Collaborative goal setting and reviewing in music therapy for children with special needs: An action research project to improve practice and measure efficacy

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LIST OF ABBREVIATIONS

ASD - Autism Spectrum Disorder
EBHS – Evidence-based Health Sciences
EPICURE – Engagement, Processing, Interpretation, (self and social) Critique, Usefulness, Relevance and Ethics
GAS - Goal attainment scaling
IEP – Individual Education Plan
IMTAP- Individualized Music Therapy Assessment Profile
IP – Individual Plan (used in early childhood education settings)
MTDA – Music Therapy Diagnostic Assessment
NZRMTTh – New Zealand Registered Music Therapist
OT – Occupational Therapist
PRAR Model - Problem Resolving Action Research Model
Raukatauri - Raukatauri Music Therapy Centre
SCERTS - Social Communication, Emotional Regulation and Transactional Support
SLT – Speech Language Therapist
SMART – Specific, Measurable, Achievable, Realistic, Time-bound
EXECUTIVE SUMMARY

The intent of this project was to investigate the goal setting and review process at the Raukatauri Music Therapy Centre (Raukatauri or sometimes referred to as RMTC) with the aim of creating an improved collaborative process. Goal setting and reviewing progress is an integral part of music therapy practice at Raukatauri and enables therapists, clients and their families, and other professionals to understand the direction of therapy and identify progress. This project enabled the clinical team at Raukatauri to engage in a rigorous investigation of practice with the aim of seeking ways to improve the goal setting and review system. In particular, the clinical team were interested in identifying changes that would ensure the process was meaningful and relevant to those involved.

Research project funding was obtained from the Lottery Community Sector Research Fund. Action research was chosen as an appropriate methodology for this type of collaborative practice-based research as discussed in Chapter 3. Improvements and changes could be implemented and evaluated as part of the action research cycle of observation, reflection, planning and action.

The data collection methods used in this project were: questionnaires; focus group interviews; documentary analysis; and journaling. Analysis methods included thematic analysis of qualitative responses in questionnaires and focus group transcripts. There were three phases to the project: reconnaissance, implementation; and evaluation. In keeping with action research and qualitative methodologies, the design was emergent and findings from each phase were analysed and informed the development of subsequent phases.

The reconnaissance phase (Chapter 4) started with a literature review and the establishment of a set of effectiveness criteria against which to compare our current practice. Alongside this literature review, data were collected via a reconnaissance questionnaire, focus group
interviews, documentary analysis, team discussion and journaling. Analysis of the initial findings suggested the existing system was satisfactory and relevant, and matched well with the effectiveness criteria that had been established. During the analysis, gaps were identified in our documentation of the goal setting and review process and potential improvements were drawn out of the questionnaire and focus group findings. The improvements focused on changing our documentation in order to reflect and capture the collaborative process of goal setting and review, improving our communication, and creating more opportunities to share video footage. Central to the identified improvements was the need to align the goal setting and review process with the Raukatauri values (creativity, open communication, professional integrity, empathy and respect) and with our approach to music therapy (client-centred, music-centred, developmental and psychodynamically informed).

The implementation phase (Chapter 5) took place during December 2010 to the end of January 2011 and involved the team using the changed documentation when engaged in goal setting and review. The team also kept reflective journals which were an essential part of evaluating and reflecting on the process and impact of the research. The journals helped to identify changes in practice that were less quantifiable: changes in attitude or approach that had come about as a result of the research.

Data were collected for the evaluation phase (Chapter 6) through an evaluation questionnaire, individual journaling by team members and team discussion. Findings from the evaluation phase showed that the changes had been well-received. Due to the small sample size of the evaluation questionnaire, interpretation was made cautiously. However, the research team discussion revealed some interesting thoughts about the impact of the research, including: increased confidence among clinical team; increased sharing of strategies; more effective communication and collaboration; more effective sharing of video footage; and increased openness about the challenges in music therapy practice. These impacts are discussed in Chapter 7.
The final stage of the research project was to create a set of best practice guidelines. The guidelines consist of a series of statements regarding the actions and thinking required for a meaningful and collaborative goal setting and review process. The guidelines are relevant to other music therapists wishing to address goal setting in a similar way and are presented in Chapter 8 of the report.

One of the expected outcomes of the project was increased research capability among the clinical team at Raukatauri. The team agreed that this project was relevant to everyday practice, the action research methodology was accessible, and the clinical team's reflective and analytic skills (outside of the music therapy room) have increased. There are clear parallels between the action research process and music therapy which have helped the team embrace the research process so fully. This has increased the confidence of individuals in their ability to undertake and contribute to a research project. Action research has been shown to be an accessible form of research that can focus on one's own practice. This has been essential for the team to enable them to engage in the research project as all staff hold full case-loads and finding extra time for research is problematic.

Finally, recommendations have been made for future actions and research. The question of how clients can contribute to the goal setting and review process needs to be addressed by the clinical team along with further investigation into relevant assessment tools that could be used. The team are also keen to explore ways of recording whether progress has been generalised outside of music therapy sessions. Future research could focus on the significance of sharing video footage as a communication tool and a way to provide evidence of progress in music therapy. There is also scope for further research involving parents/carers and other professionals. This could focus on measuring the efficacy of music therapy in relation to the goals and focus areas that are set. The use of narrative assessment or goal
attainment scaling could be implemented and evaluated to identify if either are a useful method for consistently evaluating progress.

Ethical approval

UREC REGISTRATION NUMBER: (2009-1047)

This study has been approved by the UNITEC Research Ethics Committee from 15 March 2010 to 14 March 2011.
CHAPTER 1 INTRODUCTION

1.1 Context

The Raukatauri Music Therapy Centre (Raukatauri) is New Zealand’s first music therapy centre delivering music therapy to children and young people with special needs up to the age of 21. There are six New Zealand Registered Music Therapists (NZRMThs) on the clinical team who provide approximately 100 sessions of music therapy per week. The therapists have a variety of training backgrounds, with the common approach being improvisational, client-centred music therapy.

Goal setting and reviewing progress is an integral part of music therapy practice at Raukatauri and enables therapists, clients and families to understand the direction of therapy and identify progress. The goals that are set by the therapist in consultation with the parents/carers are informed by an assessment period when the client starts therapy. This period is essential to assess the client’s individual strengths and needs.

There are some comprehensive models of assessment and treatment planning emerging in music therapy, many of which stem from a behavioural approach to music therapy. A behavioural approach is usually therapist-led and focuses specifically on changing or modifying target behaviours which are often identified as objectives within broader goals. The approach at Raukatauri is client-centred, music-centred, developmental and psychodynamically informed. We aim to gain a holistic view of the client and their needs in relation to their environment. At Raukatauri, the process of establishing a therapeutic relationship through the use of music is central to therapy and goals emerge from the therapeutic relationship rather than being imposed by the therapist. When seeking a way to describe the progress made in music therapy, behavioural goals offer a way in which progress can be measured or quantified, providing the evidence for efficacy. However, this method of setting goals does not fit easily with a relationship based approach to therapy and we were
interested in finding ways to describe progress in music therapy that could not be easily measured or quantified.

1.2 Rationale

Early in 2009, the team reviewed the goal setting process and accompanying documentation and a new system for monitoring progress was implemented.

We wanted to design a goal setting template that would allow us to record a client's progress in a format that was easy to understand and could provide evidence for use when discussing goals with parents/carers, school teachers and other professionals. We started with a template (Appendix A) that one of our therapists, Rebecca, had designed to fit with the Individual Education Plans (IEP's) of children she worked with in schools. Most of the goals were success orientated and had achievable objectives that could be measured using a tick box. There were three main boxes:

- Long-term goal – generally seen as a 'life skill';
- Short-term objective – music therapy based goal; and
- Success criteria – the evidence that would demonstrate the objective had been achieved.

The template also had a space to record comments from parents/carers and a space to record progress towards the long-term goal.

We asked a group of parents for initial feedback on the template and the response was generally positive. However, parents also commented that the most powerful way for them to understand their child's progress was to watch video excerpts from the sessions. Some found the reports too long and wordy and one person appreciated having regular updates from the
therapist by telephone especially when they did not see the therapist regularly because therapy took place in school.

As the clinical team started to use the new template, the following further concerns and questions were raised about the process:

- It was problematic to describe a process that is not linear;
- How could we report on the long-term goal, which usually represented a life skill not a specific music therapy goal?;
- Could we encourage parents to report on the long-term goals?;
- How could we describe an internal or relational change that was not manifested in a particularly outward way?;
- How could we describe and set success criteria for non-behavioural goals without limiting the client?;
- Could we formulate goals without setting unnecessary boundaries on therapy sessions?;
- Did the goal setting process change the way we worked within the music therapy relationship e.g. did achieving the goal sometimes dominate the therapeutic encounter and therefore limit what the client may bring to therapy?;
- How did we know what parents/carers wanted from the reports?; and
- Who were the templates for- therapist or parent/carer?

