) pioneer investigation into current practice and trends in school music therapy, Smith and Hairston (1999) conducted a similar study, providing more comparative data and greater information regarding employer categories. The authors sent forms to 244 members of the National Association for Music Therapy who indicated they were working in school settings; the authors received 138 that met qualifications for the study (indicating a 33% increase in participants over McCormick's 1988 study eleven years prior). Survey questions were based upon McCormick's (1988) study, as well as the Wilson (1996) monograph, and included questions related to employment demographics, years worked, required training, student populations, caseload, music therapy department information, and two optional sections allowing respondents to share information regarding music education inservices. Smith and Hairston found that of the 138 NAMT members who indicated school settings as their place of employment, most were employed by school systems (53%). Participants reported the most frequent model of service delivery as direct services (62%), followed by consultation (13%). Smith and Hairston note that consultation practices may have increased since McCormick's (1988) study, but that this was not listed as an option on the previous survey. Results suggested that the rest of therapist's time was spent travelling, documenting, and preparing for future sessions. Nearly 40% of respondents needed a teaching certificate for employment and therapists identified four employer categories from which new school music therapists must decide.

These three surveys (Jones & Cardinal, 1998; McCormick, 1988; Smith & Hairston, 1999) serve as baselines for future research. The authors indicate that surveys of the field should be ongoing to accommodate for and monitor changes in the field that may correlate with changes in general education. In the eleven years between McCormick's (1988) and Smith and Hairston's (1999) studies, a great deal had changed. School music therapists and interested readers may wonder what has happened in schools in the 17 years since the most recent survey. Past researchers note that, at the very least, future studies should investigate the following factors: whether inclusive or segregated settings best-serve the needs of the music therapist; types of consultation roles that music therapists may consider; whether further education is necessary to meet expanding roles of music therapists; how music therapists are affected by

inclusion trends; effects of increasing consultant roles; and whether inclusive trends affect employer categories, such as agency-based or district employee (Jones & Cardinal, 1998; Smith & Hairston, 1999).

Purpose of the Study

Little is known about the role of the school music therapist within the current education system. Past surveys of the field have demonstrated little variation in service provision from "traditional" direct service models (Jones & Cardinal, 1998; McCormick, 1988; Smith & Hairston, 1999), though newer literature in music therapy describes new and innovative practices that are more aligned with current trends in special and general education (Chong & Kim, 2010; Rickson, 2012; Skewes McFerran & Rickson, 2014a, 2014b; Twyford & Rickson, 2013). Two AMTA publications since the Wilson (2002) monograph provide valuable resources for school music therapists; however, they provide limited information regarding models of music therapy and trends in school music therapy service delivery. Humpal and Colwell's (2006) monograph outlines additional aspects of practice such as eligibility and assessment, goals and treatment objectives, and techniques for effective clinical practice. Adamek and Darrow's (2010, 2018) book, *Music in Special Education,* provides the reader with historical and current legal issues regarding special music education, possibilities for collaboration between music educators and music therapists, and strategies for including learners with special needs in music classrooms (primarily as a tool for pre-service therapists and music educators). The authors briefly describe and provide helpful example scenarios of direct services, consult to student services, district-wide models, and consultation to various school professionals—though their description is mostly a brief overview of each service delivery option rather than a detailed look at decision-making factors when choosing a model (such as recent changes in educational laws and trends) or current practices in schools. Neither music therapy researchers nor clinicians have provided new literature providing detailed descriptions of multiple models of music therapy in schools since the Wilson (2002) monograph. Wilson's monograph serves as a resource to define and give examples of particular models to choose from but delivers limited information regarding practitioner preference or how a practitioner should make clinical decisions regarding service

delivery models within their own school context. It seems that an update of past surveys and literature regarding school music therapy is overdue.

In a quickly growing field such as music therapy, practitioners and advocates looking to start new programs in school districts that have not previously had music therapy need guidance, not only for personal support, but for providing evidence-based services to best meet student needs and align with current law and practice in special education. Special education philosophies and models, and in turn IEP-based related service professions, have changed greatly in the last 30 years; changes have also been influenced by the passage of special education laws and policies such as IDEA, NCLB, CCSS, and ESSA. A music therapist who fails to understand these changes or adapt to the educational climate and philosophical orientation of the school or special education department in which they are employed may find their job in jeopardy. While previous researchers have conducted surveys to determine the characteristics and job responsibilities of public school music therapists in the past (Jones & Cardinal, 1998; McCormick, 1988; Smith & Hairston, 1999), any information gleaned is now over fifteen years old and may not reflect current music therapy provision in public schools. A new and updated look at (a) the job characteristics of the music therapist in modern school systems, (b) models of service delivery in which music therapists operate, and (c) variables that may impact how practitioners make clinical decisions regarding models of service delivery (such as therapist training, individual student needs, and district finances) is warranted and timely.

In the present study, the researcher surveyed board-certified music therapists working in public school settings to investigate and outline current trends in school-based music therapy. The current study expanded upon previous, similar survey studies and literature (Smith & Hairston, 1999; Wilson, 2002) by providing an updated and more detailed demographic profile of public music therapists and exploring relationships between possible variables that may impact a music therapist's decisions to provide services within a particular model. The purpose of this study was to investigate existing school music therapy service provision, including the role of the therapist and models of service delivery to provide an up-to-date overview of the field as of 2017. The guiding research questions include:

1. What are the demographic, job, and caseload characteristics of music therapists in public school settings?
2. What service delivery models of music therapy are most common in public school settings?
3. Are school music therapists able to make decisions regarding service delivery model(s)?
    a. Do they practice within the model they feel is best for their students?
4. Which, if any, variables influence a public school music therapist's preference or decision to deliver services within a particular model?
    a. Do they consider certain therapist-, student-, or workplace-relate variables more relevant to service delivery model preferences or decisions than others?
    b. Are there any relationships among a public school music therapist's demographic, job, and caseload characteristics and his or her preferred or decided model(s) of music therapy service delivery?

Chapter 3

Method

Study Design

The researcher chose to conduct a survey of public school music therapists, with the purpose of investigating existing school music therapy service provision, including the role of the therapist and models of service delivery to provide an up-to-date overview of the field as of 2017. The current study expands upon previous surveys by providing updated, descriptive characteristics of practicing school music therapists and their caseloads; investigating common service delivery models of music therapy; and exploring perceptions of practicing therapists regarding the relevance of certain therapist, student, and workplace variables upon the preferred or chosen model(s) of service delivery. This descriptive study provides a more complete picture of the public school music therapist and music therapy service provision within the current educational climate.

Recruitment and Participants

All board-certified music therapists who were currently working in public school settings in 2017 and who provided CBMT their contact information were recruited as participants. Inclusion criteria involved the qualification of Music Therapist-Board Certified (MT-BC) by the Certification Board for Music Therapy (CBMT) and those who responded within the survey (described below) that they currently provide music therapy services in public school settings. Both full- and part-time public music therapists employed by school districts within the past five years were included as potential participants, as well as music therapists working in public schools who were self-employed or employed by another organization but contracting with public school settings. Participants were excluded if they had worked in school settings previously but had not been employed in such capacity in over five years, as well as those who worked exclusively in private schools or other childcare settings that were not considered public school settings. Additional demographic data were not considered in inclusion or exclusion criterion.

The researcher initially submitted an email list order form to the CBMT, to request an unfiltered email list of all board-certified music therapists. CBMT typically provides email addresses for approved

requests for educational, professional, or research purposes and may be purchased for one-event use. Once the researcher received a list of emails for all the board-certified music therapists listed in the CBMT membership directory, potential participants were emailed an invitation to participate in the survey. In an effort to prevent the possibility of music therapists completing the survey who did not have current or recent work experience in public school settings, the first question of the survey, "*Have you been employed as a music therapist in public school settings, either part-time or full-time, within the past 5 years?"* functioned to eliminate potential respondents who did not meet inclusion criteria. Respondents who indicated they did not work in public school settings (i.e. respondents who worked in private or independent schools, or those who had not worked in public schools within the last five years) were electronically forwarded to a disqualification page on SurveyMonkey that did not allow further participation in the survey.

A total of 6,716 board-certified music therapists were emailed an invitation to participate in the survey. Of this pool, 474 clicked on the survey link in the recruitment email to begin the survey. After eliminating 141 respondents who indicated on the first question that they were either not recently employed in public schools, or were employed in a private or independent school setting, 333 respondents continued to the demographic question page. A total of N =302 school music therapists answered *at least some* demographic questions. While 85 of these participants dropped out of the survey at various points, 217 (71.9%) music therapists who met inclusion criteria and answered at least some questions completed the entire survey. Initial demographic information collected by the researcher indicated that the majority of respondents had practiced music therapy in the school setting for an average of 0-4 years (51.0%). Of the board-certified school music therapists represented, 2.3% also held certification as a general educator, 19.5% held licensure or certification as a music educator, and 5.6% held licensure or certification as a special educator. Approximately 44.0% of music therapists in schools worked full-time and 56.0% worked part-time. While this information provides a brief overview of the demographic characteristics of the participants, a further demographic picture is depicted within the results section of this paper.

Survey Design and Materials

For the present study, the researcher developed a survey from themes found in related literature in music therapy, other related services, and special education. Specifically, the researcher reviewed survey questions from closely related studies, which were pilot-tested and created by researchers with decades of experience in the fields of music therapy (McCormick, 1988; Smith & Hairston, 1999) and speech-language pathology (Brandel & Frome Loeb, 2011). After reviewing previous surveys and reviewing the most current literature regarding music therapy service provision and models in schools, as well as current trends in special education and related services, the researcher determined a need to build upon previous survey tools with additional questions and response options that reflected current practices and relevant issues in school settings.

The survey tool that was used in the present study is called *Music Therapy in Public Schools: 2017*. The purpose of the survey was to collect information from public school music therapists regarding current trends as related to music therapy service provision models in school settings. Survey questions, which correspond to particular research questions, were designed to investigate demographic, job, and caseload characteristics of music therapists in public school settings; common service delivery models of school music therapy; and variables that may have impacted service delivery model decisions such as ability to make decisions, preferences, and relevant therapist, student, and workplace characteristics.

To determine whether there were any inherent problems within the survey tool, the researcher conducted pilot testing of the initial draft of the survey. A description of the study and the survey itself were sent to three board-certified music therapists who within the previous year worked in public school settings in the United States and had conducted research or contributed literature regarding school music therapy. In particular, the researcher recruited authors and clinicians from three different regions of the United States who have worked in and described different models of music therapy within their writing, to gain a variety of perspectives and potentially reduce researcher bias. The researcher sent a link to the online survey to these three pilot-test participants and asked them to provide feedback regarding

(a) ease of completion, (b) confusion of questions, (c) redundancy, (d) missing information, (e) inaccurate information, and (f) any additional comments to improve the survey. The researcher asked pilot-test participants to complete the online survey, record the amount of time it took to complete the survey, and respond to these six prompts and provide any additional feedback in written form via email. Revisions of the survey were then made based upon feedback from pilot-test participants.

The final revised survey, *Music Therapy in Public Schools: 2017,* was 38 questions long and took approximately 15-20 minutes to complete (see Appendix B). Survey items included eight demographic questions, nine questions regarding job characteristics, twelve questions related to caseload characteristics and time allotment of job responsibilities, three questions related to service delivery models and ability to make decisions, five questions related to decision variables, and a textbox for the respondent to share additional information.

Most survey questions were provided in multiple-choice format, with the option of "Other: please specify" as an option for participants to type additional responses. Directions within the survey specified whether the respondent had the option of choosing "all that apply" or a single option. Some multiple-choice options were provided in a drop-down menu and others were provided in a matrix format (for example, see Appendix A, survey question 29) for ease of response selection. Attitudinal questions included a Likert-type multiple-choice scale option that ranged from 1, *strongly disagree*, through 3, *neither agree nor disagree*, to 5, *strongly agree*. Survey question (Q) 38 was the only question that was neither multiple-choice nor matrix and provided an opportunity for respondents to enter final comments.

Survey questions were arranged within the topics above and related to the four guiding research questions, as follows ("Q" number corresponds to the survey question number in Appendix B):

1. What are the demographic, job, and caseload characteristics of music therapists in public school settings?
    - *(Q1) Qualifying question used to determine whether potential respondents met inclusion criteria*

- *(Q2-Q8) Demographic characteristics: Years of school music therapy service, employer, employment status, associated region, graduation year, degrees earned, additional licensure/certification/training*
- *(Q9-Q13, Q29, Q32) Job characteristics: Necessity of additional licensure for current position, music therapy approach relevant to current practice, district demographic, district SPED student enrollment, number of music therapists in the district, time allotment in job responsibilities, model of music therapy during education vs. model implemented in current job*
- *(Q14-Q28) Caseload characteristics: Number of students on therapist caseload; team model; supervisor; IEP status of music therapy; number, length, and frequency of music therapy sessions in 1-on-1, group, or whole-class settings; how length and frequency is determined; professionals with which the therapist collaborates or provides consultation*

2. What service delivery models of music therapy are most common in public school settings?
    - *(Q30) Model(s) of service provision*
3. Are school music therapists able to make decisions regarding service delivery model(s)?
    - *(Q31) Ability to make decisions*

    a. Do they practice within the model they feel is best for their students/?
        - *(Q36a,b,c) Level of agreement regarding whether the therapist is operating within the best model, for the amount of time, and in the location necessary for progress toward a child's goals.*
4. Which, if any, variables influence a public school music therapist's preference or decision to deliver services within a particular model?

    a. Do they consider certain therapist-, student-, or workplace-related variables more relevant to service delivery model preferences or decisions than others?

- *(Q33-Q35) Relevance of certain therapist, student, and workplace variables*
- *(Q36d, Q37) Educational laws or trends that may impact service provision*

b. Are there any relationships among a public school music therapists' demographic, job, and caseload characteristics and his or her preferred or decided model(s) of music therapy service delivery?

- *No corresponding research question; the researcher will determine results by comparing specific responses on Q2-Q17 and Q29 to those on Q30*

Human Research Protection Program and Informed Consent

The human research protection program (HRPP) at the researcher's university affiliation received a description of the proposed study and survey for review and approval before the researcher conducted pilot-testing of the survey, contacted the CBMT for a list of potential participants, and sent survey links to participants who met inclusion criteria for survey eligibility. The HRPP approved the study protocol and study tools (survey, information statement, recruitment email) in March of 2017 without need for revisions.

All survey participants received an HRPP-approved recruitment email with a link to the survey and an information page to read before proceeding to survey questions. The content of the information statement (see Appendix A) included the purpose of the research study, expected duration of the participant's involvement, a description of procedures to be followed, an overview of foreseeable risks, an explanation of potential benefits, a statement regarding participant identity protection, researcher contact information, HRPP contact information where participants can direct questions regarding their rights, and a statement that participation is voluntary and may be discontinued at any time. The information statement also informed participants that clicking "next" to proceed to the first question of the survey implied voluntary consent to participate.

Procedures

The following section outlines a step-by-step procedure for conducting the present study. First, the researcher began by conducting a pilot-test of the survey tool to increase validity and reliability of the tool, clarify questions as needed, and eliminate potential researcher biases or assumptions. Feedback garnered from pilot-test comments was used to revise the survey as necessary before sending to potential respondents. The researcher then contacted the Certification Board for Music Therapists (CBMT) and requested a list of emails of all board-certified music therapists (see the Recruitment & Participants section above). After collecting emails of potential respondents, the researcher distributed and administered the final version of the online survey, *Music Therapy in Public Schools: 2017,* through SurveyMonkey (www.surveymonkey.com).

Participants received a URL to an information statement and survey, distributed to potential participants using a blind-carbon copy email option (according to stipulations by CBMT). The researcher chose settings within SurveyMonkey such that respondents could submit only once from the same device (to avoid multiple submissions from one individual) and the option for the respondent to change answers on any survey page until they completed the survey. None of the survey questions asked for identifying information; the researcher chose the "Anonymous Responses" option on SurveyMonkey within the "Collect Responses" tab so that respondent IP addresses were not paired with responses. Additionally, the researcher enabled the SurveyMonkey option for SSL encryption to encrypt data sent to and from SurveyMonkey; therefore, participant responses remained confidential. The researcher stored the list of emails on a password-protected device and erased the data once the survey links were sent to potential respondents; this information could not be linked to individual survey responses. The participants were then asked to complete the 38-question survey which took approximately 15-20 minutes to complete. To garner a recommended online survey response rate between 20 and 24% (Sax, Gilmartin & Bryant, 2003), the researcher planned to use SurveyMonkey administration scheduling to send an initial email and schedule two follow-up reminders, each one week after the previous email. However, after receiving 217 complete responses, the researcher decided to refrain from sending follow-up reminders, since this was a

higher number than the approximate number of music therapists (~200) who had reported to the CBMT that they worked in public schools.

Data Analysis

Any data gleaned through survey participation was stored on the researcher's password-protected private account on SurveyMonkey. Identifying information for participants was neither collected nor stored for data collection. The researcher only accessed this account through a password-protected personal laptop. For data analysis, the researcher downloaded and stored SurveyMonkey data within a password-protected file folder for analysis in SPSS, also on the researcher's personal laptop. Survey data were analyzed using SPSS software and organized by research question. For each survey question, the researcher analyzed and reported data in the following ways, as organized by research questions and sub-questions:

Research question 1. Responses to survey Q1 were analyzed, as this question was used to determine whether potential respondents met inclusion criteria. Participant responses to Q2-Q8, regarding therapist demographic characteristics, were analyzed using descriptive statistics and reported within a single table including question, answer category, and number and percentages of how many participants responded to a particular answer category. Data corresponding to Q9-Q13, Q29, and Q32 were analyzed and reported in the same manner, though were displayed in a table corresponding to job characteristics. Results for Q29 were demonstrated within a table of average percentages per category to present readers with a visual representation of the average school music therapist's "work week." For survey questions corresponding to caseload characteristics, Q14-Q28, data were also analyzed according to number and percentages of participants who responded to a particular answer category, and displayed in table format.

Research question 2. Responses to Q30, one of the core questions of the survey, were analyzed using descriptive statistics and reported in table format by music therapy service delivery model. The table includes number and percentage of respondents that indicated each service delivery model.

Research question 3. Responses to survey Q31 corresponding to therapist ability to make service delivery model decisions, were analyzed using descriptive statistics. The researcher reported the results

gleaned regarding the number and percentage of participants who chose each answer option in a table titled Therapist Decisions & Preferences. For research question 3a, which corresponds to survey Q36a-c, the researcher reported percentages of respondents who chose each Likert-type scale response (from *strongly disagree* to *strongly agree*).

Research question 4. Responses to survey Q33-35, which corresponded to the relevance of certain variables toward a therapist's preference or decision to deliver services within a particular model, were analyzed using descriptive statistics, including number and percentage of respondents who chose each Likert-type scale response (from *highly irrelevant* to *highly relevant).* Responses to Q33-35 were represented in two tables—one for respondents who are able to make decisions regarding service delivery model (who answer "yes" or "sometimes" on Q31) and one for respondents who are not able to make decisions (who answer "no" on Q31) and are answering based upon preferences. Each table includes variables category (therapist, student, and workplace variables), specific individual variables, and number and percentage of respondents who chose each Likert-type response according to variables.

To visually demonstrate results, the three most "relevant" variables chosen in each category were bolded. Additionally, the researcher created two diagrams, similar to the school-based intervention decision-making model (SIDM) in Brandel and Frome Loeb's (2011) study (see p.462), displaying bolded terms within each variable category—one for therapists who are able to make decisions regarding service delivery model(s) and one for those therapists who chose variables based upon hypothetical variable relevance. Finally, for responses to Q36d and Q37, regarding educational laws or trends that may impact service provision, the researcher visually displayed results within a bar graph which includes the number and percentage of respondents who chose each answer option.

