THE VIRGINIA BOARD OF HEALTH PROFESSIONS

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

JUNE 2019

VIRGINIA BOARD OF HEALTH PROFESSIONS
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EXECUTIVE SUMMARY

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

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

AUTHORITY

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

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

7. To advise the Governor, the General Assembly and the Director on matters relating to the regulation or deregulation of health care professions and occupations;

12. To examine scope of practice conflicts involving regulated and unregulated professions and advise the health regulatory boards and the General Assembly of the nature and degree of such conflicts;

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

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

**CRITERION ONE: RISK FOR HARM TO THE CONSUMER**

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

**CRITERION TWO: SPECIALIZED SKILLS AND TRAINING**

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

**CRITERION THREE: AUTONOMOUS PRACTICE**

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

**CRITERION FOUR: SCOPE OF PRACTICE**

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

**CRITERION FIVE: ECONOMIC IMPACT**

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

**CRITERION SIX: ALTERNATIVES TO REGULATION**

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

**CRITERION SEVEN: LEAST RESTRICTIVE REGULATION**

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

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

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

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

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

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

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

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

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

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

A music therapist has a genuine interest in people and a desire to help others empower themselves. The essence of music therapy practice involves establishing caring and professional relationships with people of all ages and abilities. Empathy, patience, creativity, imagination, an openness to new ideas, and understanding of oneself are also important attributes. Because music therapists are accomplished musicians as well as therapists, a background and love of music are also essential. A music therapist must be versatile and able to adjust to changing circumstances. Music therapists must express themselves well in speech and in writing. In addition, they must be able to work well with other health care providers. (AMTA, 2019)
A music therapist is versatile and able to adjust to changing circumstances. Many different instruments may be used within a therapeutic context. Music therapy students generally choose one instrument to be their instrument of focus during their educational course of study and are given basic training on a variety of instruments (guitar, piano percussion, voice). The choice of instrument or musical intervention used in a music therapy session is dependent upon goals and objectives, the client’s preferences, and the music therapist’s professional judgement. (AMTA, 2019)

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

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

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

ASSOCIATIONS

AMERICAN MUSIC THERAPY ASSOCIATION

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

VIRGINIA MUSIC THERAPY ASSOCIATION

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

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

CRITERION ONE: RISK OF HARM

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

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

Table 1. CBMT-Violations 1998-June 2019

<table>
<thead>
<tr>
<th>State</th>
<th>Falsification of Records</th>
<th>Misuse of Credential</th>
<th>Negligence and Malpractice</th>
<th>Inappropriate Boundaries/Dual Relationships</th>
<th>Sexual Offenders or Sexual Harassment</th>
<th>Financial Exploitation</th>
</tr>
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<tbody>
<tr>
<td>Alabama</td>
<td>1</td>
<td>1</td>
<td></td>
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<tr>
<td>Arkansas</td>
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<tr>
<td>Illinois</td>
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<tr>
<td>Indiana</td>
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<td>North Carolina</td>
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<td>Ohio</td>
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<tr>
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<tr>
<td>Virginia</td>
<td>1</td>
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<tr>
<td>Wisconsin</td>
<td>1</td>
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<td><strong>Total</strong></td>
<td><strong>8</strong></td>
<td><strong>27</strong></td>
<td><strong>7</strong></td>
<td><strong>5</strong></td>
<td><strong>4</strong></td>
<td><strong>2</strong></td>
</tr>
</tbody>
</table>

*States with existing licensure
Since 1998, Pennsylvania has had the highest number of reported disciplinary actions with seven cases reported. (Table 2) The greatest number of cases (13) were reported in 2018. (Table 3) Overall, Misuse of Credentials was the most frequently disciplined violation, 27 actions in 20 years. (Table 1)

**Table 2. CBMT-Disciplinary Action by State**

<table>
<thead>
<tr>
<th>State</th>
<th>Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>1</td>
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<tr>
<td>Arkansas</td>
<td>2</td>
</tr>
<tr>
<td>Arizona</td>
<td>2</td>
</tr>
<tr>
<td>California</td>
<td>5</td>
</tr>
<tr>
<td>Connecticut*</td>
<td>1</td>
</tr>
<tr>
<td>Florida</td>
<td>1</td>
</tr>
<tr>
<td>Illinois</td>
<td>1</td>
</tr>
<tr>
<td>Indiana</td>
<td>4</td>
</tr>
<tr>
<td>Maryland</td>
<td>1</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>3</td>
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<tr>
<td>Michigan</td>
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<tr>
<td>Missouri</td>
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<tr>
<td>New Mexico</td>
<td>1</td>
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<tr>
<td>New York</td>
<td>3</td>
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<tr>
<td>North Carolina</td>
<td>1</td>
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<tr>
<td>Ohio</td>
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<td>Oregon*</td>
<td>1</td>
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<tr>
<td>Pennsylvania</td>
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<tr>
<td>Texas</td>
<td>5</td>
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<tr>
<td>Virginia</td>
<td>1</td>
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<tr>
<td>Wisconsin</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>53</strong></td>
</tr>
</tbody>
</table>

*States with existing licensure

Source: CBMT

**Table 3. CBMT-Disciplinary Action by Year**

<table>
<thead>
<tr>
<th>Year</th>
<th>Incidents Reported</th>
</tr>
</thead>
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<tr>
<td>Prior to 2010</td>
<td>5</td>
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<tr>
<td>2010</td>
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<tr>
<td>2011</td>
<td>0</td>
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<tr>
<td>2012</td>
<td>1</td>
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<td>2013</td>
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<td>2014</td>
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<td>2015</td>
<td>9</td>
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<td>2016</td>
<td>11</td>
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<tr>
<td>2017</td>
<td>7</td>
</tr>
<tr>
<td>2018</td>
<td>13</td>
</tr>
<tr>
<td>2019</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>53</strong></td>
</tr>
</tbody>
</table>

Source: CBMT

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

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

The Virginia Department of Education does not formally recognize the profession and its national board certification credential. VMTA purports that a lack of recognition has led to the disruption of student progress, school staff being asked to provide services they are not qualified to offer, and significant frustration for families affected by the interpretation of the federal special education law. (VMTA, 2019)
To protect the public from threats of harm in clinical practice, music therapists comply with safety standards and with transport protocols for clients. A therapist is trained to recognize the potential harm of music experiences and use them with care. The therapist knows the potential harm of verbal and physical interventions during music experiences and uses them with care. A music therapist practices infection control protocols (e.g., universal precautions, disinfecting instruments) and recognizes client populations and health conditions for which music experiences are contraindicated. (VMTA, 2019)

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

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

**CRITERION TWO: SPECIALIZED SKILLS AND TRAINING**

**EDUCATION**

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

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

**Musical Foundations (45%)**
- Music Theory, Composition and Arranging, Music History and Literature, Applied Music Major, Ensembles, Conducting, Functional Piano, Guitar, and Voice

**Clinical Foundations (15%)**
- Exceptionality and Psychopathology, Normal Human Development, Principles of Therapy, The Therapeutic Relationship

**Music Therapy (15%)**

**General Education (20-25%)**
- English, Math, Social Sciences, Arts, Humanities, Physical Sciences, etc.

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

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

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

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

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

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

CREDENTIALING

Nationally, the CBMT is the only organization to certify a music therapist to practice music therapy. Since 1986, the CBMT MT-BC program has been fully accredited by the National Commission for Certifying Agencies (NCCA). Some music therapists hold older designations as a registered music therapist (RMT), certified music therapist (CMT) or advanced certified music therapist (ACMT) which were issued by the American Music Association of Music Therapy (AMTA) or the National Association of Music Therapy (NAMT). The ACMT and NAMT merged into the American Music Therapy Association (AMTA). The AMTA has phased out the AMT, CMT and ACMT designations as well as the national registry. Currently music therapists seeking national certification must obtain the MT-BC credential.
The CBMT administers the examination, which is based on a nationwide music therapy practice analysis that is reviewed and updated every five years to reflect current clinical practice. Both the practice analysis and the examination are psychometrically sound and developed using guidelines issued by the Equal Employment Opportunity Commission, and the American Psychological Association's standards for test validation.

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

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

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

**Criterion Three: Autonomous Practice**

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

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

<table>
<thead>
<tr>
<th>Year</th>
<th>Number Certified Each Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985-2008</td>
<td>88</td>
</tr>
<tr>
<td>2009</td>
<td>11</td>
</tr>
<tr>
<td>2010</td>
<td>11</td>
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<td>2012</td>
<td>8</td>
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<tr>
<td>2013</td>
<td>10</td>
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<tr>
<td>2014</td>
<td>18</td>
</tr>
<tr>
<td>2015</td>
<td>17</td>
</tr>
<tr>
<td>2016</td>
<td>20</td>
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<td>2017</td>
<td>16</td>
</tr>
<tr>
<td>2018</td>
<td>16</td>
</tr>
<tr>
<td>2019</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>227</td>
</tr>
</tbody>
</table>

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

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

**CRITERION FOUR: SCOPE OF PRACTICE AND OVERLAP**

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

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

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

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

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

WAGES & SALARIES

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

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

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

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

WORKFORCE ADEQUACY

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

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

<table>
<thead>
<tr>
<th>State</th>
<th>Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecticut</td>
<td>$48,730</td>
</tr>
<tr>
<td>Georgia</td>
<td>$43,270</td>
</tr>
<tr>
<td>Nevada</td>
<td>$53,580</td>
</tr>
<tr>
<td>North Dakota</td>
<td>$44,510</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>$36,980</td>
</tr>
<tr>
<td>Oregon</td>
<td>$56,970</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>$43,610</td>
</tr>
<tr>
<td>Utah</td>
<td>$42,030</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>$41,010</td>
</tr>
</tbody>
</table>

Source: Career Explorer-Music Therapist Salary
REIMBURSEMENT

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

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

MEDICARE

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

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

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

MEDICAID

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

PRIVATE INSURANCE

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

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

OTHER SOURCES

Additional sources for reimbursement and financing of music therapy services include many state departments of mental health, state departments of developmental disabilities, state adoption subsidy programs, private auto insurance, employee worker’s compensation, county boards of developmental disabilities, IDEA Part B related services funds, foundations, grants, and private pay. (AMTA, 2019)
IMPACT OF LICENSURE ON THE DEPARTMENT OF HEALTH PROFESSIONS
Some regulated professions lack a sufficient number of individuals to cover their regulatory costs. This places a strain on a board’s cash resources.

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

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

Table 6. Current State Licensure Recognition

<table>
<thead>
<tr>
<th>State</th>
<th>Licensure</th>
<th>Title Certification</th>
<th>Title Protection</th>
<th>Registry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecticut</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Georgia (LPMT)</td>
<td>X - 140</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nevada (LPMT)</td>
<td>X - 23</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Dakota (MT-BC/L)</td>
<td>X - 18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oklahoma (LPMT)</td>
<td>X - 23</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oregon (LPMT)</td>
<td>X - 76</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rhode Island (LPMT)</td>
<td>X - 8</td>
<td></td>
<td></td>
<td>X***</td>
</tr>
<tr>
<td>Utah (SCMT)</td>
<td></td>
<td></td>
<td></td>
<td>X - 54**</td>
</tr>
<tr>
<td>Wisconsin (WMTR)</td>
<td></td>
<td></td>
<td></td>
<td>X - 38*</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>288</td>
<td>54</td>
<td></td>
<td>38</td>
</tr>
</tbody>
</table>

*Applicants must be certified, registered or accredited as Music Therapists by one of the following organizations:
The Certification Board for Music Therapists, National Music Therapy Registry, American Music Therapy Association, or another national organization that certifies, registers, or accredits Music Therapists.

**Currently seeking licensure

***Rhode Island-registration functions as a license

Source: AMTA
Table 7. 2018 Legislative Activity by State

<table>
<thead>
<tr>
<th>State</th>
<th>Licensure</th>
<th>Title Certification</th>
<th>Title Protection</th>
<th>Registry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illinois</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iowa</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Michigan</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minnesota</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Missouri</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>New Jersey</td>
<td>X</td>
<td></td>
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<td>New York</td>
<td>X</td>
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<td>North Carolina</td>
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<tr>
<td>Ohio</td>
<td>X</td>
<td></td>
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<tr>
<td>Pennsylvania</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utah</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9</strong></td>
<td><strong>1</strong></td>
<td><strong>1</strong></td>
<td></td>
</tr>
</tbody>
</table>

Source: AMTA

Music Therapy Licensure in Other States

Connecticut (2016)
Music therapists in Connecticut are not strictly regulated and are provided title protection only. Individuals who are not board certified by the CBMT and have not graduated with a bachelor’s degree from an AMTA accredited program cannot call themselves “music therapists” or “certified music therapists”. An individual that wrongly uses either title is guilty of a class D felony. (Connecticut, 2019)

Georgia (2012)
In Georgia, music therapists are licensed, pursuant to statute, by the Secretary of State. Music therapists who wish to be licensed must obtain a bachelor’s degree from an accredited AMTA school, complete a minimum of 1,200 hours of clinical training, have passed the CBMT exam, have passed a criminal background check, and must be at least 18 years of age. Licensure renewal requires maintaining the MT-BC credential, and 40 hours of continuing education approved by the CBMT. (Georgia, 2019)

Nevada (2011)
Music therapists are licensed in Nevada by the Bureau of Health Care Quality and Compliance. Licensure protects the public health, safety and welfare from unqualified or unlicensed individuals. Qualifications for licensure include at least a bachelor’s degree from an accredited AMTA school, submission of a licensing fee, completion of a minimum of 1,200 hours of clinical training, a passing grade on the CBMT exam, a criminal background check, and must be at least 18 years of age. Licensure renewal requires completion of 100 hours of continuing education every three years from a CBMT approved program. (Nevada, 2019)
North Dakota (2011)
Music therapists in North Dakota are regulated by the Board of Integrative Health Care. Qualifications for licensure include graduation from a board-approved program, completion of a board-approved exam, good standing with the CBMT, have the physical, mental, and professional competencies to practice and have not committed any acts that would warrant discipline. Licenses expire biannually and 40 hours of approved continuing education must be completed biannually. (North Dakota, 2019)

Oklahoma (2011)
Music therapists in Oklahoma are licensed by the State Board of Medical Licensure and Supervision. Music therapists must hold at least a bachelor's degree in music therapy by an AMTA approved program, completed at least 1,200 hours of clinical training in an approved program, have a passing grade on the CBMT exam, be at least 18 years old, and be in good moral character. Licenses expire every two years and music therapists must remain in good standing with the CBMT. (Oklahoma, 2019)

Oregon (2015)
In Oregon the Health Licensing Office regulates music therapists. To obtain licensure, a music therapist must pass the CBMT certification exam within two years preceding application submission, maintaining CMBT certification as well as a professional designation and must be at least 18 years of age. To maintain licensure music therapists must complete a minimum of ten continuing education credits each year. (Oregon, 2019)

Rhode Island (2014)
Music therapists in Rhode Island are regulated by the Department of Health and are termed “registered,” with registration functioning as a license. To qualify for registration as a music therapist an applicant must hold a bachelor's degree from an AMTA approved school, complete a minimum of 1,200 hours of clinical training provided by an AMTA approved program, pass the CBMT certification board exam, currently be a board certified music therapist, and be at least 18 years of age. Registrations expire biannually and renewal requirement is that the music therapist remain board certified. (Rhode Island, 2019)

Utah (2014)
Utah music therapists are regulated by the Division of Occupational and Professional Licensing. To qualify for certification as a music therapist an applicant must be in good standing with the CBMT, be of good moral character, and pay an application fee. Certificates expire biannually and to renew a music therapist must prove good standing with the CBMT. This certification system functions closer to a title protection act than a practice act, but it does allow for more disciplinary measures than traditional title protection. (Utah, 2019)

Wisconsin (2011)
The Department of Safety and Professional Services regulates Wisconsin music therapists. Music therapists fall under a subset of creative arts therapists, which itself is a subset of psychotherapists. Music therapists must be CBMT board certified, disclose criminal convictions or pending criminal charges and pay an application fee. Registration expires biannually and to renew a registration a music therapist must maintain CBMT certification.

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

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


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


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


Nevada Music Therapy Regulations: http://dpbh.nv.gov/Reg/MusicTherapist/MusicTherapists - Home/

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

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


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

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

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

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

APPENDIX 1 – SENATE BILL 1547 (Page 22)

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SENATE BILL NO. 1547
AMENDMENT IN THE NATURE OF A SUBSTITUTE
(Proposed by the House Committee on Health, Welfare and Institutions
on February 14, 2019)
(Patron Prior to Substitute—Senator Vogel)
A BILL to direct the Board of Health Professions to evaluate whether music therapists and the practice of music therapy should be regulated and the degree of regulation to be imposed.

Be it enacted by the General Assembly of Virginia:

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

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

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

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

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

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

- **Public Protection.** The public is entitled to have access to qualified music therapists who practice competently, safely, and ethically.
- **Requisite Training and Skill Sets.** The scope of music therapy practice includes professional and advanced competencies. The music therapist only provides services within the scope of practice that reflect his/her level of competence. The music therapy profession is not defined by a single music intervention or experience, but rather a continuum of skills sets (simple to complex) that make the profession unique.
- **Evidence-Based Practice.** A music therapist’s clinical practice is guided by the integration of the best available research evidence, the client’s needs, values, and preferences, and the expertise of the clinician.
- **Overlap in Services.** Music therapists recognize that in order for clients to benefit from an integrated, holistic treatment approach, there will be some overlap in services provided by multiple professions. We acknowledge that other professionals may use music, as appropriate, as long as they are working within their scope.
- **Professional Collaboration.** A competent music therapist will make referrals to other providers (music therapists and non-music therapists) when faced with issues or situations beyond the original clinician’s own practice competence, or where greater competence or specialty care is determined as necessary or helpful to the client’s condition.
- **Client-Centered Care.** A music therapist is respectful of, and responsive to the needs, values, and preferences of the client and the family. The music therapist involves the client in the treatment planning process, when appropriate.

Music Therapy Practice

**Music therapy** means the clinical and evidence-based use of music interventions to accomplish individualized goals for people of all ages and ability levels within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. Music therapists develop music therapy treatment plans specific to the needs and strengths of the client who may be seen individually or in groups. Music therapy treatment plans are individualized for each client. The
Music therapists are members of an interdisciplinary team of healthcare, education, and other professionals who work collaboratively to address the needs of clients while protecting client confidentiality and privacy. Music therapists function as independent clinicians within the context of the interdisciplinary team, supporting the treatment goals and co-
treating with physicians, nurses, rehabilitative specialists, neurologists, psychologists, psychiatrists, social workers, counselors, behavioral health specialists, physical therapists, occupational therapists, speech-language pathologists, audiologists, educators, clinical case managers, patients, caregivers, and more.

Music therapy-specific assessment, treatment planning, and implement-
tation consider diagnosis and history, are performed in a manner con-
gruent with the client’s level of functioning, and address client needs across multiple domains.

Potential for Harm

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

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

cal practice are investigated.

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

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

- Recognize and respond to situations in which there are clear and present dangers to a client and/or others.
- Recognize the potential harm of music experiences and use them with care.
- Recognize the potential harm of verbal and physical interventions during music experiences and use them with care.
- Observe infection control protocols (e.g., universal precautions, disinfecting instruments).
• Recognize the client populations and health conditions for which music experiences are contraindicated.
• Comply with safety protocols with regard to transport and physical support of clients.

Definition of Governing Bodies

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

AMTA is committed to:

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

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

CBMT is committed to:

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

The unique roles of AMTA (education and clinical training) and CBMT (credentialing and continuing education) ensure that the distinct, but related, components of the profession are maintained. This scope of music therapy practice document acknowledges the separate but complementary contributions of AMTA and CBMT in developing and maintaining professional music therapists and evidence-based practices in the profession.

Education and Clinical Training Requirements

A qualified music therapist:

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

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

Board Certification Requirements

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

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

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

By establishing and maintaining the certification program, CBMT is in compliance with NCCA guidelines and standards that require certifying agencies to: 1) have a plan for periodic recertification, and 2) provide evidence that the recertification program is designed to measure or enhance the continuing competence of the individual.
The CBMT recertification program provides music therapists with guidelines for remaining current with safe and competent practice and enhancing their knowledge in the profession of music therapy.

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

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

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

References
AMTA Standards of Clinical Practice

PREAMBLE

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

Further Clarification:

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

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

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

INTRODUCTION

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

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

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

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

1.0 Standard I - Referral and Acceptance

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

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

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

1.2.1 a Music Therapist

1.2.2 members of other disciplines or agencies

1.2.3 self

1.2.4 parents, guardians, advocates or designated representatives

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

2.0 Standard II - Assessment

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

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

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

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

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

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

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

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

3.0 Standard III - Treatment Planning

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

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

3.2 Comply with federal, state, and facility regulations.

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

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

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

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

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

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

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

3.8.1 The program plans of other disciplines.

3.8.2 Established principles of normal growth and development.

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

4.0 Standard IV - Implementation

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

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

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

4.1.2 Appropriate musical instruments and materials, as well as the best possible sound reproduction equipment should be used in music therapy services.
4.1.3 The Music Therapist will make every effort to ensure safe and quality client care.

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

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

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

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

4.6 Incorporate the results of such evaluations in subsequent treatment.

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

5.0 Standard V - Documentation

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

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

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

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

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

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

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

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

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

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

6.0 Standard VI - Termination of Services

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

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

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

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

*American Music Therapy Association Standards of Clinical Practice*

revised 11/23/13
6.4 Summarize the client's progress and functioning level at the time of termination.

7.0 Standard VII - Continuing Education

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

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

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

8.0 Standard VIII - Supervision

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

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

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

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

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

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

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

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

ADDICTIVE DISORDERS

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

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

1.0 Standard I - Referral and Acceptance

A client will be accepted for music therapy in accordance with specific criteria.
1.1 A client may be a candidate for music therapy when a cognitive, communication, psychological, educational, social, or physiological need might be ameliorated or prevented by such services.