We found it especially challenging when reporting to include the intangible parts of the therapy process, the significant moments when you know something has shifted but the shift may not be measurable in an objective way. We wondered about the use of the words 'objective' and 'success criteria' and whether it was acceptable to have some obviously measurable goals, such as turn-taking, alongside broader goals such as emotional expression.
As music therapists we are trained to listen intently to the client and respond from a client-centred position. We were keen to extend this position to the goal setting process with parents/carers and were curious about whether there were ways we could work more collaboratively with parents/carers and other professionals around goal setting.

These reflections formed the basis for the research project for which we were fortunate to receive a grant from the Lottery Community Sector Research Fund.

1.3 Research aim, phases and questions

The aim of the research was to evaluate the current process of goal setting and reviewing at Raukatauri and to collaboratively implement changes that would lead to improved and more effective practice. The initial ‘reconnaissance’ phase was designed to clarify the purpose of the goal setting and review system and to gather information from parents/carers and other professionals about their opinions of the current system. Running parallel to this was an examination of the literature to identify current thinking and research about effective goal setting and reviewing in music therapy practice. Using the literature review and drawing on the team's experience, a set of effectiveness criteria was developed against which to compare our current practice. The comparison process helped the team identify areas for improvement which were then introduced in the ‘implementation’ phase. These improvements were evaluated through gathering feedback from parents/carers and team discussion (the ‘evaluation’ phase). It was anticipated that an outcome of the research would be a set of best practice guidelines applicable to the goal setting and review process at Raukatauri.

The following questions were developed to guide the various phases of the research:

Reconnaissance phase:

1. What is the purpose of the goal setting and review system?

2. What criteria does the current research/thinking suggest about an effective goal setting and review system?
3. How well does our current system match the effectiveness criteria established?

The following questions were identified as being important to guide the reconnaissance analysis (how well our current system matches with the effectiveness criteria):

- Is the client making progress?
- Is progress being generalised?
- What does it mean if progress is not being generalised?
- How do we measure the broader value of the session in itself and how do our video recordings contribute to this?
- Does the review system improve our practice?
- How do we use video footage to communicate to parents and other professionals?
- What do the overall reconnaissance results indicate for improvement?

Implementation phase:

- How can we prioritise and plan for the implementation of improvements to the system?
- How can we track implemented improvements to our goal setting and review system?

Evaluation phase:

1. How can we collect data to show the impact of the improvements?
2. How can we record and publicly report on this evaluative data?
3. Can we create best practice guidelines applicable to our work at Raukatauri?

As the whole clinical team was involved in goal setting and reviewing, it was decided the project would benefit from being a collaborative venture with the whole team involved at various phases of the research. Action research was chosen as the most appropriate methodology for this type of practice based research.
1.4 Organisation of this report

The chapters that follow are organised to first provide the reader with a theoretical understanding of the research questions and action research methodology used in this project. The report then looks at each phase of the research in turn, with details of data collection and analysis, presentation of findings and conclusions for each phase. The report finishes with a discussion of the implications of the research and future recommendations.
CHAPTER 2  LITERATURE REVIEW

2.1 Introduction

Review of relevant literature took place throughout the entire research project. As music therapy is an allied health profession and our clients are children and young people (0-21 years) with special needs, we looked at literature from the fields of music therapy, special education and selected literature from other health professions. We set out to discover what was written in the music therapy literature about setting goals and objectives with the aim of identifying what was considered to be best practice. This initial review of the literature informed the development of the effectiveness criteria against which we evaluated our own practice. The effectiveness criteria are presented at the end of the chapter.

We returned to the literature several times during the project as the research became more defined. This meant that we encountered new literature at various stages in the project. Green (1999) discusses this approach to literature in action research and suggests that “in any research which is fundamentally exploratory there will be a need to see that literature is identified in an ongoing way as issues emerge, rather than being identified at the outset as is the case in many, less exploratory, studies” (p.121).

This review starts with definitions of goals and objectives and then moves on to why they are important and how they are set. Much of the literature we found refers to Specific Measurable Achievable Realistic Time-bound (SMART) goals and objectives, which are clearly of value when measuring and monitoring progress. We also looked at literature that included more qualitative examples of goals and objectives. We have looked briefly at the model of goal attainment scaling (Turner-Stokes, 2009) and the New Zealand Ministry of Education’s narrative assessment model (Ministry of Education, 2009). Finally, the literature review ends with a summary of the impact of the literature review on our thinking as a team.
2.2 What are goals and objectives?

In order to provide some context for the research, it was important to find out how music therapists define goals and objectives.

The Music Therapy New Zealand (2011) definition states that:

Music therapy is the planned use of music to assist the healing and personal growth of people with identified emotional, intellectual, physical or social needs.

Music therapists use the shared qualities of music in a shared relationship with their clients, to meet personal needs, support learning and promote healing and change.

(Music Therapy New Zealand, 2011)

The use of the phrase 'planned use of music' implies an overall plan or design for the music therapy process. This is echoed by Davis, Gfeller and Thaut (1999) who state that “the essence of a treatment plan lies in therapeutic goals and objectives, which are based on established treatment priorities” (p.281). The phrases 'shared relationship' and 'personal needs' emphasise that music therapy is an interpersonal and individualised process, rather than a predetermined standardised treatment plan.

Wheeler, Shultis and Polen (2005) give clear guidelines for the student music therapist on planning goals and objectives and use Bruscia’s definitions to guide the process:

A goal is a statement that describes the direction of the therapist’s efforts and the end towards which that effort is directed…

An objective is a statement that describes what the client will be doing as a result of the therapist’s efforts and as evidence that that goal has been achieved.

(Bruscia, 1993, cited in Wheeler et al., 2005, p.67)
Berger (2009) comments that “the terms goal and objective have been as widely and variously defined as the term music itself” (p.1) and asks “how can we [music therapists] develop discreet goals and objectives defining our treatment service?” (p.2). Berger goes on to advocate for music therapy goals and objectives that target the work with the client specifically as “treatment with music” (p.6). She challenges music therapists to think carefully about how they assess and set goals and objectives. It seems that her concern with defining goals and objectives is not in the definition of the terms themselves, but in the language music therapists use when writing goals and objectives.

Despite Berger’s comment about the wide and various definitions of the terms goal and objective, there does appear to be consensus that goals are long-term or the desired end result of therapy and objectives are the short-term strategies employed to attain the goal (Davis, Gfeller & Thaut, 1999; Hanser, 1999; Wheeler et al., 2005).

2.3 Why are goals and objectives important?

The need to define goals and objectives may have come from the interest in applying a medical model to music therapy, as discussed by Bunt (1994). Bunt describes the emphasis that was placed on physiological research in the early development of music therapy and the “formulation of biologically based reference points in attempting to explain the influence of music” (p.30). He acknowledges the value of this early research into physiological responses but also states that “it is very difficult to be categorical about the use of music and to isolate the physical from the psychological and the emotional” (p.33-34).

Wheeler et al. (2005) suggest that, regardless of the approach used, therapy must have a focus:

Whether a music therapist operates within a framework that uses concrete goals and objectives or works to help the client evolve through the musical interaction without
having pre-stated goals and objectives in mind, it is essential that the music therapy have a focus or aim. (p.57)

While there are many different approaches to music therapy, it would seem that the need to define treatment goals and objectives is common and the definitions above provide a useful reference point for music therapists working in a range of areas and with a range of goals.

Wheeler et al. (2005) advise that different settings may require different formats for goals and objectives and give the example of a setting where clients are able to participate in the development of the treatment plan. They suggest that the emphasis may shift to focus more on what the “client wants to do” (p.61) and that the documentation will change accordingly.

Goals and objectives are seen as important in helping music therapists provide evidence for the success of the treatment. McFerran and Stephenson (2006, 2010) engage in a lively debate and performed some preliminary research regarding the nature of evidence in music therapy which reflects the current demand for evidence-based practice, the dominant culture of science and medicine. The evidence-based practice movement calls for claims for efficacy to be substantiated by scientific evidence, with the randomised controlled trial being accepted as the gold standard of evidence-based knowledge. Holmes, Murray, Perron and Rail (2006) state that the premise of evidence-based health sciences (EBHS) is that “if healthcare professionals perform an action, there should be evidence that the action will produce the desired outcomes” (p.181). Holmes et al. (2006) extend this to argue that evidence-based health sciences do not allow for multiple viewpoints regarding what counts as knowledge and evidence and encourage health professionals to question “whether EBHS serves a state or governmental function, where ready-made and convenient 'goals and targets' can be used to justify cuts to healthcare funding” (Holmes et al., 2006, p.181).
When considering the goal setting process, McFerran (McFerran & Stephenson, 2006) notes the value of an evidence-based model for offering information about observable and measurable responses. She sees this model as providing guidance in the initial stages of therapy from which the therapist can “develop an individually tailored program that suits the presenting needs of the student and evolves to address their emerging capacities” (p.123). If this is the case, then the goal setting process also needs to be individualised and tailored to capture the emerging capacities of the individual.