The final, and perhaps most consequential, data analysis procedure pertained to research question 4b, regarding whether there are any relationships among a public school music therapists' demographic, job, and caseload characteristics and his or her preferred or chosen model(s) of music therapy service delivery. While there are no corresponding survey questions to display within a table or graph, the researcher used the Analyze Results page within SurveyMonkey. The Compare feature on this page

allows users to cross-tabulate results for certain questions to see a side-by-side comparison of how respondents who selected certain answer choices answered other questions within the survey. The researcher used this function to align responses to Q2-Q17 and Q29 (demographic, job and caseload characteristics) and those on Q30 (preferred or decided service delivery model). The researcher included only those comparisons which showed the most difference by demographic category, which were visually displayed in tables. Substantial differences among responses were used to analyze whether any relationships existed between characteristics of music therapists and service delivery model(s) of music therapy.

Chapter 4
Results

The purpose of this study was to investigate existing school music therapy service provision, including the role of the therapist and models of service delivery, to provide an up-to-date overview of the field as of 2017. From the 6,716 emails sent to an unfiltered list of potential participants (all board-certified music therapists), 474 began the survey, 333 indicated they were eligible to participate (Q1), 302 answered at least one page of questions, and 217 completed the entire survey. Since the survey was sent to all board-certified music therapists (regardless of population served or work setting), there was no way to calculate an accurate response rate. The *n* of 217 music therapists who completed the survey out of 333 who met eligibility criteria, however, indicates a 65.2% completion rate of the eligible school music therapists that began the survey. Question 1 (Q1) functioned only as an opt-out question to determine eligibility for survey completion and was therefore excluded from any data tables. All participants who indicated "yes" to Q1 were deemed eligible as survey respondents because they were working in public schools as board-certified music therapists in the past five years. Therefore, from this point forward, the researcher will refer to survey respondents as "school music therapists" or "music therapists."

Approximately 9% (n = 31) of music therapists who indicated eligibility on Q1 exited the survey before they began the initial demographic questions. The researcher chose to report the data below based upon the school music therapists that answered all of the demographic questions (N = 302), rather than the 333 who began the survey or the 217 who completed the entire survey. Music therapists were able to save and exit the survey on each new page; thus, points where groups of eligible therapists exited the survey correspond to the 11 electronic survey pages as presented through *SurveyMonkey*. In data tables outlining results (see Appendices C-F), percentages are based on the number of music therapists that responded to each individual question (noted by *n* in the first column of each table) and vary across questions due to respondent drop-outs across the survey.

Overall, more than half (65.2%, n = 217) of school music therapists who indicated that they met eligibility (n = 333) requirements completed the entire survey. In addition, a total of 58 music therapists

(26.7% of the 217 total that completed the survey) answered the additional, non-required and open-ended Q38 to share additional thoughts or comments regarding current practices and trends in school-based music therapy. While 302 eligible school music therapists provided at least demographic data, 85 participants exited the survey at various points with 217 completing the entire survey. The researcher chose to report data for the total number of music therapists who answered each question and thus, the data pool for each research question varied and is defined under each sub-heading below and in corresponding data tables. This chapter includes a description of the survey data provided by eligible school music therapists, organized by section headers for each of the four guiding research questions and survey divisions.

Survey Results

Research Question 1: *What are the demographic, job, and caseload characteristics of music therapists in public school settings?*

Demographics (Q1-Q8): Training, certification, and employment.

Training. A total of 302 music therapists completed demographic information regarding their training, certification, and employment which are outlined in detail in Appendix C and highlighted in subsequent paragraphs. Most school music therapists earned a Bachelor's in Music Therapy (67.6%) or Master's in Music Therapy (30.8%), though others received a Bachelor's in Music Education (13.6%) or Equivalency in Music Therapy (13.3%). Sixty-four music therapists (21.2%) pursued other degree programs, such as Special Education (n = 17), Bachelor of Arts in Music (n = 7) or Music Performance (n = 7)—whether prior to a graduate equivalency program in music therapy or after achieving a bachelor's in music therapy (the researcher did not ask the music therapists to specify). Music therapists graduated from their degree programs between 1974 and 2017, with a mode response of 2013 (n = 33) and median of 2010. No survey questions asked where participating music therapists received their training, although some shared this information in an open-ended question at the end of the survey.

Certification. All eligible music therapists indicated within Q1 that they were practicing in school settings currently or within the last five years and all were board-certified due to their inclusion on the

CBMT-provided email list. In addition to their board certification credential, 51.7% (n = 156) of board-certified music therapists who indicated eligibility held specialized certifications in music education, special education, general education, or "other" fields. Specifically, 59 (19.5%) indicated they were also music educators with another 5.6% indicating holding a special education license or certificate. Among the 73 (24.2%) school music therapists who indicated "other" licensure, certification, or specialized training, frequent responses included Neurologic Music Therapy (n = 18), Licensed Professional Music Therapist (n = 9), Neonatal Intensive Care Unit- Music Therapy (n = 6), Licensed Creative Arts Therapist (n = 5), as well as others [see Appendix C for a full list]. Of the 259 music therapists who answered Q9, 13.5% (n = 35) specified an additional music education license was *required* to maintain their position in the school district(s)— six percent less than the total number of dual certified music educators and music therapists who participated in the survey (n = 59, 19.5%).

Employment. School music therapists who described their employment status (n = 302) indicated that 56.0% work part-time in school districts while 44.0% work full time. The majority of music therapists (56.6%) indicated that they had worked either between one and four years (40.4%) in public school settings, or between five and nine years (16.2%). There was a fairly equal representation from music therapists who had been employed less than a year to those who had worked in public schools for over two decades (approximately 1% difference). Most music therapists in public schools were employed by the district (36.8%), though many were employed by an agency, company, or private practice (29.1%); or as an independent contractor to school districts (23.8%). Some music therapists who chose "other" responses indicated employment through grant funding (n = 4), through a university (n = 3), or through a combination of school district employment and contract services (n = 3). Music therapists represented employment in all regions of the U.S., though the highest response was received from school music therapists working in the Great Lakes region (22.9%). The Mid-Atlantic (20.9%) and Southwestern (15.2%) regions represented the next highest regional response rates.

Job characteristics (Q9-Q13, Q29, Q32): District overview, music therapist characteristics, and hourly distribution of weekly job tasks.

District overview. While all survey respondents were board-certified music therapists, 13.5% (*n* = 35) of the 259 music therapists who answered questions related to job characteristics were required by their district to have an additional teaching certification (whether in special, general, or music education was not specified). Most school music therapists worked in suburban school districts (39.8%) and indicated on Q12 that 1,000 or more students received special education services in their district (25.5%). Many also indicated on Q11-13, however, that they worked in "multiple districts" which may have had different demographics, population of students in SPED, and number of music therapists in the district—though some did not select "multiple districts" for all three questions (Q11-13, *n* = 59-78, 22.8%-30.1%). Additional response data for Q9-Q13 are presented in Appendix D.

Music therapist characteristics. The highest percentage of school music therapists (39.0%) worked as the sole music therapist in their district, though nearly 11% (n = 28) shared the total student caseload among five or more district music therapists. Regarding service provision, music therapists indicated that they found various approaches to be relevant, including a behavioral approach (87.3%), Neurologic Music Therapy approach (46.3%), Nordoff-Robbins Music Therapy approach (41.7%), Orff approach (39.8%), or another music-centered approach (39.4%). For this question, music therapists could pick multiple relevant approaches; therefore, total percentages exceeded 100%. Of the music therapists who indicated on Q32 that they had participated in a school-based practicum or internship experience (70.2%), over half chose "yes" or "sometimes" (54.4%) to indicate that the model of music therapy in which they provided services in their district(s) was the same as the model(s) in which they provided services during the school-based practicum or internship.

Hourly distribution of weekly job tasks. Table 1 outlines the average number of hours participating school music therapists spend per week in various school tasks. Music therapists did not have to include a response to every task and, thus, the total number of respondents to each option varies and as such percentages are based on the number of people responding to each task. Additionally, results

were not disseminated by part-time vs. full-time employees and, thus, the number of hours per task may vary based on that demographic data. On average, however, results indicated that most school music therapists spent less than one hour per week on individual tasks such as assessments, co-planning, co-leading, indirect services (consultation), IEP meetings, other meetings, supervision, professional development, and "other" tasks (such as instrument repair and session preparation). Music therapists spent an average of one to three hours per week planning, documenting, and traveling to provide services. The majority of school music therapists spend at least 20 hours per week providing direct services in either 1-on-1, small group, or whole class settings (though response averages were fairly evenly distributed, within a 12% range, for nearly all categories of hour distributions).

Table 1

Hourly Distribution of Weekly Job Tasks (Q29)

Task	***<1 hr***	***1-3 hrs***	**4-6 hrs**	**7-9 hrs**	**10-14 hrs**	**15-19 hrs**	**20+ hrs**	***n***
Assessments	133 (59.6%)	67 (30.0%)	16 (7.2%)	5 (2.2%)	1 (0.5%)	1 (0.5%)	0	223
Planning *(independent of others)*	27 (11.6%)	129 (55.6%)	60 (25.9%)	14 (6.0%)	2 (0.9%)	0	0	232
Co-planning *(collaboration)*	148 (69.8%)	55 (25.9%)	6 (2.8%)	3 (1.4%)	0	0	0	212
Direct services *(1:1, small group, or whole class)*	11 (4.8%)	30 (13.1%)	27 (11.8%)	25 (10.9%)	48 (21.0%)	37 (16.2%)	51 (22.3%)	229
Co-leading direct services *(collaboration)*	126 (62.4%)	54 (26.7%)	10 (5.0%)	4 (2.0%)	2 (1.0%)	3 (1.5%)	3 (1.5%)	202
Indirect services *(consultation)*	121 (56.8%)	73 (34.3%)	12 (5.6%)	5 (2.4%)	1 (0.5%)	1 (0.5%)	0	213
Documentation	41 (17.9%)	122 (53.3%)	44 (19.2%)	16 (7.0%)	5 (2.2%)	1 (0.4%)	0	229
IEP meetings	126 (60.6%)	65 (31.3%)	14 (6.7%)	2 (1.0%)	1 (0.5%)	0	0	208
Other meetings	118 (56.7%)	79 (38.0%)	10 (4.8%)	1 (0.5%)	0	0	0	208
Supervision *(i.e. interns)*	138 (63.9%)	37 (18.9%)	14 (7.1%)	5 (2.6%)	0	0	2 (1.0%)	196
Professional development	138 (63.9%)	68 (31.5%)	6 (2.8%)	3 (1.4%)	0	0	1 (0.5%)	216

(continued)

Table 1 (continued)

Task	*<1 hr*	*1-3 hrs*	4-6 hrs	7-9 hrs	10-14 hrs	15-19 hrs	20+ hrs	*n*
Travel	43 (19.1%)	82 (36.4%)	50 (22.2%)	32 (14.2%)	12 (5.3%)	3 (1.3%)	3 (1.3%)	225
Other	34 (63.0%)	11 (20.4%)	2 (3.7%)	5 (9.3%)	0	0	2 (3.7%)	54

Note. The total number of respondents to this question is $n = 235$. The numbers (n) in the far right column represent the number of music therapists who indicated that they participate in the given job task; not everyone chose a response for each task. The number in each adjacent column represents the number of music therapists that chose each time option for the given job task. "Other" responses included: instrument maintenance and cleaning ($n = 3$), preparation of visual aids, creating manipulatives or lessons, session preparation, rehearsal planning, practice, communication for scheduling, anti-bullying/mediation groups, providing workshops and training, school assembly projects (i.e. drum circle day), enrichment groups, modified music support, student breaks or crises, building duties (lunch, busses), community liaison, office management, contractor supervision, small business owner needs, and administrative tasks.

Caseload characteristics (Q14-Q28): Student caseload; administrative characteristics; number, length, and frequency of sessions; 1-on-1 sessions; small group sessions; whole, inclusive class sessions; how length and frequency is determined; collaboration and consultation with other professionals.

Student caseload. For Q14, regarding number of students each of the music therapists served on their caseload, most of the 259 responding music therapists provided specific numbers ($n = 255$, 98.5%), so the researcher calculated descriptive statistics such as mean, median, and range for these 255 numeric responses. Numeric groupings were added post-survey; after the researcher reviewed data for this question (see Appendix E). The majority of music therapists served under 50 students in their caseload (56.5%); the highest frequency of music therapists served zero to 24 students (33.7%), followed by those who served 25 to 49 students (22.8%). Nearly 90% of music therapists served less than 200 students. In some cases, music therapists indicated that they served as many as 1,000 students, though only 2.4% ($n = 6$) served 400 or more students on their current caseload.

Administrative characteristics. The majority of the 259 school music therapists who responded to administrative-related survey questions practiced within either a multidisciplinary (35.1%) or

interdisciplinary (34.0%) team model within the special education department. Some, however, did not work within the special education department at all (21.2%). Although most school music therapists indicated being supervised by a special education administrator (46.0%), responses for Q16 regarding the job title of their direct supervisor were varied. Other therapists indicated they were supervised by another music therapist (24.3%); or a wide variety of "other" school professionals (18.5%) such as a school principal (n = 7), special education teacher (n = 5), or "none" (n = 11). For additional "other" responses, see Appendix E. Responses were also varied as to how music therapy is listed on the music therapists' district IEPs. By a small margin, most indicated that music therapy was "not specified on IEP's" (34.0%). Of those who did specify music therapy on IEPs, 32.8% listed music therapy as a "direct service," 26.6% listed music therapy as a "mixture of direct and indirect services," and only 6.6% listed music therapy as an "indirect service" only (i.e. consultation or programmatic services).

Number, length, and frequency of sessions. On the survey, Q18-Q26 pertained to the (a) number, (b) length, and (c) frequency of sessions for different group sizes. A total of 246 music therapists answered these questions and were asked to rate characteristics for each group size in which they served students. The data were arranged according to group size (1-on-1 sessions, small group sessions, or whole group sessions) in the following section, though additional details are included in Appendix E.

One-on-one (1-on-1) sessions. Seventy-seven (31.3%) of the 246 school music therapists who responded to this question indicated that they did *not* facilitate 1-on-1 sessions with an individual student. Of those that did indicate they facilitate 1-on-1 sessions (n = 169), 60 (35.5%) facilitated only one to four individual sessions per week. The average length of 1-on-1 sessions for most music therapists was 20 to 30 minutes (60.9%), with a typical frequency of once per week (80.5%). Multiple music therapists who chose "other" described that they provided 1-on-1 services at a frequency of biweekly, or twice a month (n = 9). Some music therapists also noted that they provided a session length of "30 minutes exactly," rather than choosing between 20-30 minutes or 30-45 minutes (since both options include 30 minutes) or asked clarifying questions about what constituted a 1-on-1 session.

Small group sessions. More school music therapists facilitated small group sessions than 1-on-1 sessions; only 26.0% indicated "none" to number of small groups facilitated, as compared to 31.3% of music therapists who indicated "none" to number of 1-on-1 sessions. The number of music therapists who indicated "none" or "do not facilitate small groups," however, varied slightly for Q21-23, so the *n* used below for calculating percentages out of those who facilitated *at least some* small group sessions varies by question (*n* = 182-185 for Q21-23). Of the music therapists who indicated that they did conduct *at least some* small group sessions on Q21 (*n* = 182), most (44.5% of *n* = 182) conducted between one and four individual sessions per week. The length of these small group sessions was an average of 20 to 30 minutes (47.8% of *n* = 184) and at a frequency of once per week (77.3% of *n* = 185). Similar to 1-on-1 sessions, music therapists who chose "other" often described that they provided small group services at a frequency of "biweekly" (*n* = 7).

Inclusive, whole class sessions. The highest number of music therapists *did not* facilitate whole class sessions (*n* = 81-83, with some variation from Q24-26). However, of those that *did* (*n* = 163-165, with some variation from Q24-26), most provided between one and four sessions per week (37.2% of *n* = 164) or 10 to 19 sessions per week (26.8% of *n* = 164). The length of whole class music therapy sessions was typically 20 to 30 minutes (47.2% of *n* = 163), with a frequency of once per week (70.3% of *n* = 165). Even more-so than 1-on-1 or small group sessions, music therapists who chose "other" described the frequency of services to be "biweekly" (*n* = 15) or "once a month" (*n* = 3).

Overall, music therapists indicated that the average length of their 1-on-1 sessions was shorter than the length of their small group or whole class sessions. However, the frequency for all group size categories, was somewhat consistently once per week with the number of sessions typically between one and four, or 10-19 sessions per week. "Other" responses pertaining to session frequency were more varied. The "other" response of "as needed (for behaviors)" was unique to 1-on-1 sessions. Additionally, the inclusion of *n* "times per school year" was unique to small group or whole class sessions vs. 1-on-1 sessions, which were mostly indicated as *n* "times per week".

How length and frequency is determined. For survey Q27, regarding determinants of length and frequency of sessions, school music therapists were able to select more than one option; therefore, percentages calculated to over 100 percent for some options (see Appendix E for percentages per option). The greatest percentage of music therapists indicated "individual student needs" as the highest determinant of length and frequency of sessions (51.2%). Other frequent responses included "mandated by IEP team" (26.8%) and "therapist caseload" (25.2%). Over 18% (n = 45) of music therapists also indicated "other" determinants of length and frequency, including grant requirements/specifications (n = 7), budgeting (n = 5), independent contract terms (n = 5), teacher plan/prep time coverage (n = 4), and more (see notes in Appendix E).

Collaboration and consultation with other professionals. Music therapists who responded to Q28 indicated whether they provided collaboration or consultation with various school-related professionals. This survey question was presented in a matrix style and response was optional; therefore, fewer music therapists answered this question than the questions directly before and after (n = 226). Also, "collaboration" and "consultation" response percentages were calculated according to the total number of music therapists who chose "collaboration" and/or "consultation" for each school professional, rather than the total number of responses for the survey question (see Table 2 for further explanation of responses). Percentages in the "collaboration" and "consultation" columns may add up to over 100% of the total number of responding music therapists because they could choose both options. Some music therapists indicated "other" professionals with whom they consult or collaborate, including ABA interventionists, parents, SPED coordinators, vision impairment teachers, orientation and mobility specialists, social workers, vocational trainers, Deaf and hard-of-hearing educators, and psychologists.

Results indicated that the professionals with whom school music therapists either collaborated with or provided consultation the most were special educators (98.7%), paraprofessionals (84.5%), and speech-language pathologists (79.2%); though more than half also collaborated or consulted with occupational therapists, physical therapists, and general educators. School music therapists provided more *consultation* than collaboration with general educators, music educators, community services, and medical

professionals. Conversely, school music therapists *collaborated* more than consulted with special educators, paraprofessionals, SLP's, OT's, PT's, and other creative arts therapists.

Table 2

Consultation & Collaboration (Q28)

Question	Category	*Collaboration*	*Consultation*	*n* (%) that answered within this category
Q28: Professionals with whom the MT provides consultation or collaborates (*n* = 226)	**Special Educators**	**177 (79.4%)**	**123 (55.2%)**	**223 (98.7%)**
	Paraprofessionals	**141 (73.8%)**	**92 (48.2%)**	**191 (84.5%)**
	Speech-Language Pathologists	**139 (77.7%)**	**92 (51.4%)**	**179 (79.2%)**
	Occupational Therapists	114 (71.7%)	88 (55.4%)	159 (70.4%)
	Physical Therapists	101 (71.1%)	75 (52.8%)	142 (62.8%)
	General Educators	50 (43.1%)	82 (70.7%)	116 (51.3%)
	Music Educators	31 (34.1%)	70 (76.9%)	91 (40.3%)
	Community Services (i.e. Case Managers, Social Workers)	38 (48.1%)	51 (64.6%)	79 (35.0%)
	Guidance Counselors	25 (41.7%)	38 (63.3%)	60 (26.6%)
	Other Creative Arts Therapists	31 (63.3%)	25 (51.0%)	49 (21.7%)
	Medical Professionals	16 (37.2%)	31 (72.1%)	43 (19.0%)

Note. Other responses to Q28 (consultation and collaboration) included: ABA associates or behavioral interventionists (3), Parents (3), SPED administrators/coordinators (3), Vision impairment teachers (2), Orientation and mobility specialists (2), Social workers, Vocational trainers, Deaf/hard of hearing educator, and Psychologist (1).