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

1.2.1 a Music Therapist
1.2.2 members of other disciplines or agencies
1.2.3 self
1.2.4 parents, guardians, advocates or designated representatives
1.2.5 Members of a treatment team

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

2.0 Standard II - Assessment

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

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

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

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

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

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

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

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

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

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

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

3.0 Standard III - Treatment Planning

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

3.1 Help the client attain and maintain the maximum level of functioning.
3.2 Comply with federal, state, and facility regulations.
3.3 Delineate the type, frequency, and duration of music therapy involvement.
3.4 Contain goals viii that focus on assessed needs and strengths of the client.
3.5 Contain objectives ix which are operationally defined for achieving the stated goals within estimated time frames.
3.6 Specify procedures, including music and music materials, for attaining the objectives.

3.6.1 The Music Therapist will include music, instruments, and musical elements, from the client's culture as appropriate.
3.7 Provide for periodic evaluation and appropriate modifications as needed.

3.8 Optimize, according to the best professional judgment of the Music Therapist:
   3.8.1 The program plans of other disciplines.
   3.8.2 Established principles of normal growth and development.

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

3.10 Comply with infection control procedures.

3.11 Incorporate medical precautions as necessary.

4.0 Standard IV - Implementation

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

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

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

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

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

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

4.6 Incorporate the results of such evaluations in subsequent treatment.

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

4.8 Include family member participation in the treatment plan when appropriate.

4.9 Disclose information to the patient and the patient's family consistent with the physician's judgment and discretion in accordance with regulations when appropriate.

4.10 Disclose information consistent with the treatment team's recommendations in accordance with federal, state, and local confidentiality regulations.

5.0 Standard V - Documentation

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

5.1 The Music Therapist will periodically document the client's level of functioning with regard to the goals and objectives.
5.2 The documentation of progress will describe significant intervention techniques and the client's responses to them.

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

   - 5.3.1 Write in an objective, professional style based on observable client responses.
   - 5.3.2 Include the date, signature, and professional status of the therapist.
   - 5.3.3 Place such documentation in the client's file and maintain its confidentiality unless proper authorization for release is obtained.

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

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

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

6.0 Standard VI - Termination of Services

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

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

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

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

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

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

7.0 Standard VII - Continuing Education

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

   - 7.1.1 The Music Therapist will maintain knowledge of current developments in research, theory, and techniques concerning addictive disorders and related areas.
   - 7.1.2 Related areas may include, but need not be limited to, family systems theory and 12 step programs, such as Alcoholics Anonymous, Narcotics Anonymous and Adult Children of Alcoholics.

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

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

8.0 Standard VIII - Supervision
8.1 It is the responsibility of the Music Therapist to seek and participate in supervision on a regular basis.

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

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

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

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

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

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

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

CONSULTANT

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

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

1.0 Standard 1 - Referral and Acceptance

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

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

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

1.2.1 a Music Therapist

1.2.2 members of other disciplines or agencies

1.2.3 self
1.2.4 parents, guardians, advocates or designated representatives

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

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

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

2.0 Standard II - Assessment

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

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

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

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

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

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

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

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

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

3.0 Standard III - Treatment Planning

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

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

3.2 Comply with federal, state, and facility regulations.

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

3.4 Contain goals viii that focus on assessed needs and strengths of the client.
3.5 Contain objectives which are operationally defined for achieving the stated goals within estimated time frames.

3.6 Specify procedures, including music and music materials, for attaining the objectives.
   3.6.1 The Music Therapist will include music, instruments, and musical elements, from the client's culture as appropriate.

3.7 Provide for periodic evaluation and appropriate modifications as needed.

3.8 Optimize, according to the best professional judgment of the Music Therapist:
   3.8.1 The program plans of other disciplines.
   3.8.2 Established principles of normal growth and development.

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

3.10 Comply with infection control procedures.

3.11 Incorporate medical precautions as necessary.

4.0 Standard IV - Implementation

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

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

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

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

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

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

4.6 Incorporate the results of such evaluations in subsequent treatment.

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

5.0 Standard V - Documentation

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

5.1 The Music Therapist will periodically document the client's level of functioning with regard to the goals and objectives.
5.2 The documentation of progress will describe significant intervention techniques and the client's responses to them.

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

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

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

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

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

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

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

6.0 Standard VI - Termination of Services

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

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

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

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

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

7.0 Standard VII - Continuing Education

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

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

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

8.0 Standard VIII - Supervision

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

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

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

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

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

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

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

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

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

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

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

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

1.0 Standard I - Referral and Acceptance

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

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

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

1.2.1 a Music Therapist

1.2.2 members of other disciplines or agencies

1.2.3 self

1.2.4 parents, guardians, advocates or designated representatives

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

2.0 Standard II - Assessment

A client will be assessed by a Music Therapist for music therapy services.
2.1 The music therapy assessment will include the general categories of psychological, cognitive, communicative, social, and physiological functioning focused on the client's needs and strengths. The assessment will also determine the client's responses to music, music skills and musical preferences.

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

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

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

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

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

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

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

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

2.9.1 Motor functioning
2.9.2 Sensory processing, planning and task execution
2.9.3 Emotional status
2.9.4 Coping skills
2.9.5 Infection control procedures
2.9.6 Attending behaviors
2.9.7 Interpersonal relationships

3.0 Standard III - Treatment Planning

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

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

3.2 Comply with federal, state, and facility regulations.

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

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

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

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

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

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

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

3.8.1 The program plans of other disciplines.

3.8.2 Established principles of normal growth and development.

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

3.10 Comply with infection control procedures.

3.11 Incorporate medical precautions as necessary.

4.0 Standard IV - Implementation

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

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

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

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

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

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

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

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

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

4.6 Incorporate the results of such evaluations in subsequent treatment.

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

5.0 Standard V - Documentation

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

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

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

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

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

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

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

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

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

6.0 Standard VI - Termination of Services

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

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

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

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

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

7.0 Standard VII - Continuing Education

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

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

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

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

8.0 Standard VIII - Supervision

8.1 It is the responsibility of the Music Therapist to seek and participate in supervision on a regular basis.
8.1.1 Types of supervision may include but are not limited to direct observation, peer review, verbal feedback, group supervision, individual supervision, and music based supervision.

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

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

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

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

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

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

EDUCATIONAL SETTINGS

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

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

1.0 Standard I - Referral and Acceptance

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

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

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

1.2.1 a Music Therapist

1.2.2 members of other disciplines or agencies

1.2.3 self

1.2.4 parents, guardians, advocates or designated representatives

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

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2.0 Standard II - Assessment

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

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

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

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

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

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

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

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

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

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

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

3.0 Standard III - Treatment Planning

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

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

3.2 Comply with federal, state, and facility regulations.

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

3.4 Contain goals that focus on assessed needs and strengths of the client.

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

3.6 Specify procedures, including music and music materials, for attaining the objectives.
3.6.1 The Music Therapist will include music, instruments, and musical elements, from the client's culture as appropriate.

3.7 Provide for periodic evaluation and appropriate modifications as needed.

3.8 Optimize, according to the best professional judgment of the Music Therapist:
   3.8.1 The program plans of other disciplines.
   3.8.2 Established principles of normal growth and development.

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

3.10 Comply with infection control procedures.

3.11 Incorporate medical precautions as necessary.

4.0 Standard IV - Implementation

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

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

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

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

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

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

4.6 Incorporate the results of such evaluations in subsequent treatment.

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

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

5.0 Standard V - Documentation

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

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

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

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

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

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

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

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

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

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

**6.0 Standard VI - Termination of Services**

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

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

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

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

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

**7.0 Standard VII - Continuing Education**

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

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

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

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

**8.0 Standard VIII - Supervision**

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

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

8.1.2 The Music Therapist may seek supervision from music therapists as well as other professionals including but not limited to psychologists, psychiatrists, social workers, art therapists, dance/movement therapists, drama therapists, physical therapists, occupational therapists, speech language pathologists, physicians, and nurses.
8.2 It is the responsibility of the Music Therapist providing supervision to maintain knowledge of current developments in research, theory, and techniques in music therapy supervision and supervision in general.

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

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

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

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

OLDER ADULTS

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

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

1.0 Standard I - Referral and Acceptance

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

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

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

1.2.1 a Music Therapist

1.2.2 members of other disciplines or agencies

1.2.3 self

1.2.4 parents, guardians, advocates or designated representatives

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

2.0 Standard II - Assessment

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

2.1 The music therapy assessment will include the general categories of psychological, cognitive, communicative, social, and physiological functioning focused on the client's needs and strengths. The assessment will also determine the client's responses to music, music skills and musical preferences.
2.2 The music therapy assessment will explore the client's culture. This can include but is not limited to race, ethnicity, language, religion/spirituality, socioeconomic status, family experiences, sexual orientation, gender identity or expression, and social organizations.

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

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

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

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

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

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

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

2.9.1 Motor skills.
2.9.2 Reality orientation
2.9.3 Emotional status
2.9.4 Spatial and body concepts
2.9.5 Long and short term memory
2.9.6 Attending behaviors
2.9.7 Infection control precautions
2.9.8 Sensory acuity and perception
2.9.9 Independent functioning and adaptive needs
2.9.10 Coping skills

3.0 Standard III - Treatment Planning

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

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

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

4.0 Standard IV - Implementation

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

5.0 Standard V - Documentation

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

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

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

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

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

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

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

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

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

6.0 Standard VI - Termination of Services

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

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

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

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

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

7.0 Standard VII - Continuing Education

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

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

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

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

8.0 Standard VIII - Supervision
8.1 It is the responsibility of the Music Therapist to seek and participate in supervision on a regular basis.

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

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

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

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

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

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

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

MEDICAL SETTINGS

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

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

1.0 Standard I - Referral and Acceptance

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

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

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

1.2.1 a Music Therapist

1.2.2 members of other disciplines or agencies

1.2.3 self

1.2.4 parents, guardians, advocates or designated representatives

1.3 The final decision to accept a client for music therapy assessment will be made by a Music Therapist.
1.3.1 Note: Some medical settings may require a physician's order for music therapy services.

2.0 Standard II - Assessment

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

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

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

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

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

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

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

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

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

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

   2.9.1 Emotional/psychosocial
   2.9.2 Coping skills
   2.9.3 Infection control precautions
   2.9.4 Activity status, pre-operative and post-operative
   2.9.5 Attitude toward surgery and/or medical procedures
   2.9.6 Cardiac precautions
   2.9.7 Impact of surgery and/or loss of body function on self-image
   2.9.8 Medical equipment precautions
   2.9.9 Medical regime and possible side effects
2.9.10 Mental status
2.9.11 Pain tolerance and threshold levels
2.9.12 Postural restrictions
2.9.13 Scheduling requirements, coordination with other medical treatments
2.9.14 Support during medical procedures

3.0 Standard III - Treatment Planning

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

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

3.2 Comply with federal, state, and facility regulations.

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

3.4 Contain goals which focus on assessed needs and strengths of the client.

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

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

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

3.7 Provide for periodic evaluation and appropriate modifications as needed.

3.8 Optimize, according to the best professional judgment of the Music Therapist:

3.8.1 The program plans of other disciplines.

3.8.2 Established principles of normal growth and development.

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

3.10 Comply with infection control procedures.

3.11 Incorporate medical precautions as necessary.

4.0 Standard IV - Implementation

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

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

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

4.1.2 Appropriate musical instruments and materials, as well as the best possible sound reproduction equipment should be used in music therapy services.
4.1.3 The Music Therapist will make every effort to ensure safe and quality client care.

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

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

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

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

4.6 Incorporate the results of such evaluations in subsequent treatment.

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

4.8 Include family member participation in the treatment plan when appropriate.

4.9 Disclose information to patient and family members consistent with the physician's judgment and discretion and in accordance with hospital regulations.

5.0 Standard V - Documentation

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

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

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

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

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

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

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

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

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

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

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

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

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

6.0 Standard VI - Termination of Services

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

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

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

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

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

6.5 Include consultation with the attending physician and/or other treatment team members regarding termination of music therapy services when appropriate.

7.0 Standard VII - Continuing Education

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

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

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

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

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

8.0 Standard VIII - Supervision

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

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

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

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

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

8.2.2 The Music Therapist providing supervision is required to will adhere to all AMTA Standards of Clinical Practice and will assure that the Music Therapist supervisee has read and agrees to adhere to the AMTA Standards of Clinical Practice. The Music Therapist providing supervision shall hold the supervisee accountable for adhering to the AMTA Standards of Clinical Practice.
8.2.3 The Music Therapist providing supervision will complete any necessary documentation pertaining to supervision accurately, completely, and in a timely manner.

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

MENTAL HEALTH

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

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

1.0 Standard I - Referral and Acceptance

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

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

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

   1.2.1 a Music Therapist
   1.2.2 members of other disciplines or agencies
   1.2.3 self
   1.2.4 parents, guardians, advocates or designated representatives
   1.2.5 Members of a treatment team

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

2.0 Standard II - Assessment

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

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

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

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

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

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

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

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

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

   2.9.1 Motor functioning
   2.9.2 Sensory processing, planning and task execution
   2.9.3 Substance use or abuse
   2.9.4 Reality orientation
   2.9.5 Emotional status
   2.9.6 Vocational status
   2.9.7 Educational background
   2.9.8 Client's use of music
   2.9.9 Developmental level
   2.9.10 Coping skills
   2.9.11 Infection control precautions

3.0 Standard III - Treatment Planning

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

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

3.2 Comply with federal, state, and facility regulations.

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

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

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

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

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

3.7 Provide for periodic evaluation and appropriate modifications as needed.

3.8 Optimize, according to the best professional judgment of the Music Therapist:

3.8.1 The program plans of other disciplines.

3.8.2 Established principles of normal growth and development.

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

3.10 Comply with infection control procedures.

3.11 Incorporate medical precautions as necessary.

4.0 Standard IV - Implementation

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

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

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

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

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

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

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

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

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

4.6 Incorporate the results of such evaluations in subsequent treatment.

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

5.0 Standard V - Documentation

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

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

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

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

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

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

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

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

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

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

### 6.0 Standard VI - Termination of Services

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

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

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

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

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

### 7.0 Standard VII - Continuing Education

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

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

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

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

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

### 8.0 Standard VIII - Supervision

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

8.1.1 Types of supervision may include but are not limited to direct observation, peer review, verbal feedback, group supervision, individual supervision, and music based supervision.
8.1.2 The Music Therapist may seek supervision from music therapists as well as other professionals including but not limited to psychologists, psychiatrists, social workers, art therapists, dance/movement therapists, drama therapists, physical therapists, occupational therapists, speech language pathologists, physicians, and nurses.

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

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

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

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

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

**PHYSICAL DISABILITIES**

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

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

**1.0 Standard I - Referral and Acceptance**

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

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

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

   1.2.1 a Music Therapist
   1.2.2 members of other disciplines or agencies
   1.2.3 self
   1.2.4 parents, guardians, advocates or designated representatives

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

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

**2.0 Standard II - Assessment**

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

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

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

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

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

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

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

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

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

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

   2.9.1 Motor skills
   2.9.2 Sensory processing, planning and task execution
   2.9.3 Emotional status
   2.9.4 Vocational status
   2.9.5 Coping skills
   2.9.6 Infection control precautions
   2.9.7 Activity status
   2.9.8 Impact of surgery &/or loss of body function on self-image.
   2.9.9 Medical regime & possible side effects
   2.9.10 Mental status
   2.9.11 Postural restrictions

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

3.0 Standard III - Treatment Planning

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

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

4.0 Standard IV - Implementation

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

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

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

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

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

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

4.6 Incorporate the results of such evaluations in subsequent treatment.

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

5.0 Standard V - Documentation

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

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

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

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

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

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

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

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

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

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

6.0 Standard VI - Termination of Services

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

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

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

6.3 Allow sufficient time for approval, coordination, and effective implementation whenever possible.
6.4 Summarize the client's progress and functioning level at the time of termination.

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

7.0 Standard VII - Continuing Education

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

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

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

8.0 Standard VIII - Supervision

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

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

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

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

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

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

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

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

PRIVATE PRACTICE

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

1.0 Standard I - Referral and Acceptance

The Music Therapist responds to a referral or request for services and accepts or declines a case at his or her own professional discretion.
1.1 A client may be a candidate for music therapy when a cognitive, communication, psychological, educational, social, or physiological need might be ameliorated or prevented by such services.

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

   1.2.1 a Music Therapist
   1.2.2 members of other disciplines or agencies
   1.2.3 self
   1.2.4 parents, guardians, advocates or designated representatives

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

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

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

   1.5.1 Frequency of sessions
   1.5.2 Length of each session
   1.5.3 Projected length of music therapy services
   1.5.4 Terms of payment for services

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

2.0 Standard II - Assessment

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

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

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

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

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

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

2.6 The final decision to accept a client for music therapy services, either direct or consultative, will be made by a Music Therapist and, when applicable, will be in conjunction with the interdisciplinary team. Screening may be used as part of this process.
2.7 The results, conclusions, and implications of the music therapy assessment will become the basis for the client's music therapy program and will be communicated to others involved with provision of services to the client. When appropriate, the results will be communicated to the client.

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

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

3.0 Standard III - Treatment Planning

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

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

3.2 Comply with federal, state, and facility regulations.

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

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

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

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

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

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

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

3.8.1 The program plans of other disciplines.

3.8.2 Established principles of normal growth and development.

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

3.10 Comply with infection control procedures.

3.11 Incorporate medical precautions as necessary.

4.0 Standard IV - Implementation

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

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

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

4.1.2 Appropriate musical instruments and materials, as well as the best possible sound reproduction equipment should be used in music therapy services.
4.1.3 The Music Therapist will make every effort to ensure safe and quality client care.

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

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

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

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

4.6 Incorporate the results of such evaluations in subsequent treatment.

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

5.0 Standard V - Documentation

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

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

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

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

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

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

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

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

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

5.6 Periodic evaluation will be sent to the referral source when appropriate.

5.7 The Music Therapist will document:

5.7.1 Each session with the client

5.7.2 The client's payment for services

6.0 Standard VI - Termination of Services

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

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

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

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

7.0 Standard VII - Continuing Education

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

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

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

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

8.0 Standard VIII - Supervision

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

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

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

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

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

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

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

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

WELLNESS

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

American Music Therapy Association Standards of Clinical Practice

revised 11/23/13
Music therapy in wellness involves the specialized use of music to enhance quality of life, maximize well being and potential, and increase self-awareness in individuals seeking music therapy services.

1.0 Standard I - Referral and Acceptance

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

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

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

   1.2.1 a Music Therapist
   1.2.2 members of other disciplines or agencies
   1.2.3 self
   1.2.4 parents, guardians, advocates or designated representatives

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

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

   1.4.1 Frequency of sessions
   1.4.2 Length of each session
   1.4.3 Projected length of music therapy services
   1.4.4 Terms of payment for services

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

2.0 Standard II – Assessment

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

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

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

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

2.4 All interpretations of test results will be based on appropriate norms or criterion referenced data vii.
2.5 The music therapy assessment procedures and results will become a part of the client's file.

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

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

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

3.0 Standard III - Treatment Planning

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

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

3.2 Comply with federal, state, and facility regulations.

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

3.4 Contain goals that focus on assessed needs and strengths of the client.

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

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

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

3.7 Provide for periodic evaluation and appropriate modifications as needed.

3.8 Optimize, according to the best professional judgment of the Music Therapist:

3.8.1 The program plans of other disciplines.

3.8.2 Established principles of normal growth and development.

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

3.10 Comply with infection control procedures.

3.11 Incorporate medical precautions as necessary.

4.0 Standard IV – Implementation

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

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

4.1.1 The Music Therapist's provision of music will reflect his or her best abilities as a musician.
4.1.2 Appropriate musical instruments and materials, as well as the best possible sound reproduction equipment should be used in music therapy services.

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

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

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

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

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

4.6 Incorporate the results of such evaluations in subsequent treatment.

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

5.0 Standard V - Documentation

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

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

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

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

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

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

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

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

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

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

6.0 Standard VI - Termination of Services

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

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

6.2 Coordinate with the individualized treatment plans of other services received by the client.
6.3 Allow sufficient time for approval, coordination, and effective implementation whenever possible.

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

7.0 Standard VII - Continuing Education

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

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

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

8.0 Standard VIII – Supervision

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

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

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

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

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

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

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

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

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


FOOTNOTES

i. Music Therapist - Professional Music Therapists who hold the professional credential MT-BC or the professional designation RMT (Registered Music Therapist), CMT (Certified Music Therapist) or ACMT (Advanced Certified Music Therapist). Further information on credentials and designations is available from the Certification Board for Music Therapists (CBMT) or the National Music Therapy Registry (NMTR)
ii. Intellectual and developmental disabilities - Refers to one or more conditions of childhood or adolescence which interfere with normal development and or adaptive functioning (e.g., autism, mental retardation, sensory/motor/physical/cognitive impairments). Defined (PL 95-682) as chronic mental or physical impairment manifested before age 22. Results in substantial functional limitations in three or more areas of life activities: self care; learning; mobility; self direction; economic sufficiency; receptive and expressive language; capacity for independent living. Requires lifelong individually planned services.

iii. Assessment - The process of determining the client's present level of functioning. Screening may be incorporated into this process.

iv. Treatment plan - A program of therapeutic or educational intervention, e.g. IEP (Individual Educational Plan)/ITP (Individual Treatment Plan)/IFSP (Individualized Family Service Plan)/ISP (Individual Service Plan)/IHP (Individual Habilitative Plan), which focuses on the specific needs and strengths of the individual client.

v. Best professional judgment - The Music Therapist's use of current knowledge that exists in music therapy and related fields in making decisions regarding the provision of music therapy services.

vi. Screening - An intake procedure wherein the music therapist meets with the client to determine whether or not formal assessment and treatment are indicated.

vii. Appropriate norms or criterion-referenced data - Standardized tests, whose interpretations are based on data derived from "normal" populations, are generally not beneficial for program planning. Such tests should be used with caution. Criterion-referenced assessments, designed with the client's level of functioning in mind, are usually more helpful in determining both the strengths and weaknesses of the client.

viii. Goal - A projected outcome of a treatment plan. Goals are often stated in broad terms, as opposed to objectives which are stated more specifically.

ix. Objective - One of a series of progressive accomplishments leading toward goal attainment; may include conditions under which the expected outcome occurs.

x. Evaluation - The review of a client's status in reference to the program plan goals, with consideration given to the appropriateness and/or necessary modification of the plan.

xi. Best professional judgment - The Music Therapist's use of current knowledge that exists in music therapy and related fields in making decisions regarding the provision of music therapy services.

xii. Safety - Avoidance of harm through structuring care processes, supplies, equipment, and the environment to reduce/eliminate client and staff injuries, infection, and care errors. A safe auditory environment includes protecting clients from continued exposure to loud sounds. For example, continued exposure to sound levels above 85 dB TWA (Time Weighted Average) for more than 8 hours can result in hearing loss (2002) Occupational Safety and Health Centers for Disease Control and Prevention http://www.cdc.gov/niosh/98-126a.html accessed: 8-1-02
American Music Therapy Association Standards for Education and Clinical Training

Preamble

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

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

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

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

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

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

The Association's standards are based on a vision of the future for music therapy education and clinical training. In establishing and maintaining these standards, it has a responsibility related to education and clinical training in relationship to the outside world that includes clients, professionals of other disciplines, and settings. The Association's relationships with the outside world include the identification of levels of professional practice and training, interface with professionals of other disciplines and with their professional associations, involvement with regulatory entities, and alliances in the private sector. The Association works from a philosophy of inclusiveness that embraces a wide range of approaches and a broad base of therapeutic models including uses of music for persons with disabilities and disease, as well as those who desire music therapy for health, wellness, and prevention. The Association must therefore give academic institutions and clinical training programs the flexibility they need to simultaneously meet student needs, market needs, client needs, and quality standards.
The Association believes it can maintain high quality in education and clinical training while it provides for maximum flexibility in the ways professional standards and competencies are implemented. It also believes that standards can be implemented in ways that prevent overregulation and micromanagement. Quality assurance for education and clinical training must be accomplished at the local level, managed by the academic faculty at the academic institutions and the music therapy supervisors at clinical training sites rather than solely by the Association. The Association shall use these competency based standards as the basis for evaluating academic and clinical training programs and awarding its approval.