In a response to McFerran and Stephenson (2006), Rickson (2007) describes an initiative by the New Zealand Ministry of Education which advocates for a model where evidence comes from three sources, “namely from professional practitioners, from families and young people about their lived experience; and from 'research' (both national and international)” (p.28). Furthermore, Rickson suggests that this model will empower practitioners and families to contribute their views and experiences, “will lead to increased collaboration, improved communication, and ultimately to more practical solutions for individuals and groups of learners” (p.28).

In summary, the early music therapy literature suggests that setting goals and objectives has long been held as part of good practice (Cohen & Gericke, 1972) and in the current evidence-based climate, this practice can help substantiate claims of efficacy. Goals and objectives are important because they are a tool through which the process of music therapy can be described and articulated. They can show progress and also provide a tool for capturing evidence of that progress. However, in order to serve our clients, goals and objectives should stay close to the experience of the individual in therapy and should be based around the client's needs, not the needs of the therapist or the funding body.
2.4 How do we set goals and objectives?

This section is divided into two parts with literature relating to the role of assessment presented first. This is followed by literature about the types of goals and objectives that are set in music therapy.

2.4.1 The role of music therapy assessment

The process of setting goals and objectives in music therapy has to begin with an assessment of need (Cohen & Gericke, 1972; Cohen, Averbach & Katz, 1978; Davis et al., 1999; Wheeler et al., 2005). Davis et al. (1999) state that “information learned from an assessment helps determine the nature and scope of treatment. The data help the music therapist decide if the client is suited to music therapy and, if so, what treatment goals and techniques are appropriate” (p. 277). A great deal has been written about music therapy assessment and it is beyond the scope of this study to consider the literature in detail as our focus is on goal setting not assessment. However, selected literature has been reviewed, focusing on both the assessment process and an ongoing debate about the development of standardised tools in order to provide some context.

Nordoff and Robbins (1977, 2007) discuss the importance of assessment and goal determination but caution that “formulating goals and objectives from a pre-clinical assessment can have only limited effect” (2007, p.197). They suggest that the music therapist will be aware of goals that are shared with parents/carers and other therapists as well as specific behavioural goals. However, they emphasise that “it is impossible to form realistic clinical goals for creative music therapy until you and the child have entered into a process of musical inter-responsiveness...Therefore assessment and the determination of clinical goals can only originate in clinical practice itself” (2007, p.197-198). They argue that while initial clinical goals might be set, the therapist has no way of knowing how these goals might be realised during the course of therapy. Indeed, if we did know, then it could be argued that the entire course of therapy is predetermined rather than unfolding through clinical improvisation.
and the relational aspects of the therapeutic relationship. In the creative music therapy process where the importance of working towards *musical goals* is stressed, clinical intentions and actions are determined from moment to moment and start with the child. When the emphasis is on creating a strong musical and therapeutic alliance with the child, the therapist is in the best position to work “resourcefully for the *psychotherapeutic and/or developmental* goals the course of therapy has the possibility of realising for the child” (2007, p.199).

Nordoff and Robbins advocate an ongoing and client-led assessment process that continues throughout therapy and informs therapeutic decisions. A child-led approach to assessment is also described by Twyford, Parkhouse and Murphy (2008) whose transdisciplinary assessments for children with complex needs are “dynamic and child led” (p.50). Their unstructured approach - “providing opportunities for both the child and therapists to explore a range of activities as situations evolved and presented themselves” (p.50) - nevertheless relied on pre-planned aims, although they do not state what these were.

Loewy (2000) provides an interesting perspective on music therapy assessment and views the assessment period as “the foremost stage of a therapeutic relationship which sets the tone for understanding future goal planning and mapping of the music therapy experience” (Loewy, 2000). Loewy uses a music psychotherapy model and focuses on what she terms “Areas of Inquiry” (p.47) that help describe the music therapy experience from a relational perspective.

In a contrasting approach, music therapists working within the medical model of ‘Neurologic Music Therapy’, strongly advocate for a process of medical assessment, formulation of rehabilitation/developmental goals, and prescription of standardised music therapy techniques (Thaut, C., 1999; Thaut, M., 2005). We have already discussed Berger’s (2009) similar emphasis on “treatment with music”. Berger is cautious about “approaching music therapy purely from the standpoint of “connection” and “warm fuzzies”” as she states that this omits “an entire realm of physiologic clinical responsibility implied by the word *therapy*” (Berger,
Thaut, Thaut and Berger focus on the treatment of physical diagnoses and place less emphasis on interpersonal relationships and clients’ strengths. This process seems overly rigid for the client-led framework valued at Raukatauri, where the emphasis is on the therapeutic relationship, music therapy process, and developmental and individualised therapy goals.

There appears to be ongoing debate about whether music therapists can develop standardised assessment tools. Sabbatella’s (2004) comprehensive literature review of assessment and clinical evaluation in music therapy provides a useful summary for the music therapist who is looking for specific tools for assessment and evaluation. Sabbatella concludes that “at the beginning of the 21st century, music therapy as a discipline needs to develop assessment tools at a more scientific level and to increase in number and quality studies related to different music therapy evaluation areas” (p.19). Wigram (1995, 1999, 2000, 2002) has written extensively about assessment and it is interesting to note that his approach advocates both a descriptive model of assessment and the use of tools such as his adaptation of Bruscia's Improvisation Assessment Profiles (Wigram, 1999, 2000).

Other examples of assessment tools include Nordoff and Robbins’ (1977 and 2007) rating scales and Bruscia’s (1987) Improvisation Assessment Profiles, both of which can be applied to a wide range of clients. These are practical (but non-standardised) tools to assist the music therapist in listening to, interacting with and understanding the client. Oldfield (2000, 2006) provides a full description of the Music Therapy Diagnostic Assessment (MTDA) which she developed in her work within Child and Family Psychiatry. Initially a descriptive assessment process, Oldfield developed a scoring system for the MTDA which was the focus of her PhD research (2004, 2006). Other potentially useful assessment tools within music therapy include those developed by Rainey Perry (2003) and the Individualized Music Therapy Assessment Profile (IMTAP) (Baxter, Nelson, Berghofer, Peters, MacEwan & Roberts, 2007).
In New Zealand, Ayson (2010) discussed the value of the SCERTS (Social Communication, Emotional Regulation and Transactional Support) Model for music therapy assessment. This has also been addressed in the wider music therapy literature (Walworth, 2007; Walworth, Register & Engel, 2009). The SCERTS Model is a multi-disciplinary approach to developing Social Communication, Emotional Regulation and Transactional Support in people with autism and related disabilities. Walworth et al. (2009) consider the SCERTS Model to be of value to music therapists working with children with Autism Spectrum Disorder (ASD) as it allows the therapist to “specifically identify the objective skills children with ASD demonstrate when participating in music therapy” (p.208).

While there are a number of tools available, Bunt and Hoskyns (2002) identify some of the challenges inherent in applying standardised assessment and evaluation procedures to music therapy:

1. The reluctance of many practitioners to reify and put into boxes aspects of the musical and therapeutic process;
2. The challenge of using any preset categories in both open-ended and rigorous ways; and
3. The overriding question of whether to concentrate on the non-musical behaviours as manifest in the music or to focus on the specific contributions of music for aiding further understanding. (p.253)

Furthermore, the New Zealand Ministry of Education’s guide for narrative assessment (2009) also challenges standardised assessment:

Many approaches to assessment are shaped by the desire to ensure that the methods used are valid and can stand up to scrutiny…generalisability and predictability of assessment information are seen as important. Such factors are seen as demonstrating
the validity of the assessment… The problem with this view is that it assumes that scientific beliefs and criteria are the only way of gauging whether a method is useful or not. (p.38)

In the New Zealand context, it is also relevant to consider the Māori concept of hauora (well-being) (Hoskyns, 2008; Ministry of Education, 2007; Ministry of Health, 2008). This holistic philosophy emphasises physical well-being (taha tinana), mental and emotional well-being (taha hinengaro), social well-being (taha whānau) and spiritual well-being (taha wairua), symbolised by Durie as the four equal walls of a house (the Te Whare Whā model) (Durie, 2004, cited in Ministry of Education, 2007; cited in Ministry of Health, 2008). This philosophy supports the emphasis on holistic assessment and goal setting at Raukatauri.

In summary, there is a significant body of literature available to guide music therapists in their assessment processes. There is also a range of assessment tools available and yet these do not seem to be used consistently, a concern raised by Walworth (2007) who calls for “further documentation of evidence-based practices including assessment and documentation tools used with children at risk or diagnosed with ASD” (p.207). When considering whether to use a standardised assessment approach at Raukatauri, the team were clear that the emphasis is on delivering therapy that is effective and meaningful for the individual with a focus on the therapeutic relationship. It follows that our approach to assessment is just as individualised as treatment will be and that we focus on a range of areas and use tools as appropriate and necessary to assist in understanding a client’s responses.