Research question 2: *What service delivery models of music therapy are most common in public school settings?*

The researcher designed one survey question, Q30, to answer the second research question. Within the survey, the researcher provided a list of models of music therapy most commonly referenced within related literature and asked school music therapists to choose "all that apply." A total of 228 music therapists selected at least one model. Results indicated that the most common model of music therapy in public school districts was "direct services, with a whole class, within a self-contained special education classroom" (*n* = 156, 68.4%). This was the most common by nearly 20%, as the next most common model indicated by school music therapists was "direct services, outside the general classroom, 1-on-1" (*n* = 111, 48.7%). The next two most common models diverged from direct services: "collaboration with other school professionals" (*n* = 96, 42.1%) and "consultation for individual students" (*n* = 89, 39%). Overall, however, multiple sub-models of direct services made up three of the five most common models.

Table 3

Models of Music Therapy

Question	Model	*Location*	*Group Size*	*n*	%
Q30: Models of music therapy (n = 228) *Directions: Choose all that apply*	Direct services	In general classroom	1-on-1	41	18.0%
	Direct services	In general classroom	Small groups	60	26.3%
	Direct services	**Outside general classroom**	**1-on-1**	**111**	**48.7%**
	Direct services	Outside general classroom	Small groups	74	32.5%
	Direct services	Outside general classroom	Large groups	33	14.5%
	Direct services	**Self-contained SPED classroom**	**Whole class**	**156**	**68.4%**
	Inclusive (co-leading)	In general classroom	Whole class	12	5.3%
	Inclusive (leading)	In general classroom	Whole class	36	15.8%
	Consultation	For individual Students		89	39.0%
	Consultation	For individual professionals		70	30.7%
	Consultation	Whole program or department		35	15.4%
	Collaboration with other school professionals			**96**	**42.1%**
	Co-leading (i.e. music therapy + physical therapy)			66	29.0%
	Community music therapy in schools (addressing needs and culture of the school system)			18	7.9%
	After school music therapy programs			22	9.7%
	Inservices and workshops			64	28.1%
	Preventive music therapy			6	2.6%
	Adaptive music education			48	21.1%
	Other*			9	4.0%

* Other *responses included assessment only (2); Educational Enrichment; after school tutoring; inclusive music enrichment to Latch Key program; and mentoring.*

Note. Percentages are based on the number of those that responded to the question and thus varies among questions.

Research question 3: *Are school music therapists able to make decisions regarding service delivery model(s)? Do they practice within the model they feel is best for their students?*

According to music therapists who answered Q31 (n = 228), most were able to decide the model of music therapy in which they provided services in their district (73.7%). Only 6.1% indicated that "no," they were not able to decide the model, while an additional 20.1% were "sometimes" able to make this decision. Follow-up responses to "sometimes" included common themes such as "yes, but with supervisor approval;" "yes, but models have changed with input of SPED administrators to support longevity of the program;" that the school music therapists "tried to implement other models but not successfully or

permanently," and that the "model may change if determined different models are best to support students."

To indicate whether they were able to practice within the model they determine is best for their students, music therapists (n = 217) answered three Likert-type questions (Q36a,b,c). Responses indicated a level of agreement (from "strongly disagree" to "strongly agree") as to whether the music therapist felt as though they were operating within the (a) best model, (b) for the amount of time necessary, and (c) in the location necessary to make progress toward a student's goals (see Appendix F). The majority of music therapists "agreed" that they were able to provide services within the (a) best model (52.5%), for the (b) amount of time necessary (47%), and in the (c) location necessary (53.5%) to make student progress. The next highest response category for all three questions was "strongly agree." Music therapists more "strongly agreed" that they were able to provide services within the (a) model necessary, and were more likely to "neither agree nor disagree" or "disagree" with (b) amount of time necessary and in the (c) location necessary to make progress toward student goals.

> **Research question 4:** *Which, if any, variables influence a public school music therapist's preference or decision to deliver services within a particular model? Do they consider certain therapist-, student-, or workplace-related variables more relevant to service delivery model preferences or decisions than others?* (Q33-35, 36d, 37)

To determine whether any variables influenced a school music therapist's preference or decision to deliver services within a particular model, the researcher asked survey participants to rate the relevance of individual variables. Each variable was categorized as a (a) therapist, (b) student, or (c) workplace variable and presented on a different survey page corresponding to one of these three categories. One to two music therapists dropped out of the survey on each page (see Table 4 below for the n and list of variables for each question). Responding music therapists rated along a Likert-type scale with options of (1) "highly irrelevant," (2) "somewhat irrelevant," (3) "unknown," (4) "somewhat relevant," and (5) "highly relevant." The researcher chose to calculate and present the number and percentage of music therapists that chose *either* "relevant" or "highly relevant" in Table 4, to compare which top three (bolded) variables were most influential toward a music therapist's decision in each category.

Therapist variables.

Of the nine therapist-related variables included within the survey, music therapists indicated that caseload, prior clinical experience, and philosophical approach were the most relevant toward a decision for a particular service delivery model. The percentage of music therapists who chose each answer was relatively similar (no larger than a 13% difference) other than the option of "part-time vs. full-time"—which more than 20% fewer music therapists chose as relevant. "Other" relevant therapist variables listed by music therapists included "interpersonal skills (with other staff)," "effectiveness of the therapist," "scheduling concerns," and "personality and preference" (see Table 2 for a complete list of responses).

Student variables.

Most music therapists indicated that the top three most relevant variables of the seven student-related variables included "strengths, needs, and abilities;" "nature and severity of the child's disability;" "age, and developmental level." Over 90% of music therapists selected *each* of these options, though nearly as many also chose "motivation and attitude", as well as "preference for and responses to music". Music therapists found all seven student variable options to be more "relevant" or "highly relevant" (from 80.18% to 94.59%) than therapist variables (from 45.98%- 80.35%). "Other" student variables listed by music therapists included "student schedules" and "degree of distractibility for other students."

Workplace variables.

Of the 10 workplace variables, music therapists indicated more variation in relevance (with a range from 42.1% at lowest relevance to 84.7% at highest relevance). The top three most relevant workplace variables to school music therapists included "classroom or SPED teacher support," preferences, or attitudes" (84.7%); "IEP specifications" (80.1%); and "administrative support, preferences, or attitudes" (79.2%). Less than half of school music therapists found that "travel time" and "geographic location" were relevant to their choice of service delivery model. "Other" workplace variables listed included "room availability per campus," "degree of assistance from the teacher and/or paras," "setting of the session and size of the group," "access to technology," and "level of knowledge the workforce possesses regarding music therapy." In all variable categories (student, therapist, workplace), at least one music

therapist indicated in "other" that they either did not understand the question or had concerns about the question wording.

Laws, mandates, and trends.

On survey question Q36d, the highest percentage of music therapists (35%) indicated that they "neither agreed nor disagreed" with the statement that "recent laws and mandates in general and special education impact model(s) of service delivery in which I provide services." However, each Likert-type option from "strongly disagree" to "strongly agree" was chosen by at least 19 music therapists (8.8%). On Q37, which asked school music therapists to choose any and all educational trends and laws that directly impacted their model(s) of service delivery, more than half of the music therapists (53.9%) chose "inclusion" and at least 18% chose each option of Common Core State Standards Initiative of 2010 (30.9%), No Child Left Behind Act of 2001 (28.6%), and Every Student Succeeds Act of 2016 (18.4%). Over a fourth of participants (n = 56, 25.8%) described "other" choices such IDEA or parts of IDEA (n = 7), defunding or budget restrictions, standardized assessments, "none" (n = 31), and "unknown" (n = 7).

Table 4

Relevance of Variables on Model of Music Therapy

Question	Category	n = MTs who chose "relevant" or "highly relevant"	%= MTs who chose "relevant" or "highly relevant"
Q33: **Therapist** variables by reported relevance (n = 224)	**Caseload (students)**	**180**	**80.4%**
	Prior clinical experience	**180**	**80.4%**
	Philosophical approach	**178**	**79.5%**
	Preferences of model	175	78.1%
	Workload (job responsibilities)	169	75.5%
	Years worked in school settings	165	73.7%
	Practicum or internship experience	158	70.5%
	Professional development	151	67.4%
	Part-time vs. full-time	103	46.0%
	Other responses included: Parents or team may override the therapist decision; Interpersonal skills (with other staff); Effectiveness of the therapist (through data); Scheduling concerns; Personality and preference; Self-education (conference, reading, etc.); Question didn't fit with the therapist experience; Did not understand the question/concerns about question wording (2)		(continued)

Table 4 (continued)

Question	Category	*n* = MTs who chose "relevant" or "highly relevant"	%= MTs who chose "relevant" or "highly relevant"
Q34: **Student** variables by reported relevance (*n* = 222)	**Strengths, needs, and abilities**	**210**	**94.6%**
	Nature & severity of a child's disability	**208**	**93.7%**
	Age and developmental level	**205**	**92.3%**
	Motivation and attitude	199	89.6%
	Preference for and response to music	198	89.2%
	Least-restrictive environment (IEP-based)	179	80.6%
	Need for peer modeling	178	80.2%
	Other responses included: Student schedules (other services, etc.); Student response to music rather than preference; Degree of distractibility for other students; Did not understand the question/concerns about question wording		
Q35: **Workplace** variables by reported relevance (*n* = 221)	**Classroom or SPED teacher support, preferences, or attitudes**	**188**	**84.7%**
	IEP specifications	**177**	**80.1%**
	Administrative support, preference, or attitudes	**175**	**79.2%**
	Team input	162	73.3%
	Relationship with school personnel	150	67.9%
	SPED department model	131	59.3%
	Number of students in SPED	122	55.2%
	Finances	115	52.0%
	Travel time	93	42.1%
	Geographic location	93	42.1%
	Other responses included: Room availability per campus; Degree of assistance from the teacher and/or paras; Setting of the session and size of the group; Amount of time therapist sees each class; Access to technology; Location may determine volume and instruments chosen; Level of knowledge the work force possesses regarding music therapy; Did not understand the question/concerns about question wording		

Question	Category	*n*	%
Q36d: Recent laws and mandates impact model(s) of service delivery (*n* = 217)	Strongly Agree	19	8.8%
	Agree	56	25.8%
	Neither agree nor disagree	**76**	**35.0%**
	Disagree	44	20.3%
	Strongly Disagree	22	10.1%

Question	Category	*n*	%
Q37: Which laws and trends impact model(s) (*n* = 217)	**Inclusion (movement from segregated settings to general classrooms)**	**117**	**53.9%**
	Common Core State Standards Initiative of 2010	67	30.9%
Directions: Choose all that apply	No Child Left Behind Act of 2001	62	28.6%
	Other*	56	25.8%
	Every Student Succeeds Act of 2016	40	18.4%
	**Other responses included: None (31); Unknown (8); IDEA/Parts of IDEA, such as FAPE (7); Defunding/budget restrictions (2); Standardized assessments (2); All*		

Comparison of Results

> **Research question 4b.** *Are there any relationships among a public school music therapist's demographic, job, and caseload characteristics and their preferred or decided model(s) of music therapy service delivery?*

Before analyzing results related to this research question, the researcher looked to determine whether music therapists self-report that they are *able to choose* the model of music therapy in which they provide services. If unable to choose, any found relationships between demographic, job, and caseload characteristics and model of service delivery may have been coincidental. The music therapists did report, however, that they overwhelmingly were either able to decide the model of service delivery (73.7%) or "sometimes" able (20.2%), depending on factors such as "with supervisor approval" (see Table A4).

While there are no survey questions corresponding directly to research question 4b, the researcher looked for relationships that emerged in the data by comparing specific responses on demographic and job characteristic questions, Q2-Q17, to service delivery model(s) chosen in Q30. To do so, the researcher used the Compare function on *SurveyMonkey* to isolate the percentage of music therapists who chose a particular response on Q2-Q17 (henceforth labeled as a "sub-demographic") who *also* indicated a particular model choice on Q30. The researcher then compared the difference in percentages (*%* change) for each *sub-demographic model choice* (SDMC) and the *original sample model choice* (OSMC) for all participating music therapists that chose each model on Q30. For example, one SDMC described below is the number of music therapists per region (labeled a "sub-demographic") who chose a particular model choice, such as "direct services, in classrooms, with small groups." That number is then compared to the OSMC, or the *total* number of participating music therapists from the original sample who chose the same model.

Comparison results that showed the highest percent change (at least a 15% increase or decrease in SDMC from the OSMC) are reported in Table 6 below. Sub-demographics that did *not* show a percent of change of at least 15% are not included in Table 6, though are listed and italicized below each demographic question in the table. Also, under questions such as Q7, related to degree(s) earned, the researcher chose not to include percentages for sub-demographic groups in which less than $n = 15$ music

therapists answered, as sub-demographic groups this small appeared to skew data. For example, the percentage of music therapists who chose each model on Q30 that also indicated on Q7 they had earned a PhD was much higher than those who had earned a bachelor's degree in music therapy, but this was due to the small number of respondents in the sub-demographic (n = 6). The researcher was not able to use the Compare feature on *SurveyMonkey* to align results of Q6 (year graduated), Q12 (number of students), or Q14 (caseload number) to Q30 because music therapists typed in a numerical response rather than a multiple choice-type response; therefore, data for these questions are not included in Table 6 below. Finally, the researcher chose to include Table 5 below (which is a near-duplication of Table 3 above) as a reference for "model number", to aid in interpretation of Table 6, column 3 (model choice).

Table 5

Models of Music Therapy (Numbered, for Table 6 Reference)

Model	*Location*	*Group Size*	*n*	%
1. Direct services	In general classroom	1-on-1	41	18.0%
2. Direct services	In general classroom	Small groups	60	26.3%
3. **Direct services**	**Outside general classroom**	**1-on-1**	**111**	**48.7%**
4. Direct services	Outside general classroom	Small groups	74	32.5%
5. Direct services	Outside general classroom	Large groups	33	14.5%
6. **Direct services**	**Self-contained SPED classroom**	**Whole class**	**156**	**68.4%**
7. Inclusive (co-lead)	In general classroom	Whole class	12	5.3%
8. Inclusive (lead)	In general classroom	Whole class	36	15.8%
9. Consultation	For individual Students		89	39.0%
10. Consultation	For individual professionals		70	30.7%
11. Consultation	Whole program or department		35	15.4%
12. **Collaboration with other school professionals**			**96**	**42.1%**
13. Co-leading (i.e. music therapy + physical therapy)			66	29.0%
14. Community music therapy in schools (addressing needs and culture of the school system)			18	7.9%
15. After school music therapy programs			22	9.7%
16. Inservices and workshops			64	28.1%
17. Preventive music therapy			6	2.6%
18. Adaptive music education			48	21.1%
19. Other*			9	4.0%

* Other *responses included assessment only (2); Educational Enrichment; after school tutoring; inclusive music enrichment to Latch Key program; and mentoring.*

Table 6

Sub-Demographic Model Choice (SDMC) Compared to Original Sample Model Choice (OSMC) from Table 5

Question	Sub-Demographic (*SD*)	Model Choice (MC)	*OS* % for MC	*SD* % for MC	+/- (% of change)
Q2: Years employed	Less than 1 year	3	48.7%	65.2%	+ 16.5%
	Less than 1 year 5-9 years	4	32.5%	13.0% 51.22%	- 19.5% + 18.7%
	20+ years	6	68.4%	88.0%	+ 19.6%
	Less than 1 year 20+ years	10	30.7%	13.0% 52.0%	- 17.7% + 21.3%
	20+ years	12	42.1%	64.0%	+ 21.9%
	Less than 1 year 10-14 years 20+ years	16	28.1%	5.0% 50.0% 60.0%	- 23.1% + 21.9% **+ 31.9%**
	Less than 1 year	18	21.1%	5.0%	- 16.1%
	Sub-demographic options included less than 1 year; 1-4; 5-9; 10-14; 15-19; and 20+.				
Q3: Employer	Independent contractor	6	68.4%	45.3%	- 23.1%
	Public school district	9	39.0%	55.7%	+ 16.7%
	Independent contractor	12	42.1%	26.4%	- 15.7%
	Sub-demographic options included independent contractor; a public school district; a private or independent school; an agency, company, or private practice; and other.				
Q4: Employment status	*Insubstantial differences found between full-time and part-time status and model chosen.*				
	Sub-demographic options included yes; no; and sometimes.				
Q5: Region	New England	2	26.3%	43.8%	+ 17.5%
	Great Lakes New England	3	48.7%	31.3% 68.8%	- 17.4% + 20.1%
	New England	4	32.5%	62.5%	**+ 30.0%**
	New England	6	68.4%	87.5%	+ 19.1%
	Southwestern	9	39.0%	69.1%	**+ 30.1%**
	Southwestern	10	30.7%	47.6%	+ 16.9%
	Sub-demographic region options included Great Lakes; Mid-Atlantic; Midwestern; New England; Southeastern; Southwestern; Western; and International.				
Q7: Degree(s)	*Insubstantial differences between earners of different degrees listed—other than differences due to insufficient number of respondents.*				
	Sub-demographic options included bachelor's degree in MT; bachelor's degree in ME; master's degree in MT; master's degree in ME; equivalency in MT; PhD in MT or ME; or other.				

(continued)

Table 6 (continued)

Question	Sub-Demographic (*SD*)	Model Choice (MC)	*OS* % for MC	*SD* % for MC	+/- (% of change)
Q8: Additional Certification	Music education license/certification	3	48.7%	28.3%	- 20.4%
	Special education license/certification	7	5.3%	26.7%	+ 21.4%
	Special education license/certification	12	42.1%	60.0%	+ 17.9%
	Special education license/certification	18	21.1%	60.0%	**+ 31.9%**
	Sub-demographic options included license or certification in music education; general education; special education; none; and other.				
Q9: Need Teaching License	Yes	3	48.7%	25.8%	- 22.9%
	Yes	18	21.1%	45.0%	+ 23.9%
	Sub-demographic options included yes; no; and sometimes.				
Q10: Relevant Approaches	Kodaly	18	21.1%	39%	+ 17.9%
	Sub-demographic options included Orff approach; Dalcroze approach; Kodaly approach; Nordoff-Robbins music therapy; psychodynamic approach; behavioral approach; neurologic music therapy; other music-centered approach; none of the above; and other approaches.				
Q11: District Demographic	Rural	2	26.3%	43.5%	+ 17.2%
	Rural	3	48.7%	65.2%	+ 16.5%
	Sub-demographic options included rural; suburban; urban; and multiple school districts.				
Q13: Number of MTs in District	5+	6	68.4%	84.0%	+ 15.6%
	3	9	39.0%	63.2%	+ 24.2%
	2 3	10	30.7%	45.2% 57.9%	+ 14.5% **+ 27.2%**
	3	11	15.4%	47.4%	**+ 32.0%**
	2	12	42.1%	58.1%	+ 16.0%
	3	16	28.1%	48.0%	+ 19.9%
	Sub-demographic options included 1; 2; 3; 4; and 5+ music therapists.				
Q15: SPED Team Model	Not on SPED team	3	48.7%	22.9%	**- 25.8%**
	Not on SPED team Interdisciplinary Transdisciplinary	9	39.0%	8.3% 55.0% 69.2%	**- 30.7%** + 16.0% **+ 30.2%**
	Transdisciplinary	11	15.4%	38.5%	+ 23.1%
	Not on SPED team	12	42.1%	16.7%	**- 25.4%**
	Not on SPED team	13	29.0%	4.2%	- 24.8%
	Transdisciplinary Not on SPED team	16	28.1%	62.0% 8.0%	**+ 33.9%** - 20.1%
	Sub-demographic options included multidisciplinary; interdisciplinary; transdisciplinary; I do not work within the special education team; and other.				