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

AMTA Standards for Education and Clinical Training

1.0 GENERAL STANDARDS FOR ACADEMIC INSTITUTIONS

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

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

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

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

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

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

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

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

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

1.10 The music therapy unit shall take primary responsibility for academic advisement and career counseling of all music therapy majors.
1.11 The music therapy unit shall conduct periodic evaluation of its programs and graduates according to competency objectives of each degree program. The results of these evaluations shall be used as the basis of program development, quality control, and change.

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

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

2.0 STANDARDS FOR COMPETENCY-BASED EDUCATION

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

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

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

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

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

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

2.4 Internship programs shall be designed according to competency objectives delineated by the Association, and in relation to the competency objectives addressed by affiliate academic institutions.

2.5 The academic institution and internship program shall evaluate students of its programs according to the competency requirements established by AMTA, and shall use the evaluation in determining each student’s readiness for graduation.

3.0 STANDARDS FOR BACHELOR’S DEGREES

3.1 Academic Component

3.1.1 The bachelor’s degree in music therapy (and equivalency programs) shall be designed to impart professional competencies in three main areas: musical foundations, clinical foundations, and music therapy foundations and principles, as specified in the AMTA Professional Competencies. A program of academic coursework and clinical training that gives students who have degrees outside of music therapy the equivalent of a bachelor’s degree in music therapy may be offered post-baccalaureate. For equivalency programs combined with the master’s degree, all AMTA Standards for Master’s Degrees must be met.

3.1.2 In compliance with NASM Standards, the bachelor’s degree in music therapy shall be divided into areas of study as follows (based on 120 semester hours or its equivalent). Please note that the following outline of content areas listed below is not intended to designate course titles.
Musical Foundations (45%)
Music Theory
Composition and Arranging
Music History and Literature
Applied Music Major
Ensembles
Conducting
Functional Piano, Guitar, Percussion, and Voice
Improvisation

Clinical Foundations (15%)
Exceptionality and Psychopathology
Normal Human Development
Principles of Therapy
The Therapeutic Relationship

Music Therapy (15%)
Foundations and Principles
Assessment and Evaluation
Methods and Techniques
Pre-Internship and Internship Courses
Psychology of Music
Music Therapy Research
Influence of Music on Behavior
Music Therapy with Various Populations

General Education (20-25%)
English, Math, Social Sciences, Arts, Humanities, Physical Sciences, etc.

Electives (5%)

3.1.3 The academic institution shall take primary responsibility for the education and clinical training of its students at the professional level. This involves: offering the necessary academic courses to achieve required competency objectives, organizing and overseeing the student’s clinical training, integrating the student’s academic and clinical learning experiences according to developmental sequences, and evaluating student competence at various stages of the program.

3.1.4 The music therapy unit shall evaluate each student’s competence level in the required areas prior to completion of degree or equivalency requirements.

3.2 Clinical Training Component

3.2.1 The academic institution shall take primary responsibility for providing students with the entire continuum of clinical training experiences with a representative range of client populations across the lifespan in diverse settings. Toward that end, the academic institution shall establish and maintain training and internship agreements with a sufficient number and diversity of field agencies that have the client population, supervisory personnel, and program resources needed to train interns and/or provide pre-internship clinical training experiences. Qualified supervision of clinical training is required and coordinated or verified by the academic institution.

3.2.2 The academic institution shall design its own clinical training program, including types of pre-internship and internship requirements, the number of hours for each placement, the variety of client types involved, and whether internship sites will be approved by the Association, the academic institution, or both. These pre-internship and internship experiences shall be designed, like academic components of the program, to enable students to acquire specific professional level competencies. At least three different populations should be included in pre-internship training. A qualified, credentialed music therapist must provide direct supervision to the pre-internship student, observing the student for a minimum of 40% of pre-internship clinical sessions. (See Qualification Standards for definition of pre-internship supervisor.) Direct supervision includes observation of the student's clinical work with
feedback provided to the student. The academic institution shall describe the design of its clinical training program in
the application for approval or re-approval by the Association.

NOTE: Academic course hours that include role-playing or instructing students in music skills, session planning,
documentation, and related skills for hypothetical clinical sessions in music therapy may not be utilized as clinical
training hours.

3.2.3 Internship, here defined as the culminating, in-depth supervised clinical training at the professional level, may
be designed in different ways: part or full time, in one or more settings, for varying periods or time frames, and near or
distant from the academic institution. Internships are always under continuous, qualified supervision by a credentialed
music therapist. (See Qualification Standards for definition of internship supervisor.) Each internship shall be
designed or selected to meet the individual needs of the student. This requires joint planning by the academic faculty,
the internship supervisor, and the student, as well as continuous communication throughout the student's placement.

3.2.4 Internship programs may be approved by an academic institution, the Association, or both. Academic
institutions will maintain information about affiliated internship programs that they have selected and approved for
their own students, and the Association will maintain a national roster of all AMTA-approved internship sites open to
any student from any academic institution. Internship sites may choose to establish both university-affiliated
internship(s) and a national roster internship program so long as the internship site stays within the standards set by
the National Roster Internship Guidelines. The internship supervisor shall make final acceptance decisions regarding
applicants for their internship, regardless of whether the internship has been approved by the academic institution or
the Association.

3.2.5 University-affiliated internship programs must meet all AMTA standards of the Clinical Training Component and
Qualifications for Clinical Supervisors in this document, as well as AMTA Guidelines for Distance Learning (if
applicable). These programs will be reviewed in conjunction with academic program approval or re-approval by the
Association. University-affiliated internships must be designed so that the music therapy intern spends at least half of
the internship hours at one or more placements under the direct supervision of a credentialed music therapist who
regularly provides professional music therapy services at that placement(s). For any portion of the internship when
there cannot be a music therapist on site, the student must have a credentialed music therapist providing direct
supervision under the auspices of the university. Direct supervision includes observation of the intern's clinical work
with feedback provided to the intern.

3.2.6 The academic institution shall develop an individualized training plan with each student for completion of all
facets of clinical training based on the AMTA competencies, student's needs, student's competencies, and life
circumstances. The various clinical training supervisors will work in partnership with the academic faculty to develop
the student's competencies and to meet the individualized training plan. It is recommended that this training plan for
clinical training shall include specification of placements, minimum hours in each aspect of clinical training including
both pre-internship and internship experiences, and the roles and responsibilities of the student, the qualified on-site
supervisor, and the academic faculty. A written internship agreement will also be made between the student,
internship supervisor, and the academic faculty to describe the student's level of performance at the initiation of the
internship. The academic faculty will assume responsibility for the initiation of the internship agreement with the intern
and the internship director. The internship agreement shall include:

- The academic institution's evaluation of the student's level of achievement on each of the AMTA
  Professional Competencies based on information gathered from music therapy faculty, recent
  supervisors, written evaluations of clinical work, and the student.
- The number of clinical training hours the student has completed (> 180) and the minimum number
  of hours required for internship (> 900) to a total of > 1200).
- The starting and estimated ending dates of the internship. For national roster sites, these are
  provided by the internship director.
- Any academic requirements the student must fulfill for the University during internship. The
  signature of the internship director on the internship agreement signifies that these requirements
  may be reasonably completed over and above the site's requirements of the intern.

All parties will participate in the formulation of the agreement which should be completed by the end of the first week
of the internship. The agreement will carry the signatures of the academic faculty involved in assessing student
competence, the internship director, and the student.
The internship agreement may also include other pertinent information, such as the length of the internship; the student’s work schedule; the supervision plan; role and responsibilities of each party; and health, liability, and insurance issues. The content and format of each internship agreement may vary according to the situation and parties involved. This internship agreement is required for both the university affiliated and AMTA national roster internship programs. These individualized training plans and internship agreements are separate and distinct from any affiliation agreements or other legal documents that delineate the terms of the relationship between the university and the clinical training site(s).

3.2.7 The internship program shall have its own competency-based evaluation system to determine whether each intern has attained required AMTA competencies. The internship program shall also solicit intern site evaluations for quality assurance purposes. These evaluations shall be forwarded to the intern’s academic institution.

3.2.8 Every student must complete a minimum of 1200 hours of clinical training, with at least 15% (180 hours) in pre-internship experiences and at least 75% (900 hours) in internship experiences. Clinical training is defined as the entire continuum of supervised field experiences, including observing, assisting, co-leading, leading, and assuming full responsibility for program planning and music therapy treatment implementation with clients. It is recommended that hours of clinical training include both direct client contact and other activities that relate directly to clinical sessions in music therapy. Such experiences also may include time in group and individual supervision of client sessions, session planning, and documentation for clients.

Academic institutions may opt to require more than the minimum total number of hours, and internship programs may opt to require more hours than the referring or affiliate academic institution. In addition, when a student is unable to demonstrate required professional level competencies, additional hours of internship may be required of the student by the academic institution in consultation with the internship supervisor.

3.2.9 The internship must be satisfactorily completed before the conferral of any music therapy degree or completion of a non-degree equivalency program. The student must have received a grade of C- or better in all foundational music therapy courses in order to be eligible for internship. The academic institution has the ultimate responsibility to determine whether these requirements have been successfully met.

NOTE: Foundational coursework related to the professional competencies must be completed prior to beginning internship. If an academic program chooses to offer coursework concurrent with internship, the course content should be integrated with the internship and provide an in-depth examination of topics related to the internship experience.

3.2.10 Existing internship sites already approved by the Association shall maintain their approval status pending adherence to the National Roster Internship Guidelines.

4.0 STANDARDS FOR MASTER’S DEGREES

The purpose of the master’s degree programs in music therapy is to impart advanced competencies, as specified in the AMTA Advanced Competencies. These degree programs provide breadth and depth beyond the AMTA Professional Competencies required for entrance into the music therapy profession.

4.1 Curricular Standards: Each graduate student in a master’s degree program is expected to gain in-depth knowledge and competence in both of the following areas. These areas may be addressed in either separate or combined coursework as deemed appropriate.

4.1.1 Music Therapy Theory (e.g., principles, foundations, current theories of music therapy practice, supervision, education, implications for research);

4.1.2 Advanced Clinical Skills: In-depth understanding of the clinical and supervisory roles and responsibilities of a music therapist. Advanced clinical skills are acquired through one or more clinical component(s) supervised under the auspices of the institution. These clinical component(s) are defined as substantive music therapy fieldwork experiences that focus on clinical practice and occur after the 1200 hours of required clinical training and acquisition of the AMTA Professional Competencies. Students in advanced clinical training courses should demonstrate a depth of understanding of relevant and advanced clinical approaches, theoretical frameworks, and/or advanced clinical supervisory theories and techniques. Each institution must specify the minimum required number of hours and the method of supervision. Students must be evaluated based on the AMTA Advanced Competencies.
In addition, each graduate student in a master’s degree program is expected to gain in-depth knowledge and competence in one or more of the following areas:

4.1.3 Research (e.g., quantitative and qualitative research designs and their application to music therapy practice, supervision, administration, higher education);

4.1.4 Musical Development and Personal Growth (e.g., leadership skills, self-awareness, music skills, improvisation skills in various musical styles, music technology);

4.1.5 Clinical Administration (e.g., laws and regulations governing the provision of education and health services, the roles of a clinical administrator in institutions and clinical settings).

4.2 Curricular Structures

4.2.1 Practice-Oriented Degrees. These degrees focus on the preparation of music therapists for advanced clinical practice.

4.2.2 Research-Oriented Degrees. These degrees focus on the preparation of scholars and researchers in music therapy, preparing graduates for doctoral study.

4.2.3 Degrees Combining Research and Practice Orientations. These degrees focus on the simultaneous development of the ability to produce research findings and utilize, combine, or integrate these findings within the practice of music therapy.

4.2.4 Graduate education requires the provision of certain kinds of experiences that go beyond those typically provided in undergraduate programs. These include opportunities for active participation in small seminars and tutorials and ongoing consultation with faculty prior to and during preparation of a final project over an extended period of time.

4.2.5 A culminating project such as a thesis, clinical paper, or demonstration project is required.

4.2.6 Master’s degree programs include requirements and opportunities for studies that relate directly to the educational objectives of the degree program, including supportive studies in music and related fields.

4.2.7 Within master’s degree programs, academic institutions are encouraged to develop graduate level specialization areas and courses on advanced topics based on faculty expertise and other resources available at the institution. Therefore, the curriculum and the requirements of each program must be tailored to the resources available, the mission of the institution, and the contribution they aspire to make to the profession of music therapy.

4.2.8 At least one-half of the credits required for the master’s degree must be in courses intended for graduate students only. A single course that carries both an undergraduate and a graduate designation is not considered a course intended for graduate students only. To obtain graduate credit, students enrolled in a single course that carries a separate undergraduate and graduate designation or number must complete specific published requirements that are at a graduate level. Distinctions between undergraduate and graduate expectations must be delineated for such courses in the course syllabi. Only courses taken after undergraduate courses that are prerequisite to a given graduate program may receive graduate credit in that program.

4.2.9 Students entering the master’s degree without the bachelor’s degree in music therapy and/or the MT-BC credential must take a minimum of 30 semester hours or 45 quarter hours graduate credits toward advanced competence in addition to and beyond any courses needed to demonstrate AMTA Professional Competencies.

4.2.10 A master’s degree in music therapy must include a minimum of 12 semester hours or 18 quarter hours of graduate credits in music therapy in addition to and beyond any courses needed to demonstrate the AMTA Professional Competencies. These courses must be intended for graduate students only and should not carry designations for both graduate and undergraduate students.

4.3 Degree Formats and Titles
4.3.1 Master of Music degree places advanced music therapy studies within a musical context: 40% music therapy, 30% music, and 30% electives in related areas. The studies in music may include coursework in diverse areas (e.g., performance, ethnomusicology, advanced musicianship, and analysis). The electives consist of supportive studies in related areas that bear directly on the specific educational objectives of the degree program.

4.3.2 Master of Music Therapy degree places advanced music therapy studies within a disciplinary context of theory, research, and practice in music therapy: 50% music therapy and 50% electives. The electives consist of supportive studies in related areas that bear directly on the specific educational objectives of the degree program.

4.3.3 Master of Arts or Master of Music Education degree places advanced music therapy studies within the context of creative arts therapy, expressive therapies, psychology, counseling, social sciences, education, arts, and/or humanities: 40% music therapy, 30% specialization field, and 30% electives. The electives consist of supportive studies that bear directly on the specific educational objectives of the degree program.

4.3.4 Master of Science degree places advanced music therapy studies within the context of medicine, allied health, and the physical sciences: 40% music therapy, 30% science specialization, and 30% electives. The electives consist of supportive studies that bear directly on the specific educational objectives of the degree program.

4.3.5 Master’s degrees in music therapy may be designed additionally to prepare certified professionals for state licensure.

5.0 STANDARD FOR DOCTORAL DEGREES

The doctoral degree shall impart advanced competence in research, theory development, clinical practice, supervision, college teaching, and/or clinical administration, depending on the title and purpose of the program. Requirements for the doctoral degree must remain flexible to ensure growth and development of the profession. The academic and clinical components of each doctoral degree must be formulated by the institution according to student need and demand, emerging needs of the profession, faculty expertise, educational mission of the institution, and the resources available. Admission of candidates for doctoral degrees in music therapy should require at least three years of full-time clinical experience in music therapy or its equivalent in part-time work. Doctoral students who have less than five years full-time clinical experience in music therapy or the equivalent in part-time experience should be encouraged to acquire additional experience during the course of the doctoral program. AMTA and NASM will work together in the delineation of the doctoral degree in music therapy.

6.0 STANDARDS FOR QUALIFICATIONS AND STAFFING

The following are minimal qualification standards to be used by academic institutions when hiring faculty, selecting clinical supervisors, making placements, and approving their own internship programs, and by the Association in endorsing internship programs for the national roster. These standards shall be upheld by the Association through its initial and periodic reviews of academic institutions and internship programs on the national roster, rather than through authorization of individual faculty and supervisors.

6.1 Academic Faculty

6.1.1 Undergraduate Faculty: An individual employed full-time at a college or university with primary responsibilities for teaching music therapy and/or directing a music therapy program at the undergraduate level.

- Holds an appropriate professional credential or designation in music therapy;
- Holds a master’s degree in music therapy or related area, with a minimum of 12 semester hours or the equivalent of graduate credits in music therapy beyond the undergraduate equivalency requirements;
- Has at least three years of full-time clinical experience in music therapy or its equivalent in part-time work;
- Pursues continuing education relevant to his/her teaching responsibilities;
- Demonstrates the following: mastery of all professional level and applicable advanced competencies in music therapy; effectiveness as a music therapy clinician in at least one area of practice; the ability to teach and clinically supervise undergraduate students; and the ability to organize and administer an undergraduate music therapy program.
6.1.2 Graduate Faculty: An individual employed full-time at a college or university with primary responsibilities for teaching music therapy and/or directing music therapy programs at the master's and/or doctoral level.

- Holds an appropriate professional credential or designation in music therapy;
- Holds a master’s degree in music therapy or related area, with a minimum of 12 semester hours or the equivalent of graduate credits in music therapy beyond the undergraduate equivalency requirements. A doctorate is preferred.
- Has at least five years of full-time clinical experience in music therapy or its equivalent in part-time work;
- Pursues continuing education relevant to his/her teaching responsibilities;
- Demonstrates the following: mastery of all professional level and applicable advanced competencies in music therapy; effectiveness as a music therapy clinician in at least one area of practice; the ability to teach and clinically supervise graduate students; ability to guide graduate research; and the ability to organize and administer a graduate music therapy program.

6.1.3 Adjunct Faculty: An individual employed by a college or university to teach specific courses in music therapy on a part-time basis.

- Holds an appropriate professional credential or designation in music therapy;
- Holds a bachelor's degree in music therapy or its equivalent;
- Has at least two years of full-time clinical experience in music therapy or its equivalent in part-time work;
- Pursues continuing education relevant to his/her teaching responsibilities.
- Demonstrates specific competencies appropriate to the teaching assignment.

6.1.4 Academic Program Director (or equivalent institutional title): An individual employed full-time by the university with primary responsibilities for directing/coordinating the music therapy program. These responsibilities maybe assumed by an existing undergraduate or graduate music therapy faculty member. For undergraduate programs, the program director must meet the requirements for Standard 6.1.1. For graduate programs, the program director must meet the requirements for Standard 6.1.2. Their degrees, credentials, and experience reflect the degree program(s) that they are managing. The Academic Program Director:

- Is accountable for upholding the educational and clinical training standards of the music therapy program
- Is accountable for upholding the AMTA Standards for Education and Clinical Training and the AMTA Code of Ethics.
- Receives, responds to, and distributes communication from AMTA regarding program status to appropriate music therapy faculty and administration.
- Is responsible for monitoring and communicating eligibility of music therapy students for internship via a letter of eligibility.
- Is responsible for monitoring and communicating eligibility of music therapy students to register for the CBMT exam.

6.2 Clinical Supervisors

6.2.1 Pre-internship Supervisor: An individual who has a clinical practice in music therapy (either private or facility-based) and supervises students in introductory music therapy clinical training (variously called fieldwork, practicum, pre-clinical, etc.).

- Holds an appropriate professional credential or designation in music therapy;
- Holds a bachelor’s degree in music therapy or its equivalent;
- Has at least one year of full-time clinical experience in music therapy or its equivalent in part-time work;
- Pursues continuing education relevant to his/her clinical and supervisory responsibilities;
- Demonstrates the following: all professional level competencies; effectiveness as a music therapy clinician in at least one area of practice; general understanding of the supervisory needs of pre-internship students, and professional level skills in supervision.
NOTE: In an exceptional case, a student may have an on-site supervisor or facility coordinator who may not be a music therapist but holds a professional, clinical credential (e.g., OT, nurse, special educator, etc.). Under these circumstances, the student must have a credentialed music therapist as a supervisor under the auspices of the university. A pre-internship supervisor (a credentialed music therapist) must provide direct supervision to the student, observing the student for a minimum of 40% of pre-internship clinical sessions. Direct supervision includes observation of the student's clinical work with feedback provided to the student.

6.2.2 Internship Supervisor: An individual who has a clinical practice in music therapy (either private or institutional) and supervises students in the final field experiences required for the music therapy degree or equivalency program.

- Holds an appropriate professional credential or designation in music therapy;
- Holds a bachelor's degree in music therapy or its equivalent;
- Has at least two years of full-time clinical experience in music therapy or its equivalent in part-time work;
- Has sufficient experience working in the internship setting as defined in the National Roster Internship Guidelines or by the university program;
- Pursues continuing education relevant to his/her clinical and supervisory responsibilities;
- Demonstrates the following: all professional level competencies; effectiveness as a music therapy clinician in at least one area of practice; general understanding of the supervisory needs of internship students, and established skills in supervision.