2.4.2 What types of goals and objectives?

Throughout the reconnaissance phase of this research project there was a tension between a perceived demand for SMART goals and recognition of the value of more descriptive goals. Some relevant literature is presented here to provide context for these contrasting positions.
Darrow’s (2004) book gives a useful overview of different approaches in music therapy including the philosophical and theoretical orientations of each approach. This reminds us that goal setting will vary depending on therapist orientation and the theoretical framework that has been chosen to best support the client's needs. Wheeler et al (2005) support this position and give examples of different formats for setting goals that are appropriate in a range of settings. They suggest that an “effectively written goal statement includes a level of specificity about the direction in which change is sought, but without being too precise” (Wheeler et al., 2005, p.57). The authors give examples of specific goals and objectives that might be considered prescriptive. However, they do emphasise the importance of establishing appropriate and meaningful goals and objectives and give examples of “client-driven music therapy outcomes and skills” (p.61) which emerge from a collaborative process of goal setting between client and therapist.

Some music therapists strongly advocate for SMART goals and objectives. According to Cohen and Gericke (1972), “goals and objectives answer the question “what” (what is to be achieved), not “why” (purpose) or “how” (methods, procedures, curriculum)” (p.163). Berger (2002) gives specific examples of goals the music therapist may apply when working to address deficits resulting from sensory issues. Berger's approach is firmly based in assessing the child's physiological state and applying music therapy treatment. However, she also emphasises that “music therapy is its own intervention, and not a step-child of occupation therapy, speech pathology or academic educational goals. The goals of music therapy are systemic – physiologic, psychologic, cognitive, emotional” (p.163).

When considering how to write goals and assessments, Loewy (2000) makes an interesting point about the importance of descriptive analysis in assessment and claims that narratives rather than check lists or charts best reflect the significance of music therapy. As mentioned earlier, Loewy's approach focuses on the music therapy experience and relationship between therapist and client. She states that “Charts, scales and checklists may quantify the experience
of music. The clients in music therapy, as well as the profession itself, may be better understood through explicit descriptive writing” (p.57). This is echoed by Cooper's (2006) research findings: “Although reports are required to be concise, narrative descriptions of significant aspects of the session are useful to clarify how judgements and recommendations have been reached” (p.181).

The literature shows that the goal setting process, and therefore the type of goals that are defined, is intrinsically linked to the theoretical orientation and philosophical underpinnings of the music therapist and the needs of the client. This view is confirmed by Bruscia (1998) who states that “goals may be broad or specific depending upon the clients and the therapist's orientation” (p.28). Bruscia also emphasises the need to seek input from the client, their family and others involved with the client's care when establishing goals.

2.5 Other ways of setting goals and objectives and describing progress

In this section, two different approaches to setting goals and objectives are described. Goal attainment scaling is a method that has been used widely in the mental health field and, from New Zealand, the Ministry of Education's narrative assessment approach is described.

2.5.1 Goal attainment scaling

Goal attainment scaling (GAS) is a system of quantifying the achievement of agreed goals. It involves establishing criteria against which progress can be ranked according to whether it is as expected, below, or above expected. GAS was first introduced to the field of mental health services in the 1960s by Kiresuk and Sherman (Bovend'Eerdt, Botell & Wade, 2009). Recent literature shows that GAS has been applied in other fields including adult and paediatric rehabilitation (Bovend'Eerdt et al., 2009; Steenbeek, Ketelaar, Galama & Gorter, 2007; Turner-Stokes, 2009), education (Roach & Elliott, 2005) and sensory integration (Mailloux et al., 2007). Bovend'Eerdt et al. (2009) suggest that for GAS to be successful, the goals need to be defined and measurable, but also that a strength of the system is that it can apply to
individualised goals and does not rely on standardised measures. Mailloux, et al (2007) also comment on the value of GAS for client-centered therapies stating that it “captures individualised progress that is meaningful to the family” (p.255). Furthermore Steenbeck et al (2007) suggest that “The method can be used to measure progress in heterogeneous populations with a variety of treatment goals” (p.556). Examples of goals given in the literature tend to be written in a SMART format and Bovend'Eerdt et al. (2009) advise that GAS is used as part of a complete goal-setting process that involves consultation with the patient, family and others involved.

While GAS is not a method of writing goals, it may provide a useful way to assess whether a goal has been achieved. It may also help the therapist and family define what constitutes progress and focus on the strategies needed to attain the goal.

2.5.2 A narrative approach

The New Zealand Ministry of Education's (2009) recent work on narrative assessment is directly relevant to this research project. Narrative assessment involves writing learning stories where the narrative describes the detailed observation of a child's actions or behaviour. The behaviour or action is then linked to the key competencies of the National curriculum and the story usually ends with a reflective comment on how the child's learning can be extended. Rather than assessment being based on measuring against a standard of ability or skill, the focus is on what the child can do and how the educator can extend and build on this. This is called 'ipsative' assessment and refers to “the ways in which teachers notice the progress of an individual student rather than comparing his or her achievement to that of others” (Ministry of Education 2009, p.6). This model fits well with the approach used at Raukatauri which values the child's contributions in their own right. It is also supported by music therapist Jourdan who discussed the value of narrative assessment for music therapists working in an educational setting (Jourdan, 2010).
In the guide for teachers, the following questions about assessment are posed: “What are the consequences of assessment in terms of strengthening the student’s identity?” and “How meaningful is the assessment for the student and his or her family?” (Ministry of Education, 2009 p.39). In the same document, the Ministry acknowledge that “assessment tools can both enable and constrain what can be noticed and reported” and advocate for a narrative assessment approach that “supports noticing student learning in more personalised and holistic ways” (p.6). Photographs and video have been successfully incorporated into learning stories for children with special needs (Erb, 2008) as well as in mainstream early childhood education.

Other benefits of narrative assessment include the possibility for identifying and documenting “both intended and unintended outcomes” and bridging communication gaps between home and school (Ministry of Education, 2009). In Early Childhood Education in New Zealand, strong relationships with parents and whanau, as well as opportunities for collaboration, have been seen to “dramatically lift children's achievement” (New Zealand Education Gazette, 2010). For this research project, narrative assessment may address the team’s concern that goals and objectives should reflect the flexibility inherent in the music therapy process. Bridging communication gaps is also a vital component of collaborative goal setting and reflects the value of ‘open communication’ at Raukatauri.

Collaborative approaches in music therapy are the subject of a recent book by Twyford and Watson (2008) who state that sharing knowledge and providing “coordinated care” can enhance understanding of the child and their abilities. This is of value for the child, their family, therapists and other professionals as it “ensures an increased awareness and identification of needs” (p.86). Twyford and Watson encourage therapists to be open to sharing their skills and to plan and problem solve together.
2.6 **What did the literature review mean for the research project?**

The practice of setting SMART goals and objectives may provide reassurance and structure for the music therapist as well as providing useful data that can be used to demonstrate efficacy of treatment. The impetus for this research study was a sense of dissatisfaction with this type of goal setting. While we found that it was helpful to show progress in specific areas, it also missed much of what was taking place in music therapy that could not be easily quantified and measured. Clearly there is a need for congruence between the theoretical orientation and the goal setting process. As a team we felt that having specific goals might make us feel accountable in the therapy process, but did not always honour and value what the individual might bring to each session. We also had concerns about the values inherent in the SMART goal setting system and what it might mean if a client did not attain a goal that had been set. Did it mean that the client had failed, or that we had set the wrong sort of goal? At worst, we felt there was the potential for damage to the therapeutic relationship and to potential progress in music therapy if we continued to work towards a goal that was no longer appropriate.

A descriptive approach to assessment, goal setting and review, also supported by selected literature, seems to better support the individualised developmental and improvisational approach at Raukatauri, the desire to work collaboratively and honour the whole child, and the need to represent the client’s voice, needs, experiences and progress. This reflects the Raukatauri values: creativity; open communication; professional integrity; empathy; and respect.

2.7 **Effectiveness criteria**

The literature review informed the development of a set of criteria against which our practice could be evaluated and improvements identified. The collaborative process of developing the criteria needed to reflect both the current thinking identified in the literature review and the
values embodied in the creative and improvisatory approach to music therapy at the Centre. Before presenting the criteria, the process used to establish the criteria will be described.

### 2.7.1 Process

The criteria were established through the following process:

- A synopsis of the main points from the literature that related to standards of practice in goal setting and review was created;

- A team workshop was led by Eileen Piggot-Irvine, Research Advisor. The workshop resulted in a set of criteria that included:
  - criteria for matching current documentation;
  - criteria for review and evaluation of goals; and
  - underlying principles for goal setting and review.