(continued)

Table 6 (continued)

Question	Sub-Demographic (*SD*)	Model Choice (MC)	*OS* % for MC	*SD* % for MC	+/- (% of change)
Q16: Supervisor	*Insubstantial differences found between music therapist supervisor and model chosen.*				
	Sub-demographic options included another music therapist; SPED administrator; district administrator (non-SPED); a music educator; and other.				
Q17: How MT is listed on the IEP	MT not on IEP	3	48.7%	28.4%	- 20.3%
	Direct service			70.8%	+ 22.1%
	Indirect service			21.4%	**- 27.3%**
	Mix of direct/indirect	6	68.4%	83.6%	+ 15.2%
	MT not on IEP	9	39.0%	12.4%	**- 26.6%**
	Mix of direct/indirect			70.5%	**+ 31.5%**
	Indirect service	10	30.7%	7.1%	- 23.6%
	Mix of direct/indirect			55.7%	**+ 25.0%**
	Mix of direct/indirect	12	42.1%	62.3%	+ 20.2%
	Indirect service	14	28.1%	8.0%	- 20.1%
	Sub-demographic options included music therapy is not specified on the IEP's; as a direct service; as an indirect service; and a mixture of direct and indirect service.				

Sub-demographic model choices (SDMC) that demonstrated a percent of change from the original sample model choice (OSMC) of at least 25% are bolded for emphasis in Table 6. They are described below as "substantial" demographic, job characteristic, or caseload factors that may impact a music therapist's chosen model of service delivery. The term "substantial" was chosen by the researcher to apply to results at the level of +/- 25% change, though does not necessarily indicate *statistical significance* without additional forms of data analysis. The most substantial changes from OSMC to SDMC are described below by corresponding survey question:

Sub-demographic model choice (SDMC) by *number of years employed as a school music therapist* (Q2). Music therapists that had been employed for at least 20 years indicated that they chose to facilitate more inservices and workshops than the majority of school music therapists (+31.9%). Over half (60.0%) of music therapists with experience of over 20 years provided this model as at least part of their service delivery in their district. In comparison, music therapists who had practiced less than one year in their district were 23.1% *less* likely to provide this model than the majority of school music therapists.

SDMC by *region of employment* (Q5). Music therapists in the New England region were 30.0% more apt to provide direct services, outside of the general classroom, in small groups than the overall

sample of school music therapists. Also, music therapists in the Southwestern region were 30.1% more likely to provide consultation for individual students. While less substantially, the New England region was more likely than the general population to provide direct services—whether inside or outside of a general classroom, in small groups, or in self-contained SPED classrooms with the whole class. Overall, the three regions that differed most from the percent of the general population of school music therapists who chose each model were the New England, Great Lakes, and Southwestern regions.

SDMC by *additional certification held* (Q8). The music therapists who were also licensed or certified in special education tended to provide far more adaptive music education as a model of music therapy than the greater sample of school music therapists (+31.9%). This sub-demographic of music therapists was also somewhat more likely to provide inclusive (co-lead) services to a whole a general classroom (+21.4%) and collaborate with other school professionals (+17.9%). On the other hand, music therapists with music education certification or licensure were somewhat *less* likely to provide music therapy outside of the general classroom, as a direct service to individual students (-20.4%).

SDMC by *number of music therapists in the district* (Q13). In districts in which there were 3 music therapists employed, the music therapists were substantially more likely than the general sample to provide consultation—either for individual professionals (+27.2%), or for the whole program or department (+32.0%). For districts in which 5 or more music therapists were employed, music therapists were somewhat *more* likely to provide direct services to whole, self-contained SPED classrooms (+15.6%).

SDMC by *SPED team model* (Q15). There were more substantial differences between sub-demographics in Q15 than any other demographic question. In particular, music therapists that identify as "not on a SPED team" were substantially less likely to provide direct services, 1-on-1, outside of a general classroom (-25.8%); to provide consultation for individual students (-30.7%); or to collaborate with other school professionals (-25.4%). On the other end of the spectrum, those music therapists who were highly integrated in their SPED program and identified their team model as "transdisciplinary" were

substantially *more* likely than the general sample to provide consultation for individual students (+30.2%), and inservices and workshops (+33.9%).

SDMC by *how music therapy is listed on the IEP* (Q17). In districts where music therapy was "not listed on the IEP", music therapists reported that they were 26.6% less likely to provide consultation for individual students. If music therapy was listed as an "indirect service," music therapists were less likely to provide direct services, outside of the general classroom with an individual student (-27.3%). However, if music therapy was listed as a "mixture of direct and indirect services," music therapists were substantially more likely to provide consultation services for individual students (+31.5%) or for individual professionals (+25.0%).

SDMC found to be "less substantial" or "insubstantial" For a number of demographic, job characteristic, or caseload-related questions there were primarily differences from the OSMC to SDMC of between 15% and 24.9%. These differences were also included in Table 6 but were considered by the researcher to be "less substantial" than differences of 25% or greater from OSMC to SCMC described in the above paragraphs and bolded in Table 6. In particular, the researcher found "less substantial" differences between the OSMC and SDMC for sub-demographics related to: employer (Q3), whether the music therapists needed a teaching license (Q9), which approach(es) the music therapist found relevant to their practice (Q10), and district demographics (Q11). In addition, there were some survey questions where the differences between OSMC and SDMC were between 0%-14.9% and thus considered by the researcher to be "insubstantial." These included employment status (Q4), degree(s) earned (Q7), and supervisor (Q16).

Overall, results indicated that the most substantial relationships between a music therapist's chosen model of service delivery and their demographic, job, or caseload characteristics included: (a) number of years employed as a public school music therapist, (b) region of employment, (c) additional certification held by the music therapist, (d) number of music therapists in the district, (e) SPED team model, and (f) how music therapy is listed on the IEP.

Chapter 5

Discussion

Response Rate

In the present study, the researcher sent an online survey to board-certified music therapists working in public school settings to investigate and outline current trends in school-based music therapy, including the role of the therapist and models of service delivery. The researcher received a 65.2% completion rate of the eligible school music therapists who began the survey (n = 333) for a total of n = 217 completed, eligible responses. A number of respondents dropped out at each new page of the survey (typically between 11 and 43), though n = 302 music therapists answered at least some questions and were included in data analysis. The number of completed, eligible responses from comparable studies include McCormick's (1988) n = 54 of a potential N = 184 and Smith and Hairston's (1999) n = 138 of a potential N = 244. The response rate is difficult to compare to past school music therapy surveys, because previous researchers used a smaller sample of potential respondents; McCormick (1988) and Smith and Hairston (1999) sent surveys only to professionals that indicated that they worked in school settings, while the current study was sent to *all* board-certified music therapists. McCormick (1988) mentioned that it was a potential limitation to narrow the sample in this way; thus, the current survey was sent to a much larger sample pool of music therapists.

The CBMT informed the researcher that the number of current board-certified music therapists who had indicated a "practice setting" as public schools was 195 as of February, 2017, which is less than the total number of eligible responses completed in the current survey (n = 217). While the number provided by the CBMT would surely change over time and is only as accurate as self-reported by board-certified music therapists, one may surmise from this response rate (111.3% of the estimated respondent pool) that data gleaned from this study is well-representative of the population of school music therapists as a whole. Due to this high response rate, the researcher chose to refrain from sending follow-up reminders to complete the survey. There was a 57.3% increase in total number of responses from the last school music therapy survey (Smith & Hairston, 1999) to this current survey. The method of seeking

responses (emailed, electronic survey vs. mailed) and larger potential sample pool may have contributed to a higher number of responses, though there may also be a larger number of music therapists working in school settings.

The survey tool emailed to the music therapists consisted of 38 total questions, ranging over 5 main categories; including demographics, job characteristics, caseload characteristics and time allotment of job responsibilities, service delivery models and ability to make decisions, and decision variables. When possible, results were compared to those of previous surveys and the current review of literature (Chapter 2). The following discussion of findings is organized by (a) research question and (b) survey page category. Suggestions for future research are provided within each category and summarized later in this chapter. Furthermore, study limitations, delimitations, assumptions, and implications for clinical work and training are discussed.

Discussion of Results

Q1: Demographic, job, and caseload characteristics of music therapists in public school settings.

Demographics (Q1-Q8): Training, certification, and employment. The participating school music therapists represented a range of regional associations and background experiences. Some demographic data were similar with what one might predict based upon a recent music therapy workforce analysis (AMTA, 2016). For example, the largest regional representations, as included in Appendix C, were the Great Lakes, Mid-Atlantic, and Southwestern regions. The AMTA workforce analysis indicated Great Lakes, Mid-Atlantic, and Midwestern regions, so there was slightly higher representation than predicted from the Southwestern region. Overall, the sample was fairly balanced as a representation of the larger music therapy community of music therapists from the United States. Additional demographic information such as age, gender, and ethnicity were not surveyed and were not delimitations of the present study.

Training. Most responding school music therapists received bachelor's degrees in music therapy (n = 204), though 49.0% had received a master's degree or master's equivalency, compared to 40.1% of

all music therapists that responded to the 2016 AMTA workforce survey. Nearly a third (30.8%) of school music therapists indicated having completed a master's in music therapy specifically. In 1998, Jones and Cardinal found that only 34.7% of music therapists working with individuals with disabilities had earned a master's degree in any field—indicating an increase of 14.3% in graduate education. In the future, researchers may consider potential factors leading to the increase in percentage of graduate degrees earned, as well as how this number compares to the percentage of graduate degrees earned (or required) by other related service professionals working in school settings or music therapists working in other settings (i.e. music therapists who work in medical or private practice).

One component of demographic data of particular interest to the researcher was that 27.5% (n = 83) of music therapists in schools were also trained as special, general, or music educators. Of all participating music therapists, 13.5% (n = 35) were *required* to have this dual certification. Comparatively, McCormick (1988) noted that about 50% of states surveyed required teacher certification in addition to music therapy credentials, and Smith and Hairston (1999) found that 51% of respondents had a teaching degree—which was "slightly higher" than the number of respondents required to have the additional training. It appears that the dual certification trend and requirement is decreasing, but over a quarter of school music therapists still maintained dual certification in 2017. Because the option to double major in music education and music therapy is not possible at some universities, perhaps a master's equivalency degree (to obtain the second degree/license/qualification) is encouraged or required for many music therapists working in schools. Future researchers may wish to investigate whether dual certification is common for other related service professionals. Could the amount of schooling for those districts that require or encourage dual certification deter future music therapists from entering school practice settings?

Certification. Nearly a quarter (24.2%) of music therapists indicated that they held additional certifications *other than* music therapy board-certified or a teaching credential or certification (whether in music, special, or general education). In some cases, this might have been due to the recent increase in music therapy state licensure. In other cases, certification may be related to population served or even

educational background. For example, the 18 music therapists who denoted certification in Neurologic Music Therapy (NMT) may have been trained at a university program that emphasized this approach to music therapy. Perhaps some music therapists find it easier to locate jobs with a particular training, or perhaps they feel that specific training is necessary for best-practice with their given caseload characteristics. Future researchers may want to explore why music therapists have additional certifications in these areas. Do clinicians find the additional training required for their work in schools, encouraged by their educational program or internship, related to personal characteristics or interests, or determined by other factors? Researchers may also explore how these certifications impact work in special education settings, if at all

Employment. In the present study, most music therapists indicated that they worked part-time in public school settings (56.0%), while 44.0% are employed full-time. Interestingly, previous school music therapy surveys indicate the reverse results: Smith and Hairston (1999) found that a 60% majority of music therapists worked full-time and, prior to that, McCormick (1988) noted that 75% were employed full-time as school music therapists. Future researchers may inquire as to why full-time employment has decreased in favor of part-time employment in schools by nearly 15% per decade. Are music therapists choosing, instead, to work in multiple settings with diverse populations? Or contracting more through private practices or agencies? Or are school districts unwilling to hire full-time music therapists due to budgeting factors (i.e., benefits) or perceived need? These possibilities are explored below as possible variables that impact service delivery.

In 1999, Smith and Hairston found school systems to be the most common employer of participants (52.9%). Results of the current study, however, indicated that employers were more varied: many were hired as an employee of a school district (36.8%); or by an agency, company, or private practice (29.1% as compared to 11.6% in 1999); or contracted independently to school districts (23.8% as compared to 24.6% in 1999). Smith and Hairston (1999) also differentiated employer by full-time and part-time, which was not distinguished in the current study. Previous researchers recommended future examination of whether inclusive trends affect employer categories such as agency-based or district

employee (Jones & Cardinal, 1998; Smith & Hairston, 1999). Isolating the effect of a trend such as inclusion might be difficult due to a number of other factors that may affect practice in schools (i.e. budgeting, student needs, attitudes toward music therapy, etc.). Future researchers may investigate *which* variables have impacted shifts in school music therapy employment trends.

The majority of music therapists had worked between either one and four years (40.4%) or five and nine years (16.2%). Presumably, then, most participating school music therapists began working after the most recent survey of school music therapist demographics (Smith & Hairston, 1999). Only 10.9% had worked for over a decade in schools. The fact that most music therapists had practiced in schools for less than a decade may account for some overall differences between school music therapy in 1988, as surveyed by McCormick, and school music therapy in 2017. As a comparison, Jones and Cardinal (1998) found that most music therapists had worked in their positions with individuals with disabilities for an average of 10.3 years, and Smith and Hairston (1999) found that many had worked over 8 years (33.0%). While these data are somewhat difficult to compare due to the difference in categorical options within each survey design, future research may be warranted as to whether school music therapists are leaving the field or switching to another music therapy work setting sooner and, if so, why? On the other hand, the researcher found that many school music therapists working in 2017 had graduated in the past few years—with a graduation year mode of 2013 (n = 33) and median of 2010. The seemingly shorter length of practice represented in the survey data may be related, then, to an increasing number of new clinicians entering the school music therapy field. Other possible factors may include positive variables such as increased job opportunities around the country, or more negative variables such as burnout and turnover. Variables related to length of practice in schools may be a worthwhile area for future research.

Job characteristics (Q9-Q13, Q29, Q32): District overview, music therapist job characteristics, and hourly distribution of weekly job tasks.

District overview. No previous school music therapy surveys have investigated the demographic make-up of the school districts in which music therapists provide services. Perhaps unsurprisingly, the highest number of music therapists work in suburban school districts (39.8%), followed by "multiple

districts" (30.1%)- which may include mixed classifications of suburban, rural, or urban. Only 10.0% of music therapists work in rural school districts, which may be due to factors such as unrealistic travel time between schools and financial allocation. Some music therapists wrote supporting comments on Q38 such as "in other rural districts in which I used to work, music therapy services were decreased because of funding" and "it is much more difficult in larger districts with a larger number of students, schools, travel issues, and time constraints." An unfortunate reality one may surmise, then, is that few students in rural and urban districts have accessibility to music therapy assessment and services. Innovative models of music therapy to reach these districts may be an area for future research. Could web-based consultation, for example, or regular inservices be an option for rural teachers that wish to incorporate music techniques within their students' curriculum?

Music therapist job characteristics. Previous researchers found that an average of 2.6 music therapists were employed in each district represented in the survey participant pool (Smith & Hairston, 1999). While the researcher in the present study did not ask for an exact number and, thus, an average is not calculable—the majority of respondents worked alone (39.0%), and many responded "multiple districts" (22.8%) which may mean a different number of music therapists in each district. Unfortunately, some music therapists commented on Q38 that that the number of music therapists in their district has recently decreased. For instance, one music therapist noted "currently we are down to two music therapists in our district… and in May we will be down to one"—citing changes in state taxes as a contributing factor.

The majority of music therapists find that either a behavioral approach to music therapy, Neurologic Music Therapy, or a Nordoff-Robbins Music Therapy approach are most relevant to their jobs as music therapists. This is perhaps unsurprising, as many university programs that offer music therapy degrees have been traditionally associated with one of these approaches—which may depend on factors such as the area of the country or faculty philosophical orientation. As one may have anticipated, more than half (54.4%) of participants who indicated that they had a school-based practicum or internship (70.2% of all participants) provided services in the same model as in their previous clinical training.

These same data, however, indicate that approximately 30% of school music therapists were not trained in school settings—neither in practicum nor internship. How does this compare to training for school OT's, SLP's, or PT's? Additional characteristics of the music therapist were not a consideration of this study, nor within previous school music therapy studies, but may be fruitful for additional research in future studies.

Hourly distribution of weekly job tasks. Overall, participants indicated that there are multiple variations to a "typical" given work week. Twenty-three participants wrote in additional "other" tasks of great variety (see Table 1). Perhaps unsurprisingly, the largest portion of the school music therapy work week was spent providing direct services (22.3% indicated "20+ hours" and 21.0% indicated "10-14 hours"). The researcher was surprised, however, that most music therapists spent less than an hour per week co-planning or co-leading (collaboration), and providing indirect services (consultation)—particularly since 42.1% indicated on Q30 that they collaborate with other school professionals, and 39.0% provide consultation for individual students as a model of music therapy. Also, many music therapists are spending a great deal of time traveling; 4-6 hours (indicated by nearly a quarter of respondents) would be around 13.3% - 20% of a 30-hour work week (the minimal length considered "full time" in the current study). Fewer music therapists spent the same amount of time on documentation (19.2%)—and most only spend 1-3 hours per week on documentation (such as taking data, progress reporting, or writing assessments). Results in Table 1 provide additional insight to supplement *which* service provision model(s) music therapists are implementing (research question 2, discussed below) by also indicating *how much* of services within different models music therapists are providing in a given week.

While the hourly distributions of job tasks for participants were not divided by part-time vs. full-time school music therapists, this may be of interest to future researchers. If asking this question again in a future study, the researcher might ask the participants to estimate what approximate percentage of their total time in schools per week was spent on each task—rather than how many hours total—as this may be a more interesting, and likely accurate, way of viewing the data that is subsequently comparable between

part-time and full-time employees. This will also align more closely to previous studies, since Smith and Hairston (1999) presented data as percentages of a work week rather than an hourly distribution.

Caseload characteristics (Q14-28): Student caseload; administrative characteristics; number, length, and frequency of sessions; collaboration and consultation with other professionals.

Student caseload. McCormick (1988) found that most music therapists served a caseload of 50-200 students per week, often in groups of 5-10 students, at an interval of twice weekly. Jones and Cardinal (1998) discovered a caseload average of 66.7 students per week, and Smith and Hairston (1999) found an average of 75 students per week. Similar to findings of Smith and Hairston's study, the average caseload for music therapists in 2017 was 76, but ranged from 0-1,000 students and with a mode of 30. Music therapists in 2017 saw students most commonly in small group (73.9%) or 1-on-1 settings (68.7%), once weekly for 30 minutes. The average caseload has slightly increased since most recent surveys but, more notably, the frequency of service has decreased from 2-3 times per week (McCormick, 1988), to once per week for over half of all 1-on-1 and small group sessions in this current study. What has contributed to this decreased frequency? Music therapists were asked in this study whether they felt they were able to provide music therapy in the chosen model(s), for the amount of time, and in the location necessary for student progress (Q36a-c)—but were not asked whether they could provide services at the appropriate *frequency* or, if not, possible contributing factors to session frequency. This could be an additional focus for future research.

Administrative characteristics. Within special education department teams, music therapists worked mostly within a multidisciplinary approach (35.1%)—defined in the attached survey as "team members acknowledge importance of contributions from several disciplines and services remain independent…members exchange information about independent work, conduct assessments in separate environments…. and develop separate plans for intervention within their discipline" (Friend & Cook, 2012, p. 146). Interaction within this approach may be isolating for music therapists- as this is the least collaborative SPED team model. Supervision of music therapists has changed over time as well. While McCormick (1988) found principals or assistant principals to be the most common employers, school

music therapists in 2017 were supervised by SPED administrators (46.0%) or, sometimes, another music therapist (24.3%). This may be directly related to the increase in inclusive practices; the principal supervisors in the 1988 study may have overseen separate schools for children with disabilities, whereas SPED administrators today may oversee multiple special services in the various school campuses that a music therapist may visit. Future researchers may investigate whether this change in employer has had any impact on the day-to-day job responsibilities or role of the therapist within the special education team.