6.3 Staffing

6.3.1 Academic institutions shall have a minimum of one full-time faculty position in music therapy for each degree program offered. If an equivalency program is offered in an institution without a degree program in music therapy, the institution shall have a minimum of one full-time faculty position in music therapy who meets the standards for academic undergraduate faculty stated in Standard 6.1.1. Additional full or part-time faculty may be required depending upon student enrollment in each degree program and teaching loads.

7.0 STANDARDS FOR QUALITY ASSURANCE

7.1 Differential Roles

7.1.1 The academic institution and internship site shall take primary responsibility for assuring the quality of their programs, jointly and/or separately. This shall be accomplished by regular, competency-based evaluations of its programs and graduates, by faculty, supervisors, and/or students. Each academic institution and internship program shall develop its own system of evaluation, and shall use the results as the basis for program development, quality assurance, and program change.

7.1.2 AMTA shall assure the quality of education and clinical training by: a) establishing and maintaining standards of excellence for education and clinical training in the field; and b) using these standards as evaluative criteria for granting its approval to academic institutions and internship programs.

7.1.3 AMTA shall consider academic institutions and/or internship programs for approval upon initial application and review, and every ten years thereafter in conjunction with the NASM accreditation/affirmation review.

7.2 National Association of Schools of Music (NASM)

7.2.1 Only academic institutions accredited or affirmed by NASM are eligible to apply for AMTA approval. Schools that are eligible for NASM membership must be accredited by NASM. Schools that are ineligible for NASM accreditation must obtain a Statement of Affirmation from NASM through the Alternative Review Process for music therapy programs. Correspondence will be noted as confidential.

8.0 GUIDELINES FOR DISTANCE LEARNING

Rationale: Technology is rapidly becoming integrated into all aspects of our daily lives. The utilization of technology in education in university teaching is a natural step. With this in mind, it is imperative that the American Music Therapy Association (AMTA) formulate guidelines for distance learning in education. Technology beyond the posting of syllabi, course outlines, and use as a communication device, is currently being used in 50% of music therapy undergraduate and 58% of graduate programs in the United States (Keith & Vega, 2006). Of those undergraduate training programs,
45% of these programs use face-to-face instruction and use technology only for discussions and online assignments. American Music Therapy Association receives a significant number of requests from prospective music therapy candidates who are unable to move geographically to institutions with AMTA approved music therapy programs. The AMTA Academic Program Approval Committee has received applications for new program approval for distance learning programs and is therefore in need of standards and guidelines for its program approval process. Institutions are encouraged to be innovative both in education delivery and financially. It is recognized that with the rapid changes in technology, these standards and guidelines will require flexibility and will be in a continued state of development.

8.1 Definition: The National Association of Schools of Music (NASM) defines distance learning as learning that "involves programs of study delivered entirely or partially away from regular face-to-face interactions between teachers and students in classrooms, tutorials, laboratories, and rehearsals associated with course work, degrees, and programs on the campus. . . . Programs in which more than 40% of their requirements are fulfilled through distance learning will be designated as distance learning programs... The distance aspect of these programs may be conducted through a variety of means, including teaching and learning through electronic systems..."

8.2 Standards Applications: The American Music Therapy Association requires that all AMTA approved music therapy programs meet the NASM standards for distance learning: "Distance learning programs must meet all NASM operational and curricular standards for programs of their type and content. This means that the functions and competencies required by applicable standards are met even when distance learning mechanisms predominate in the total delivery system." (NASM) The American Music Therapy Association also requires that baccalaureate, equivalency, and master's degree programs in music therapy meet AMTA Standards for Education and Clinical Training when such programs meet the above criteria for distance learning. All new distance learning programs that meet the above criteria must apply for AMTA academic program approval even if the existing degree/equivalency program already has AMTA program approval.

8.3 General Standards: There are several NASM standards that must be fully addressed before a music therapy program initiates a distance learning format. They include the following:

8.3.1 Financial and Technical Support. "The institution must provide financial and technical support commensurate with the purpose, size, scope, and content of its distance learning programs." (NASM)

8.3.2 Student Evaluations "Specific student evaluation points shall be established throughout the time period of each course or program." (NASM)

8.3.3 Student Technical Competence and Equipment Requirements. "The institution must determine and publish for each distance learning program or course (a) requirements for technical competence and (b) any technical equipment requirements. The institution must have means for assessing the extent to which prospective students meet these requirements before they are accepted or enrolled. The institution shall publish information regarding the availability of academic and technical support services." (NASM)

8.3.4 Distance Learning vs. Traditional Learning. "When an identical program, or a program with an identical title, is offered through distance learning as well as on campus, the institution must be able to demonstrate functional equivalency in all aspects of each program. Mechanisms must be established to assure equal quality among delivery systems." (NASM)

8.3.5 Student Instructions, Expectations, and Evaluation. "Instructions to students, expectations for achievement, and evaluation criteria must be clearly stated and readily available to all involved in a particular distance learning program. Students must be fully informed of means for asking questions and otherwise communicating with instructors and students as required." (NASM)

8.4 Guidelines for Music Therapy Programs

8.4.1 Hours of Face-to-Face Instruction: Distance learning programs should specify how much face-to-face instruction will occur per course, if any. Such courses are often referred to as "hybrid courses" (also known as blended or mixed mode courses) in which a significant portion of the learning activities have been moved online. Faculty need to be knowledgeable about modules and course management systems specific to their college/university, different file types, browsers, broadcasting systems, etc., and continue to keep updated with new technology.
8.4.2 Office Hours: The course instructor may fulfill office hours either by posting virtual office hours or by instituting a policy of responding to student needs within a 48 hour time frame.

8.4.3 Support Services: The methods and technological requirements for online learning should be published (e.g., Discussion Board on Blackboard, webinars, Skype, etc.). It is suggested that each course of study devote time to teaching the use of technology in the program. The program shall publish information regarding the availability of academic and technical support services. Any online courses outside of music therapy that are available for support should also be indicated. Provisions for using library resources should be published.

8.4.4 Admission: Admission will be in compliance with each university’s admission policies and procedures for music therapy programs.

8.4.5 Residency Requirement and Transfer Credits: If the university has a "residency requirement," such a requirement will be honored by the music therapy programs. Furthermore, music therapy core courses and clinical training from AMTA approved institutions will be eligible for transfer as determined by the university’s policies and evaluation of student competencies. The number of credit hours that can be taken at another educational institution and in what areas should be indicated to the student at the time of admission.

8.4.6 Music Therapy Courses: Music therapy programs must meet the curricular structures as outlined in the AMTA Standards for Education and Clinical Training. Academic faculty should determine what learning should be done in residence as opposed to online and how this must be implemented. Course syllabi should clearly provide the course outline and assignments to indicate what each course entails, including the technological requirements and the online course management systems. Means of evaluation of the student's work at periodic times throughout the course must be provided in the syllabi. Course syllabi should indicate the AMTA Professional Competencies and/or Advanced Competencies (whichever if applicable) that will be addressed in the course(s) and how these competencies will be evaluated using distance learning methods.

8.4.7 Academic Faculty: Academic faculty teaching music therapy courses must meet AMTA standards for academic faculty. These guidelines for distance learning apply to all baccalaureate, equivalency, and master’s degree programs in music therapy. Administering an online program and teaching online courses will require a significant amount of time over and beyond the credits awarded for the course. Load issues and overload issues should be taken into account when designing the program and distributed in a fair and equitable way to the music therapy faculty.

8.4.8 Music Competencies: Each student’s music competencies in performance and functional music skills will be evaluated prior to acceptance into a distance learning program and upon completion of the program will meet AMTA standards stated in the Professional Competencies and/or Advanced Competencies (whichever is applicable to the degree/ equivalency programs). This includes competencies in functional keyboard, guitar, voice, percussion, and improvisation. Music competencies may be evaluated through face-to-face auditions, web-based conferencing juries, or through videotaping. Credit for functional music skills may be acquired either at the college/university offering the program or transferred in from other academic institutions. Requirements for meeting any deficiencies in these areas must be specified in a plan for the student’s remediation and continued evaluation. Methods of evaluating musical proficiencies long distance must be specified.

8.4.9 Clinical Training: The pre-internship and internship learning experiences for students should meet all AMTA standards for clinical training. Pre-internship field experiences may be established through distance learning. There should be legal contracts and/or affiliation agreements for these distance learning relationships which specify the roles and responsibilities of the academic faculty, pre-internship supervisors, internship supervisors, and the student. The music therapy faculty/staff at the academic program site (full-time or adjunct) should provide training and supervision for the on-site pre-internship and (if applicable) university affiliated internship clinical training supervisors and serve as a liaison between the academic program and the pre-internship/internship clinical training program(s). All clinical training supervisors must meet the AMTA "Standards for Qualifications and Staffing" for Pre-internship Supervisor and Internship Supervisor (whichever is applicable), including that of holding an appropriate professional credential or designation in music therapy (e.g., MT-BC; ACMT; CMT; RMT).

8.4.10 Online Supervision: Online supervision may be provided for the clinical supervisors along with site visits by the academic faculty. Supervision for the student’s clinical training experiences includes individual supervision of the student by the qualified music therapist at the host site, as well as supervision by the academic faculty. Feedback of the student’s clinical work can be provided to academic faculty through such means as audio-visual media and other forms of technology and telecommunications to evaluate the student’s clinical competencies. Please note that the issues related to client confidentiality must be addressed.
8.4.11 Group Supervision: Group supervision may also be provided through online discussion boards such as those found in Blackboard and/or live-time webinars with faculty and students. Please note that the issues related to client confidentiality must be addressed.

8.4.12 Related Coursework: The music therapy program should state explicitly whether courses that are required outside of the music therapy program (e.g., psychology, statistics or other research courses) are also available in distance-learning format.


Glossary of Selected Terms

AAMT: The American Association for Music Therapy was one of the two former organizations that merged to form the American Music Therapy Association.

Academic Institution: A college or university offering music therapy degree program(s).

Academic Faculty: The full-time, part-time and adjunct teaching professionals in an academic institution that have responsibility for instruction, research, and service as per academic institution policies. Academic faculty members have responsibility for the music therapy academic program(s).

Accreditation (NASM): The process whereby a private, governmental accredited agency grants public recognition to an academic institution that meets standards of quality for higher education in a particular field, as determined through initial and subsequent periodic reviews. In the field of music, the National Association of Schools of Music (NASM) is the only authorized accrediting agency empowered to accredit academic institutions offering music degrees in any area in the United States. Thus, NASM accreditation (or "NASM membership") signifies that all the music degrees offered by an academic institution have been evaluated by NASM and found to be consistent with national standards. Please note the following differences between NASM accreditation, NASM affirmation, and AMTA approval: NASM accredits an academic institution based on the quality of all of its music degree programs; NASM affirms an institution ineligible for NASM accreditation, based on the adequacy of its music resources for music therapy programs; AMTA approves an academic institution based on the quality of its music therapy programs only. See respective definitions.

ACMT: "Advanced Certified Music Therapist" is a designation formerly given by the American Association for Music Therapy.

Affirmation (NASM): NASM offers an alternative review process for music therapy programs that are ineligible to apply for NASM accreditation (e.g., in an institution in a foreign country). The alternative review process leads to a statement of affirmation from NASM assuring that the institution and its music programs provide a context for and qualitative outcome by the music therapy program consistent with NASM standards. Academic institutions that meet NASM standards and receive such affirmation are not "accredited" members of NASM. Please see under "Accreditation (NASM)" for an explanation of the differences between NASM accreditation, NASM affirmation, and AMTA approval.

AMTA: The American Music Therapy Association is the organization formed by the unification of AAMT and NAMT.

Appropriate Music Therapy Credential or Designation: Appropriate music therapy credentials or designations include three designations that were issued by the former Associations—RMT or Registered Music Therapist, CMT or Certified Music Therapist, and ACMT or Advanced Certification in Music Therapy; and the MT-BC or Music Therapist-Board Certified, which is the professional credential in music therapy granted in the United States. An appropriate music therapy credential or designation could also include a professional designation or credential from a country other than the United States.

Approval of Academic Institutions: Approval is a process whereby the professional association in music therapy grants public recognition to an academic institution for its degree (and/or equivalency) programs in music therapy. Approval is granted when the degree program meets the Association’s standards of quality, as determined through initial and periodic review by the Association. Please see under "Accreditation (NASM)" for an explanation of the differences between NASM accreditation, NASM affirmation, and AMTA approval.
Approval of Internship Sites: Internship approval by AMTA is the process by which AMTA determines that an internship site meets its standards of quality and grants public recognition to that fact. The Association maintains a national roster of approved internship sites for use by approved academic institutions and their students. Academic institutions also may approve and individually affiliate with internship sites. These university-affiliated internship programs will be reviewed in conjunction with academic program approval or re-approval by the Association.

Approval Review Process: The entire sequence of procedures established by AMTA for the evaluation of an academic institution or internship site. The “review” typically involves application by the academic institution or internship site using established forms, a process of evaluation by designated committees within the Association according to the standards and criteria for approval established by the association, and procedures for communication and appeal.

Board Certification: The credential of Music Therapist-Board Certified (MT-BC) is initially obtained by successful passage of the national board certification examination designed and administered by the Certification Board for Music Therapists (CBMT). Each certificant must re-certify every five years. Re-certification may be accomplished either through re-examination or through accrual of appropriate continuing education as specified by CBMT.

CBMT: The Certification Board for Music Therapists.

Clinical Training: Clinical training is the entire continuum of supervised field experiences, including observing, assisting, co-leading, leading, and assuming full responsibility for program planning and music therapy treatment implementation with clients. This continuum includes all experiences formerly called observations, fieldwork, field experience, practicum, pre-clinical experience, and internship. For the sake of clarity, clinical training has been conceived as having two main components: pre-internship and internship. Pre-internship training consists of all the various practical field experiences taken by a student in conjunction with music therapy coursework as pre-requisites for internship placement. This may include experiences formerly called observations, practica, fieldwork, pre-clinical placements, etc. The internship is the culminating, in-depth supervised clinical training experience in a degree program in music therapy (or its equivalent) that leads to the achievement of the professional competency objectives.

CMT: “Certified Music Therapist” is a designation formerly given by the American Association for Music Therapy.

Competency-Based Education in Music Therapy: An approach to higher education and clinical training which has the following components: 1) the specification of student competencies or learning outcomes that serve as educational objectives for the program; 2) the distribution of these competency objectives into a developmentally sequenced curriculum of instruction, study, and/or practical training, 3) the design of specific courses and practical or field experiences to meet designated competency objectives, and 4) methods of quality assurance based on student competence upon completion of the program. The inventory entitled the AMTA Professional Competencies lists the professional competencies and the AMTA Advanced Competencies lists the advanced competencies.

Credential: Please see “Appropriate Music Therapy Credential or Designation.”

Equivalency Program: A program of academic coursework and clinical training that gives students who have degrees outside of music therapy the equivalent of a bachelor’s degree in music therapy. Like the bachelor’s degree, an equivalency program is designed to impart professional level competencies in music therapy and to prepare the student to begin professional practice. Usually, the equivalency program consists of all core music therapy courses at the undergraduate level, all clinical training requirements, plus any pertinent courses in other fields (e.g., abnormal psychology). In those academic institutions offering a bachelor’s degree, the student usually earns undergraduate credit for these equivalency courses, while in some that only offer the master’s degree, students earn graduate credit for the same courses. It should be noted that an equivalency program is always regarded as professional level, regardless of the level of credit awarded for the coursework.

Internship: The culminating, in-depth supervised clinical training experience in a professional level degree program (or its equivalent) in music therapy.

Music Therapy Unit: The academic department, section, division, or subdivision within a college or university that takes administrative and programmatic responsibility for the music therapy degree(s) offered (e.g., a department of music therapy, a music therapy section within the department of music education, a music therapy program within the division of arts).
**MT-BC:** Music Therapist-Board Certified. Also see Board Certification.

**NAMT:** The National Association for Music Therapy was one of the two former organizations that merged to form the American Music Therapy Association.

**NASM:** The National Association of Schools of Music is the sole agency designated by the government to accredit music schools in the USA. (Refer to "Accreditation."

**Pre-internship:** Pre-internship training is constituted by clinical training experiences conducted in conjunction with academic work in music therapy that are prerequisites for internship placement. This may include experiences formerly called observations, practica, fieldwork, pre-clinical placements, etc. Pre-internship experiences include both direct client contact and other activities that relate directly to clinical sessions in music therapy.

**Professional Designation:** Please see "Appropriate Music Therapy Credential or Designation."

**RMT:** Registered Music Therapist is a designation formerly given by the National Association for Music Therapy.
Preamble to AMTA Professional Competencies

The American Music Therapy Association has established competency-based standards for ensuring the quality of education and clinical training in the field of music therapy. As the clinical and research activities of music therapy provide new information, the competency requirements need to be reevaluated regularly to ensure consistency with current trends and needs of the profession and to reflect the growth of the knowledge base of the profession. The Association updates these competencies based on what knowledge, skills, and abilities are needed to perform the various levels and types of responsibilities to practice at a professional level.

In November 2005 the AMTA Assembly of Delegates adopted the Advisory on Levels of Practice in Music Therapy. This Advisory, which was developed by the Education and Training Advisory Board, distinguishes two Levels of Practice within the music therapy profession: Professional Level of Practice and Advanced Level of Practice. This Advisory describes the Professional Level of Practice as follows:

A music therapist at the Professional Level of Practice has a Bachelor’s degree or its equivalent in music therapy and a current professional designation or credential in music therapy (i.e., ACMT, CMT, MT-BC, or RMT). At this level, the therapist has the ability to assume a supportive role in treating clients, collaborating within an interdisciplinary team to contribute to the client’s overall treatment plan.

The AMTA Professional Competencies are based on music therapy competencies authored for the former American Association for Music Therapy (AAMT) by Bruscia, Hesser, and Boxhill (1981). The former National Association for Music Therapy (NAMT) in turn adapted these competencies as the NAMT Professional Competencies revised in 1996. In its final report the Commission on Education and Clinical Training recommended the use of these competencies, and this recommendation was approved by the AMTA Assembly of Delegates in November 1999. The AMTA Professional Competencies has had several minor revisions since its adoption in 1999.

A. MUSIC FOUNDATIONS

1. Music Theory and History
   1.1 Recognize standard works in the literature.
   1.2 Identify the elemental, structural, and stylistic characteristics of music from various periods and cultures.
   1.3 Sight-sing melodies of both diatonic and chromatic makeup.
   1.4 Take aural dictation of melodies, rhythms, and chord progressions.
   1.5 Transpose simple compositions.

2. Composition and Arranging Skills
   2.1 Compose songs with simple accompaniment.
2.2 Adapt, arrange, transpose, and simplify music compositions for small vocal and nonsymphonic instrumental ensembles.

3. Major Performance Medium Skills
3.1 Perform appropriate undergraduate repertoire; demonstrate musicianship, technical proficiency, and interpretive understanding on a principal instrument/voice.
3.2 Perform in small and large ensembles.

4. Functional Music Skills
4.1 Demonstrate a basic foundation on voice, piano, guitar, and percussion.
   4.1.1 Lead and accompany proficiently on instruments including, but not limited to, voice, piano, guitar, and percussion.
   4.1.2 Play basic chord progressions in several major and minor keys with varied accompaniment patterns.
   4.1.3 Play and sing a basic repertoire of traditional, folk, and popular songs with and without printed music.
   4.1.4 Sing in tune with a pleasing quality and adequate volume both with accompaniment and a capella.
   4.1.5 Sight-read simple compositions and song accompaniments.
   4.1.6 Harmonize and transpose simple compositions in several keys.
   4.1.7 Tune stringed instruments using standard and other tunings.
   4.1.8 Utilize basic percussion techniques on several standard and ethnic instruments.
4.2 Develop original melodies, simple accompaniments, and short pieces extemporaneously in a variety of moods and styles, vocally and instrumentally.
4.3 Improvise on pitched and unpitched instruments, and vocally in a variety of settings including individual, dyad, small or large group.
4.4 Care for and maintain instruments.

5. Conducting Skills
5.1 Conduct basic patterns with technical accuracy.
5.2 Conduct small and large vocal and instrumental ensembles.

6. Movement Skills
6.1 Direct structured and improvisatory movement experiences.
6.2 Move in a structured and/or improvisatory manner for expressive purposes.

B. CLINICAL FOUNDATIONS

7. Therapeutic Applications
7.1 Demonstrate basic knowledge of the potential, limitations, and problems of populations specified in the Standards of Clinical Practice.
7.2 Demonstrate basic knowledge of the causes, symptoms of, and basic terminology used in medical, mental health, and educational classifications.
7.3 Demonstrate basic knowledge of typical and atypical human systems and development (e.g., anatomical, physiological, psychological, social.)
7.4 Demonstrate basic understanding of the primary neurological processes of the brain.

8. Therapeutic Principles
8.1 Demonstrate basic knowledge of the dynamics and processes of a therapist-client relationship.
8.2 Demonstrate basic knowledge of the dynamics and processes of therapy groups.
8.3 Demonstrate basic knowledge of accepted methods of major therapeutic approaches.

9. The Therapeutic Relationship
9.1 Recognize the impact of one's own feelings, attitudes, and actions on the client and the therapy process.
9.2 Establish and maintain interpersonal relationships with clients and team members that are appropriate and conducive to therapy.
9.3 Use oneself effectively in the therapist role in both individual and group therapy, e.g., appropriate self-disclosure, authenticity, empathy, etc. toward affecting desired therapeutic outcomes.
9.4 Utilize the dynamics and processes of groups to achieve therapeutic goals
9.5 Demonstrate awareness of the influence of race, ethnicity, language, religion, marital status, gender, gender identity or expression, sexual orientation, age, ability, socioeconomic status, or political affiliation on the therapeutic process.

C. MUSIC THERAPY

10. Foundations and Principles
Apply basic knowledge of:
10.1 Existing music therapy methods, techniques, materials, and equipment with their appropriate applications.
10.2 Principles and methods of music therapy assessment, treatment, evaluation, and termination for the populations specified in the Standards of Clinical Practice.
10.3 The psychological aspects of musical behavior and experience including, but not limited to, perception, cognition, affective response, learning, development, preference, and creativity.
10.4 The physiological aspects of the musical experience including, but not limited to, central nervous system, peripheral nervous system, and psychomotor responses.
10.5 Philosophical, psychological, physiological, and sociological basis of music as therapy.
10.6 Use of current technologies in music therapy assessment, treatment, evaluation, and termination.