- Descriptors were added to the criteria and a template was created against which to evaluate our current documentation.

### 2.7.2 The criteria

The criteria are the result of a concerted effort by the research team to identify best practice from the available literature and our own practice. The criteria are presented in Table 2.1.
When discussing the criteria, the team expressed caution about the process being reductionist. Therefore it is important to remember that the goals and objectives do not encapsulate the entire process of music therapy with the client, they serve to describe, plan and monitor an aspect of the client’s progress.

<table>
<thead>
<tr>
<th>Step</th>
<th>Criteria</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>One: Define long-term goals</td>
<td>Goals are based on evidence from holistic music therapy assessment.</td>
<td>Therapist undertakes assessment period with child. Attention is paid to the whole child, their communication, intentions, interaction, verbal and non-verbal gestures, affect and emotions, musical patterns and themes, preferences.</td>
</tr>
<tr>
<td></td>
<td>Goals are based on strengths that have emerged in music therapy sessions.</td>
<td>This ensures that the goals are client-centred and emerge from therapy rather than being imposed on therapy. A strength based goal gives priority to developing the client’s current interests, skills and motivation e.g. using a particular instrument to develop turn-taking skills because the client has a preference for that instrument.</td>
</tr>
<tr>
<td></td>
<td>Goals include and honour the priorities of the family/carers.</td>
<td>Information is gathered at consultation, review meeting and through informal discussion that identifies the family’s priorities. Therapist ensures that the goals reflect these priorities.</td>
</tr>
<tr>
<td></td>
<td>Goals take account of the family’s cultural background and values.</td>
<td>Information is gathered at consultation, review meeting and through informal discussion that reveals the family’s background and values. Therapist ensures that goals reflect family’s culture and values.</td>
</tr>
<tr>
<td></td>
<td>Goals are discussed collaboratively with the family/carers.</td>
<td>Family/carers are given an opportunity to ask questions and discuss the goals. This might be formal (review meeting) or informal (feedback after a session), verbal or written feedback. In collaborative outreach work, the feedback from parents/carers might take place through other professionals e.g. teacher.</td>
</tr>
<tr>
<td></td>
<td>Goals are discussed collaboratively with other professionals involved.</td>
<td>The therapist seeks the opportunity to discuss goals with other professionals especially when there is the potential for music therapy goals to support other therapy goals e.g. IEP goals. This might be face to face or an invitation given to share thoughts by telephone or written feedback.</td>
</tr>
<tr>
<td></td>
<td>Goals support the current needs of the client.</td>
<td>The current needs are those that are identified by the therapist, family/carers and other professionals involved. A need is stated as a change towards which the client may progress e.g. to become more independent or to develop social communication skills.</td>
</tr>
</tbody>
</table>
## Goals are individualised
Goals are not pre-determined; they are created specifically for the individual and relate to observations and experiences in the music therapy room.

## Goals are easily understood.
Plain English is used.

## Goal setting process reflects Raukatauri values: Creativity, Open-communication, Professional integrity, Empathy, Respect.
Therapist uses value-based decision making to inform the goal setting process. The following question might be used: Do these goals and the way they have been planned and written reflect Raukatauri values?

### Two: Define objectives

<table>
<thead>
<tr>
<th>Objective</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objectives are small steps that allow observable progress.</td>
<td>Objectives state behaviour or a desired change that can be observed in music therapy. If change or generalisation is expected outside music therapy this is also stated.</td>
</tr>
<tr>
<td>Objectives are specific.</td>
<td>Examples of what the therapist is looking for are given. For example: the client will acknowledge the therapist’s presence when sharing the same instrument - this can be seen in the client's use of eye contact and body language.</td>
</tr>
<tr>
<td>Objectives are measurable.</td>
<td>The therapist selects specific criteria that can be observed in order to describe progress. It is noted that in practice, progress can be broad or specific and may be recorded quantitatively or qualitatively.</td>
</tr>
<tr>
<td>Objectives are achievable.</td>
<td>Objectives are based on the strengths of the client as observed during the process of therapy.</td>
</tr>
<tr>
<td>Objectives are realistic.</td>
<td>The therapist reviews objectives informally after each session as they write notes and complete monitoring sheets. More formal review takes place 6 monthly. Objectives might change as the therapist completes the cycle of observation and reflection.</td>
</tr>
<tr>
<td>Objectives are reviewed regularly.</td>
<td></td>
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</tbody>
</table>

### Three: Define success criteria
Success criteria are given as an indication of what the therapist is looking for. Success criteria are usually measurable, observable actions that support attainment of the objective.

### Four: Define strategies
Strategies should link goals and objectives with music therapy methods and techniques. Examples of strategies are given that may identify theoretical approaches and specific techniques for use in the session. For example: clinical improvisation will focus on extending the client's capacity for communication.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Description</th>
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<tbody>
<tr>
<td>Strategies may include ideas that can be used outside the music therapy setting.</td>
<td>Monitoring sheets should be designed to record qualitative and/or quantitative data. Monitoring sheets are designed specifically for the client, relate directly to the goals and objectives, and allow a suitable method of recording progress e.g. video indexing may be used to record development of musical responses.</td>
</tr>
</tbody>
</table>

### Five: Monitor progress during ongoing therapy sessions.

Progress notes provide a descriptive account of what occurred in the session and are completed for every session. Progress notes can include: narrative description of session, musical examples and transcription, bullet points of significant moments, therapist’s reflections, thoughts and feelings, plan for next session.

Selective video analysis and indexing takes place. Therapist uses video to reflect on and review progress as well as to confirm observations.

| Six: Share plan | Goals and objectives are shared with family/carers, client (if appropriate) and other professionals involved. | Therapist disseminates goals and objectives to parents/carers and requests permission to send copies to other professionals working with the client. |
| Written report is shared with all involved. | Written report includes feedback on progress towards goals and objectives, other relevant observations and information from therapy sessions. Parent/carer and other professionals’ observations and comments may also be included. |

| Seven: Review | Review of the overall plan takes place at least every six months unless agreed otherwise with family/carer, or outreach facility. | For some clients, more frequent reviews are appropriate. The therapist should plan reviews according to needs and reasonable requests of client and family/carers. |
| Review process is completed collaboratively with family/carer. | Therapist invites comment and feedback from family/carer. This may be done face to face, via telephone, email or written communication. In Outreach settings, another professional may provide feedback from family/carer. |
| Review process takes account of the views of other professionals involved in the client’s care. | Therapist invites comment and feedback from appropriate professionals as necessary. This may be done face to face, via telephone, email, written communication or indirectly from parent/carer communication. Information from IEP and other reports is taken into account. |
| Review is based on evidence from therapy sessions. | The therapist gathers information from progress notes, monitoring sheets, video/audio footage and indexing to inform the review process. |
| Review process may include gathering information and observations from outside the therapy room. | Parents/carers and other professionals are invited to give feedback about child’s progress towards goals and objectives. This may happen formally (in review meeting) or informally as the opportunity arises. |
| Review is completed by the therapist. | In some cases, the review process may be completed by the therapist without direct involvement from parent/carer (outreach settings) or other professional (Raukatauri). |
| Goals are re-assessed and modified as necessary. | |
The following underlying principles were also identified by the team:

<table>
<thead>
<tr>
<th>Principle</th>
<th>Descriptor</th>
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<tbody>
<tr>
<td>Time management – the goal setting and review process should be manageable within the therapist’s working hours and caseload.</td>
<td>Each client will require a varying level of time, depending on the nature of the therapeutic endeavour, the stage of the work (assessment, established long-term, ending). The therapist should assess what is reasonable and practicable within their caseload and respond accordingly. Monitoring sheets should be quick and easy to complete.</td>
</tr>
<tr>
<td>Goal and objective setting is a reporting tool to help describe, plan and support aspects of progress in therapy.</td>
<td>Goal and objective setting is not intended to encompass the entire process of therapy.</td>
</tr>
<tr>
<td>Goals and objectives do not need to limit the client’s progress or the family/therapists’ expectations. Goals and objectives support the process of therapy rather than define the process.</td>
<td>This might result in broader goals for a child where the focus is on developing a trusting relationship rather than achieving specific skills.</td>
</tr>
<tr>
<td>Goals reflect the overall direction/intention of therapy.</td>
<td></td>
</tr>
<tr>
<td>The therapist draws on a wide range of music therapy strategies and techniques within their competence as a practitioner in order to meet the needs of the client.</td>
<td>It is not expected that every intention or strategy is documented in the goals and objectives plan.</td>
</tr>
<tr>
<td>For group work, the therapist may have specific goals and objectives for the group and the experiences offered in the group as well as individual goals.</td>
<td></td>
</tr>
<tr>
<td>Regular supervision and team discussion is essential for reflective practice and to help prioritise the next step for each client.</td>
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</table>
2.7.3  Reflections on the process of establishing the criteria

Establishing the criteria was one of the first major tasks that the research team tackled together. One of the challenges was using the findings from the literature review as guiding points, while also creating space for our own values and practice as a team to be recognised. During the process of identifying the criteria, the team expressed concern that the process was reductionist. The issue of setting criteria against which to evaluate our current system was reflective of the goal setting process itself; where criteria are set against which the progress of the client is evaluated. In a journal entry following a team discussion, Claire (research team leader) noted that: “the research has really gone to the heart of our practice” (01/09/10). Although difficult to articulate, the team found a lack of congruence between the process of setting SMART goals and being able to meet the client where they are in the therapy room. In establishing the effectiveness criteria, the team had endeavoured to reflect the individualised approach at Raukatauri.