The researcher found interesting results related to how music therapy was specified within student IEP's. While no previous school music therapy surveys had addressed this topic, the researcher predicted—based on most recent music therapy literature on how to conduct assessments in public schools and include music therapy on the IEP (Brunk & Coleman, 2002; Pellitteri, 2000; Ritter-Cantesanu, 2014)—that music therapy would be commonly listed as a direct service. Results indicated, however, that only 32.8% list music therapy as a "direct service." Nearly a third of music therapists do not specify their services on student IEP's at all and some list services as a "mixture of direct and indirect services" (26.6%). Very few music therapist list services as "indirect service" only—perhaps because some districts may not list any consultation and programmatic services in IEPs.

Future research studies could explore the topic of music therapy and the IEP at much greater depth. For the music therapists who list services in IEPs, *how* is music therapy described in the document? Are music therapists included in the process of writing or updating the IEP? Is the student's music therapist listed as one of their IEP team members? If so, how? (i.e. As a "music therapist," "adaptive music specialist," or "music therapy consultant"?). What types of goals are music therapists including in the IEP's—are they written by the music therapist or is the MT co-implementing the pre-existing academic goals? Would music therapists who are *not* listed in IEP's prefer to be included on the IEP? One music therapist indicated as such on survey Q38: "When the music therapist is on the IEP, then they are a more vital part of the SPED team and are less likely to be cut." The researcher is currently

engaged in a qualitative follow-up study (described below) to explore some of these questions in depth regarding music therapy and the IEP.

Number, length, and frequency of sessions. Most music therapists who participated in the current survey facilitated small group sessions (73.9%), which aligns with previous survey data (McCormick, 1988). For all group size survey options—1-on-1, small group, or whole classroom—the majority of music therapists indicated that they provided one to four sessions of each model per week. Many music therapists also saw students 1-on-1, and the sessions were most typically once per week for up to 30 minutes—less frequently than in McCormick's previous (1988) study. Therapists facilitated small group and whole classroom sessions at this same frequency and length (once a week for 20-30 minutes), though more music therapists commented "biweekly" for 1-on-1 sessions than group sessions.

Despite the seemingly "blanket" response of "once per week for approximately 30 minutes," regardless of group size (which aligns with findings regarding SLP service delivery reported by Brandel and Frome Loeb, 2011), 71.4% of music therapists agreed or strongly agreed that they provided music therapy for the *amount of time* necessary to meet student outcomes (Q36b). Though survey respondents indicated a number of variables contributing to different *models* of music therapy (such as individual student need), it seems that perhaps the frequency and length of music therapy sessions is more "typical" across the board. Should school music therapists, however, be "dosing" services more specifically to the individual student need? Is "once per week for approximately 30 minutes" the appropriate length and frequency for most students to truly make progress- or would more frequent sessions contribute to more effective growth toward goals? Would there be differences in length and frequency of services across student age categories (i.e. elementary vs. secondary)? Future researchers may wish to pursue these questions and reference Brandel and Frome Loeb's (2011) study as a guide for investigating decision-making factors related to length and frequency of sessions in schools.

Collaboration and consultation with other professionals. The researcher found it unsurprising that most music therapists collaborated frequently with special educators, paraprofessionals, and other related service providers—since these may be the individuals who interact most closely with students on a

music therapist's caseload. One interesting result, however, was that music therapists who worked with general educators and music educators provided more *consultation* than collaboration. Previous researchers discussed the benefits of collaborating with *music* educators and that music therapists are looking for opportunities to collaborate and consult with other music specialists (Darrow, 1999; Jellison & Draper, 2015; VanWeelden & Whipple, 2014), though current survey results indicated that less than half (40.3%) of all music therapists were consulting or collaborating with music educators—and of this sub-group, most provided consultation (76.9%). Music therapy clinicians may benefit from reviewing the list of "other" responses to Q28 to determine whether there are additional professionals with whom they could collaborate or consult for a potentially more effective, interdisciplinary approach to meeting student needs. Future researchers may also investigate the *nature* of the consultation or collaboration with other professionals, to help provide clinicians additional answers as to *how* these services are provided- since they involve learned and practiced skills (Friend & Cook, 2012).

Table 7

Comparison to Previous School Music Therapy Survey Findings

Question Category	McCormick (1988)	Jones & Cardinal (1998)	Smith & Hairston (1999)	Current Study- Gillespie (2017)
Sample pool	NAMT members who listed workplace as "school settings"	NAMT members who listed population as "individuals with disabilities"	NAMT members who listed workplace as "school settings"	All CBMT members who indicated willingness to receive emails (no workplace or population specified)
N	54	373	138	333 partial, 217 complete
Regions (highest representation)	Great Lakes (41%), Southwest (20%), Mid-Atlantic/ Southeast (13%)			Great Lakes (22.9%), Mid-Atlantic (20.9%), Southeastern (13.9%)
State Representation	Minnesota (19%), Texas (15%), Michigan (9%)		Highest numbers are Texas, Minnesota, and Michigan	
Degree(s) earned		***Highest Degree:*** Bachelor's (63.8%), master's degree (34.7%) and doctorate (1.6%)		***All That Apply:*** Bachelor's in MT (67.6%), master's degree-any (49%), doctorate (2%), "Other" (21.2%)

Table 7 (continued)

Question Category	McCormick (1988)	Jones & Cardinal (1998)	Smith & Hairston (1999)	Current Study- Gillespie (2017)
Years employed as an MT in schools		10.3 years average	>8 years (33%), 1-3 years (33%), 4-8 years (25%), <1 year (9%)	1-4 years (40.4%), 5-9 years (16.2%), 10-14 years (10.9%)
Teaching certification obtained vs. required	Obtained: N/A Required: "In about 50% of states surveyed"		Obtained: Yes (51%) Required: "Slightly" less than obtained	Obtained: Yes (27.5%) Required: 13.5% of those obtained
Supervisor	Principal or Assistant Principal (41%), Director of Exceptional Education (24%)			SPED Administrator (46.0%), another music therapist (24.3%)
Employment %	Full-time (75%), part-time (15%) or contract (12%)		Full-time (60%), part-time (40%)	Part-time (56.0%), full-time (44.0%)
Employer			School (41%), self-employed (19%), agency (9%)	School district (36.8%), agency (29.1%), self-employed/independent contractor (23.8%)
Number of MT's			Average of 2.6	1 (39.0%), "Multiple Districts" (22.8%), 2 (14.7%), 5 or more (10.8%)
Job description/ Hourly distribution	***Included in job description:*** Direct services (87%), developing goals/obj (74%), planning IEP's (70%), documenting progress (69%), worked as a music educator with 'normal' students (28%), consultant or specialist responsibilities (4%)		***Percentage of total work week:*** Direct service delivery (62%), travel (18%), documentation (14%), consultation (13%), preparation (11%)	***Hourly distribution:*** *(See Table 1 for more)* On average, ≥20 hours of direct services; 1-3 hours of planning, documentation, and travel; <1 hour of assessments, co-planning, co-leading, indirect services (consultation), IEP meetings, etc.
Caseload	50-200 per week (72%)	Average of 66.7 per week	Average of 75 per week	Average of 76 Range: 0-1,000 Mode: 30 Common range: 0-24 (33.7%)

Table 7 (continued)

Question Category	McCormick (1988)	Jones & Cardinal (1998)	Smith & Hairston (1999)	Current Study- Gillespie (2017)
Group size	Groups of 5-10 (67%)			Small groups (73.9%), 1-on-1 (68.7%), inclusive whole class (66.7%)
Location		Institutional (40%), SPED classroom or office on SPED campus (28%), SPED classroom on general campus (15.1%), other such as pull-out (7.9%), inclusive (2.1%)		***Noted as "model:"*** Direct in self-contained SPED classroom, whole class (68.4%); Direct, outside general classroom 1-on-1 (48.7%); *see Table 3 for others*
Frequency	Twice weekly (52%), once weekly (33%), or three times per week (24%)			***Once weekly for each:*** 1-on-1 (55.3%), small group (58.1%), whole class (47.2%)
Models noted			Direct services (93%), Some consultation (40%)	Direct services *(see Table 3- noted by model AND location)*; collaboration with other school professionals (42.1%)
Other survey information obtained	How job was obtained, amount of parent contact, student diagnoses, who refers, frequent goal areas, musical interventions or 'procedures' used	Number of SPED courses taken, more specific information regarding attitudes of MT's toward inclusion benefits and negatives	More comparisons of demographic-to-demographic data (i.e. employment % and employer), populations served, association membership, internship at site	Individuals with whom MT's collaborate/consult, relevance of variables on model of MT, additional training, relevant approaches, district demographics, number of students receiving SPED services, SPED team model, music therapy and the IEP, relationship between internship and practice, more specific caseload characteristics (number, length, and frequency for each group size), attitudes regarding therapist ability to make decisions

Q2: Most Common Service Delivery Models of Music Therapy in Public School Settings.

Results of the current survey indicate that the most common service delivery model in which music therapists practice is a direct service to whole, self-contained special education classrooms (68.4%). While the researcher predicted direct services to be most common, the setting of self-contained special education classrooms was surprising given the amount of literature reviewed that referenced increasing inclusive practices both in music therapy and related special education literature (Jones & Cardinal, 1998; Wilson, 2002; Turnbull, et al. 2013). In contrast, the next two highest results for model of music therapy were more predictable; one based on traditional models of music therapy ("direct services outside a general classroom, 1-on-1"—or the "pull-out" model), and the other as a model which could be considered a component of general "good practice" in any field ("collaboration with other school professionals"). Other common models that stood out to the researcher included "consultation for individual students" (39.0%)—a model that is infrequently referenced in music therapy literature and, perhaps, deserves more attention if more than a third of music therapists operated within this model; consultation for individual professionals (30.7%), which is outlined by Rickson (2010-2012) but not in music therapy literature published within the United States; and inservices and workshops (28.1%), which have not been described in school music therapy literature for over a decade (Culton, 2002; Johnson, 2002).

Previous researchers indicated that music therapy is evolving to more inclusive models of service delivery to align with changes in special education (Johnson, 2002; Jones & Cardinal, 1999; Smith & Hairston, 1999; Skewes McFerran & Rickson, 2014a, 2014b). Smith and Hairston stated that "inclusive practices are the latest impetus for change in music therapy conducted in school settings" (p. 275). Results of the current study, however, indicated little change toward inclusive music therapy practices. Jones and Cardinal (1998) found that nearly 90% of the 373 respondents served students in "segregated settings" such as institutions, or a separate SPED classroom on a SPED campus—with as few as 2.1% of respondents serving students inclusively in general classrooms. In the current study, only 5.3%- 26.3% of music therapists indicated that they practiced within the general classroom—either as a direct service or

whole-class, inclusive service—and only 15.8% of music therapists led inclusive music therapy groups in general classrooms. The researcher acknowledges, however, that the term "inclusion" itself could have multiple definitions—as some schools may consider an "inclusive" model to be outside the general classroom and in a specific SPED classroom (or "center-based classroom"), where typically developing peers push-in to support social and academic goals. Future researchers should be careful to provide a definition for an "inclusive" classroom, but also allow participants to describe variations in their districts to avoid confusion or skewed results.

Another interesting result is related to changes in consultation practices found in the current study. Rickson (2010) wrote that collaboration and consultation models are increasing—which may not be indicated by current data. Smith and Hairston (1999) found that nearly 41% of music therapists were engaged in consultation, while the current survey results indicate that between 15.4%-39.0% of music therapists provide consultation for either a whole program, individual professionals, or individual students. This would indicate a slight *decline* in consultative models of service delivery in music therapy. What might be the reason for this decline? Might it be related to the limited number of resources as to *how* to provide effective music therapy consultation in schools in recent years? Or the limited time spent on consultation as a model in school music therapy literature? Are music therapists remaining flexible to additional service delivery options such as consultation, or resistant to changes in models? Also, do music therapists graduate with the skills to provide consultation, or might additional training be warranted as indicated in previous literature (Dunn, 1988; Johnson, 2002; Law et al., 2002; Rickson, 2010)? One survey respondent articulated this concern in response to Q38, stating that "[Consultation] can be "difficult for many MTs to navigate, especially new graduates, because our educational focus is on direct services. I don't think the average MT graduate receives music education in the area of consultation models or what that looks like in practice."

Q3: Music Therapists' Ability to Decide Service Delivery Model(s). Most music therapists indicated that they were able to decide the model(s) of music therapy provided in their district (73.7%), which was more than predicted by the researcher. At least five music therapists provided follow-up

comments on Q38 that stressed their ability to make decisions and described feelings of district support. Statements included: "we have full support from administration (which is wonderful);" "the center is supportive of my choices;" "I get to determine almost everything about who participates, what models are used and how to engage educators…;" and "we are not tied to any laws or regulations or funding… music therapy is a service our district values and supports."

Based on the review of literature and personal experiences in school settings, the researcher predicted that the district model(s) would be tied to administrative decisions rather than music therapist choice. Administrator influence was one of the common themes, however, in the response follow-up to the selection of "sometimes" the most common response of those that were not able to decide service delivery model(s) was related to funding. Related responses on Q38 included "I think many school districts would like a consultation model as often as possible due to finances and LRE," "one of the reasons I have maintained the 1:1 direct service model is SPED funding," and "previous districts that I have worked with wanted to move to a consultation-based model."

Another surprising, encouraging result is that music therapists were not only *able* to decide the model(s) provided, but tended to "agree" that they are able to provide services in the *best model* for achieving student goals—implying that music therapists feel the most common models of music therapy as listed above are also potentially the most effective for student outcomes. With that in mind, future researchers may wish to follow-up on the results that music therapists mostly "neither agree nor disagree" or "disagree" that they are able to provide services for the *amount of time* necessary and in the *location* necessary for student progress. Would they provide services at a longer duration dosage and, if so, how long? What factors might influence the length of time they feel necessary? Where would they provide services, if they could choose an ideal school location? One respondent spoke to this question in response to Q38—stating the setting "significantly impacted the quality of services" and "the most difficult variable for me was the setting… I found it frustrating when I was forced to provide group services in the classroom when 1:1 in a quieter environment would have been more appropriate and vice versa."

Q4a: Variables that Influence Service Delivery Model(s).

The researcher discusses which therapist, student, and workplace variables that music therapists considered most relevant toward a preference or decision to deliver services within a particular model and includes "other" responses that may be considered in future research. Figure 1, below, presents variables considered by participants to be most relevant in a conceptual model adapted from Brandel and Frome-Loeb's (2001) SIDM model of decision-making variables indicated by school SLPs.

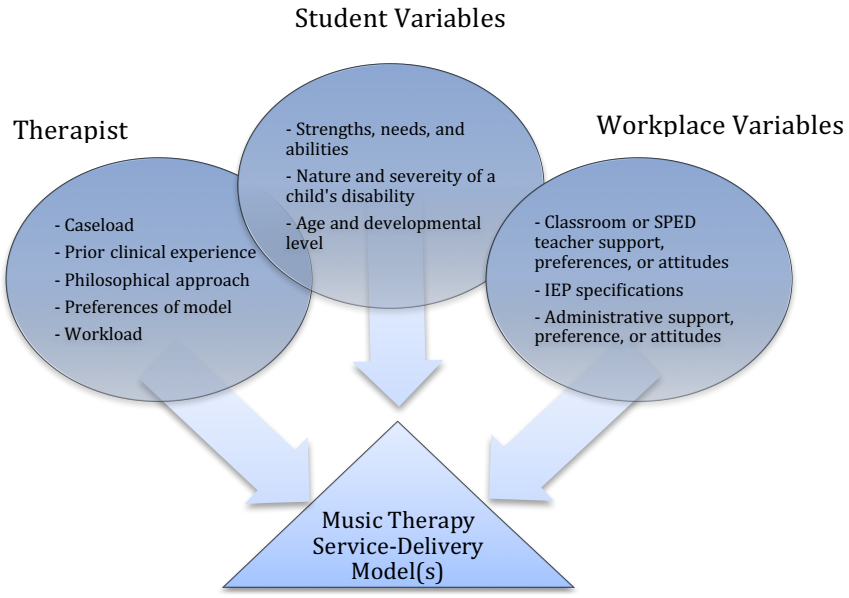

Figure 1. School music therapy service delivery variables model (SMT-SDVM). This figure is adapted from Brandel and Frome-Loeb's (2011) *School-based intervention decision-making model (SIDM)* for speech-language pathologists (pg. 462). The top 3-5 variables were chosen based on percentage of music therapists who chose "relevant" or "highly relevant" for the variable. Thus, the figure demonstrates the "most relevant" variables (or potential combination of variables from therapist, student, and workplace categories) that impact a chosen music therapy service-delivery models(s), as indicated by participating school music therapists. For more complete results, see Table 4.

Therapist variables. More than half of music therapists (at least 67%) agreed all *therapist variables* listed in the survey tool were relevant or highly relevant to a choice of model(s) of music therapy, other than "part-time vs. full-time" status in public schools. While the most relevant variables are highlighted in Figure 1, the sub-group percentage that chose each response was relatively similar. Themes within "other" responses to this question indicate that music therapists felt there were additional, *personal*

factors of the therapist that impacted the model of music therapy (see Table 4), which should be included as options if this survey tool is to be adapted and used in future research. Qualitative responses to follow-up Q38 highlight therapist variables such as education ("this can be difficult for many music therapists to navigate, especially new graduates."), therapist effectiveness ("I think that the quality, effectiveness and professional level of services being delivered in schools varies widely…"), employment status ("when multiple music therapists are part-time employed and not by the district itself, this does not always benefit the students or therapists"), and therapist preference ("[regarding consultation], I don't like it and I feel like we are allowing music teachers to pretend like they can do what we do").

At least two music therapists indicated that they did not understand this question or had concerns about the question wording—which should be a consideration for future researchers. Definitions or examples of each music therapy model before listing variables may have helped clarify differences between each model. Additionally, the question may not have been relevant for those who are not *able* to decide the model of music therapy in their district. These considerations should also be applied to questions related to student and workplace variables (Q34-35), since these questions were designed in the same format on the survey tool. Additional considerations for adapting the survey tool will be described below in a summary of suggestions for future research.

Student variables. At least 80% of music therapists found all student variables listed in the survey to be "relevant" or "highly relevant" as related to the choice of service delivery model(s). When comparing the lowest percentage in each variable column for all student, therapist, and workplace variables (see Table 4), one might presume that music therapists feel that *student variables* are more relevant to service-delivery models, overall, than therapist and workplace variables. All but twelve (n = 210) music therapists found the strengths, needs, and abilities of the student to be "relevant" or "highly relevant." Music therapists listed "other" considerations related to student scheduling logistics and "distractibility for other students"—which could potentially overlap with workplace variables (which is why these categories overlap in the Venn diagram format of Figure 1 below). On follow-up Q38, music therapists noted additional student variables such as the student's environment ("both social and

educational goals are easily derailed through distraction and perceived stigma [of classroom inclusion]") and student need vs. benefit ("there is a greater need for evaluations done by music therapists on whether or not a student should receive music therapy in school to be closely scrutinized"; and "[therapists] must show how the student is not making the expected progress in order to consider adding music therapy, even if it would be beneficial").

Workplace variables. Based on prior research within the review of literature (Ropp et al, 2006), the researcher predicted that administrative factors might be one of the most influential variables that affects service delivery model(s). Indeed, music therapists reported that "administrative support, preference, or attitudes" was the 3rd "most relevant" workplace variable (79.2% of music therapists found this variable relevant). "Classroom or SPED teacher support, preferences, or attitudes," however, was the *most* relevant workplace model from the list of variable options provided in the survey. If administrator and teacher relationships are negatively impacting the ability to choose a certain model, how do music therapists learn to navigate these relationships and advocate for most appropriate service delivery? The third most relevant variable chosen by participants was "IEP specifications," which was described in more detail on qualitative responses to the last survey question, Q38. Overall, more follow-up responses to Q38 related to workplace variables than therapist or student variables. Therefore, the researcher will list those responses that highlight the relevance of particular workplace variables, arranged by the three "most relevant" workplace variables listed as options on the survey:

Administrative support, preference, or attitudes.