11. Client Assessment
11.1 Select and implement effective culturally-based methods for assessing the client’s strengths, needs, musical preferences, level of musical functioning, and development.
11.2 Observe and record accurately the client's responses to assessment.
11.3 Identify the client's functional and dysfunctional behaviors.
11.4 Identify the client’s therapeutic needs through an analysis and interpretation of assessment data.
11.5 Communicate assessment findings and recommendations in written and verbal forms.

12. Treatment Planning
12.1 Select or create music therapy experiences that meet the client's objectives.
12.2 Formulate goals and objectives for individual and group therapy based upon assessment findings.
12.3 Identify the client's primary treatment needs in music therapy.
12.4 Provide preliminary estimates of frequency and duration of treatment.
12.5 Select and adapt music, musical instruments, and equipment consistent with the strengths and needs of the client.
12.6 Formulate music therapy strategies for individuals and groups based upon the goals and objectives adopted.
12.7 Create a physical environment (e.g., arrangement of space, furniture, equipment, and instruments that is conducive to therapy).
12.8 Plan and sequence music therapy sessions.
12.9 Determine the client's appropriate music therapy group and/or individual placement.
12.10 Coordinate treatment plan with other professionals.

13. Therapy Implementation
13.1 Recognize, interpret, and respond appropriately to significant events in music therapy sessions as they occur.
13.2 Provide music therapy experiences that address assessed goals and objectives for populations specified in the Standards of Clinical Practice.
13.3 Provide verbal and nonverbal directions and cues necessary for successful client participation.
13.4 Provide models for and communicate expectations of behavior to clients.
13.5 Utilize therapeutic verbal skills in music therapy sessions.
13.6 Provide feedback on, reflect, rephrase, and translate the client's communications.
13.7 Assist the client in communicating more effectively.
13.8 Sequence and pace music experiences within a session according to the client's needs and situational factors.
13.9 Conduct or facilitate group and individual music therapy.
13.10 Implement music therapy program according to treatment plan.
13.11 Promote a sense of group cohesiveness and/or a feeling of group membership.
13.12 Develop and maintain a repertoire of music for age, culture, and stylistic differences.
13.13 Recognize and respond appropriately to effects of the client's medications.
13.14 Maintain a working knowledge of new technologies and implement as needed to support client progress towards treatment goals and objectives.

14. Therapy Evaluation
14.2 Establish and work within realistic time frames for evaluating the effects of therapy.
14.3 Recognize significant changes and patterns in the client's response to therapy.
14.4 Recognize and respond appropriately to situations in which there are clear and present dangers to the client and/or others.
14.5 Modify treatment approaches based on the client's response to therapy.
14.6 Review and revise treatment plan as needed.

15. Documentation
15.1 Produce documentation that accurately reflects client outcomes and meet the requirements of internal and external legal, regulatory, and reimbursement bodies.
15.2 Document clinical data.
15.3 Write professional reports describing the client throughout all phases of the music therapy process in an accurate, concise, and objective manner.
15.4 Effectively communicate orally and in writing with the client and client’s team members.
15.5 Document and revise the treatment plan and document changes to the treatment plan.
15.6 Develop and use data-gathering techniques during all phases of the clinical process including assessment, treatment, evaluation, and termination.

16. Termination/Discharge Planning
16.1 Assess potential benefits/detriments of termination of music therapy.
16.2 Develop and implement a music therapy termination plan.
16.3 Integrate music therapy termination plan with plans for the client’s discharge from the facility.
16.4 Inform and prepare the client for approaching termination from music therapy.
16.5 Establish closure of music therapy services by time of termination/discharge.

17. Professional Role/Ethics
17.1 Interpret and adhere to the AMTA Code of Ethics.
17.2 Adhere to the Standards of Clinical Practice.
17.3 Demonstrate dependability: follow through with all tasks regarding education and professional training.
17.4 Accept criticism/feedback with willingness and follow through in a productive manner.
17.5 Resolve conflicts in a positive and constructive manner.
17.6 Meet deadlines without prompting.

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*revised 11/23/13*
17.7 Express thoughts and personal feelings in a consistently constructive manner.
17.8 Demonstrate critical self-awareness of strengths and weaknesses.
17.9 Demonstrate knowledge of and respect for diverse cultural backgrounds.
17.10 Treat all persons with dignity and respect, regardless of differences in race, ethnicity, language, religion, marital status, gender, gender identity or expression, sexual orientation, age, ability, socioeconomic status, or political affiliation.
17.11 Demonstrate skill in working with culturally diverse populations.
17.12 Adhere to all laws and regulations regarding the human rights of clients, including confidentiality.
17.13 Demonstrate the ability to locate information on regulatory issues and to respond to calls for action affecting music therapy practice.
17.14 Demonstrate basic knowledge of professional music therapy organizations and how these organizations influence clinical practice.
17.15 Demonstrate basic knowledge of music therapy service reimbursement and financing sources (e.g., Medicare, Medicaid, Private Health Insurance, State and Local Health and/or Education Agencies, Grants).
17.16 Adhere to clinical and ethical standards and laws when utilizing technology in any professional capacity.

18. Interprofessional Collaboration
18.1 Demonstrate a basic understanding of professional roles and duties and develop working relationships with other disciplines in client treatment programs.
18.2 Communicate to other departments and staff the rationale for music therapy services and the role of the music therapist.
18.3 Define the role of music therapy in the client's total treatment program.
18.4 Collaborate with team members in designing and implementing interdisciplinary treatment programs.

19. Supervision and Administration
19.1 Participate in and benefit from multiple forms of supervision (e.g., peer, clinical).
19.2 Manage and maintain music therapy equipment and supplies.
19.3 Perform administrative duties usually required of clinicians (e.g., scheduling therapy, programmatic budgeting, maintaining record files).
19.4 Write proposals to create new and/or maintain existing music therapy programs.

20. Research Methods
20.1 Interpret information in the professional research literature.
20.2 Demonstrate basic knowledge of the purpose and methodology of historical, quantitative, and qualitative research.
20.3 Perform a data-based literature search.
20.4 Integrate the best available research, music therapists’ expertise, and the needs, values, and preferences of the individual(s) served.

REFERENCES


American Music Therapy Association Professional Competencies

revised 11/23/13


Revised 11/30/08
Revised 7/10/13
Revised 11/23/13
I. Referral, Assessment, and Treatment Planning: 40 items

A. Referral
1. Utilize or develop appropriate referral protocol for population.
2. Evaluate the appropriateness of referral for music therapy services.
3. Prioritize referrals according to immediate client needs when appropriate.
4. Educate staff, treatment team, or other professionals regarding appropriate referral criteria for music therapy based on population needs.

B. Assessment
1. Observe client in music and/or non-music settings.
2. Obtain client information from available resources (e.g., client, caregiver, documentation, family members, other professionals, treatment team members).
3. Identify client functioning level, strengths, and areas of need within the following domains:
   a) cognitive.
   b) communicative.
   c) emotional.
   d) musical.
   e) physiological.
   f) psychosocial.
   g) sensorimotor.
   h) spiritual.
4. Identify client’s:
   a) active symptoms.
   b) behaviors.
   c) clinical history.
   d) cultural and spiritual background, when indicated.
   e) family dynamics and support systems.
   f) learning styles.
   g) manifestations of affective state.
   h) music background and skills.
   i) preferences.
   j) social and interpersonal relationships.
   k) stressors related to present status.
   l) resources.
6. Understand the possible effects of medical and psychotropic drugs.
7. Select musical assessment tools and procedures.
8. Select non-musical assessment tools and procedures.
9. Adapt existing assessment tools and procedures.
10. Develop assessment tools and procedures.
11. Create an assessment environment or space conducive to the assessment protocol and/or client’s needs.
12. Engage client in musical and non-musical experiences to obtain assessment data.
13. Identify client response to different:
   a) types of musical experiences (e.g., improvising, recreating, composing, and listening) and their variations.
   b) types of non-musical experiences.
   c) styles of music.
   d) elements of music (e.g., tempo, pitch, timbre, melody, harmony, rhythm, meter, dynamics, form, lyrics).

C. Interpret Assessment Information and Communicate Results
1. Evaluate reliability and presence of bias in information from available resources.
2. Identify factors which may impact accuracy of information gathered during assessment (e.g., precipitating events, medications, health considerations).
3. Draw conclusions and make recommendations based on analysis and synthesis of assessment findings.
4. Acknowledge therapist’s bias and limitations in interpreting assessment information (e.g., cultural differences, clinical orientation).
5. Communicate assessment findings and recommendations in oral, written, or other forms (e.g., video, audio).

D. Treatment Planning
1. Involve client in the treatment planning process, when appropriate.
2. Consult the following in the treatment planning process:
   a) clinical and research literature and other resources.
   b) client’s family, caregivers, or personal network, when appropriate.
   c) other professionals, when appropriate.
3. Coordinate treatment with other professionals.
4. Evaluate the role of music therapy within the overall therapeutic program.
5. Consider length of treatment when establishing client goals and objectives.
6. Establish client goals and objectives that are:
   a) achievable.
   b) measurable.
   c) realistic.
   d) specific.
   e) time-bound.
7. Use a data collection system for measuring clinical outcomes to reflect criteria in objective.
8. Create environment or space conducive to client engagement.
9. Consider client’s age, culture, language, music background, and preferences when designing music therapy experiences.
10. Design music therapy experiences that address client goals and objectives based on available research; clinical expertise; and the needs, values, and preferences of the client.
11. Use appropriate musical instruments and equipment consistent with treatment needs.
12. Use non-music materials consistent with music therapy goals and clients’ learning styles (e.g., adaptive devices, visual aids).
13. Plan sessions of appropriate duration and frequency.
14. Determine group and/or individual placement based on assessment findings.
15. Structure and organize music therapy experiences within each session to create therapeutic contour (e.g., transitions, pacing, sequencing, energy level, intensity).
16. Design programs to reinforce goals and objectives for implementation outside the music therapy setting.

II. Treatment Implementation and Termination: 70 items

A. Implementation
1. Develop a therapeutic relationship by:
   a) building trust and rapport.
   b) being fully present and authentic.
   c) establishing boundaries and communicating expectations.
   d) providing ongoing acknowledgement and reflection.
   e) providing a safe and contained environment.
   f) recognizing and managing aspects of one’s own feelings and behaviors that affect the therapeutic process.
   g) recognizing and working with transference and countertransference dynamics.
   h) understanding group dynamics and process.
2. Provide music therapy experiences to address client’s:
   a) ability to empathize.
   b) ability to use music independently for self-care.
   c) abuse and trauma.
   d) activities of daily living.
   e) adjustment to life changes or temporary or permanent changes in ability.
   f) aesthetic sensitivity.
   g) affect, emotions and moods.
   h) agitation.
   i) aggression.
   j) anticipatory grief.
   k) attention (i.e., focused, sustained, selective, alternating, divided).
   l) auditory perception.
   m) autonomy.
   n) bereavement.
   o) coping skills.
   p) development of speech.
   q) executive functions (e.g., decision making, problem solving).
   r) functional independence.
   s) generalization of skills to other settings.
   t) grief and loss.
   u) group cohesion and/or a feeling of group membership.
   v) impulse control.
   w) interactive response.
   x) initiation and self-motivation.
   y) memory.
   z) motor skills.
   aa) musical and other creative responses.
   ab) neurological and cognitive function.
   ac) nonverbal expression.
   ad) on-task behavior.
   ae) oral motor control.
   af) pain (i.e., physical, psychological).
   ag) participation/engagement.
   ah) physiological symptoms.
   ai) pragmatics of speech.
   aj) preparedness for stressful situations.
   ak) quality of life.
   al) range of motion.
   am) reality orientation.
   an) responsibility for self.
   ao) self-awareness and insight.
   ap) self-esteem.
   aq) sense of self with others.
   ar) sensorimotor skills.
   as) sensory integration.
   at) sensory orientation (i.e., maintenance attention, vigilance).
   au) sensory perception.
   av) social skills and interactions.
   aw) spirituality.
   ax) spontaneous communication/interactions.
   ay) strength and endurance.
   az) support systems.
   ba) verbal and nonverbal communication.
   bb) verbal and/or vocal responses.
   bc) vocal production.
   bd) wellness.
3. Recognize how the following theoretical orientations inform music therapy practice:
   a) behavioral.
   b) cognitive.
   c) holistic.
   d) humanistic/existential.
   e) neuroscience.
   f) psychodynamic.
4. Recognize how the following music therapy treatment approaches and models inform clinical practice:
   a) behavioral.
   b) culture centered.
   c) community music therapy.
   d) developmental.
   e) humanistic.
   f) improvisational.
   g) medical.
h) neurological.
i) psychodynamic.

5. To achieve therapeutic goals:
a) apply the elements of music (e.g., tempo, pitch, timbre, melody, harmony, rhythm, meter, dynamics).
b) apply receptive music methods.
c) apply standard and alternate guitar tunings.
d) apply a variety of scales, modes, and harmonic progressions.
e) arrange, transpose, or adapt music.
f) compose vocal and instrumental music.
g) empathize with client’s music experience.
h) employ active listening.
i) employ functional skills with:
   1.) voice.
   2.) keyboard.
   3.) guitar.
   4.) percussion instruments.

j) employ music relaxation and/or stress reduction techniques.
k) exercise leadership and/or group management skills.
l) facilitate community building activities.
m) facilitate transfer of therapeutic progress into everyday life.
n) identify and respond to significant events.
o) improvise instrumental and vocally.
p) integrate current technology into music therapy practice according to client need.
q) integrate movement with music.
r) observe client responses.
s) provide visual, auditory, or tactile cues.
t) provide verbal and nonverbal guidance.
u) provide guidance to caregivers and staff to sustain and support the client’s therapeutic progress.
v) mediate problems among clients within the session.
w) select adaptive materials and equipment.
x) share musical experience and expression with clients.
y) sight-read.
z) use creativity and flexibility in meeting client’s changing needs.
aa) use music to communicate with client.
ab) use song and lyric analysis.
ac) utilize a varied music repertoire (e.g., blues, classical, folk, jazz, pop) from a variety of cultures and subcultures.

6. Comply with safety protocols with regard to transport and physical support of clients.
7. Inspect materials and instruments on a regular basis.

C. Termination and Closure
1. Assess potential benefits and detriments of termination.
2. Determine exit criteria.
3. Inform and prepare client.
5. Provide a client with transitional support and recommendations.
6. Help client work through feelings about termination.
7. Address client needs during staffing changes (e.g., therapist leaves job, job transfer, leave of absence).

III. Ongoing Documentation and Evaluation of Treatment: 10 items

A. Documentation
1. Develop and use data-gathering techniques and forms.
2. Record client responses, progress, and outcomes.
3. Employ language appropriate to population and facility.
4. Document music therapy termination and follow-up plans.
5. Adhere to internal and external legal, regulatory, and reimbursement requirements.
6. Provide written documentation that demonstrates evidence-based outcomes related to addressed goals/interventions.

B. Evaluation
1. Identify information that is relevant to client’s treatment process.
2. Differentiate between empirical information and therapist’s interpretation.
3. Acknowledge therapist’s bias and limitations in interpreting information (e.g., cultural differences, clinical orientation).
4. Review treatment plan regularly.
5. Modify treatment plan regularly.
6. Respond to signs of distress (e.g., psychological, physical) and limits of client tolerance to treatment.
7. Analyze all available data to determine effectiveness of therapy.
8. Consult with music therapy and non-music therapy professionals.
9. Communicate with client and/or client’s family, caregivers, treatment team, and personal network as appropriate.
10. Make recommendations and referrals as indicated.
11. Compare the client and therapist subjective experience/response to the elements, forms, and structures of music.

IV. Professional Development and Responsibilities: 10 items

A. Professional Development
1. Assess areas for professional growth and set goals.
2. Review current research and literature in music therapy and related disciplines.
3. Participate in continuing education.
4. Engage in collaborative work with colleagues.
5. Seek out and utilize supervision and/or consultation.
6. Expand music skills.
7. Develop and enhance technology skills.

B. Professional Responsibilities
1. Document all treatment related communications.
2. Document all non-treatment related communications.
3. Maintain and expand music repertoire.
4. Interact with the client in an authentic, ethical, and culturally competent manner that respects privacy, dignity, and human rights.
5. Respond to public inquiries about music therapy.
6. Conduct information sharing sessions, such as in-service workshops, for professionals and/or the community.
7. Communicate with colleagues regarding professional issues.
8. Maintain professional and effective working relationships with colleagues and community members.
9. Work within a facility’s organizational structure, policies, standards, and procedures.
10. Maintain client confidentiality as required by law (e.g., HIPAA, IDEA).
11. Supervise staff, volunteers, practicum students, or interns.
12. Adhere to the CBMT Code of Professional Practice.
13. Fulfill legal responsibilities associated with professional role (e.g., mandated reporting, release of information).
14. Practice within scope of education, training, and abilities.
15. Maintain equipment and supplies.
16. Engage in business management tasks (e.g., marketing, payroll, contracts, taxes, insurance).
17. Prepare and maintain a music therapy program budget.
18. Prepare accountability documentation for facility administration and/or local, state, and federal agencies.
19. Maintain assigned caseload files (e.g., electronic, digital, audio, video, hard copies) in an orderly manner.
20. Serve as a representative, spokesperson, ambassador, or advocate for the profession of music therapy.

This document, CBMT Board Certification Domains, was developed from the results of the 2014 Music Therapy Practice Analysis Study. CBMT Board Certification Domains defines the body of knowledge that represents competent practice in the profession of music therapy and identifies what a board certified music therapist, a credentialed MT-BC, may do in practice. Continuing Music Therapy Education credits must relate to an area identified in the CBMT Board Certification Domains. This new document will be utilized as the source of reference for exam content, certification, and recertification requirements beginning on April 1, 2015.
AMTA Code of Ethics

Preamble

The Code of Ethics of the American Music Therapy Association, Inc., summarizes our values as professionals and describes principles and standards for guiding the practice of music therapy in a responsible, fair, and accountable manner. We, the members of the American Music Therapy Association, hold Kindness, Social Responsibility, Dignity and Respect, Equality, Accountability, Excellence, Integrity, and Courage to be Core Values. These values are reflected in five ethical principles which include (1) respecting the dignity and rights of all, (2) acting with compassion, (3) being accountable, (4) demonstrating integrity and veracity, and (5) striving for excellence. These values and principles provide guidelines for ethical decision-making in our daily practice. Standards of behavior guide our conduct as professionals. Ethical practice is more than following a list of rules. It is a commitment to virtuous, caring, courageous thinking that involves self-examination and the well-being of others as our highest intent. We commit ourselves to uphold the value and worth of every person, and to treat all with dignity.

Music therapists who encounter ethical dilemmas are advised to follow a decision-making process available in the literature (Dileo, 2000; Swisher, Arslanian, & Davis 2005, & Markkula Center for Applied Ethics). Music therapists are advised to also consult the Scope of Music Therapy Practice and the AMTA Standards of Clinical Practice for more detailed information to guide clinical decision-making.

It is important for music therapists to recognize our responsibility to adhere to laws, regulations, or policies of organizations and other governing bodies outside the AMTA. In cases where such laws, regulations, or governing body policies conflict with ethical responsibilities, the music therapist will address and seek to resolve this conflict with those in decision-making positions with the best interests of the client foremost in mind. Music therapists are reminded that we practice within the norms and standards of the communities in which we work and that our behavior may influence public attitude toward the profession.

Purpose

This Code of Ethics describes the highest ideals for music therapists as an aspirational guide to professional conduct. It is equally intended to educate and guide music therapists in ethical practice, as well as inform those outside the profession.

Applicability

This Code of Ethics is applicable to all those holding the MT-BC credential or a professional designation from the National Music Therapy Registry (ACMT, CMT, RMT), and professional membership in the American Music Therapy Association. This Code is also applicable to music therapy students and interns under clinical supervision. All music therapy practitioners are expected to uphold the spirit and purpose of the Code, and to practice according to these standards.

Upholding our right to freedom of inquiry and communication, we accept the responsibilities inherent in such freedom: competency, objectivity, consistency, integrity, and continual concern for the best
interests of society and our profession. Therefore, we collectively and individually affirm the following declarations of professional conduct.

Core Values

This Code of Ethics is grounded in a set of eight Core Values: 1. Kindness, 2. Social Responsibility, 3. Dignity/Respect, 4. Equality, 5. Accountability, 6. Excellence, 7. Integrity, and 8. Courage. These Core Values provide a foundation to guide music therapists in their practice and interactions. These Core Values should be considered in determining all ethical courses of action. (See glossary for detailed definition of these values)

Principles for Ethical Practice

Principle #1 Respect dignity and rights of all

Music therapists respect the dignity and rights of all people; this informs our relationships with clients, colleagues, students, research subjects, and all people we encounter. By acknowledging the worth of all people, this principle also encourages the music therapist to reflect sensitivity in all interactions.

To operationalize this principle, the music therapist will:

1.1 provide quality client care regardless of the client’s race, religion, age, sex, sexual orientation, gender identity or gender expression, ethnic or national origin, disability, health status, socioeconomic status, marital status, or political affiliation.

1.2 identify and recognize their personal biases, avoiding discrimination in relationships with clients, colleagues, and others in all settings.

1.3 respect, acknowledge, and protect the rights of all clients, including the rights to safety, treatment, respect, dignity, and self-determination, as well as the rights to choose a provider, to exercise legal and civil rights, and to participate in treatment decisions.

1.4 respect the client’s right of ownership to creative products as a result of participation in music therapy.

1.5 obtain informed consent from the client or legal guardian. In cases in which the client is unable to provide consent, assent will nonetheless be sought.

1.6 respect and protect the client’s confidentiality at all times and following any applicable institutional or legal rules and regulations. The music therapist will inform the client of all limitations to confidentiality prior to the beginning of treatment.

1.7 protect the rights of clients, students and research participants under applicable policies, laws and regulations. Music therapists will ensure students, researchers, volunteers, and employees abide by privacy laws and exceptions as currently defined in Pub.L. 104-191 - Health Insurance Portability and Accountability Act and Pub. L. 93-380 - Family Educational Rights and Privacy Act, and Title IX-Education Amendments Act.