2.8  Conclusion

The literature revealed a range of approaches to goal setting and review within music therapy. The literature revealed some consensus about the importance of goal setting and regular review of progress. It was also clear from the literature that some form of assessment is required to inform the goal setting process and that both assessment and goal setting will depend on the approach to music therapy. The literature review also revealed the potential benefit of approaches such as Goal Attainment Scaling and a Narrative Approach to goal setting for music therapy.

Establishing the criteria enabled the team to clearly identify and describe the stages of an effective goal setting and review process. This was used to guide the documentary analysis as well as forming the basis for the match analysis conducted at the end of the reconnaissance phase, both of which are discussed in Chapter 4.
This chapter has presented the main findings from the literature review and the effectiveness criteria that were informed by this review. It is important now to turn to the research methodology employed for this project which is the focus of Chapter 3.
CHAPTER 3 RESEARCH METHODOLOGY

3.1 Introduction

The central aim of this project was to examine the process of goal setting and review used at Raukatauri with a focus on collaborative goal setting with parents/carers and other professionals. As shown in the previous chapter, there is a range of approaches to goal setting in music therapy that are informed by the orientation of the music therapist. For this project, it was agreed that a collaborative approach to goal setting that honoured the Raukatauri values of creativity, open-communication, professional integrity, empathy and respect, was important. As the research was to take place within a particular culture, that of a music therapy centre, a qualitative approach to the research was seen as appropriate and action research was chosen as the methodology.

This chapter introduces action research as the chosen methodology and examines the characteristics of this approach. The Problem Resolving Action Research (PRAR) Model (Piggot-Irvine, 2009) is described along with an overview of data collection and analysis methods. To conclude, a case is made for the use of action research as an appropriate methodology for practice-based research in music therapy, followed by a brief presentation of data collection methods used and the consideration of rigour and credibility for a study such as this.

3.2 What is action research?

Action research is an applied research methodology which aims to improve practice, create knowledge, and generate living theories of practice (McNiff & Whitehead, 2010). It is a tool widely used by individuals and organisations in sectors including education, health, technology and community development to promote improvement, change management and professional development (Piggot-Irvine, 2009). Action is about improving practice through implementation of change, while research is about creating knowledge about practice;
making informed decisions about what and how change will be implemented (McNiff & Whitehead, 2010; Piggot-Irvine, 2009). A number of interchangeable terms are used, such as participatory research, emancipatory research, thematic research, collaborative research, mutual inquiry, community-driven research (Stige, 2005), practice-based research, practitioner research or action enquiry (McNiff & Whitehead, 2010).

Stige (2005) considers the roots of action research to be multiple, “compound and emerging” (p.405). As a methodology, action research is influenced by the work of philosophers such as Ludwig Wittgenstein and Jurgen Habermas. Stige (2005) considers the questions “What counts as knowledge?” and “Whose knowledge counts?” (p.405) as critical to action research and suggests that knowledge is considered “as emerging and embodied processes situated in a context of shared practice” (p.406). Participatory action research also focuses strongly on communication and emancipation, emphasising a “bottom-up approach” (Stige, 2005, p.407) that privileges experience and action rather than theory and hypothesis. Piggot-Irvine and Bartlett (2008) elaborate on the range of values and features of action research as described by Zuber-Skerritt (Zuber-Skerritt, 2005 cited in Piggot-Irvine & Bartlett, 2008) which includes the following: collaboration; trust; honesty; respect; imagination; and openness (p.26).

### 3.3 What are the elements/characteristics of action research?

Action researchers focus on improving their own practice using a systematic process of iterative action-reflection cycles (Piggot-Irvine, 2009; Stige, 2005). Through the process, the researchers identify a problem and undertake practical actions followed by collective reflection and evaluation to solve that problem. It involves experiential learning which ultimately aims for improvement and transformation of the situation at both personal and professional level (Piggot-Irvine, 2009).
McNiff and Whitehead (2010) emphasise that in action research the individuals or groups involved in investigating the situation all become researchers themselves. It is insider research, meaning that the practitioners themselves are in control of their own practices within a specific context (McNiff & Whitehead, 2010; Piggot-Irvine, 2009). This notion is different from traditional research methods where an official researcher usually conducts the situation from an outsider perspective.

As action research focuses on improving the practice of the researchers themselves, their values are considered important. Action researchers rely on their abstract values such as love, fairness or democracy which form the basis of the conceptual framework of their projects (McNiff & Whitehead, 2010). The researchers’ values become the standard of judgement in determining what they do in their research process. This also implies that they hold a responsibility to evaluate whether their values are justifiable and positively influence other people. Constant interrogation, deconstruction and decentring are critical processes in action research to allow self-inquiry and therefore improvement on one’s thinking (McNiff & Whitehead, 2010).

In action research, individuals often work collaboratively with others to examine their actions (McNiff & Whitehead, 2010; Piggot-Irvine, 2009). They seek critical feedback from others during the cyclical process of action and modification which helps to “avoid self-limiting reflection” (Schon, 1982, cited in Piggot-Irvine, 2009, p.18). Therefore it becomes a co-creation of knowledge of practice (McNiff & Whitehead, 2010). Within an organisation, a team of researchers may experience a sense of community by undertaking the research collaboratively (Piggot-Irvine, 2009) and a motivation for their work by integrating it into practice (Sagor, 2000, as cited in Piggot-Irvine, 2009).
3.4 Models of action research

Piggot-Irvine states that there are a number of different action research models. However, most share common processes of identifying an issue for development, implementing changes and evaluating the implementation (Piggot-Irvine, 2009). McNiff (2002) describes Kurt Lewin's theory of action research “as a spiral of steps involving planning, fact-finding (or reconnaissance) and execution...which later came generally to be understood as the action-reflection cycle of planning, acting, observing and reflecting” (p.41). The cyclical process of identifying an issue, developing a critically informed plan, acting to implement the plan, observing and reflecting on the actions, and further repeating these steps until the problem is solved, is typical of action research (McNiff, 2002; McNiff & Whitehead, 2010; Piggot-Irvine, 2009; Stige, 2005).

The Problem Resolving Action Research (PRAR) Model is comprehensively illustrated by Piggot-Irvine (2009), as shown in Figure 1. By utilising the mini cycles, or spin off cycles between the main cycles, the researchers are able to deal with unexpected side issues that are likely to arise (Piggot-Irvine, 2009) whereas a typical cyclical process does not allow such flexibility.
3.5 Data collection and analysis in action research

The data collection methods associated with action research include interviews, questionnaires, focus groups and observation (Piggot-Irvine, 2009). Piggot-Irvine identifies a range of less well known data collection approaches including “journaling, concept mapping, model building, nominal group technique, plus minus interesting and repertory grid technique” (p.24) which are described more fully by Piggot-Irvine and Bartlett (2008). Methods of analysis can be drawn from a range of other qualitative research methodologies such as grounded theory (Browne & Sullivan, 1999) and phenomenology (Van Manen, 1990). Given the cyclical process of action research, data is collected and analysed at each phase of

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**Figure 1. The Problem Resolving Action Research (PRAR)**
the research process. Conclusions are drawn at each phase which influence the actions in the subsequent phases, making action research an inductive process.

3.6 How is action research applied in music therapy?

Action research is increasingly used by music therapists who wish to improve their own practice (Rickson, 2009). It is an approach that can “enable music therapy researchers to generate detailed description of the music therapy process which can in turn be rigorously and systematically analysed” (Bunt, 1994, cited in Rickson, 2009, p.3). Action research is a “constructive and context-sensitive alternative [research method] for music therapists” (Stige, 2005, p. 413) that allows music therapists to document the value of their work. However, there are limited examples of action research in the music therapy literature.

Stige (2005) describes a group of researchers, including music therapists, music educators, amateur musicians and community members, who undertook an action research project to realise a goal of integrating musical life into the local community. Within this project called ‘Upbeat’ involving a group of people with mental challenges, the researchers went through three years of action-reflection cycles involving participation in music performances in the community. They achieved the goal together with an emerging awareness of the importance of music therapy theory and practice in the community (Stige, 2005).