- "For some of [the districts I serve], it has been challenging, even with data and observations, to make administrators see what we do is relevant and valuable."
- "Politics within the school's administration play a big role in services."
- "Administrators… will come up with many reasons why a student doesn't need music therapy on their IEP."
- "My school calls it adapted music. They don't want me calling what I do music therapy."
- "I am listed as a music educator… this is because the district will not fund music therapy."
- "The admin and [special education] higher ups don't like to refer to what I do as music therapy."
- "Building rapport with special ed administrators, classroom teachers, and other related service personnel is vital..."

Classroom or SPED teacher support, preferences, or attitudes.

- "The biggest misconception I dealt with was that music therapy was 'music time' instead of therapy."
- "When mentioning adding music therapy to a child's IEP, parents, educators, and other professionals… often scoff at the idea and write off MT as ineffective and strictly fun…"
- "It's about pleasing the teachers."
- "It has been difficult to collaborate with other professionals and establish a music therapy program that my colleagues acknowledge."

IEP specifications.

- "When the MT is on the IEP, then they are a more vital part of the SPED team and are less likely to be cut."
- "I inherited a caseload where it seems that music therapy was deemed an appropriate service because the students enjoyed music."
- "It has been difficult in my district to obtain services for students that need them… many students who should be receiving services are discouraged from asking for an assessment… the school district is resistant to paying for services it does not want."
- "[I] think there is a greater need for evaluations done by music therapists on whether or not a student should receive music therapy in school to be more closely scrutinized."

Results also highlight an additional workplace variable—finances, which 52.0% of music therapists found relevant or highly relevant in the survey, but many (n = 16) chose to highlight in follow-up survey comments (Q38). Considering this number of comments, future researchers may investigate the full impact of this variable. Overall, music therapists noted that services are being cut in smaller or more rural districts and administrators are asking some therapists to move to more consultative models as a means of cost-effectiveness. In some districts, music therapists are losing jobs; in others, administrators are discouraging them from assessing students for eligibility due to funding concerns. Multiple previous studies mention that cost-effectiveness is a factor in determining models (Brownell, Weldon-Stephens, & Lazar, 2002; Pellitteri, 2000; Rickson 2012; Ropp et al., 2006), which seems to be confirmed by a combination of quantitative survey data and qualitative follow-up comments such as the following:

Finances.

- "This is the first time music therapy has been paid for in this area… right now there is only funding available to [provide services] to 3 schools at a time."
- "One of the reasons I have maintained the 1:1 direct service model is SPED funding. If an MT is only providing consultation to the classroom, then their services can be seen as unnecessary when a district is looking at funding cuts."
- "We provide music therapy through grant funding… therefore, we must provide services to a larger number of kids in a shorter amount of time."
- "I think many school districts would like a consultation model as often as possible due to finances, LRE, etc."

- "I've received a lot of resistance to include music therapy as a service for students because of the school's ability to pay for the service."
- "The reason I stopped seeing students as a direct service is because financially it didn't make sense to drive from school to school for 30 minutes per school at a time."
- "In other rural districts in which I used to work, music therapy services were cut because of funding."
- "… Teachers have applied for grant funding to keep the group going and we are waiting to hear back…"
- "Our district offers both IEP services and programmatic services as part of their day depending on need and if the school purchases the programmatic service."
- "Music therapy in public school settings would be more common, more sought-out if the districts could bill… for services as they do for OT, PT, ST, etc… Our state task forces are working to address things like this…"

Laws, mandates, and trends. Beyond therapist, student, and workplace variables that may impact a chosen service delivery model, the researcher predicted that service delivery may also be impacted by recent changes in overarching laws, mandates, and trends. However, school music therapists did not seem to have strong agreement or disagreement as to whether recent laws and mandates impact their model(s) of music therapy (35.0% specified "neither agree nor disagree"). In fact, slightly more music therapists "strongly disagree" (10.1%) than "strongly agree" (8.8%) about the impact of these factors. Based on the amount of attention on the subject in music therapy, other related services, and special education, the researcher predicted that the survey participants would agree with the statement in question (Q36d). The majority of respondents (53.9%) chose that inclusion has impacted their model(s) of service delivery—though participants could choose more than one survey option. This is supported by responses to Q38 such as "it can be a balancing act of bridging music therapy practice with Common Core expectations" and "the push for inclusion of all students may impact our model."

The researcher acknowledges that there was some inherent question bias on Q37, regarding laws, due to the lack of a "none" option (and requirement in SurveyMonkey that respondents choose at least one option). Many music therapists wrote "none" in the box for "other" responses (n = 31) and others wrote "unknown" (n = 8). Despite this survey flaw, the researcher noted that at least 40 music therapists chose each of the four articulated options—potentially indicating that the laws and trends highlighted in Q37 and the review of literature have at least some impact on service delivery models of music therapy.

Future researchers could seek to determine the level and nature of impact, or attitudes toward certain laws and mandates which would also support previous survey research by Jones and Cardinal (1998). Because of the complexity of factors related to laws and education—including potential differences by state, the researcher recommends a qualitative approach to investigating and analyzing research in this area.

Q4b: Relationships Between a Music Therapist's Characteristics and Model(s) of Service Delivery.

No studies to date have examined relationships between music therapist demographic characteristics and clinical decisions in school music therapy. While the researcher chose to look at the impact of certain pre-determined demographic characteristics on a therapist's chosen service-delivery model for the purposes of this study, many additional characteristics could and should be considered and researched perhaps in a qualitative format. For example, the researcher discussed in the review of literature that the music therapist's gender, race, political orientation, personality traits, etc. could impact service delivery. The researcher did not survey participants for these demographic characteristics—partially to minimize the length of the survey and to better align with previous research. Additional music therapist characteristics should be considered and perhaps surveyed in future studies to more fully capture this complex topic.

After comparing the results of music therapist demographic characteristics and model(s) of service delivery, and looking for relationships that emerged in the data, many sub-demographic model choices (SDMC) supported researcher predictions for this study based on review of the literature. Due to the "expert" role that the music therapist must take on to provide inservices and workshops, it is perhaps predictable that music therapists with more training and experience would provide inservices more regularly than the general sample. It also makes sense that music therapists with special education licensure would provide education-focused models such as adaptive music education, co-led inclusive classroom services, and collaboration with education professionals. The relationship between number of music therapists and model chosen is supported by previous literature; Hughes, Rice, DeBedout, and Hightower (2002) described that Fulton County schools have 5 music therapists and provide consultation and inservices directly. In the current study, music therapists in a department of 3 or more music

therapists were more likely than the general sample to provide consultation—which, as some participants described in follow-up comments (Q38), were provided as an enrichment service the district supported on top of the provision of direct services. Finally, it is perhaps not surprising that those therapists who indicated they were "not on a SPED team" were less likely to provide consultation or collaboration with other professionals or, in contrast, that those in a "transdisciplinary" team are more likely to provide consultation, inservices and workshops. This supports Johnson's (2002) claim that music plays a larger role on the transdisciplinary team due to its multi-sensory nature and ability to cross domains.

Some demographic characteristics that the researcher predicted to be impactful toward a model of service delivery, through review of literature and personal experience, were not found to be as such. For instance, researchers suggested that school location could impact a chosen model—such as rural districts providing consultative services to manage logistics of distance between schools (Rickson, 2010, 2011; Twyford & Rickson, 2013)—though this was found to be a "less substantial" factor toward service-delivery model. While the researcher predicted that music therapy approach, requirement of additional licensure, employment status (part- vs. full-time), and degrees earned might have significant impact toward certain models chosen- these demographic variables were all considered in the "less substantial" or "insubstantial" result categories during data analysis. Some results were unclear; therapist region seemed to be a more substantial indicator of model(s) chosen, yet the reason *why* music therapists from certain regions employ more direct services outside classrooms (New England regions) vs. consultation (Southwestern region) remains unanswered. The researcher found it surprising that in districts where music therapy was not listed on the IEP, music therapists were *less likely* to provide consultation for individual students—since some participants commented on Q38 that consultation was provided as an interim step prior to assessing a student for direct services.

The researcher predicted that the most impactful music therapist characteristic would be his or her caseload, though some caseload information was not surveyed—such as number of school campuses or classrooms in which services were provided, additional job requirements, or travel time between sites. Participants were asked to indicate the number of students on their caseload, though the answer format

was short answer instead of multiple choice, so these data were not compared by sub-demographic model choices as with other therapist characteristics. On Q33, however, music therapists reported that caseload was one of the most relevant therapist variables that impacts their service delivery model. It would seem reasonable that larger caseloads might lead therapists to choose small group or classroom-based services rather than one-on-one "pull out" sessions (if the therapist was not able to share their caseload with another music therapist). Further research is needed to test this hypothesis. Future researchers should closely consider the impact of therapist caseload on model choices.

Limitations, Delimitations, and Assumptions of the Present Study

The researcher acknowledges limitations, delimitations, and assumptions within the study's procedures, survey instrument, measures, and overall study design, which are outlined below.

Procedures. For the present study, the researcher chose to contact only one organization (CBMT) to receive emails for potential participants, to assure that all participants met the initial criteria of board-certification. Future researchers may consider requesting email addresses from both the AMTA and CBMT and removing any duplicates to assure music therapists who are members of one group or the other are considered equally as participants, though this may not be necessary given the large sample pool and acceptable number of responses to the current study. The survey was available only on www.surveymonkey.com and was sent to *all* board-certified music therapists who opted to receive emails for surveys to help reduce the problem of receiving a potentially limited list of those who identified as school-based music therapists (since not all members of CBMT provide or update current job setting). One potential delimitation that may have deterred the number of responses is participants were given an internet-only option to complete the survey. The researcher did not send a follow-up email as intended in the study procedures, as it did not seem necessary based on the number of completed surveys received, though additional responses resulting from a follow-up email could have provided a more complete picture of school music therapy.

Survey Instrument. The length of the survey may have deterred participants from completing the survey, as the largest number of music therapists dropped out after initial demographic questions (n =

43) and at least some music therapists dropped out at each new survey page on *SurveyMonkey*. Perhaps the survey took longer than the researcher or participants anticipated, or participants were not able to complete the survey in one sitting due to their busy school schedules. Since the largest portion dropped out after demographics, perhaps the survey tool could be simplified and streamlined for quicker responses on the "job characteristics" page. While the researcher attempted to limit the number of open-ended responses, multiple questions within the demographic and job characteristic sections included the phrasing "other (please specify)" to account for assumptions, potential bias, and limited perspective within the survey. This could have increased the amount of work or time spent on each question for respondents. On other questions, some respondents had to write out "other" responses due to lack of an option that fit their job situation. While the researcher believes that added effort to type answers in "other" boxes could have contributed to the drop-out rate, this delimitation was mitigated by the richness of the information gleaned from "other" responses. One option to potentially limit the length and reduce response confusion would be to filter survey questions and imbed skip logic based on demographic information (i.e. part-time vs. full-time, those who provide assessments only vs. direct services, those who are not able to determine their service delivery model, or those who work with elementary vs. secondary levels).

Operational definitions. Future researchers in this subject area should define terms more clearly in the survey tool. Some music therapists noted confusion about the differences between the terms "consultation" and "collaboration"—as well as the different sub-categories of each model. While there are multiple definitions of consultation in music therapy and related literature, future researchers may wish to use the most common elements of each definition or choose one from prominent literature describing music therapy models (i.e. Johnson, 2002, pg. 94). Additionally, operational definitions for terms such as "eligibility" and "caseload" could have been defined more clearly. The researcher did not define whether "on your caseload" specifically meant the number of students with music therapy on their IEP, or also those students who received indirect or programmatic services in large classroom environments. Because of the differences in terminology between music therapists and individual school districts ecologies

within which they work (which, in some cases, may mean multiple districts), an extra level of clarity in definitions could be beneficial in future studies to mitigate the effects of researcher assumptions.

Survey ranges. Respondents had some difficulty responding to a few questions in which the ranges overlapped at end points. In particular, on Q19, Q22, and Q25, the researcher provided options of "20-30 minutes" and "30-45 minutes"—both of which included 30 minutes. Multiple music therapists wrote "30 minutes" in the "other" box, since the researcher failed to include 30 minutes in a single option. For these questions, future researchers may either more clearly differentiate multiple-choice options or allow respondents to type in a number for more precise data. Because of the number of "other" responses for the *frequency* of sessions, the researcher would recommend that future researchers provide respondents with a matrix to specify "x" number of sessions per number of "day/week/month/quarter/or school year." Some respondents wrote in "other" responses that it "depends on the district" or that the question was hard to answer because they work both in schools and private practice settings. Future researchers should perhaps request that respondents answer questions based on a single school district (i.e. where they provide the most services), or that they differentiate between their work in schools and in private practice if they are contracting to the district rather than working as a district employee.

Another limitation of the survey instrument for the purposes of data analysis was a minor misalignment between demographic questions related to music therapist characteristics and the variables provided in Q33—relevance of therapist variables. The researcher chose to base demographic questions on previous related surveys (Jones & Cardinal, 1998; McCormick, 1988; Smith & Hairston, 1999) and therapist variables for Q33 were those described in related literature such as Brandel and Frome-Loeb's similar study (2011). If the therapist characteristics (demographic questions) and therapist-related variables were more aligned, the researcher might have been able to compare results of 4a and 4b and determine whether service delivery decisions are actually impacted by the same factors the music therapists self-reported. While this may have provided interesting data for analysis and comparison, this alignment was not critical to answering the four initial research questions.

Study design and measures. Because of the research questions guiding this study, survey questions were somewhat limited to the topic of service delivery models in public school settings. Previous surveys, however, were more generalized in their questions—to capture a broader picture of school music therapy. Future researchers may wish to align questions more closely to previous studies by McCormick (1988) and Smith and Hairston (1999) to garner more direct comparisons of changes over time. However, this researcher feels that a look at the overarching music therapy models in schools and the way model choice could impact other job characteristics is a justifiable expansion of focus from previous studies to also help contextualize responses for day-to-day job characteristics of music therapists and types of service provision.

Due to the complex nature of measuring for any possible variables that may have impacted service delivery, multiple-choice matrixes may have been too narrow of a measurement tool. One participant commented that the survey was "way too cut and dry" to encompass a "number of factors" related to their private practice. Follow-up research to this study could pursue information through qualitative means (i.e. individual interviews or focus groups of music therapists) to measure data in new ways and seek knowledge from a more grounded theoretical approach. This would allow the theory to emerge from the data, rather than adapting from Brandel and Frome-Loeb's multiple-choice framework (2011). While it seemed that a survey was appropriate to measure music therapist demographic, job, and caseload characteristics; service delivery models; and decision-making abilities (research questions 1-3), mixed methods or qualitative methods may be more appropriate research designs for research questions such as 4a and 4b in future studies. Adding a qualitative component may address some of the limitations and assumptions of the present survey by allowing music therapists to voice their experiences using their own terms, describe variables that were not available in multiple-choice matrixes, and detail their day-to-day school experiences in such a way that may have been difficult to parse into hours per week or "other" survey options.

Suggestions for Future Research

Future researchers may address these limitations and assumptions by considering the following changes and additions to the study's procedures, survey instrument, overall study design and measures, and decision-making variables. Since suggestions are also included within each research question sub-heading above, this section will summarize suggestions in a more succinct format.

Procedures. Future researchers may want to adapt procedures to include alternative methods of completing the survey (i.e. *SurveyMonkey* and mailout), or contact both the AMTA and CBMT to expand a list of more possible participants. Though the researcher did not send follow-up emails for the current study, future researchers that do so may garner even higher response rates. Consideration should be taken as to when survey request emails are sent and how the dates fit in relation to the common public school calendars (i.e. avoid major seasonal breaks and national holidays, since school music therapists may or may not be checking their school emails at these times).

Survey instrument. The researcher suggests that this survey tool, *Music Therapy in Public Schools: 2017*, is adapted to include suggestions above such as updated survey ranges and inclusion of additional operational definitions. Additionally, future researchers should pilot the survey with public school music therapists working in different areas or models (as done in the present study) to assure that the options are inclusive of multiple perspectives and minimized in bias. The overall length of their surveys may be reduced by focusing questions on a single topic—rather than 38 detailed (and sometimes multi-faceted) questions regarding topics of demographics, models of music therapy, job characteristics, caseload characteristics, and variables that impact decisions.

Study design and measures. A qualitative follow-up (such as individual interviews or focus groups) to the quantitative survey data could provide narrative depth to future studies that this study may be missing. While multiple-choice options and matrices were used to streamline responses and reduce survey time, the researcher believes that some respondents would have been willing to spend more time speaking with the researcher to help contribute to research on this topic. This was evident by the number of music therapists who chose to answer the optional, open-ended Q38 and wrote a great deal of detail to

explain their current position or additional decision-making variables that impact service delivery. Additional qualitative information that could be helpful to practicing clinicians might include suggestions and tips from practicing clinicians for how to manage some of the workplace factors that impact services such as attitudes of teachers and scheduling concerns.

In reducing the scope of the survey instrument and including qualitative data collection methods, future researchers could go more in-depth into some of the *why* and *how* questions that arose as the researcher analyzed results of this survey. For example, some additional questions that arose during this study for future research included:

- Why do more school music therapists seek higher education than in the past?
- Why do music therapists continue to be dual-certified in education and therapy (even though only half of those certified in education are required to do so)? And why do many school music therapists seek additional certifications and training?
- Why are school music therapists slowly transitioning from full-time to part-time work in schools? Or from employment by a district to employment by a separate agency, company, or private practice?
- Why have modern music therapists been practicing for fewer years than in previous studies?
- Why have there been changes in the frequency of services provided per week?
- How are music therapists making decisions about how music therapy is included in the IEP? What is the role of the music therapist in this process?
- Are music therapy goals written in the IEP, or are music therapist co-implementing goals with other related services?
- Which goal areas are commonly addressed, and for which populations?
- Do school music therapists use common interventions for common goals areas? Are some interventions more effective than others? What is the decision-making process for determining an intervention for a goal in schools (and does it involve evidence-based practice?)
- What is the nature of school music therapy consultation? How is the skill learned and practiced, and do music therapists feel that additional training is necessary?
- What does the whole treatment process look like, from referral to eligibility assessment to termination of services?
- What are the day-to-day experiences of the school music therapist and what is their quality of life while working in schools?

After considering these potential future research questions, the researcher decided to design a qualitative follow-up study (Gillespie, 2018). The purpose of this follow-up is to investigate the similarities and differences between eligibility assessment processes for school music therapists—depending on their model(s) of service delivery and in relation to IEPs. Since 66.0% participants in the current study indicated that music therapy was listed on the IEP in some format (direct, indirect, or a

mixture), the researcher assumes that this data also implies that music therapists engage in some form of "eligibility assessment." Such an assessment is typically used to determine which students qualify for music therapy as a service listed on the IEP (per IDEA requirements of related services)—at least for direct services (Brunk & Coleman, 2000, 2002; Ritter-Cantesanu, 2014). By conducting semi-structured phone interviews with individual music therapists, the researcher hopes to expand upon information gleaned in Q17 ("How is music therapy listed on the IEP?") to determine common eligibility assessment tools used (if any), the role of the therapist in this process, service-delivery decisions made during the assessment, typical referral processes, and suggestions music therapists have for best-practice. This qualitative follow-up to the current study may provide additional, practical information for clinicians looking to establish processes within their district's service-delivery model.