1.8 acquire knowledge and information about the specific cultural group(s) with whom they work, seeking supervision and education as needed.
1.9 avoid entering into dual relationships when doing so would violate professional boundaries or clinical objectivity.

1.10 avoid accepting gifts or other considerations that could influence or give an appearance of influencing professional judgment.

1.11 avoid engaging in sexual or romantic relationships with clients, their family members, caregivers, students, trainees, research participants, or employees.

1.12 work collaboratively with peers using open direct communication to resolve differences of opinion or to recognize others’ perceptions.

1.13 respect the professional services offered by colleagues in music therapy and other disciplines and endeavor to communicate openly when a change in provider occurs or is pending.

**Principle #2 Act with compassion**

As music therapists we are often confronted with much suffering and feel the need to assist in the alleviation of discomfort. By manifesting patience, wisdom, and genuine desire to help meet the needs of our clients, we offer compassion to those we serve. In addition, it is important for music therapists to extend compassion to themselves when confronted with their own human limitations.

To operationalize this principle, the music therapist will:

2.1 act with the best interest of clients in mind at all times.

2.2 actively listen to their clients and affirm and validate their experiences.

2.3 be aware and accepting of client's individual factors and cultural differences in the treatment process.

2.4 empower clients to make desired changes in their lives.

2.5 act with compassion and genuine interest when dealing with peers.

2.6 seek peer/professional supervision to assist with reflection and practice improvement.

2.7 practice self-kindness and mindfulness and extend compassion to self if faced with feelings of inadequacy or failure.

**Principle #3 Be accountable**

The act of being accountable encompasses the obligation to report, explain, and be answerable for resulting consequences. Accountability is valued as a means to establish trust and strengthen professional and client-based relationships. The music therapist will be honest, fair, accurate, respectful, timely, and maintain privacy in all interactions.

To operationalize this principle, the music therapist will:

3.1 fulfill their legal and professional obligations to the profession with respect to any applicable local, state, and federal laws and regulations, and employer policies.
3.2 accurately inform potential and current clients of credentials and fulfill educational requirements for maintenance and renewal.

3.3 work in a manner to reflect truthful and fair business practices that benefit clients, society, and the profession.

3.4 seek remuneration that is fair and reasonable.

3.5 conduct, document, and report professional, academic, and research activities in an accurate and timely manner, and in accordance with applicable regulations and best practices.

3.6 identify and fully disclose errors, adverse, or sentinel events that compromise the safety of clients and others, to all appropriate persons.

3.7 differentiate personal views from those of the profession, the employer or agency.

3.8 report any illegal actions to authorities.

3.9 give credit and recognition when using the ideas and work of others.

3.10 provide comprehensive, accurate, and objective information about expectations for treatment outcomes.

3.11 offer services commensurate with training and corresponding scope(s) of practice(s), recognizing personal limitations.

3.12 exercise caution and professional judgment in all electronic, written, verbal, and inferred communications being especially aware of electronic messages and potential public access.

3.13 be familiar with the Code of Ethics, abide by its principles and report witnessed violations to the Ethics Board, refraining from frivolous or punitive reporting. When a question arises regarding behaviors and ethics, the member is encouraged to consult with the Ethics Board.

3.14 cooperate and participate in ethics board inquiries and processes when requested to do so.

**Principle #4. Demonstrate integrity and veracity**

Demonstrating integrity and veracity challenges each individual to act with truthfulness and accuracy in all communications. These qualities compel us to be incorruptible and devoted to truth in all professional relationships and interactions. Additionally, adherence to the principle of veracity requires thoughtful analysis of how full disclosure of information may affect outcomes. If there are circumstances in which a music therapist must weigh the consequences when two or more values are in conflict, it is incumbent upon the music therapist to seek peer supervision or counsel from other resources.

To operationalize this principle, the music therapist will:

4.1 demonstrate truthfulness while using discernment and judgement while contemplating potential outcomes.
4.2 use resources available to them to enhance and better their practice (e.g., peer/professional supervision).

4.3 use caution when predicting the potential outcomes of services offered.

4.4 truthfully and accurately document outcomes of treatment.

4.5 fully disclose any financial interest in products or services that they recommend to clients.

4.6 make referrals to other professionals to address client needs beyond the scope of music therapy practice or beyond the therapist's professional competence.

4.7 provide accurate information to clients entering into a therapeutic or research relationship, and obtain informed consent from the client or research participant.

4.8 ensure that billing and business practices are accurate and reflect the nature and extent of the services provided.

**Principle #5. Strive for excellence**

The music therapist seeks to continually improve skills and knowledge, evaluating the strength and applicability of evidence into all areas of professional practice and behavior. Striving for excellence in music therapy encompasses all aspects of music therapy: education, training, supervision, clinical practice, business and research. Striving for excellence does not imply perfection, but the ongoing commitment to expand our knowledge and skills in all areas.

To operationalize this principle, the music therapist will:

5.1 achieve and maintain professional competence through learning and personal growth, and encourage colleagues to do the same.

5.2 strive to be self-aware and to continually improve skills and knowledge by integrating the best available evidence and findings from research to maintain best practices.

5.3 use caution, critical thinking, and strong consideration of the best available evidence when incorporating new and evolving interventions and technologies into their practice, education, or supervision.

5.4 will serve as a positive role model for students and interns regarding professional behavior, most especially regarding ethical behavior; assuring that students learn about and operate under the guidelines of this Code.

5.5 educators and clinical training directors ensure that students and interns meet or exceed the AMTA professional competencies before recommending entrance into the profession.

Music therapists are reminded that a Code of Ethics cannot describe every possible situation but offers the music therapist guidelines for ethical decision-making and professional conduct. Music therapists are encouraged to seek supervision or assistance as needed.
References:


Fellman, S.J. (2018). Will your code of ethics get your association in trouble? Online webinar, GKG Law, June 28, 2018


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**SEMESTER TOTAL**: 18

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**SEMESTER TOTAL for Voice Major/Minor**: 14

**SEMESTER TOTAL for Non-Voice Major/Minor**: 15

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**SEMESTER TOTAL**: 16.5

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**Piano Proficiency Completion:**

- Applied Class Piano Sequence Completed ☐
- Piano Proficiency Exam Passed ☐

**Date:**

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**Degree Total for Voice Major/Minor**: 127.5

**Degree Total for Non-Voice Major/Minor**: 128.5

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**General Education Domains**

- D1-Effective Communication
- D2-Artistic Expression
- D3-Quantitative Literacy
- D4-The Nature of Science
- D5-Moral Reasoning
- D7-The Individual in the World
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**Electives**

(To be chosen in coordination with academic advisor according to student learning needs and interests)

1
1
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1

**DEGREE TOTAL** 34

Minimum degree requirements: 34 Semester Hours WITH GPA of 3.0 or better.

*Continuous enrollment for at least one credit is required in fall and spring semesters after initial registration to support completion of the lecture and supporting document. Summer registration is optional. Registration and billing are automatic until the requirement is fulfilled or the student submits a written statement of withdrawal from the curriculum. Extra CONR requirements may not be used as elective credits.

The tracking sheet serves as a condensed curriculum requirement reference sheet. Refer to the 2018-2019 Graduate Catalog for binding information regarding curricular requirements. Graduation degree audits will be based upon requirements stated in the Graduate Catalog.
<table>
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**Music Therapy Foundations (min. 39 cr.)**

**Clinical Foundations* (min. 15 cr.)**
- Abnormal Psychology | 3
- Human Anatomy & Physiology | 3
- Found. of Psychology | 3
- Dev. Psychology | 3

**General Education** (min. 33 cr.)

**Recommended Admissions Status**
- Accept
- Reject

**Summary earned prerequisites:**
- Musical Foundations credits
- Clinical Foundations credits
- General Electives credits

**Recommended Admissions Status**
- Accept
- Reject

**Additional credits (to total 54)**

**Minimum degree requirements:** 39 Semester Hours WITH GPA of 3.0 or better.

**AMTA competencies met?**
- Musical Foundations | Yes No
- Clinical Foundations | Yes No
- General Electives | Yes No
- MT Foundations | Yes No

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* AMTA competencies should include the study of normal human development, exceptionality, psychopathology, principles of therapy, and the therapeutic relationship. See AMTA document, "Professional Competencies," for specific requirements.

** Music Foundations should include the study of music theory and history, composition and arranging, major performance medium, keyboard, guitar, voice, nonsymphonic instruments, improvisation, conducting and movement. See AMTA document, "Professional Competencies," for specific requirements.

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* Clinical Foundations should include the study of normal human development, exceptionality, psychopathology, principles of therapy, and the therapeutic relationship. See AMTA document, "Professional Competencies," for specific requirements.

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***The tracking sheet serves as a condensed curriculum requirement reference sheet. Refer to the 2018-2019 Graduate Catalog for binding information regarding curricular requirements. Graduation degree audits will be based upon requirements stated in the Graduate Catalog.***
CBMT Code of Professional Practice

PREAMBLE

The CBMT is a nonprofit organization which provides board certification and recertification for music therapists to practice music therapy. The members of the Board of Directors comprise a diverse group of experts in music therapy. The Board is national in scope and blends both academicians and clinicians for the purpose of establishing rigorous standards which have a basis in a real world practice, and enforcing those standards for the protection of consumers of music therapy services and the public.

The CBMT recognizes that music therapy is not best delivered by any one sub-specialty, or single approach. For this reason, the CBMT represents a comprehensive focus. Certification is offered to therapists from a wide variety of practice areas, who meet high standards to the Practice of Music Therapy. To the extent that standards are rigorously adhered to, it is the aim of the CBMT to be inclusive, and not to be restrictive to any sub-speciality.

Maintenance of board certification will require adherence to the CBMT’s Code of Professional Practice. Individuals who fail to meet these requirements may have their certification suspended or revoked. The CBMT does not guarantee the job performance of any individual.

I. COMPLIANCE WITH CODE OF PROFESSIONAL PRACTICE

As a condition of eligibility for and continued maintenance of any CBMT certification, each certificant agrees to the following:

A. Compliance with CBMT Standards, Policies and Procedures
No individual is eligible to apply for or maintain certification unless in compliance with all the CBMT standards, policies and procedures. Each individual bears the burden for showing and maintaining compliance at all times. The CBMT may deny, revoke, or otherwise act upon certification or recertification when an individual is not in compliance with all the CBMT standards, policies, and procedures. Nothing provided herein shall preclude administrative requests by the CBMT for additional information to supplement or complete any application for certification or recertification.

B. Notification
The individual shall notify the CBMT within sixty (60) days of occurrence of any change in name, address, telephone number, and any other facts bearing on eligibility or certification (including but not limited to: filing of any criminal charge, indictment, or litigation; conviction; plea of guilty; plea of nolo contendere; or disciplinary action by a licensing board or professional organization). A certificant shall not make and shall correct immediately any statement concerning the certificant’s status which is or becomes inaccurate, untrue, or misleading.

All references to ‘days’ in the CBMT standards, policies and procedures shall mean calendar days. Communications required by the CBMT must be transmitted by certified mail, return receipt requested, or other verifiable methods of delivery when specified. The certificant agrees to provide the CBMT with confirmation of compliance with the CBMT requirements as requested by the CBMT.

C. Property of the CBMT
The examinations and certificates of the CBMT, the name Certification Board for Music Therapists, and abbreviations relating thereto are all the exclusive property of the CBMT and may not be used in any way without the express prior written consent of the CBMT. In case of suspension, limitation, revocation, or resignation from the CBMT or as otherwise requested by the CBMT, the individual shall immediately relinquish, refrain from using, and correct at the individual’s expense any outdated or otherwise inaccurate use of any certificate, logo, emblem, and the CBMT name and related abbreviations. If the individual refuses to relinquish immediately, refrain from using and correct at his or her expense any misuse or misleading use of any of the above items when requested, the individual agrees that the CBMT shall be entitled to obtain all relief permitted by law.

II. APPLICATION AND CERTIFICATION STANDARDS

In order to protect consumers of music therapy services and the public from harm and to insure the validity of the MT-BC credential for the professional and public good, CBMT may revoke or otherwise take action with regard to the application or certification of a certificant in the case of:

A. Ineligibility for certification, regardless of when the ineligibility is discovered;

B. Failure to pay fees required by the CBMT;

C. Unauthorized possession of, use of, or access to the CBMT examinations, certificates, and logos of the CBMT, the name ‘Certification Board for Music Therapists’, and abbreviations relating thereto, and any other CBMT documents and materials;

D. Obtaining or attempting to obtain certification or recertification by a false or misleading statement or failure to make a required statement; fraud or deceit in an application, reapplication, representation of event/s, or any other communication to the CBMT;
E. Misrepresentation of the CBMT certification or certification status;

F. Failure to provide any written information required by the CBMT;

G. Failure to maintain confidentiality as required by law;

H. Gross or repeated negligence or malpractice in professional practice, including sexual relationships with clients, and sexual, physical, social, or financial exploitation;

I. Limitation or sanction (including but not limited to revocation or suspension by a regulatory board or professional organization) relating to music therapy practice, public health or safety, or music therapy certification or recertification;

J. The conviction of, plea of guilty or plea of nolo contendere to a felony or misdemeanor related to music therapy practice or public health and safety;

K. Failure to timely update information to CBMT; or

L. Other violation of a CBMT standard, policy or procedure as outlined in the CBMT Candidate Handbook, Recertification Manual, or other materials provided to certificants.

III. ESTABLISHMENT OF SPECIAL DISCIPLINARY REVIEW AND DISCIPLINARY HEARING COMMITTEES

A. Upon the recommendation by the Chair, the CBMT Board of Directors may elect by a majority vote (i) a Disciplinary Review Committee and (ii) a Disciplinary Hearing Committee, to consider alleged violations of any CBMT disciplinary standards set forth in Section III.1-12 above or any other CBMT standard, policy, or procedure.

B. Each of these Committees shall be composed of three members drawn from CBMT certificants.

C. A committee member’s term of office on the committee shall run for three years and may be renewed.

D. A committee member may serve on only one committee and may not serve on any matter in which his or her impartiality or the presence of actual or apparent conflict of interest might reasonably be questioned.

E. At all times during the CBMT’s handling of the matter, the CBMT must exist as an impartial review body. If at any time during the CBMT’s review of a matter, any member of the CBMT Disciplinary Review Committee, Disciplinary Hearing Committee, or Board of Directors identifies a situation where his or her judgment may be biased or impartiality may be compromised, (including employment with a competing organization), the member is required to report such matter to the Executive Director immediately. The Executive Director and Board Chair shall confer to determine whether a conflict exists, and if so, shall replace the member.

F. Committee action shall be determined by majority vote.

G. When a committee member is unavailable to serve due to resignation, disqualification, or other circumstance, the Chair of CBMT shall designate another individual to serve as an interim member.

IV. REVIEW AND APPEAL PROCEDURES

A. Submission of Allegations

i. Allegations of a violation of a CBMT disciplinary standard or other CBMT standard, policy or procedure are to be referred to the Executive Director for disposition. Persons concerned with possible violation of CBMT’s rules should identify the persons alleged to be involved and the facts concerning the alleged conduct in as much detail and specificity as possible with available documentation in a written statement addressed to the Executive Director. The statement should identify by name, address and telephone number the person making the information known to the CBMT and others who may have knowledge of the facts and circumstances concerning the alleged conduct. Additional information relating to the content or form of the information may be requested.

ii. The Executive Director shall make a determination of the substance of the allegations within sixty (60) days and after consultation with counsel.

iii. If the Executive Director determines that the allegations are frivolous or fail to state a violation of CBMT’s standards, the Executive Director shall take no further action and so apprise the Board and the complainant (if any).

iv. If the Executive Director determines that good cause may exist to question compliance with CBMT’s standards, the Executive Director shall transmit the allegations to the Disciplinary Review Committee.

B. Procedures of the Disciplinary Review Committee

i. The Disciplinary Review Committee shall investigate the allegations after receipt of the documentation from the Executive Director. If the majority of the Committee determines after such investigation that the allegations and facts are inadequate to sustain a finding of a violation of CBMT disciplinary standards, no further adverse action shall be taken. The Board and the complainant (if any) shall be so apprised.

ii. If the Committee finds by majority vote that good cause exists to question whether a violation of a CBMT disciplinary standard has occurred, the Committee shall transmit a statement of allegations to the certificant by certified mail, return receipt requested, setting forth:

a. The applicable standard;

b. Of facts constituting the alleged violation of the standard;

c. That the certificant may proceed to request: (i) review of written submission by the Disciplinary Review Committee; (ii) a telephone conference of the Disciplinary Hearing Committee; or (iii) an in-person hearing (at least held annually proximate to the annual meeting of the CBMT) for the disposition of the allegations, with the certificant bearing his or her own expenses for such matter;

d. That the certificant shall have fifteen (15) days after receipt of such statement to notify the Executive Director if he or she disputes the allegations, has comments on available sanctions, and/or requests a written review, telephone conference hearing, or in-person hearing on the record;
C. Procedures of the Disciplinary Hearing Committee

i. Written Review. If the individual requests a review by written briefing, the Disciplinary Review Committee will forward the allegations and response of the individual to the Disciplinary Hearing Committee. Written briefing may be submitted within thirty (30) days following receipt of the written review request by the Disciplinary Hearing Committee. The Disciplinary Hearing Committee will render a decision based on the record below and written briefs (if any) without an oral hearing.

ii. Oral Hearing. If the individual requests a hearing:

a. The Disciplinary Review Committee will:

(1) forward the allegations and response of the certificant to the Disciplinary Hearing Committee; and

(2) designate one of its members to present the allegations and any substantiating evidence, examine and cross-examine witness(es) and otherwise present the matter during any hearing of the Disciplinary Hearing Committee.

b. The Disciplinary Hearing Committee shall then:

(1) schedule a telephone or in-person hearing as directed by the certificant;

(2) send by certified mail, return receipt requested, a Notice of Hearing to the certificant. The Notice of Hearing will include a statement of the time and place selected by the Disciplinary Hearing Committee. The certificant may request a modification of the date of the hearing for good cause. Failure to respond to the Notice of Hearing or failure to appear without good cause will be deemed to be the individual’s consent for the Disciplinary Hearing Committee to administer any sanction which it considers appropriate.

c. The Disciplinary Hearing Committee shall maintain a verbatim audio and/or video tape or written transcript of any telephone conference or in-person hearing.

d. The CBMT and the certificant may consult with and be represented by counsel, make opening statements, present documents and testimony, examine and cross-examine witnesses under oath, make closing statements, and present written briefs as scheduled by a Disciplinary Hearing Committee.

e. The Disciplinary Hearing Committee shall determine all matters relating to the hearing or review. The hearing or review and related matters shall be determined on the record by majority vote.

f. Formal rules of evidence shall not apply. Relevant evidence may be admitted. Disputed questions of admissibility shall be determined by majority vote of the Disciplinary Hearing Committee.

iii. In all written reviews and oral hearings:

a. The Disciplinary Hearing Committee may accept, reject, or modify the recommendation of the Disciplinary Review Committee, either with respect to the determination of a violation or the recommended sanction.

b. Proof shall be by preponderance of the evidence.

c. Whenever mental or physical disability is alleged, the certificant may be required to undergo a physical or mental examination at the expense of the certificant. The report of such an examination shall become part of the evidence considered.

d. The Disciplinary Hearing Committee shall issue a written decision following the hearing or review and any briefing. The decision shall contain factual findings, legal conclusions, and any sanctions applied. The decision of the Disciplinary Hearing Committee shall be mailed promptly by certified mail, return receipt requested, to the certificant. If the decision rendered by the Disciplinary Hearing Committee is not favorable to the certificant, the certificant may appeal the decision to the CBMT Board of Directors by submitting a written appeal statement within thirty (30) days following receipt of the decision of the Disciplinary Hearing Committee. CBMT may file a written response to the statement of the certificant.

D. Appeal Procedures

i. If the decision rendered by the Disciplinary Hearing Committee is not favorable to the certificant, the certificant may appeal the decision to the CBMT Board of Directors by submitting a written appeal statement within thirty (30) days following receipt of the decision of the Disciplinary Hearing Committee. CBMT may file a written response to the statement of the certificant.

ii. The CBMT Board of Directors by majority vote shall render a decision on the appeal without oral hearing, although written briefing may be submitted by the certificant and CBMT.

iii. The decision of the CBMT Board of Directors shall be rendered in writing following receipt and review of any briefing. The decision shall contain factual findings, legal conclusions, and any sanctions applied and shall be final. The decision shall be transmitted to the certificant by certified mail, return receipt requested.
iv. A Director may not: (a) review a matter at the appeal stage if he/she heard the matter as a member of the Disciplinary Hearing Committee; (b) review any matter in which his/her impartiality might reasonably be questioned, or (c) review any matter which presents an actual, apparent, or potential conflict of interest.

v. In all reviews:

a. The Board of Directors may affirm or overrule and remand the determination of the Disciplinary Hearing Committee.

b. In order to overturn a decision of the Disciplinary Hearing Committee, the individual must demonstrate that the Committee’s decision was arbitrary or capricious [e.g., was inappropriate because of: (a) material errors of fact, or (b) failure of the Disciplinary Review Committee or the Disciplinary Hearing Committee to conform to published criteria, policies, or procedures]. Proof is by preponderance of the evidence.

V. SANCTIONS

A. Sanctions for violation of any CBMT standard set forth herein or any other CBMT standard, policy, or procedure may include one or more of:

i. Mandatory remediation through specific education, treatment, and/or supervision;

ii. Written reprimand to be maintained in certificant’s permanent file;

iii. Suspension of board certification with the right to re-apply after a specified date;

iv. Probation;

v. Non-renewal of certification;

vi. Revocation of certification; and

vii. Other corrective action.

B. The sanction must reasonably relate to the nature and severity of the violation, focusing on reformation of the conduct of the individual and deterrence of similar conduct by others. The sanction decision may also take into account aggravating circumstances, prior disciplinary history, and mitigating circumstances. No single sanction will be appropriate in all situations.