Rickson (2009) used an action research approach to develop a music therapy consultation protocol for music therapists in special education settings and to investigate how it would be used, perceived, and valued by participants. An initial protocol was developed by analysing both interviews with music therapists and video recordings of their music therapy assessment sessions. Following this analysis (a reconnaissance phase) the special education team members and researcher worked collaboratively in iterative research cycles focusing on implementing therapeutic uses of music in classrooms. Data were gathered through field observations, journal entries and interviews which were analysed to unleash themes to help develop the consultation protocol throughout the research process. Rickson states:
Using a highly collaborative action research approach and checking interpretations with participants have also enabled me to develop a music therapy consultation protocol which will be useful for music therapists and meaningful for special education teams. Further I am confident that being closely involved with teams as a participant in the work, and engaging in high levels of critical reflection, has allowed me to accurately report the way in which the consultation process was perceived, used and valued by team members. Systematically questioning my thoughts and feelings and recording these in a journal increased my personal authenticity and the value of the project as a whole. (p.8)

Action research was selected as the ideal methodology for the research project described in Rickson’s report, because it allowed the researcher to carefully and critically examine her work in order to achieve the aim of the research through working collaboratively with participants who also benefited from this work.

3.7 How was action research applied in this project?

This project used the PRAR model of action research and moved through three distinct phases: reconnaissance, implementation and evaluation. It was a collaborative venture which involved the whole clinical team at Raukatauri. Other participants were drawn from the parents/carers whose children receive or have received music therapy at the Centre, as well as other professionals. The use of questionnaires and focus group interviews aimed to be inclusive in gathering information and honouring multiple perspectives on the process of goal setting. Additionally, the clinical team rigorously investigated and reflected on their own practice.

The data collection methods used in this project were questionnaires, focus group interviews, documentary analysis and journaling. Methods of analysis included thematic analysis of qualitative responses in the questionnaires and focus groups. The thematic analysis of the
reconnaissance phase questionnaire was influenced by the phenomenological microanalysis procedure described by McFerran and Grocke (2007) which involves a series of steps derived from the work of Amadeo Giorgi and Colaizzi at Dusquesne University in Philadelphia, USA:

- Transcribing the interview word for word;
- Identifying the key statements;
- Creating structural meaning units;
- Creating experienced meaning units;
- Developing the individual distilled essence;
- Identifying collective themes; and
- Creating global meaning units and the final distilled essence.

Although this process was not followed in its entirety, it was helpful in providing a structure to the thematic analysis.

### 3.8 Rigour and credibility in action research

The question of rigour and credibility in action research has been considered at length in a book edited by Piggot-Irvine and Bartlett (2008) which focuses on the evaluation of action research. The process of reflection is noted as having an evaluative aspect and is seen as “critical to determining the rigour of the research” (p.32). Furthermore, the authors consider action research to be rigorous “to the extent that action research projects include planned reflection, informed by robust, observation-centred, evaluative and self-evaluative questions and issues, and interpretation within the context of the action and research cycles” (p.24). Zuber-Skerritt (2008) also argues that “the results of action research are reliable and valid only if they are real, recognisable, meaningful, relevant, and “true” to the participants in the study” (p.92). She suggests that the findings of action research may be a useful starting point for others investigating a similar problem, but that as every social group and organisation is
unique, the process of finding solutions must also be unique. This is an interesting point that resonates with the project described in this report which acknowledges that while a structure for goal setting is important, it is a starting point only. It is from this starting point that relevant and meaningful goals can be agreed for each individual.

Ballinger's (2006) discussion regarding the demonstration of rigour and quality in qualitative research supports the position of Piggot-Irvine and Bartlett. Ballinger (2006) puts forward four 'considerations' to help the qualitative researcher evaluate their research. The first three considerations are: coherence; evidence of systematic and careful research conduct; and convincing and relevant interpretation. The final consideration concerns the role of the researcher and whether this “is accounted for in a way that is consistent with the orientation of the research” (p.242). According to Bradbury-Jones (2007), journaling can also enhance rigour and credibility in qualitative research through a systematic search for researcher subjectivity. Journaling therefore can be used to collect data about the topic being researched as well as the researcher's experience of engaging in the research.

From the field of music therapy, Rickson (2009) discusses the complexity of managing multiple roles in an action research project and also advocates the use of a research journal to aid the process of critical reflection. Stige, Malterud and Midtgarden (2009) aim to invite dialogue through the use of an agenda for evaluation of qualitative research. The agenda, based on the acronym – EPICURE – encourages researchers to account for engagement, processing, interpretation and (self) critique as well as focusing on (social) critique, usefulness, relevance and ethics (p.1504).

### 3.9 Ethical issues

To ensure this study was ethically sound an application was made to the UNITEC ethics committee and approval was granted prior to the start of the project (Number 2009-1047). There were three issues that required care and consideration to minimise harm to participants.
These issues were: a multi-dimensional conflict of interest on the part of the lead researcher; informed and voluntary consent; and confidentiality and anonymity.

Consistent with the action research methodology chosen, the lead researcher was an insider researcher who had professional relationships with the research team. Further to this, it was possible that the lead researcher may have a prior professional relationship with any of the participants. The following steps were taken to ensure that the potential for harm was minimised:

1. the purpose of the research, including data collection methods was disclosed to all participants at the outset of the project;
2. participants' anonymity was maintained as no names were used in the focus group notes or transcripts and all names were removed from the questionnaires;
3. the lead researcher identified any prior relationships with focus group participants and encouraged focus group participants to be aware of how their relationships with the researcher and Raukatauri may impact their contribution to the focus group.

It was important for the lead researcher to be aware of potential dual relationships and power imbalances. Specifically, this may occur where the researcher is music therapist to the child of a participant in the focus group. Smith (2008) commented on a similar potential conflict of interest in a large scale participatory action research project for the Ministry of Education. Smith advised that members' of the research teams “had to recognise and share their positions, beliefs and values about the project and their relationships with each other” (p.18).

All participants were required to give informed consent before completing the questionnaire or taking part in the focus group interviews. A detailed information sheet was provided to ensure participants had sufficient information. Questionnaires were posted to participants with the consent form which minimised the potential for any sense of obligation or pressure to participate. No-one declined to participate in this study.
A major concern for participants could have been confidentiality and anonymity. In an effort to address these issues, the following protocols were used. All questionnaires were completed anonymously and returned by way of a self-addressed envelope to the Raukatauri Music Therapy Centre. The Centre Administrator separated the consent forms from the questionnaires and blocked out any names that had been included to ensure confidentiality. With regard to the focus group interview, all participants were coded and all names were removed to ensure confidentiality.

These considerations addressed the following ethical principles: informed and voluntary consent; respect for rights and confidentiality and preservation of anonymity; and avoidance of conflict of interest.

3.10 Conclusion

This chapter has presented an overview of action research methodology including the specific approach used in this project. The use of action research is growing in music therapy research as it is an approach that values collaboration and reflective practice-based enquiry. The issues of rigour and credibility have also been addressed with an emphasis on the process of reflection being valued as an evaluative tool.

The following three chapters offer a presentation of the data that was collected and analysed during the three phases of the project: reconnaissance; implementation; and evaluation.
CHAPTER 4   RECONNAISSANCE PHASE

4.1   Introduction
Data collection and analysis took place concurrently with the literature review during the reconnaissance phase. Several data collection methods were used during this phase and are presented in this chapter along with the findings. The chapter will finish with the overall conclusions reached and the implications for the intervention phase.

4.2   Research questions
The research questions for the reconnaissance phase were as follows:

1. What is the purpose of the goal setting and review system?
2. What criteria does the current research/thinking suggest about an effective goal setting and review system?
3. How well does our current system match the effectiveness criteria established?

4.3   Data collection methods
A questionnaire to parents/carers and other selected professionals was the key data collection tool in this phase. This was followed by focus groups. These methods enabled us to explore both broad and specific issues pertinent to the parents/carers and other professionals selected to take part in the research. Data were also collected from within the research team using documentary analysis and journaling. Team workshops were held at various stages of the research and notes were kept from the workshops and subsequent meetings to discuss findings and identify improvements. These documents were used to guide the research process as it unfolded.

4.4   Questionnaire
The questionnaire (Appendix B) was designed to gather participants' views of the current goal setting and review process with the purpose of collecting information to answer the first two...
research questions. The questionnaire was appropriate at this stage of the project as it enabled us to gather both perceptions and numeric information. McNiff and Whitehead (2002) comment that “Questionnaires are helpful but notoriously difficult to construct” (p.95) and suggest that open-ended questions can be more useful than closed questions. With this in mind, the questionnaire was designed to include both closed and open questions. It was intended that the questionnaire results would identify trends which could then be explored further in the focus group interviews.

Questionnaires were posted to participants with a stamped addressed envelope for return. An information sheet, consent form and invitation to participate in the focus group were included with the questionnaire (See Appendices C, D and E).