Implications for Practice and Academic Training

The 217 school music therapists who completed this survey, *Music Therapy in Schools: 2017,* provided a wealth of information about their day-to-day jobs, backgrounds and training, the make-up of their caseloads and types of services provided, and more. Considering that most school music therapists in 2017 had worked *less than* a decade (56.0%) and the majority of research literature detailing the practice of music therapy in schools was published *more than* a decade ago—an updated survey of the field (as well as future research studies in the same vein) was warranted. Data comparisons to previous school music therapy surveys (Jones & Cardinal, 1998; McCormick, 1988; Smith & Hairston, 1999) may be useful for practice and academic training, but additional data gleaned related to new research topics introduced in this study—such as types of service-delivery model(s) offered in schools and variables that might impact service delivery—may have even more practical implications for clinicians, administrators, and music therapy educators.

Implications for clinicians. For school music therapists entering the field for the first time, or those looking to update their program to parallel trends in other related service fields- this descriptive study may provide an insightful snapshot into some of the inner workings of modern school music therapy. One implication for practicing school music therapist is the use of the results of the survey to

help in clinical decision-making. Brandel and Frome Loeb (2011) suggest that a therapist must look at certain variables related to the district, therapist, and students in making clinical decisions regarding service delivery model and program intensity. Many clinicians likely struggle to navigate decision-making processes due to lack of research on the topic, limited guidance from national organizations, or outdated reference literature that predates current educational laws and trends. Results of this study may provide some guidance as to what is *typical* for other music therapists in similar job circumstances who are able to make service delivery decisions. On the other hand, for clinicians who may be facing budget cuts and pressure from administration to change the nature of service delivery—regardless of model choices deduced by clinical reasoning (i.e. student need), the literature review of the present study may be a reference for clinicians to use when selecting additional or new models of service delivery (i.e. when moving from direct, IEP-based services to a consult-to-program model).

Clinicians must engage in reflective practice to determine if any variables may be influencing their service delivery—whether in a positive or negative manner—and seek to mitigate negative variables when possible. For example, if clinicians are working within the same model they have always provided services (regardless of what is best for student needs) due to variables such as their own training background or preferences, perhaps they may reflect on whether this potential bias may be inhibiting their clinical effectiveness. Awareness and application of service delivery models that align with trends in one's district may even help school music therapists stay afloat amidst budget cuts and changes in special education models. While reading this study or even independent completion of this survey tool may help a clinician reflect on service-delivery choices made in their district (or increase awareness of additional service-delivery options), continued professional development opportunities regarding service delivery options and best-practice in school settings is recommended.

Implications for administrators. Perhaps first and foremost, school administrators should consider the impact of budget cuts on music therapy program models and proceed with caution if deciding upon service delivery changes. Results of the current study indicate that more than half of school music therapists are affected by financial variables such as budget cuts, and that this issue has impacted service

delivery models. Music therapists shared that they have experienced "a lot of resistance" when trying to implement a model of service-delivery they feel to be most appropriate, or—worse—that "services can be seen as unnecessary when a district is looking at funding cuts." While certain models of service-delivery such as consult-to-program appear to be an efficient means of providing services to more students in a given time, empirical research does not yet indicate that this model is effective (or at least any *more* effective than direct, IEP-based services) toward meeting student goals. Administrators should weigh, then, whether a change in service delivery is appropriate within LRE specifications of IDEA or whether another model—such as assessing whether students are eligible for direct, 1-on-1 or small group services—is more appropriate in a given circumstance.

Additionally, the researcher hopes that administrators continue (or begin) to acknowledge music therapy as a related service—as outlined in the review of literature. Participants indicated that some administrators "don't want me calling what I do music therapy," or that they are "listed as a music educator… because the district will not fund music therapy," or that they "do music therapy… but only because [they are] a credentialed special education teacher [in addition to their MT-BC credential]." Is this the case for occupational therapists, physical therapists, or any other educational service provider? Recognition as a part of the SPED team of related service providers, teachers, and parents was found to be more substantially impactful toward service delivery models than any other demographic category (see Table 6); if therapists were not considered part of the SPED team as a related service, music therapists were less likely to engage in multiple common models of music therapy—such consultation and collaboration with other school professionals, and staff inservices. Because of the multi-sensory and engaging nature of music, a music therapist may be a valuable asset to any special education department which enhances outcomes for all other related services in a transdisciplinary fashion.

Implications for music therapy educators. Since the mode graduation year of participating music therapists was 2013, it is important to note that school music therapy is still a relevant field that new graduates are pursuing. What portion of undergraduate and graduate curricula is devoted to this sub-field of music therapy? What resources are music therapy educators using to train future school music

therapists? Are music therapy educators in certain regions giving more weight to particular models of music therapy, based on experience or philosophical orientation?

The researcher recommends that music therapy educators, regardless of their philosophical approach or theoretical orientation, keep an open mind to the possibilities of various direct and indirect service delivery options in school settings. These educators may include faculty, practicum supervisors, or internship directors—since most music therapists who had a school-based practicum or internship experience (54.4%) have maintained the same service delivery model in their clinical work. The review of literature for the current study indicated that inclusive and consultative services would continue to rise, since these models of service delivery may align with other related service and special education trends. Findings of this study indicate the opposite trend in music therapy—a decrease in these service-delivery models—which may be impacted by music therapy education. One commenter spoke to this by saying that "educational focus is on direct service… I don't think the average music therapy graduate receives much education in the area of consultation models or what that looks like in practice." While education may only be one factor impacting this negative trend in consultative and inclusive practice models, the researcher recommends that educators engage in reflective practice to consider potential biases in the curriculum and related impact to student learning.

A strength of the current study that may be of benefit to music therapy educators is the review of literature, which condenses descriptions of school-based music therapy services and common service delivery models in music therapy *and* other special education-related services. Such a review has neither previously existed at the same depth nor been highlighted in educational research in over 15 years. Educational resources are provided through national organizations in other related services as to parameters that may help a therapist in using clinical reasoning to determine the best model for a student (AOTA, 1987; Dunn, 1988; ASHA, 2000; APTA, 1990)—though such a list does not exist through national music therapy organizations. Educators may find this study helpful as a list of potential considerations for clinical reasoning in school music therapy until such parameters exist through music therapy organizations such as AMTA. Furthermore, the demographic, job, and caseload characteristics

described and outlined in each table can provide an easily accessible "snapshot of the field" for students who are interested in school music therapy but who wonder—*what might my job look like in a school setting? Who else will I work with and on what level? What are my options for service delivery, and what factors should I consider when looking at various school districts?*

For music therapy educators leading student researchers and future clinician-researchers, this study highlights the disparity of new research in the field of school music therapy and, thus, a ripe area of research needed in the field. Future academic research may foster further evidence-based practice and even stimulate growth in the field through increased advocacy. Participants highlighted the need for research and advocacy in follow-up comments such as "our field needs more research to show the efficacy and cost effectiveness of music therapy in the school setting, as well as education for music therapists on how to present that research as well as their own data." Additional participants noted that "we need more advocacy in the public education field… this is vital" and "there's a greater need for public education of the research and relevance of music therapy in schools and meeting the developmental needs of children."

Personal implications for the researcher. Engaging in this research study has had interesting and direct translations to my personal experience this year. Since conducting the present survey, I accepted a position as a school music therapist in a large, suburban school district. This job marks my first employment by a school district in the job title of "music therapist." My desire to engage in this research study stemmed from research questions I had as a graduate student, but also as a practitioner looking to understand what school music therapy *actually* looked like in 2017. By learning more about the topic, I had hoped that I could put my best foot forward in interviewing for school positions and feel prepared for the work by having knowledge about how music therapy programs could look given a number of variables. Interestingly, my district was looking to move toward a more "blended" model of service—including both direct and indirect, consult-to-program services—and was immediately interested in knowledge I had about current music therapy practices along this vein. Conducting this survey research has helped me feel more confident in understanding the strengths of these two service delivery models

and what realistic expectations I should have for caseload size, hours spent on different work tasks, and which school professionals I should build relationships with (for potential collaboration or consultation). Since beginning this job, I still have a lot of *how* questions related to logistics of day-to-day school music therapy processes (i.e. eligibility assessment procedures, requesting instrument funding, appropriate consultation with secondary teachers, and IEP documentation). To answer some of these questions, I am conducting a qualitative follow-up (described above) related to eligibility assessments—though I hope that future researchers and clinicians continue to research and report on these practical topics to help new clinicians such as myself, or those looking to update their program models.

Conclusion

Before this study, little was known about music therapy within the 21st century public school setting. The last survey of school music therapy was published over 18 years ago. A review of literature highlighted the dearth of recent literature and resources which describe real-world practices beyond descriptive educational materials. This study considers variations from "traditional" service delivery models to incorporate innovated practices more aligned with current trends in general and special education. Results from 217 completed survey responses provide a new and updated look at job characteristics of the modern school music therapist, models of service delivery in which music therapists operate, and variables that may impact how practitioners make clinical decisions. The current study expands upon previous and related studies of the field by providing an updated and more detailed profile of the school music therapist and exploring relationships between variables that may have impacted service delivery decisions in programs across the country.

Previous researchers in this topic area (Jones & Cardinal, 1998; McCormick, 1988; Smith & Hairston, 1999) have each recommended that surveys in the field of school music therapy should be ongoing to accommodate for and monitor changes in the field—which is the recommendation of the current researcher as well. Future studies are warranted to understand the numerous variables relevant to school music therapy practice and the implications for student progress and achievement. The researcher hopes that this study (along with future studies related to issues in school music therapy) will raise

awareness of the possibilities of service-delivery models, empower both clinicians and administrators to make decisions that are most beneficial to student achievement through music therapy, contribute to training of practicing and future clinicians, and support the relevance of music therapy as a related service in public schools.

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APPENDICES

Appendix A
Informed Consent and HRPP Approval

Dear Music Therapy Colleague,

The Division of Music Education and Music Therapy at the University of Kansas supports the practice of protection for human subjects participating in research. The following information is provided for you to decide whether you wish to participate in the present study. You should be aware that even if you agree to participate, you are free to withdraw at any time without penalty. Your name is being used with the permission of the Certification Board of Music Therapists upon its review of the research.

We are conducting a survey of board-certified music therapists who currently provide services in public schools. As a music therapist working in school settings, you have many demands on your time and may have to make decisions regarding your service delivery in your school district. In an effort to better understand job responsibilities of of the current school music therapist, as well as models of service delivery for children in public schools, we would appreciate your completion of this survey. Although participation may not benefit you directly, we believe that the information obtained from this study will help us gain a better understanding of current practices in school-based music therapy that may inform future practice, training, and research.

Your participation in this study is solicited, although strictly voluntary. Your name will not be associated in any way with the research findings. It is possible, however, with internet communications, that through intent or accident someone other than the intended recipient may see your response. During the course of this survey, you will be asked a series of questions regarding your caseload and it may be helpful to have this information available. Your participation is expected to take approximately 15-20 minutes to complete and should cause no more discomfort than you would experience in your everyday life.

If you would like additional information concerning this study before or after it is completed, please feel free to contact us by phone or mail. Completion of the survey indicates your willingness to take part in this study and that you are at least 18 years old. If you have additional questions about your rights as a research participant, you may call (785) 864-7429 or write the Human Research Protection Program (HRPP), University of Kansas, 2385 Irving Hill Road, Lawrence, Kansas 66045-7563, email irb@ku.edu.

Sincerely,
Melissa Gillespie, MT-BC, Principal Investigator and Cynthia M Colwell, PhD, MT-BC
Department of Music Education and Music Therapy Murphy Hall- University of Kansas
Lawrence, KS 66045 Gillespie: (913) 689-5882 mgillespie@ku.edu Colwell: (785) 864-9635
ccolwell@ku.edu

KU Lawrence IRB # STUDY00140573 | Approval Period 3/7/2017

Appendix B

Survey (*Music Therapy in Public Schools: 2017)*

Music Therapy in Public Schools: 2017

1. Information & Consent

Dear Music Therapy Colleague,

The Division of Music Education and Music Therapy at the University of Kansas supports the practice of protection for human subjects participating in research. The following information is provided for you to decide whether you wish to participate in the present study. You should be aware that even if you agree to participate, you are free to withdraw at any time without penalty. Your name is being used with the permission of the Certification Board of Music Therapists upon its review of the research.

We are conducting a survey of board-certified music therapists who recently or currently provide services in public schools. As a music therapist working in school settings, you have many demands on your time and may have to make decisions regarding your service delivery in your school district. In an effort to better understand job responsibilities of of the current school music therapist, as well as models of service delivery for children in public schools, we would appreciate your completion of this survey. Although participation may not benefit you directly, we believe that the information obtained from this study will help us gain a better understanding of current practices in school-based music therapy that may inform future practice, training, and research.

Your participation in this study is solicited, although strictly voluntary. Your name will not be associated in any way with the research findings. It is possible, however, with internet communications, that through intent or accident someone other than the intended recipient may see your response. During the course of this survey, you will be asked a series of questions regarding your caseload and it may be helpful to have this information available. Your participation is expected to take approximately 15-20 minutes to complete and should cause no more discomfort than you would experience in your everyday life.

If you would like additional information concerning this study before or after it is completed, please feel free to contact us by phone or mail. Completion of the survey indicates your willingness to take part in this study and that you are at least 18 years old. If you have additional questions about your rights as a research participant, you may call (785) 864-7429 or write the Human Research Protection Program (HRPP), University of Kansas, 2385 Irving Hill Road, Lawrence, Kansas 66045-7563, email irb@ku.edu.

Sincerely,
Melissa Gillespie, MT-BC, Principal Investigator and Cynthia M Colwell, PhD, MT-BC
Department of Music Education and Music Therapy Murphy Hall- University of Kansas
Lawrence, KS 66045 Gillespie: (913) 689-5882 mgillespie@ku.edu Colwell: (785) 864-9635 ccolwell@ku.edu

Music Therapy in Public Schools: 2017

2.

* 1. Have you been employed as a music therapist in public school settings, either part-time or full-time, within the past 5 years?

- ◯ Yes
- ◯ No

Music Therapy in Public Schools: 2017

3. Demographic Information

* 2. How many years have you been employed as a music therapist in school settings?

* 3. Who is your employer?

- ◯ I am an independent contractor
- ◯ A public school district
- ◯ A private or independent school
- ◯ An agency, company, or private practice which provides services for public school settings
- ◯ Other (please specify)

* 4. What is your current employment status as a public school music therapist?

- ◯ Full-time (30+ hours)
- ◯ Part-time

* 5. In which region are you employed?

* 6. When did you graduate with a degree in music therapy? (please enter the year of your most recent music therapy degree)

* 7. Please indicate which degree(s) you have earned *(all that apply)*.

- [ ] Bachelor's Degree in Music Therapy
- [ ] Bachelor's Degree in Music Education
- [ ] Master's Degree in Music Therapy
- [ ] Master's Degree in Music Education
- [ ] Equivalency in Music Therapy
- [ ] PhD in Music Therapy or Music Education
- [ ] Other (please specify)

* 8. Please indicate if you have any additional licensure, certification, or specialized training.

- [ ] Music education license or certification
- [ ] General education license or certification
- [ ] Special education license or certification
- [ ] No additional licensure or certification
- [ ] Other (please specify)

Music Therapy in Public Schools: 2017

4. Job Characteristics

* 9. Do you need a teaching certification/license to maintain your employment status in your current position as a school music therapist?

- ◯ Yes
- ◯ No

* 10. Please indicate all music therapy approach(es) you consider relevant to your clinical practice in school settings (Darrow, 2008):

- ☐ Orff approach
- ☐ Dalcroze approach
- ☐ Kodaly approach
- ☐ Nordoff-Robbins music therapy
- ☐ Psychodynamic approach
- ☐ Behavioral approach
- ☐ Neurologic music therapy
- ☐ Other music-centered approach
- ☐ None of the above
- ☐ Other approaches (please specify)

* 11. Which of the following best describes your school district demographic?

- ◯ Rural
- ◯ Suburban
- ◯ Urban
- ◯ Multiple school district demographics

* 12. What is the approximate number of students that receivespecial education services within your district?

* 13. How many music therapists are employed within your district, regardless of employer status *(excluding interns)*?

* 14. Please specify the approximate number of students on YOUR caseload *(do not include those served by other music therapists in your district)*:

* 15. Please select the special education team model that best matches the one in your primary school or district:

- **Multidisciplinary**- Team members acknowledge importance of contributions from several disciplines and services remain independent. Members exchange information about independent work, conduct assessments in separate environments, and develop separate plans for intervention within their discipline (Friend & Cook, 2012).
- **Interdisciplinary**- Team members share responsibility for services among disciplines, though individuals are primarily responsible for specific disciplines. Families may meet with the team, which likely meets on a regular basis. Assessments are conducted separately and goals are developed by discipline, but are shared with the team to form a service plan. There is no crossing or blurring of professional boundaries.
- **Transdisciplinary**- Team members commit to teach, learn, and work across disciplines in planning and providing integrated services. Teams meet regularly for information sharing, learning, and team building- often including families. Members participate in collaborative assessment, develop a plan together, and share responsibility and accountability for how the plan is implemented as a team. Work of the team surpasses individual professional identities; all coordinate efforts on behalf of the student.
- I do not work within the special education team
- Other (please specify)

* 16. Who is your direct supervisor?

- Another music therapist
- SPED administrator
- District administrator (non-SPED)
- A music educator
- Other (please specify)

* 17. How is music therapy typically listed within student IEP's in your school district?

- ◯ Music therapy is not specified on IEP's
- ◯ As a direct service (1-on-1, small groups, inclusive)
- ◯ As an indirect service (i.e. consultation or programmatic service for all students)
- ◯ Mixture of direct service and indirect service

Music Therapy in Public Schools: 2017

5. Caseload Information

* 18. Approximately how many 1-on-1 sessions do you facilitate during a typical week?

* 19. What is the typical length of your 1-on-1 music therapy sessions?

* 20. For those students who receive 1-on-1 services, how frequently do you see them, on average?

* 21. Approximately how many small group sessions do you facilitate during a typical week?

* 22. What is the typical length of your small group music therapy sessions?

* 23. For those students who receive small group services, how frequently do you tend to see them, on average?

* 24. For approximately how many classrooms do you provide inclusive, whole class sessions within a typical week?

* 25. What is the typical length of your inclusive, whole-class sessions?

* 26. For whole, inclusive classes that receive services, how frequently do you tend to see them, on average?

* 27. How is the length and frequency of your sessions determined(*please select all that apply)?*

- [ ] Therapist caseload
- [ ] Individual student needs
- [ ] District or SPED administration policy
- [ ] Scheduled by general or special educators
- [ ] Mandated by IEP team
- [ ] Other (please specify)

Music Therapy in Public Schools: 2017

6. Collaboration & Consultation

28. With which of the following school professionals do you participate in *collaboration* **or** provide *consultation*?
(please mark all that apply)

Definitions:
Collaboration is a style for direct interaction between at least two coequal parties voluntarily engaged in shared decision making as they work toward a common goal (Friend & Cook, 2012).

Consultation is a model in which the member of a specific discipline provides services indirectly to the student by working with the professionals who are in direct contact with the student (Wilson, 2002).

	Collaboration	Consultation
Music educators	☐	☐
General educators	☐	☐
Special educators	☐	☐
Paraprofessionals	☐	☐
Guidance counselors	☐	☐
Speech-language pathologists	☐	☐
Occupational therapists	☐	☐
Physical therapists	☐	☐
Other creative arts therapists	☐	☐
Medical professionals	☐	☐
Community services (i.e. case managers/social workers)	☐	☐

Other (please specify)

Music Therapy in Public Schools: 2017

7. Time Allotment of Job Responsibilities

* 29. Please specify the approximate amount of time (in hours) you spend in the following responsibilities within a typical week.