VI. SUMMARY PROCEDURE

Whenever the Executive Director determines that there is cause to believe that a threat of immediate and irreparable harm to the public exists, the Executive Director shall forward the allegations to the CBMT Board. The Board shall review the matter immediately, and provide telephonic or other expedited notice and review procedure to the certificant. Following such notice and opportunity by the individual to be heard, if the Board determines that a threat of immediate and irreparable injury to the public exists, certification may be suspended for up to ninety (90) days pending a full review as provided herein.

VII. PERIOD OF INELIGIBILITY FOLLOWING REVOCATION

If certification is revoked based on noncompliance with the Code of Professional Practice, then the individual is automatically ineligible to apply for certification or re-certification for the periods of time listed below:

A. In the event of a felony conviction directly related to music therapy practice or public health and/or safety, no earlier than seven (7) years from the exhaustion of appeals or release from confinement (if any), or the end of probation, whichever is later:

B. In any other event, no earlier than five (5) years from the final decision of revocation. After these periods of time, eligibility will be considered as set forth in CBMT’s Eligibility Review and Appeal Policy.

After these periods of time, eligibility will be considered as set forth in CBMT’s Eligibility Review and Appeal Policy.

VIII. CONTINUING JURISDICTION

CBMT retains jurisdiction to review and issue decisions regarding any matter which occurred prior to the termination, expiration, or relinquishment of certification.

ADOPTED: FEBRUARY 8, 1997
EFFECTIVE DATE: JANUARY 1, 1998
REVISED: FEBRUARY 7, 1998
REVISED: FEBRUARY 8, 2001
REVISED: OCTOBER 4, 2011

APPENDIX 9
Virginia Department of Health Professions
Board of Health Professions

Appendix

QUESTIONS TO BE CONSIDERED FOR THE EVALUATION OF THE NEED FOR REGULATION OF A HEALTH OCCUPATION OR PROFESSION

A. GENERAL INFORMATION

1. What occupational or professional group is seeking regulation?
   Board Certified Music Therapists (MT-BC)

2. What is the level or degree of regulation sought?
   Licensure

3. Identify by title the association, organization, or other group representing Virginia-based practitioners. (If more than one organization, provide the information requested below for each organization.)
   (a) Certification Board for Music Therapists (CBMT)
   (b) American Music Therapy Association (AMTA)
   (c) Virginia Music Therapy Association (VMTA)

4. Estimate the number of practitioners (members and nonmembers) in the Commonwealth.
   According to CBMT, as of January 2019, there are 227 board certified music therapists in Virginia eligible for regulation by the state.

5. How many of these practitioners are members of the group preparing the proposal? (If several levels or types of membership are relevant to this proposal, explain these levels and provide the number of members, by type).
   All 227 board certified music therapists in Virginia are included in the groups preparing this proposal.
   According to the Work Force Analysis Survey conducted by the American Music Therapy Association (AMTA) in 2018, there were 102 Music Therapists in Virginia who were 2018 members of AMTA. While AMTA professional membership is voluntary, CBMT board certification is the national credential required by the profession. AMTA and CBMT work collaboratively to represent the entire music therapy profession and assist with recognition of the profession and its credential by advocating for inclusion in state statutes and regulations.
6. Do other organizations also represent practitioners of this occupation/profession in Virginia? If yes, provide contact information for these organizations.

(a) Certification Board for Music Therapists (CBMT)
   Contact Person: Dena Register, PhD, MT-BC
   Regulatory Affairs Advisor
   506 E Lancaster Ave, Suite 102
   Downingtown, PA 19335
   1.800.765.CBMT (2268)
   1.610.269.8900
   dregister@cbmt.org
   info@cbmt.org
   www.cbmt.org

(b) American Music Therapy Association (AMTA)
   Contact Person: Judy Simpson, MT-BC
   Director of Government Relations
   8455 Colesville Road, Suite 1000,
   Silver Spring MD 20910
   301.589.3300
   simpson@musictherapy.org
   info@musictherapy.org
   www.musictherapy.org

(c) Virginia Music Therapy Association (VMTA)
   Contact Person: Nicole Drozd, MS, MT-BC
   President
   315.489.1590
   drozd.nicole@gmail.com
   www.virginiamusictherapy.org

7. Provide the name, title, organizational name, mailing address, and telephone number of the responsible contact person(s) for the organization preparing this proposal.

   Tracy Bowdish, MM, MT-BC
   Co-Chair, Virginia State Task Force for the American Music Therapy Association (AMTA) and the Certification Board for Music Therapists (CBMT)
   8336 Mona Avenue
   Norfolk, VA 23518
   320.309.4952

   Shelby Reynolds, MT-BC
   Co-Chair, Virginia State Task Force for the American Music Therapy Association (AMTA) and the Certification Board for Music Therapists (CBMT)
   25 Lovings Lane
   Fredericksburg, VA 22406
   540.222.9627
8. How was this organization and individual selected to prepare this proposal?

The Virginia State Task Force has been charged by the Mid-Atlantic Region of the American Music Therapy Association. The “Charge to the Virginia State Task Force on Occupational Regulation” states the following, “The VASTF will also work collaboratively with AMTA and CBMT to implement the State Recognition Operational Plan and to work to fulfill the AMTA mission of increasing awareness of the benefits of music therapy and increasing access to quality music therapy services within their state.” Tracy Bowdish and Shelby Reynolds serve as co-chairs for the Virginia State Task Force, which is a group of five music therapists and one student member from across the state.

9. Are there other occupations/professions within the broad occupational grouping? What organization(s) represent these entities? (List those in existence and any that are emerging).

There are no other occupations/professions within music therapy.

10. For each association or organization listed above, provide the name and contact information of the national organizations with which the state associations are affiliated.

Not applicable

B. QUESTIONS WHICH ADDRESS THE CRITERIA

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

1. Provide a description of the typical functions performed and services provided by members of this occupational group.

The Scope of Music Therapy Practice (attached) defines the range of responsibilities of a fully qualified music therapy professional with requisite education, clinical training, and board certification. Professional music therapists are qualified to complete the following tasks independently, and when applicable, in conjunction with an interdisciplinary treatment team:

- Accept referrals for music therapy services from medical, developmental, mental health, and education professionals; family members; clients; caregivers; or others involved and authorized with provision of client services. Before providing music therapy services to a client for an identified clinical or developmental need, the music therapist collaborates, as applicable, with the primary care provider(s) to review the client's diagnosis, treatment needs, and treatment plan. During the provision of music therapy services to a client, the music therapist collaborates, as applicable, with the client's treatment team;

- Conduct a music therapy assessment of a client to determine if treatment is indicated. If treatment is indicated, the music therapist collects systematic, comprehensive, and accurate information to determine the appropriate music therapy interventions to provide for the client;
• Develop an individualized music therapy treatment plan for the client that is based upon the results of the music therapy assessment. The music therapy treatment plan includes individualized goals and objectives that focus on the needs and strengths of the client and specify music therapy approaches and interventions to be used to address these goals and objectives;
• Implement an individualized music therapy treatment plan that is consistent with or complementary to any other developmental, rehabilitative, habilitative, medical, mental health, preventive, wellness care, or educational services being provided to the client;
• Evaluate the client's response to music therapy, documenting changes and progress in the music therapy treatment plan, and suggesting modifications, as appropriate;
• Develop a plan for determining when the provision of music therapy services is no longer needed in collaboration with the client, physician, or other provider of health care or education of the client, family members of the client, and any other appropriate person upon whom the client relies for support;
• Minimize any barriers to ensure that the client receives music therapy services in the least restrictive environment;
• Educate and collaborate with the client and the family, caregiver of the client, or any other appropriate person regarding the needs of the client that are being addressed in music therapy and the manner in which the music therapy treatment addresses those needs; and
• Utilize appropriate knowledge and skills to inform practice including use of research, reasoning, and problem-solving skills to determine appropriate actions in the context of each specific clinical setting.

2. Has the public actually been harmed by unregulated providers or by providers who are regulated in other states? If so, how is the evidence of harm documented (i.e., court case or disciplinary or other administrative action)? Was it physical, emotional, mental, social, or financial?

No known official complaints have been made to the state regarding music therapy being unregulated. It is currently difficult to accurately track public complaints as there is no mechanism in place for the public to file complaints in Virginia. One of the reasons state recognition is being sought is to then have a mechanism in place to more accurately address public complaints in the state. While it can be difficult to understand how music can cause harm, there are several examples of how the improper use of a music stimulus can be medically and emotionally harmful, especially for individuals with complex dementias, mental health issues, or the medically fragile.

A case example is provided here:

A nursing home patient with Lewy body dementia, was engaged in a group music sing-along that utilized songs from the big band era. **Lewy Body dementia is different from the more common dementia of Alzheimer's type.** People with Lewy Body dementia often have delusions, hallucinations, difficulty interpreting information, and behaviors.

At some point the man became progressively upset, and started yelling and threatening others patients and staff. The musician facilitating the sing-along decided to try a
different song to engage this man and calm him down. Unfortunately, the song choice only exacerbated the mood and situation. The patient, very distraught and confused, struck another patient and staff member, and in the process stood up and fell. This resulted in a high fracture of the right femur, a skin tear wound, and the patient who was hit suffered emotional confusion and pain.

The cost of this incident went beyond harm or money. The patient's family, deeply saddened and frustrated by the progression of dementia, was notified that they would likely have to find a different placement for their family member in a more limiting “secure” facility. Nurses had incident reports to complete, and residents and families were distressed by the event. Staff stress was elevated by the incident, and the patient spent countless hours in pain and confusion. The awful cycle of pain, confusion, and fatigue was quite difficult to moderate and support, and the patient became isolated and often inconsolable.

One problem: it is all too easy to relegate such an event to the consequences of dementia. A review, and investigation into the antecedent of this event was found to be a progression of bad decision-making and choices within the environment of the activity setting, placement of the patient, and the clear and observed effect of music and music activity increasing agitation, confusion, and distress.

The group was facilitated by an entertainer that contracted with small nursing homes and group homes. Part of his brochure included the term music therapy, and although he was not a music therapist, he used many examples of the benefits of music with the elderly.

This entertainer did not have the training and a clinical understanding in working with a patient with Lewy body dementia, and to this, did not have the necessary clinical skill set to support the needs of this patient, who became rapidly confused and decompensated into violence. Assuming that music calms and soothes, and simply changing to a different song as a method to change behavior was an inappropriate action.

Music therapists know of the risks that play into altered psychological states, and various shifts in comprehension and perception related to dementia. We make sure we have a reasonable and predictive understanding of the influence of music with our patients through assessment methods. A key point that must not be understated: the music therapist (through training and supervision) has a level of vigilance and monitoring of the patient while simultaneously engaging in, and facilitating the music experience. In contrast, musicians and entertainers are commonly focused on the performance and the identity of themselves within the performance. No one is perfect, but in this example, music therapists would not have placed a volatile patient in the setting, and would have recognized very quickly the signals leading up to increased confusion and exacerbated behaviors. This patient loved music, and needed to have a one-to-one individual type of experience.

There is an uncomfortable irony in writing this account, and harm is a real thing. This elderly gentleman was not able to heal, spent his last week in pain, and died in a nursing home in Roanoke, Virginia a few weeks after this incident.
3. **If no evidence of actual harm is available, what aspects of the provider group’s practice constitute a potential for harm?**

Potential harm to the public includes misrepresentation of the music therapy profession, as these individuals hold themselves out to the public as being able to produce outcomes that are not based upon evidence-based practice; and, these individuals show a substantial lack of supervised clinical training and feedback to promote and ensure ethical practice. This lack of formalized training and credentials pose an unnecessary and sometimes unintended risk to clients. This also has financial implications for consumers which include being overcharged by untrained individuals that are not held accountable to follow or uphold professional standards and ethics, and who are not qualified to provide the service or document measurable outcomes.

4. **To what can the harm be attributed? Elaborate as necessary.**

- lack of skills
- lack of knowledge
- lack of ethics
- lack of supervision
- practices inherent in the occupation
- characteristics of the client/patients being served
- characteristics of the practice setting
- other (specify)

Harm can be attributed to all of the above. There are a growing number of unqualified individuals in the state claiming to be music therapists who do not hold a music therapy degree from an accredited institution or carry the national credential of Music Therapist-Board Certified (MT-BC). The current lack of music therapy recognition in the state leaves Virginia residents at-risk for negative social, emotional, medical, and economic consequences due to the inability of an untrained individual having no experience or understanding of the established music therapy standards of clinical practice. In addition, unqualified and non-credentialed individuals hold themselves out to the public as being able to produce outcomes that are not based upon evidence-based practice. Finally, these individuals show a substantial lack of supervised clinical training and feedback to promote and ensure ethical practice. This also puts the consumer at-risk financially; as he or she may be paying untrained individuals for services that do not include documented measurable outcomes and scientifically based treatment.

It can be difficult to understand how music can cause harm, but there are several examples of how the improper use of a music stimulus can be medically and emotionally harmful.

For example, musicians across the state identify themselves as “Music Therapists” and claim to offer music therapy services, yet they are not trained music therapists according to the profession’s nationally established standards. For example, a nurse at a long-term care facility may claim to do “music therapy” by playing the piano for sing-a-longs for the residents. While qualified to address a number of physical issues, she is not trained to select or manipulate particular musical elements to elicit specific desired responses, nor is she trained to handle the social or emotional responses that those individuals may have in response to
musical stimuli; these types of social and emotional responses occur frequently and can be powerful.

The potential for harm could be recognized when a non-qualified individual claiming to be a music therapist does not comply with federal and state statutes and regulations, i.e., HIPAA regulations safeguarding client privacy. The potential for harm could exist if a non-qualified individual provided inappropriate applications of music interventions that could cause physical or emotional harm, or if the individual participated in unethical practice that could be harmful to the public and consumers in general. Without regulation of music therapists by the state, it would be difficult to identify music therapists who are in compliance with state regulations, which is essential for public protection.

As indicated in the examples above, music therapists often work with vulnerable populations (e.g. persons with intellectual or emotional disabilities, or persons coping with physical, mental, or terminal illness). Therefore, it is important to formally recognize the profession to safeguard consumers who may be less able to protect themselves. A person claiming to be a music therapist, but who did not have the nationally accepted academic and clinical training and did not hold the nationally recognized music therapy credential, could potentially cause significant health and/or safety risks. Similar to the requirements of other healthcare professionals, music therapists are responsible for working within AMTA Standards for Education and Clinical Training (attached), AMTA Standards of Clinical Practice (attached), and AMTA Code of Ethics (attached). Board certified music therapists must also abide by the CBMT Code of Professional Practice (attached) and work within the CBMT Board Certification Domains (attached). These standards, codes, and professional documents require that music therapists follow state and institutional laws and mandates for ethical practice.

5. Does a potential for fraud exist because of the inability of the public to make an informed choice in selecting a competent practitioner?

Yes, Virginia music therapists are seeking licensure to mitigate the potential for harm to the public and to increase consumer access to music therapy services. Regulating music therapy practice would provide the public with assurance that they are protected from the misuse of terms and techniques by unqualified individuals and to ensure competent practice. Virginians would be assured that individuals providing music therapy services are qualified clinicians who have met the education, clinical training, and credentialing requirements for the profession.

Potential fraud to the public includes misrepresentation of the music therapy profession, as these individuals hold themselves out to the public as being able to produce outcomes that are not based upon evidence-based practice; and, these individuals show a substantial lack of supervised clinical training and feedback to promote and ensure ethical practice. This lack of formalized training and credentials pose an unnecessary and sometimes unintended risk to clients. This also has financial implications for consumers which include being overcharged by untrained individuals that are not held accountable to follow or uphold professional standards and ethics, and who are not qualified to provide the service or document measurable outcomes.

Additionally, access to medically, behaviorally, or educationally necessary music therapy services would be improved, as Virginians would be able to locate qualified providers.
recognized by the state. Access to qualified music therapists would also be made easier for employers. Facilities interested in providing music therapy services would be able to utilize the state system to locate qualified professionals. Regulation will prevent the incidence of unqualified individuals having access to clients’ confidential information and potentially compromising clients’ health and wellness issues. Furthermore, the current trend in healthcare is consumer choice. Consumers need and want choices in their healthcare treatment options. Licensure for music therapists is a step toward providing Virginians access to another type of service that can improve their health and treatment outcomes.

State regulation would effectively eliminate confusion for those seeking private services, as consumers would have a means to determine competence. There are a large number of non-credentialed individuals claiming to practice music therapy who could cause psychological harm as they do not have the necessary education and clinical training to assess, develop and implement interventions. This is confusing to the general public as these individuals do not always represent themselves accurately. In Virginia, we have seen cases where musicians volunteer by playing music in hospitals under the title of “music therapy.” We have been notified that other healthcare professionals, teachers, and paraprofessionals claim to sing to students in order to provide the “music therapy” listed on a child’s IEP. These situations demonstrate fraudulent and unethical business practices with no recourse for consumers. Virginia residents deserve transparency concerning the services they receive.

6. **Does a potential for fraud exist because of the inability for third party payors to determine Competency?**

The potential for fraud does exist because of the inability for third party payers to determine competency. Since music therapy is not currently recognized as a profession in the state of Virginia, there is no standard for competent practice defined by the state. Third party payers could be paying for services by untrained individuals.

7. **Is the public seeking regulation or greater accountability of this group?**

Yes, the public is seeking regulation.

In June of 2017: The Virginia Music Therapy Association (VMTA) received emails from concerned parents in Loudoun County, stating that Loudoun County Public Schools (LCPS) planned to discontinue contracts with board certified music therapists and replace with existing staff. VMTA communicated with AMTA as well as music therapists involved and supported parents with advocacy materials about U.S. Department of Education’s recognition of music therapy as a related service under the federal Individuals with Disabilities Education Act (IDEA). In August 2017, parents received Notification from LCPS that they were using occupational therapists, speech-language pathologists, and teachers to offer “music therapy” instead of board certified music therapists. AMTA forwarded multiple LCPS IEPs received from parents to the U.S. Department of Education Office of Special Education programs. After multiple conversations with the Virginia Department of Education, AMTA was told that the district can determine who provides music therapy when the state does not have a license for the profession.

In summary, The Virginia Department of Education does not formally recognize the profession and its national board certification credential. As a result, some districts in
Virginia are claiming they can determine who is qualified to provide music therapy. This unusual interpretation of the federal special education law is not being done in any other state in our nation. This practice has led to a disruption of student progress, professional ethics questions from staff being asked to provide services they are not qualified to offer, and significant frustration within the many families affected by this interpretation of the law. The American Music Therapy Association (AMTA) has communicated with the VA Department of Education and it appears the only way to resolve this problem is for the VA Legislature to create a music therapy license that recognizes the national board certification credential.

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

1. What are the educational or training requirements for entry into this occupation? Are these programs accredited? By whom?
   - Are sample curricula available?
   - Are there training programs in Virginia?

Those who wish to become music therapists must earn a bachelor’s degree or higher in music therapy from one of over 80 American Music Therapy Association (AMTA) approved colleges and universities. These programs require academic coursework and 1,200 hours of clinical training, which includes a supervised internship. The academic institution takes primary responsibility for providing students with the entire continuum of clinical training experiences with a representative range of client populations in diverse settings. Qualified supervision of clinical training is required and coordinated or verified by the academic institution. An academic institution, AMTA, or both may approve internship programs. Clinical supervisors must meet minimum requirements outlined by AMTA Standards for Education and Clinical Training (attached). In exceptional cases, a student may have an on-site supervisor or facility coordinator (e.g. OT, nurse, special educator, etc.). Under these circumstances, the student must have a music therapist as a supervisor under the auspices of the university.

At the completion of academic and clinical training, students are eligible to take the national examination administered by the Certification Board for Music Therapists (CBMT), an independent, non-profit certifying agency fully accredited by the National Commission for Certifying Agencies (NCCA). After successful completion of the CBMT examination, graduates are issued the credential necessary for professional practice, Music Therapist-Board Certified (MT-BC). To demonstrate continued competence and to maintain this credential, music therapists are required to complete 100 hours of continuing music therapy education during every five-year recertification cycle.

All board certified music therapists receive education and training in compliance procedures for state, federal and facility regulations and accreditation. They are trained and skilled to conduct music therapy assessments, draft and incorporate goals and objectives into treatment plans, specify procedures and define expected treatment outcomes, evaluate and make appropriate modifications and accommodations, and document the process utilizing standard tools. The skill set and competencies required of music therapists are outlined in the AMTA Professional Competencies (attached) and the CBMT Board Certification Domains (attached).
Radford University and Shenandoah University are the only universities in Virginia that offer Bachelor’s level and Master’s level music therapy trainings in the state. The Bachelor of Music in Music Therapy degree is a 4-year program and the Master of Science in Music Therapy degree is a 2-3 year program. Radford University and Shenandoah University are both accredited by the National Association of Schools of Music and approved by the American Music Therapy Association.

Contact information:

Radford University
801 East Main St.
Radford, VA 24142
Director of Music Therapy: Dr. Patricia Winter
pwinter3@radford.edu

Shenandoah University
1460 University Drive
Winchester, VA 22601
Director of Music Therapy Studies: Dr. Tony Meadows
ameadows2@su.edu

Sample curricula for Shenandoah University is attached, and curricula for Radford University can be found at the following links:

Undergraduate:
https://www.radford.edu/content/dam/colleges/cvpa/forms/checksheets/17-18/music/1718bm-musictherapy.pdf

Graduate:

In addition to the collegiate training curriculum, all board certified music therapists must also complete a six-month clinical training internship in order to be eligible to sit for the board certification exam. An academic institution, AMTA, or both may approve internship programs. Clinical supervisors must meet minimum requirements outlined by the AMTA Standards for Education and Clinical Training (attached).

2. If no programs exist in Virginia, what information is available on programs elsewhere which prepare practitioners for practice in the Commonwealth? What are the minimum competencies (knowledge, skills, and abilities) required for entry into the profession? How were they derived?

   Not applicable. Formal training and education, to include a Bachelor’s Degree in Music Therapy, or a Master’s Degree in Music Therapy is required, in addition to national board certification as regulated by the Certification Board for Music Therapists (CBMT).

3. Are there national, regional, and/or state examinations available to assess entry-level competency?
   • Who develops and administers the examination?
What content domains are tested?

Are the examinations psychometrically sound -- in keeping with The Standards for Educational and Psychological Testing?

Yes. All board certified music therapists have either passed an exam developed and administered by the Certification Board for Music Therapists (CBMT) or transitioned into board certification through CBMT. CBMT is an independent, non-profit certifying agency fully accredited by the National Commission for Certifying Agencies (NCAA). This accreditation serves as the means by which CBMT strives to maintain the highest standards possible in the construction and administration of its national examination and re-certification programs, ultimately designed to reflect current music therapy practice for the benefit of the consumer. The CBMT defines the body of knowledge that represents competent practice in the profession of music therapy, creates and administers a program to evaluate initial and continuing competence of this knowledge, and issues the credential of MT-BC to individuals that demonstrate the required level of competence.

The CBMT examination is psychometrically sound. It meets accreditation standards with NCCA and is developed in accordance with the APA standards for Educational and Psychological testing. CBMT programs meet or exceed the same standards for Educational and Psychological testing. CBMT programs meet or exceed the same standards licensing boards use in test development and administration. In accordance with APA standards, a practice analysis is reviewed every five years in cooperation with a team of experts in the field, surveyed certificants, and CBMT’s testing firm, Applied Measurement Professionals (AMP). It is from this process that the CBMT Board Certification Domains (attached) are updated to reflect current clinical practice and outlines the tasks necessary to practice music therapy completely to ensure consumer protection. The five content domain areas, essentially performance domains, encompass the certificate's scope of practice.

4. Are there requirements and mechanisms for ensuring continuing competence? For example, are there mandatory education requirements, re-examination, peer review, practice audits, institutional review, practice simulations, or self-assessment models?

Yes. At the completion of academic and clinical training, students are eligible to take the national examination administered by CBMT, an independent, non-profit certifying agency fully accredited by the National Commission for Certifying Agencies since 1986. After successful completion of the CBMT examination, graduates are issued the credential necessary for professional practice, Music Therapist-Board Certified (MT-BC). To demonstrate continued competence and to maintain this credential, music therapists are required to complete 100 hours of continuing music therapy education within every five-year recertification cycle. If certification is not maintained, the individual must successfully pass the exam again to obtain the MT-BC credential.

5. Why does the public require state assurance of initial and continuing competence? What assurances do the public have already through private credentialing or certification or institutional standards, etc.?

Establishing a state licensure for music therapists protects the public because licensure would only be granted to those who are credentialed clinicians and have met the stringent education, clinical training, and national board certification requirements established by the American
Music Therapy Association (AMTA) and the Certification Board for Music Therapists (CBMT). State licensure would effectively decrease confusion for those seeking private services, as consumers would have a means to infer competence based on finding a credentialed individual who also meets state licensure requirements. There are a large number of non-credentialed individuals claiming to be music therapists or who use the term music therapy to describe their work who could cause potential psychological and physical harm as they do not have the necessary education and clinical training to assess, develop and implement music interventions as outlined in the CBMT Board Certification Domains (attached). These individuals do not always represent themselves accurately and this is confusing to the general public.

Finally, a state license to practice music therapy would provide the public with a well-defined, easily-accessed method of determining qualified practitioners. Licensure would assist potential employers in selecting qualified music therapists as opposed to non-credentialed music professionals, decreasing the incidence of unqualified individuals having access to clients’ confidential information, and potentially compromising clients’ health and wellness issues.

Currently, complaints against a board certified music therapist can be brought to the attention of CBMT for investigation and possible disciplinary action as defined by the CBMT Code of Professional Practice. Unfortunately, this disciplinary action does not prevent the person from practicing in a state that does not formally recognize the national credential. Although CBMT is charged with setting and enforcing quality practice standards for the profession, if the state does not officially recognize this national certification through licensure, state residents and employers have no system to determine competence. Currently, any person can represent himself or herself as a music therapist in Virginia. Without the oversight provided through state occupational regulation, there are no checks and balances that insure providers have met education, clinical training, or certification requirements for the profession.

6. Are there currently recognized or emerging specialties (or levels or classifications) within the occupational grouping? If so,
   • What are these specialties? How are they recognized? (by whom and through what mechanisms – e.g., specialty certification by a national academy, society or other organization)?
   • What are the various levels of specialties in terms of the functions or services performed by each?
   • How can the public differentiate among these levels or specialties for classification of practitioners?
   • Is a “generic” regulatory program appropriate, or should classifications (specialties/levels) be regulated separately (e.g., basic licensure with specialty certification)?

No. There are advanced trainings available for music therapists to pursue as a part of their continuing education, but no formal specialties are included within the national board certification credential.
Criterion Three: The functions and responsibilities of the practitioner require independent judgment and the members of the occupational group practice autonomously.

1. What is the nature of the judgments and decisions which the practitioner must make in practice?
   - Is the practitioner responsible for making diagnoses?
   - Does the practitioner design or approve treatment plans?
   - Does the practitioner direct or supervise patient care?
   - Does the practitioner use dangerous equipment or substance in performing his functions?

   If the practitioner is not responsible for diagnosis, treatment design or approval, or directing patient care, who is responsible for these functions?

   Music therapists do not diagnose.

   Music therapists design music therapy treatment plans and collaborate with other health care providers involved in the client’s care.

   Music therapists direct the music therapy portion of treatment but do not typically direct the overall patient care program unless they serve in a management position within a healthcare or education facility. Music therapists work as treatment team members, alongside physicians, nurses, and allied health professionals.

   Music therapists do not use dangerous equipment or substance in practice.

   Music therapists access diagnosis information from the referring physician or treatment team within interdisciplinary practice.

2. Which functions typically performed by this practitioner group are unsupervised, i.e., neither directly monitored or routinely checked?
   - What proportion of the practitioner’s time is spent in unsupervised activity?
   - Who is legally accountable/liable for acts performed with no supervision?

   Supervision of music therapy services is determined by the work setting. For example, when employed by a healthcare facility, Therapy Service Department Directors may supervise music therapists, and peers often include physical therapists, occupational therapists, and speech/language pathologists. In educational settings, music therapists are typically supervised by Special Education Administrative Directors with peers in related services as listed above. For clinicians in private practice, supervision opportunities are available through peer supervision groups, paid consultations, as well as through state, regional, and national conferences.

   The employer of the music therapist is legally accountable/liable for acts performed with no supervision.

3. Which functions are performed only under supervision?
   - Is the supervision direct (i.e., the supervisor is on the premises and responsible) or general (i.e., supervisor is responsible but not necessarily on the premises)?
   - Who provides the supervision? How frequently? Where? For what purpose?
Who is legally accountable/liable for acts performed under supervision?

Is the supervisor a member of a regulated profession (please elaborate)?

What is contained in a typical supervisory or collaborative arrangement protocol?

Board certified music therapists provide interventions without direct supervision, but typically have access to a supervisor on site or through consultation. AMTA Standards of Clinical Practice state it is the responsibility of the music therapist to seek and participate in supervision on a regular basis.

Supervisors vary by clinical setting and may include: physicians, psychologists, social workers, school administrators, music therapists, and other advanced practice allied health professionals. Most music therapists receive access to periodic supervision meetings as needed or required by a facility, along with an annual performance review.

Supervision is mandatory only for selected advanced practice certifications above and beyond the scope of practice and licensure proposed herein.

Within some facilities, internal policies may require referral from a physician or other advanced practice health professional in order for music therapy to be offered. In some instances, documentation and record audits and reviews are conducted by supervisors of all clinical staff, including music therapists.

4. Does the practitioner of this occupation supervise others? Describe the nature of this supervision (as in #3 above).

Although supervisory responsibilities are not formally outlined within the scope of music therapy practice, many music therapists hold supervisory positions depending upon the clinical setting and level of additional training. Board certified music therapists are qualified to supervise music therapy practicum students and interns, once they meet the requirements outlined within the AMTA Standards for Education and Clinical Training.

5. What is a typical work setting like, including supervisory arrangements and interaction of the practitioner with other regulated/unregulated occupations and professions?

Board certified music therapists work in a variety of work settings, including but not limited to:

- Medical facilities, such as general hospital settings, hospice, oncology, physical rehabilitation, home health agencies, outpatient clinics, VA facilities, partial hospitalization and children’s hospitals or units.
- Mental health settings, such as child and adolescent treatment centers, psychiatric hospitals, community mental health centers, drug and alcohol programs, forensic facilities, and inpatient psychiatric units.
- Geriatric facilities, such as adult day care, assisted living, geriatric facilities, geriatric psychiatric units, and nursing homes.
- Developmental centers, such as group homes, intermediate care facilities, community day treatment programs, and state institutions.
- Educational facilities, such as children’s day care/preschool settings, early Intervention programs, and schools (K-12).
• Community Centers, such as Senior Centers, recreation centers or community music schools
• Other settings, such as diagnosis-specific support groups, wellness and prevention programs, and work in a music retailer setting.
• Private practice settings, which commonly contract services in any of the facilities mentioned above.

As members of the interdisciplinary team, music therapists interact, collaborate, and sometimes co-treat with a variety of health professionals, including: physical therapists, occupational therapists, speech language pathologists, social workers, counselors, physicians, psychologists, psychiatrists, neurologists, nurses, etc.

Supervision includes observation and feedback, case consultation, and/or mentorship of music therapy practice provided by a clinical supervisor, an advanced colleague, or a graduate educator.

6. **Does this occupational group treat or serve a specific consumer/client/patient population?**

Music therapists provide healthcare and education support services to individuals of all ages and ability levels, ranging from neonates in the Neonatal Intensive Care Unit (NICU) to older adults in hospice care. Client groups served include those with:

**Developmental disabilities**
Including Down Syndrome, autism spectrum disorders, Rett syndrome, Fragile X syndrome, cerebral palsy, etc.

**Mental illnesses**
For example, Post-Traumatic Stress Disorder, schizophrenia, Bipolar Disorder, depression, emotional/behavioral disorders, substance abuse, etc.

**Acute or chronic illnesses or pain**
Such as HIV/AIDS, cancer, Multiple Sclerosis, burns, surgeries, etc.

**Impairments or injuries due to aging or accidents**
Including stroke, Alzheimer’s disease or other dementias, Traumatic Brain Injury, Parkinson’s, etc.

**Hearing, visual, or speech impairments**
Including multiple impairments

**Terminal Illnesses**
Such as hospice and palliative care

**Learning Disabilities**
For example, those related to math difficulties, language difficulties, or motor difficulties

**Health and Wellness Issues**
Such as cardiac care and well seniors
7. **Are clients/consumers/patients referred to this occupational group for care or services? If so, by whom? Describe a typical referral mechanism.**

Clients have direct access to music therapy and may be referred by members of another occupational group. This distinction is typically determined by the clinical setting. For example, clients have direct access to music therapists in private practice, sometimes with a referral and sometimes without.

In schools, referrals typically come from the interdisciplinary team: parents; classroom teachers; and other professionals involved in that child’s education. Clients may also see a music therapist who is employed in an educational or healthcare setting; whether a client directly accesses music therapy services or is referred for music therapy depends on the setting.

The following practitioners may refer a client to a music therapist (not inclusive):
- Speech-Language Pathologist
- Occupational Therapist
- Physical Therapist
- Educator
- Special Educator
- Social Worker
- Clinical Case Manager
- Psychologist
- Psychotherapist
- Physician
- Neurologist
- Nurse
- Behaviorist
- Counselor
- Another client

The referral mechanism is determined by clinical setting. Examples may include: computer system orders; written consult request; verbal direction from case manager; treatment team recommendations.

8. **Are clients/consumers/patients referred from this occupational group for care or services? If so, to what practitioners are such referrals made? Describe a typical referral mechanism. How and on what basis are decisions to refer made?**

Yes. The AMTA Standards of Clinical Practice state that when assessment indicates the client's need for other services, the music therapist will make an appropriate referral. The list of practitioners to which these referrals can be made may include (not inclusive):
- Speech-Language Pathologist
- Occupational Therapist
- Physical Therapist
- Educator
- Special Educator
- Social Worker
- Clinical Case Manager
• Psychologist
• Psychotherapist
• Physician
• Neurologist
• Nurse
• Behaviorist
• Counselor

AMTA Standards of Clinical Practice state that the music therapist will document referrals made to other sources and will include plans for music therapy services as appropriate. In addition, the documentation of all referrals will include date of referral, source of referral, and services requested.

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

1. Which functions of this occupation are similar to those performed by other health occupational groups?
   - Which group(s)?
   - Are the other groups regulated by the state?
   - If so, why might the applicant group be considered different?

   Treating patients based on a referral system, development of treatment team goals, performing assessments, providing treatment, consulting with members of the interdisciplinary team, evaluating response and progress, documenting progress in medical records.

   Creative Arts therapists, recreation therapists, speech-language pathologists, occupational therapists, and physical therapists are all closely related groups due to the fact that co-treatment with these disciplines happens frequently in education settings, hospitals, and nursing homes.

   Physical Therapy (Virginia Department of Health Professions); Occupational Therapy (licensed since 1998); Speech-Language Pathology (includes a provisional license); Recreational Therapy began seeking licensure in 2012.

   Music therapy utilizes all elements of music as therapeutic tools. Music therapists actively interact with clients using music in the moment to achieve functional outcomes.

2. Which functions of this occupation are distinct from other similar health occupational groups?

   What distinguishes music therapy from other therapies is the use of music as the therapeutic medium. Music therapy practice requires a unique, specialized skill and knowledge set. Music therapists use their knowledge, skills, training, and experience to facilitate therapeutic, goal-oriented music-based interactions that are meaningful and supportive to the function and health of their clients. Music therapists actively create, apply, and manipulate various music elements through live, improvised, adapted, individualized, or recorded music to address physical, emotional, cognitive, and social needs of individuals of all ages and ability levels.
These components of clinical practice continue to evolve with advances in basic science, translational research, and therapeutic implementation. When other healthcare and education professionals report using music as a part of treatment, it involves specific, isolated techniques, using one pre-arranged aspect of music or playing a music recording to address specific and limited issues. In contrast, the use of live music interventions demands that a music therapist not only possess the knowledge and skills of a trained therapist, but also the unique skill set of a trained musician in order to manipulate the music therapy intervention to fit clients’ needs and to address issues across multiple health domains concurrently.

3. **How will the regulation of this occupational group affect the scope of practice, marketability, and economic and social status of the other, similar groups (whether regulated or unregulated)?**

Regulation of music therapy will not affect the scope, marketability, or economic/social status of the similar groups.

**Criterion Five: The economic costs to the public of regulating the occupational group are justified.**

*These costs result from restriction of the supply of practitioner, and the cost of operation of regulatory boards and agencies.*

1. **What are the range and average incomes of members of this occupational group in the Commonwealth? In adjoining states? Nationally?**

   According to the 2018 workforce analysis survey conducted by AMTA, the average full-time salary for music therapists in Virginia was $41,500. When examining the regional (Mid-Atlantic) statistics, the average full-time salary was $48,495.

   The median salary was $46,000, and the mode was $50,000. The range was $20,000-150,000. The average full-time salary for all survey respondents, both inside and outside the United States, was $48,835.

2. **What are the typical current fees for services provided by this group in the Commonwealth? In adjoining states? Nationally?**

   According to the workforce analysis conducted by AMTA, the average hourly individual rate for the Mid-Atlantic Region is $83.31. The average hourly group rate per person for the region is $78.04.

   Nationally, the average hourly individual rate is reported as $68.93. The national average hourly group rate per person is reported as $77.67.

3. **Is there any evidence that cost for services provided by this occupational group will increase if the group becomes state regulated? In other states, have there been any effects on fees/salaries attributable to state regulation?**

   No. In other states where music therapy is officially recognized, there has not been a reported increase in fees or salaries following occupational regulation.
4. **Would state regulation of this occupation restrict other groups from providing care given by this group?**
   - Are any of the other groups able to provide similar care at lower costs?
   - How is it that this lower cost is possible?

   No, other professionals in other disciplines are still able to use music within their scope of practice. However, the use of music by other professionals is not equivalent to music therapy as those professionals do not possess the specific training and knowledge that would allow them to utilize music strategically in accordance with evidence-based practice to make robust gains for their clients.

5. **Are there current shortages/oversupplies of practitioners in Virginia? In the region? Nationally?**

   The profession does not have detailed data on this topic. There are currently 8,172 board certified music therapists in the United States.

6. **Are third-party payers in Virginia currently reimbursing services of the occupational group? By whom? For what?**
   - If not in Virginia, elsewhere in the country?
   - Are similar services provided by another occupational group reimbursed by third-party payers in Virginia? Elsewhere? Elaborate.

   We are not aware of private insurance companies directly reimbursing for music therapy in Virginia at this time. Music therapy programs in healthcare facilities are often funded through the daily reimbursement rate provided by private payers and the Medicare Prospective Payment System.

   Nationally, AMTA reports that approximately 20% of music therapy services receive third-party reimbursement. Companies like Blue Cross Blue Shield, United Healthcare, Cigna, and Aetna have all paid for music therapy services at some time. Success has occurred on a case-by-case basis when the therapist implements steps within the reimbursement process and receives pre-approval for music therapy services. Approximately 23 states provide funding for music therapy services through Medicaid Waiver programs or state agency funds.

   There are not similar services provided by another occupational group that receive third-party reimbursement.

7. **If third-party payment does not currently exist, will the occupation seek it subsequent to state regulation?**

   Third-party reimbursement for music therapy in Virginia will be sought from appropriate payers as it relates to increasing music therapy access and quality of services for consumers.

**Criterion Six:** **There are no alternatives to State regulation of the occupation which adequately protect the public.** [Inspections and injunctions, disclosure requirements, and the strengthening of consumer protection laws and regulations are examples of methods of addressing the risk for public harm that do not require regulation of the occupation or profession.]
1. **What laws or regulations currently exist to govern:**
   - Facilities in which practitioners practice or are employed?
   - Devices and substances used in the practice?
   - Standards or practice?

   State laws and regulations do provide guidance to facilities where music therapists may be employed, but these rules often require the facilities to hire individuals that have a state recognized credential or require employment under a different job title/description to match state rules.

   Devices and substances: N/A

   There are currently no state laws or regulations that govern the standards of practice for music therapy in VA.

2. **Does the institution or organization where the practitioners practice set and enforce standards of care? How?**

   Many institutions or organizations that would employ music therapists are often required to hire providers who have a state recognized credential. The VA Department of Education does not recognize the profession or its credential because the profession is not licensed in the state, and as a result, students in individual school districts are not able to access music therapy services in special education. State requirements for holding a state license or state recognized credential prevents nationally board certified music therapists from working in certain healthcare and education settings in VA, which prevents state residents from accessing services.

3. **Does the occupational group participate in a nongovernmental credentialing program, either through a national certifying agency or professional association (e.g., Institute for Credentialing Excellence National Commission for Certifying Agencies).**
   - How are the standards set and enforced in the program?
   - What is the extent of participation of practitioners in the program?

   Yes. Although not legally required unless a state license, registry, certification, or title protection exists in statute, music therapists who have met AMTA education and clinical training requirements are eligible to sit for the national board certification exam administered by CBMT.

   When the CBMT was created in 1983 to be the independent credentialing body for Music Therapists, CBMT became a member organization of National Organization of Certifying Agencies. CBMT’s certification program was accredited in 1986 upon its initial application to the Commission. The CBMT’s accreditation is renewed every five years. Among Institute for Credentialing Excellence (ICE) members, formerly NOCA members, the CBMT is recognized as having a quality certification program that is a leader in the field, particularly among professions with around 6,000 practitioners.

   CBMT continues to be involved with ICE and National Commission for Certifying Agencies (NCCA) for a number of important reasons. First, NCCA accreditation is recognition that the CBMT meets the highest standards for national certification programs. Accreditation
demonstrates to certificants, employers, government agencies, payers, courts, and professional organizations that an impartial, objective Commission has reviewed the CBMT’s program. This impartial, objective review is particularly important for organizations like the CBMT that are structured to be independent from professional associations and have protection of the public as part of its mission. Accreditation and adherence to NCCA standards are an important check and balance for the CBMT Board of Directors to assure that the CBMT programs reflect the most current principles in the field of credentialing. Accreditation also shows licensure boards that the CBMT programs meet or exceed the same standards to which licensing boards adhere in test development and administration.

All board certified music therapists in Virginia participate with the CBMT certification process. Unfortunately, this participation is not officially recognized by the state, and as a result, anyone in Virginia can call themselves a music therapist, without any of the required education, clinical training, or board certification.

4. **Does a Code of Ethics exist for this profession?**
   - **What is it?**
   - **Who established the Code?**
   - **How is it enforced?**
   - **Is adherence mandatory?**

Yes. AMTA established the Code of Ethics for AMTA members (attached). It is enforced through AMTA Judicial Review Board Procedures. Adherence is mandatory for AMTA members.

CBMT has a Code of Professional Practice for MT-BCs (attached). All board certified music therapists must adhere to this Code. It is enforced through the establishment of CBMT special disciplinary review and disciplinary hearing committees.

5. **Does any peer group evaluation mechanism exist in Virginia or elsewhere? Elaborate.**

   No.

6. **How is a practitioner disciplined and for what causes?**
   - **Violation of standards of care?**
   - **Unprofessional conduct?**
   - **Other causes?**

   There is no official system in Virginia for specifically disciplining music therapists for not following standards of care or for unprofessional conduct. Individual health and education facilities have employment requirements and disciplinary procedures, but they are not specific to the profession of music therapy.

7. **Are there specific legal offenses which, upon conviction, preclude a practitioner from practice?**

   Without state licensure in Virginia, a provider could still practice in the state, despite legal offenses. CBMT can only pull the credential, but cannot legally stop an individual from practicing. The state is the only entity that can stop an individual from practicing as long as there are state laws recognizing the credential and regulating the profession.
8. Does any other means exist within the occupational group to protect the consumer from negligence or incompetence (e.g., malpractice insurance, review boards that handle complaints)?
   • How are challenges to a practitioner’s competency handled?

   There is currently no legal recourse available in Virginia to protect consumers from negligence or incompetence. Currently, consumer complaints can be brought to CBMT for possible disciplinary review. As stated previously, CBMT can only pull the credential, but they cannot prevent an individual from practicing. Only official state recognition of the credential in statute provides the legal protection for consumers against negligence and incompetence.

9. What is the most appropriate level of regulation?

   A state license would provide the highest level of protection for consumers so that they can be assured music therapy services are being provided by a qualified individual.

   A state license is necessary to address the immediate restriction of service access in special education in Virginia.