	<1	1-3	4-6	7-9	10-14	15-19	20+
Assessments	◯	◯	◯	◯	◯	◯	◯
Planning (independent of others)	◯	◯	◯	◯	◯	◯	◯
Co-planning (collaboration)	◯	◯	◯	◯	◯	◯	◯
Direct services (1-on-1, small group, or whole class)	◯	◯	◯	◯	◯	◯	◯
Co-leading direct services (collaboration)	◯	◯	◯	◯	◯	◯	◯
Indirect services (consultation)	◯	◯	◯	◯	◯	◯	◯
Documentation	◯	◯	◯	◯	◯	◯	◯
IEP meetings	◯	◯	◯	◯	◯	◯	◯
Other meetings	◯	◯	◯	◯	◯	◯	◯
Supervision (i.e. interns)	◯	◯	◯	◯	◯	◯	◯
Professional development	◯	◯	◯	◯	◯	◯	◯
Travel	◯	◯	◯	◯	◯	◯	◯
Other	◯	◯	◯	◯	◯	◯	◯

If you indicated "other" above, please describe those duties:

Music Therapy in Public Schools: 2017

8. Models of Service Provision

* 30. Within which model(s) of music therapy do you provide services?*Please select all that apply.*

- [ ] Direct services- in general classroom- 1-on-1
- [ ] Direct services- in general classroom- small groups
- [ ] Direct services- outside general classroom- 1-on-1
- [ ] Direct services- outside general classroom- small groups
- [ ] Direct services- outside general classroom- large groups
- [ ] Direct services- in a self-contained special education classroom
- [ ] Inclusive- in general classroom (co-leading)
- [ ] Inclusive- in general classroom (leading)
- [ ] Consultation- for individual students
- [ ] Consultation- for individual professionals
- [ ] Consultation- for whole program or department
- [ ] Collaboration with other school professionals
- [ ] Co-leading (i.e. music therapy + physical therapy)
- [ ] Community music therapy in schools (addressing the needs and culture of the school system)
- [ ] After school music therapy programs
- [ ] Inservices and workshops
- [ ] Preventive music therapy
- [ ] Adaptive music education
- [ ] Other (please specify)

* 31. Are you able to make decisions regarding the model(s) of music therapy in which you provide services?

- ◯ Yes
- ◯ No
- ◯ Sometimes

Comments (optional):

* 32. Are the model(s) of music therapy in which you provide services the same as those in which you practiced during your practicum or internship experience?

- ◯ I did not have a school-based practicum or internship experience
- ◯ Yes
- ◯ No
- ◯ Sometimes (please explain):

Music Therapy in Public Schools: 2017

9. Therapist Decision Variables

* 33. Please select the relevance of various therapist variables when deciding *(or if you had the ability to decide)* the model(s) of music therapy in which you provide services for students on your caseload (i.e. direct services in inclusive classrooms, small groups outside of the classroom, consultation to program).

	Highly irrelevant	Somewhat irrelevant	Unknown	Somewhat relevant	Highly relevant
Practicum or internship experience	○	○	○	○	○
Prior clinical experience	○	○	○	○	○
Years worked in school settings	○	○	○	○	○
Part-time vs. full-time	○	○	○	○	○
Professional development	○	○	○	○	○
Workload (job responsibilities)	○	○	○	○	○
Caseload (students)	○	○	○	○	○
Philosophical approach	○	○	○	○	○
Preferences of model	○	○	○	○	○

Other therapist variables you find relevant:

Music Therapy in Public Schools: 2017

10. Student Decision Variables

* 34. Please select the relevance of various student variables when deciding *(or if you had the ability to decide)* the model(s) of music therapy in which you provide services for students on your caseload (i.e. direct services in inclusive classrooms, small groups outside of the classroom, consultation to program).

	Highly irrelevant	Somewhat irrelevant	Unknown	Somewhat relevant	Highly relevant
Nature & severity of a child's disability	○	○	○	○	○
Strengths, needs, and abilities	○	○	○	○	○
Age and developmental level	○	○	○	○	○
Need for peer modeling	○	○	○	○	○
Motivation and attitude	○	○	○	○	○
Preference for and response to music	○	○	○	○	○
Least-restrictive environment (IEP-based)	○	○	○	○	○

Other student variables you find relevant:

Music Therapy in Public Schools: 2017

11. Workplace Decision Variables

* 35. Please select the relevance of various workplace variables when deciding *(or if you had the ability to decide)* the model(s) of music therapy in which you provide services for students on your caseload (i.e. direct services in inclusive classrooms, small groups outside of the classroom, consultation to program).

	Highly irrelevant	Somewhat irrelevant	Unknown	Somewhat relevant	Highly relevant
Finances	○	○	○	○	○
Number of students in SPED	○	○	○	○	○
Travel time	○	○	○	○	○
Geographic location	○	○	○	○	○
SPED department model	○	○	○	○	○
Relationship with school personnel	○	○	○	○	○
Team input	○	○	○	○	○
IEP specifications	○	○	○	○	○
Administrative support, preferences, or attitudes	○	○	○	○	○
Classroom or SPED teacher support, preferences, or attitudes	○	○	○	○	○

Other workplace variables you find relevant:

Music Therapy in Public Schools: 2017

12. Final Thoughts

* 36. Please indicate your level of agreement with the following statements:

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I am typically able to provide music therapy services within the model(s) of music therapy necessary to make progress toward a child's goals.	○	○	○	○	○
I am typically able to provide music therapy services for the amount of time necessary to make progress toward a child's goals.	○	○	○	○	○
I am typically able to provide music therapy services in the location necessary to make progress toward a child's goals.	○	○	○	○	○
Recent laws and mandates in general and special education (i.e. Common Core State Standards) impact the model(s) of service delivery in which I provide services.	○	○	○	○	○

* 37. Which, if any, of the following educational trends and laws have directly impacted your district's chosen music therapy service delivery model(s)? *(Please check all that apply)*

- ☐ Inclusion (movement from segregated settings to general classrooms)
- ☐ No Child Left Behind Act of 2001
- ☐ Common Core State Standards Initiative of 2010
- ☐ Every Student Succeeds Act of 2016
- ☐ Other (please specify)

38. Do you have any other information that you would like to share with the researcher regarding current practices and trends in school music therapy?

Appendix C

Demographic Characteristics

Question	Category	*n*	%
Q2: Years Employed as a MT in Public Schools (*n = 302*)	Less than 1	32	10.6%
	1-4 years	122	40.4%
	5-9 years	49	16.2%
	10-14 years	37	12.3%
	15-19 years	33	10.9%
	20+ years	29	9.6%
Q3: Employer (*n = 302*)	Public School District	111	36.8%
	Agency/Company/Private Practice	88	29.1%
	Independent Contractor	72	23.8%
	Other*	22	7.3%
	Private/Independent School	9	3.0%
	**Other responses included grant funding (4), university (3), both contractor and public school employed (3), both public school and private school (2), previously employed (2), Medicaid company, both independent contractor and agency employed, and nonprofit company.*		
Q4: Employment Status (*n = 302)*	Part-time (<30 hours)	169	56.0%
	Full-time (30+ hours)	133	44.0%
Q5: Employment Region (*n = 302*)	Great Lakes Region	69	22.9%
	Mid-Atlantic Region	63	20.9%
	Southeastern	42	13.9%
	Southwestern	46	13.3%
	Midwestern	40	13.3%
	Western	22	7.3%
	New England	20	6.6%
	International Member	0	0.0%
Q6: Graduation Year (*n = 302*)	Range: 1974-2017 Mode: 2013 (*n* = 33)	Median: 2010	
Q7: Degree(s) Earned (*n = 302*)	Bachelor's in Music Therapy	204	67.6%
	Bachelor's in Music Education	41	13.6%
	Master's in Music Therapy	93	30.8%
	Master's in Music Education	15	5.0%
	Equivalency in Music Therapy	40	13.3%
	PhD in Music Therapy or Music Education	6	2.0%
	Other**	64	21.2%
	***Other responses included Special Education (12), Bachelor's of Arts in Music (7), Music Performance (7), Bachelor's/Master's of Music Education in Music Therapy (6,) Education (4), Psychology (3), Still pursuing a Master's degree in multiple fields (3), Equivalency Masters in Music Education in Music Therapy (2), Teaching & Learning (2), Clinical Psychology (2),Clinical Mental Health Counseling (2), Jazz Studies & Contemporary Media, Music Technology, Applied Behavioral Analysis, Music Psychotherapy, Counseling, Expressive Therapy, Social Work, Christian Outreach, Early Childhood Education, Human & Community Resources, Mental Health Counseling, Music Theory, Administration, and Occupational Therapy.*		

(continued)

Appendix C (continued)

Question	Category	*n*	%
Q8: Additional Licensure, Certification, or Specialized Training (*n = 302*)	**No additional**	**180**	**59.6%**
	Other***	73	24.2%
	Music education	59	19.5%
	Special education	17	5.6%
	General education	7	2.3%
	*** *Other responses included NMT (18),LPMT (9), NICU-MT (6), L-CAT (5),Music Together (5), Licensed Professional Counselor (4),Orff (4),GIM (3),Certified DIR/Floortime Practitioner (2),Developmental Specialist/Therapist (2), Kindermusik (2), Nordoff-Robbins MT (2),Licensed Mental Health Clinician, Child Life Specialist, CBIS,EMT, NCTM (MTNA), Board Certified Behavior Analyst, Nonprofit Management Certification, Occupational Therapy License, Licensed Social Worker, Certified School Social Worker, Infant-Toddler Development Specialist, Yoga Teacher, Kodaly*		

Note. Percentages are based on the number of those that responded to the question and thus varies among questions.

Appendix D

Job Characteristics

Question	Category	*n*	%
Q9: Need Teaching Certification (*n = 259*)	**No**	**224**	**86.5%**
	Yes	35	13.5%
Q10: Relevant Approach(es) (*n = 259*)	**Behavioral Approach**	**226**	**87.3%**
	Neurologic Music Therapy	120	46.3%
Answers may add up to more than 100% due to option to choose multiple	Nordoff-Robbins MT	108	41.7%
	Orff Approach	103	39.8%
	Other Music-Centered	102	39.4%
	Psychodynamic	50	19.3%
	Kodaly Approach	36	13.9%
	Dalcroze Approach	28	10.8%
	Other****	26	10.0%
	None of the above	7	2.7%
	*****Other responses included CBT (4), Humanistic (3), Child-centered (3), Academic approach (2), ABA (2), Drum circle facilitation, DIR Relationship, Kindermusik, DBT, Developmental, Improvisational, Psychoeducational, MT as Conflict Resolution, Adaptive educational methods, Eclectic, Relationship-based (Abrams), Resource-oriented (Rolsvjord), Cathy Knoll Approach*		
Q11: District Demographic (*n = 259*)	**Suburban**	**103**	**39.8%**
	Multiple Districts	78	30.1%
	Urban	52	20.1%
	Rural	26	10.0%
Q12: Number of students receiving SPED services (*n = 259*)	0-4	4	1.5%
	5-9	3	1.2%
	10-19	7	2.7%
	20-49	13	5.0%
	50-99	20	7.7%
	100-199	25	9.7%
	200-299	11	4.3%
	300-399	11	4.3%
	400-499	11	4.3%
	500-999	25	9.7%
	1,000 or more	**66**	**25.5%**
	Multiple Districts	63	24.3%
Q13: Number of MTs in District (*n = 259*)	**1**	**101**	**39.0%**
	2	38	14.7%
	3	20	7.7%
	4	13	5.0%
	5 or more	28	10.8%
	Multiple Districts	59	22.8%
Q32: Are the model(s) of music therapy in which you provide services the same as those in which you practiced during your practicum or internship? (*n = 228*)	**Yes**	**88**	**38.6%**
	No	36	15.8%
	Sometimes*	36	15.8%
	I did not have a school-based practicum or internship experience	68	29.8%

(continued)

Appendix D (continued)

Question	Category	*n*	%
	** Additional comments included common themes such as: Therapist does more consultation/collaboration/co-teaching than in internship (3); Yes, but more developed (i.e. if received additional training or certification) (3); No, the population is different (3); No, because of a different philosophical approach (2); There was a wide range in internship; therapist has decided more of a specific model; Therapist has changed the model based on student/classroom needs; No, internship was not helpful; No, because frequency of sessions has increased*		

Note. Percentages are based on the number of those that responded to the question and thus varies among questions.

Appendix E

Caseload Characteristics

Question	Category	*n*	%
Q14: Number of Students on Caseload (*n = 255*) *Note: n =numeric responses, though Original n = 259 including other comments.*	Range: 0-1,000 Mode: 30 Mean: 76		
	0-24	**86**	**33.7%**
	25-49	58	22.8%
	50-99	36	14.1%
	100-199	47	18.4%
	200-299	12	4.7%
	300-399	7	2.8%
	400+	6	2.4%
Q15: SPED Team Model (*n = 259*)	**Multidisciplinary**	**91**	**35.1%**
	Interdisciplinary	88	34.0%
	Transdisciplinary	14	5.4%
	Do not work in SPED team	55	21.2%
	Other*	11	4.3%
	** Other responses included multiple districts with different models (2; both interdisciplinary and transdisciplinary (2); N/A when groups; both multidisciplinary and transdisciplinary; transdisciplinary except for MT-specific assessment; isolated from team (not invited); and collaborative on goals but not privy to student files*		
Q16: Supervisor (*n = 259*)	**SPED Administrator**	**119**	**46.0%**
	Another music therapist	63	24.3%
	Other**	48	18.5%
	District Administrator (non-SPED)	28	10.8%
	A music educator	1	0.4%
	*** Other responses to Q16 (supervisor) included none (11), principal (7), SPED Teachers (5), music therapist (4), fine arts coordinator (2), Speech-Language Pathologist (2), Arts therapy organization supervisor, Grant provider, School psychologist, Assistant principal, Coordinator of motor team services, Related services coordinator, Occupational therapist, Program director, Agency director, Expressive therapist, Guidance counselor, Child study team, Classroom teacher, Preschool director, Licensed Creative Arts Therapist, Teacher consultant, Music department, Specialized program administrator, and Program specialist*		
Q17: Music therapy on the IEP (*n = 259*)	**Not specified on IEP's**	88	34.0%
	As a direct service (1-on-1, small group, inclusive)	85	32.8%
	Mixture of direct and indirect service	69	26.6%
	Indirect service (i.e. consultation or programmatic service for all)	17	6.6%

(continued)

Appendix E (continued)

Question	Category	*n*	%
1-on-1 Sessions			
Q18: Number of **1-on-1** sessions per week (*n =246*)	**None**	**77**	**31.3%**
	1-4	60	24.4%
	5-9	37	15.0%
	10-19	41	16.7%
	20-29	26	10.6%
	30-39	4	1.6%
	40-49	1	0.4%
	50 or more	0	0.0%
Q19: Length of **1-on-1** sessions (*n =246*)	Do not facilitate	77	31.3%
	20-30 minutes	**103**	**41.9%**
	30-45 minutes	48	19.5%
	45-60 minutes	12	4.9%
	Other*	6	2.4%
Q20: Frequency of **1-on-1** sessions (*n =246*)	Do not facilitate	77	31.3%
	Once per week	**136**	**55.3%**
	Twice per week	13	5.3%
	3x per week	1	0.4%
	4x per week	0	0.0%
	5x per week	1	7.3%
	Other**	18	7.3%
	***** Other responses for length included "30 minutes exactly"- rather than specifically either the range of 20-30 or 30-45; as well as clarifying questions about what constituted a 1-on-1 session.* *****Other responses for frequency included 2x per month or bi-weekly (9); 1-2x per week (3); Every 3 weeks (2); Every 2-4 weeks; 5x per 6 weeks; 4x per 9 weeks; As needed (i.e. student behaviors)***		
Small Group Sessions			
Q21: Number of **small group** sessions per week (*n = 246*)	None	64	26.0%
	1-4	**81**	**32.9%**
	5-9	38	15.5%
	10-19	33	13.4%
	20-29	21	8.5%
	30-39	8	3.3%
	40-49	0	0.0%
	50 or more	1	0.4%
Q22: Length of **small group** sessions (*n = 246*)	Do not facilitate	62	25.2%
	20-30 minutes	**88**	**35.8%**
	30-45 minutes	69	28.1%
	45-60 minutes	23	9.4%
	Other***	4	1.6%
Q23: Frequency of **small group** sessions (*n = 246*)	Do not facilitate	61	24.8%
	Once per week	**143**	**58.1%**
	Twice per week	15	6.1%
	3x per week	1	0.4%
	4x per week	3	1.2%
	5x per week	3	1.2%

Appendix E (continued)

	Other****	20	8.1%
	*** Other responses for length were "30 minutes"- rather than specifically either the range of 20-30 or 30-60 ****Other responses for frequency included 2x per month or bi-weekly (7); Depends on class type or district (3); Every 3 weeks (2); 1-2x per week; 5x per 6 weeks; 5x per school year; 6x per month; 4x per 9 weeks		
Question	Category	*n*	%
Inclusive, Whole Class Sessions			
Q24: Number of **inclusive, whole class** sessions per week (*n = 246*)	**None**	**82**	**33.3%**
	1-4	61	24.8%
	5-9	34	13.8%
	10-19	44	17.9%
	20-29	17	6.9%
	30-39	6	2.4%
	40-49	1	0.4%
	50 or more	1	0.4%
Q25: Length of **inclusive, whole class** sessions (*n = 246*)	**Do not facilitate**	**83**	**33.7%**
	20-30 minutes	77	31.3%
	30-45 minutes	61	24.8%
	45-60 minutes	20	8.1%
	Other	5	2.0%
Q26: Frequency of **inclusive, whole class** sessions (*n = 246*)	Do not facilitate	81	32.9%
	Once per week	**116**	**47.2%**
	Twice per week	17	6.9%
	3x per week	2	0.8%
	4x per week	2	0.8%
	5x per week	1	0.4%
	Other*****	27	11.0%
	*****Other responses for frequency included 2x per month or bi-weekly (15); 1x per month (3); Mixed (i.e. weekly and bi-weekly) (3); Daily (2); Every 3-6 weeks; 5x per school year; 10-20x per school year; 4x per 9 weeks		
Q27: Determinants of length and frequency of sessions (*n = 246*) *Answers may add up to more than 100% due to option to choose multiple*	**Individual student needs**	**126**	**51.2%**
	Mandated by IEP team	66	26.8%
	Therapist caseload	62	25.2%
	District or SPED admin	56	22.8%
	Other******	45	18.3%
	Scheduled by general or special educators	42	17.1%
	******Other responses included Grant requirements/specifications (7), Budget allowance (5), Independent contract terms (5), Teacher plan/prep time coverage (4), Class schedule, Waiver-specified number of music therapy hours, District custom (not policy), Time needed for a special project, School schedule, Music therapist professional judgment		

Note. Percentages are based on the number of those that responded to the question and thus varies among questions.

Appendix F

Therapist Decisions

Question	Category	*n*	%
Q31: Ability to decide model (*n = 228*)	**Yes**	**168**	**73.7%**
	No	14	6.1%
	Sometimes*	46	20.2%
	** Additional comments included common themes such as: Yes, but with supervisor approval; Yes, but models have changed with input of SPED administrators to support the longevity of the program; Have tried to implement other models but not successfully or permanently; Services are provided as needed through contracts; Models may depend on class/student availability; The model may change if determined different models are best to support students*		
Q36a: Able to provide MT in the **model(s)** necessary (*n = 217*)	Strongly Agree	89	41.0%
	Agree	**114**	**52.5%**
	Neither agree nor disagree	5	2.3%
	Disagree	7	3.2%
	Strongly Disagree	2	0.9%
	Weighted Average: 4.29		
Q36b: Able to provide MT in the **amount of time** necessary (*n = 217*)	Strongly Agree	53	24.4%
	Agree	**102**	**47.0%**
	Neither agree nor disagree	33	15.2%
	Disagree	25	11.5%
	Strongly Disagree	4	1.8%
	Weighted Average: 3.81		
Q36c: Able to provide MT in the **location** necessary (*n = 217*)	Strongly Agree	47	21.7%
	Agree	**116**	**53.5%**
	Neither agree nor disagree	29	13.4%
	Disagree	23	10.6%
	Strongly Disagree	2	0.9%
	Weighted Average: 3.84		