4.4.1 Participant sampling and return rates

We wanted to gather data from a broad sample of people who had experienced the goal setting and review process at Raukatauri. Purposive sampling was used to select participants. There were two groups of people from whom we wished to gather information; parents/carers and other professionals. Sampling was as follows:

Parents and carers

Questionnaires were sent to parents and carers of all children who had received music therapy during the period December 2009 – April 2010. The Raukatauri case list was used to identify children who had received music therapy during this time with a total of 140 questionnaires posted to parents and carers.

Other professionals

Other professionals were also selected to receive the questionnaire. Each music therapist in the research team put forward the names of up to five professionals (e.g. therapist or teacher) to whom they had copied a report or had significant communication regarding goal setting for
a client. As this process of selection took place, we eventually sent the questionnaire to more people than originally anticipated. The reason for this was that we wanted to collect information from as varied a group as possible. A total of 39 questionnaires were posted to other professionals, as shown in Table 4.1.

Table 4.1 Questionnaire distribution

<table>
<thead>
<tr>
<th>Participant</th>
<th>Total number sent questionnaire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/carer</td>
<td>140</td>
</tr>
<tr>
<td>Support Coordinator</td>
<td>1</td>
</tr>
<tr>
<td>Teacher</td>
<td>17</td>
</tr>
<tr>
<td>Head of therapy services</td>
<td>1</td>
</tr>
<tr>
<td>Deputy principal of special school</td>
<td>1</td>
</tr>
<tr>
<td>Occupational therapist</td>
<td>1</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>1</td>
</tr>
<tr>
<td>Team leader</td>
<td>1</td>
</tr>
<tr>
<td>Service manager</td>
<td>2</td>
</tr>
<tr>
<td>Special education teacher</td>
<td>1</td>
</tr>
<tr>
<td>Director of therapy service</td>
<td>1</td>
</tr>
<tr>
<td>Paediatrician</td>
<td>1</td>
</tr>
<tr>
<td>Principal of special school</td>
<td>1</td>
</tr>
<tr>
<td>Speech language therapist</td>
<td>3</td>
</tr>
<tr>
<td>Special education advisor</td>
<td>1</td>
</tr>
<tr>
<td>Early intervention teacher</td>
<td>1</td>
</tr>
<tr>
<td>Developmental paediatrician</td>
<td>2</td>
</tr>
<tr>
<td>Clinical psychologist</td>
<td>2</td>
</tr>
<tr>
<td>Support worker</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total number of questionnaires</strong></td>
<td><strong>179</strong></td>
</tr>
</tbody>
</table>

Return rate

A total of 30 questionnaires were returned which is a return rate of 16%. Participants were not asked to identify themselves as a parent/carer or other professional on the questionnaire,
so we do not have information about the range of people who returned questionnaires. This was recognised as a limitation of the design and will be further discussed in Chapter seven.

4.4.2 Questionnaire analysis and findings

Questions were organised so that initial responses were on a Likert Scale and were supported by written responses to enable the participant to expand and describe their opinion more fully.

The analysis took place in two stages. First, the numeric data was collated and interpreted. Second, the qualitative data was analysed using a thematic approach. This analysis was influenced by phenomenology and the process described by McFerran and Grocke (2007) as presented in Chapter 3. Initially the main findings from the quantitative data are presented in this chapter, followed by the thematic analysis of the qualitative data. The chapter finishes with a summary of the findings that informed the implementation phase.

4.4.2.1 Numeric analysis

The numeric results are summarised below for each question with recommendations for improvement and further investigation identified in the discussion at the end of each section.

Part One: Goal setting

Part one of the questionnaire concerned the goal setting process. Respondents were first asked whether they had received a goal and objective sheet within the last six months. The results are shown in Figure 2.
Of 30 respondents, 23 said they had received a goal and objective sheet within the last six months. Five respondents had not received a goal and objective sheet and one respondent did not know whether they had.

Respondents were then asked to think about the most recent goal and objectives sheet they had received and rate the following statements on a scale from 1 (strongly disagree) to 5 (strongly agree). The statements are listed in Table 4.2 and the results in Figures 3(a) to (e).

**Figure 2. Number of respondents who had or had not received a goal and objective sheet**

**Table 4.2 Questionnaire statements about goal setting**

<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The goal and objective sheet is well laid out.</td>
</tr>
<tr>
<td>2</td>
<td>The goals and objectives are clear and relevant.</td>
</tr>
<tr>
<td>3</td>
<td>The success criteria are easy to understand.</td>
</tr>
<tr>
<td>4</td>
<td>The success criteria are relevant.</td>
</tr>
<tr>
<td>5</td>
<td>I have been involved in the process of goal setting</td>
</tr>
</tbody>
</table>
Figure 3(a) - (e). Layout of goal and objectives sheet

(a). The goal and objective sheet is well laid out.

(b). The goals and objectives are clear and relevant.

(c). The success criteria are easy to understand.

(d). The success criteria are relevant.

(e). I have been involved in the process of goal setting.
The results indicated support for the current goal setting process with 16 out of 23 respondents strongly agreeing that the goal and objective sheet is well laid out (Figure 3(a)). Fourteen out of 23 strongly agreed that the goals and objectives were clear and relevant (Figure 3(b)). No respondents disagreed or strongly disagreed with the statements about the success criteria (Figures 3(c) & (d)). The majority of respondents agreed (4 out of 22) or strongly agreed (14 out of 22) that they had been involved in the process of goal setting with two respondents strongly disagreeing and one respondent leaving this statement blank (Figure 3(e)).

These results suggest that the current layout of the goal and objective sheet was good and that the goals, objectives and success criteria are relevant and easy to understand. People were not asked to identify whether they were parents/carers, or other professionals on the questionnaire and are likely to have quite different experiences of being involved in the process of goal setting depending on whether their experience of music therapy is at the Centre or in an Outreach setting. Another area that needs further discussion is the process around distribution of goal and objective sheets, given that five respondents had not received a sheet.

**Part Two: Written reports**

Part two of the questionnaire concerned the written reports that are distributed to parents/carers and other professionals. *Figure 4* shows the number of respondents who had or had not received a report within the last six months.
The number of respondents who received a written report was close to the number who had received a goal and objective sheet which suggested that the process of sending out both documents together was working. However there were still five respondents who hadn't received a report within the last six months. This may be due to the selection process for questionnaire distribution which will be further discussed in relation to limitations of this project in Chapter 7.

Respondents were then asked to think about the most recent report they had received and rate the following statements on a scale from 1 (strongly disagree) to 5 (strongly agree). The statements are listed in Table 4.3 and the results in Figures 5(a) to (e).

**Table 4.3 Questionnaire statements about written reports**

<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The report is written in language I understand.</td>
</tr>
<tr>
<td>2</td>
<td>The report is relevant and meaningful to me.</td>
</tr>
<tr>
<td>3</td>
<td>The report relates to the goals and objectives.</td>
</tr>
<tr>
<td>4</td>
<td>The length of the report is too long.</td>
</tr>
<tr>
<td>5</td>
<td>The length of the report is just right.</td>
</tr>
</tbody>
</table>
(a). The report is written in language I understand.

(b). The report is relevant and meaningful to me.

(c). The report relates to the goals and objectives.

(d). The length of the report is too long.

(e). The length of the report is just right.

Figures 5(a) - (e) Responses about written reports
Fourteen out of 23 respondents strongly agreed that the report was relevant and meaningful (*Figure 5(b)*)) and 18 out of 23 strongly agreed that the report related to the goals and objectives (*Figure 5(c)*). No respondents disagreed with the first three statements which suggests that respondents found the report was written in language they could understand, was relevant and meaningful and related to the goals and objectives (*Figures 5(a), (b) & (c)*). The last two questions concerning the length of the report raised a much more mixed response. When comparing the responses to questions four and five, the majority of respondents disagreed or strongly disagreed that the report is too long and agreed or strongly agreed that the report is just right (*Figure 5(d) & (e)*). There is some difficulty around the interpretation of these results as the length of reports produced by music therapists vary depending on who the report is for and the type of report (Centre, Outreach, assessment report). The research team decided to look at a cross-section of reports in order to further explore the question of report length.

**Part three: Video footage**

Part three of the questionnaire concerned the role of video footage in the goal setting process. *Figure 6* shows the number of respondents who had or had not viewed video footage relating to the written report.

![Figure 6. Number of respondents who had or had not viewed video footage](image)
The results show that just over half of the respondents (17 out of 30) had the opportunity to view video footage relating to the report.

Those who had viewed video footage were asked to rate the following statements on a scale from 1 (strongly disagree) to 5 (strongly agree). The statements are listed in Table 4.4 and the results in Figures 7(a) to (c).

**Table 4.4 Questionnaire statements about video footage**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>The video footage helped me to understand the therapy process.</td>
</tr>
<tr>
<td>2.</td>
<td>The video footage related to the goals and objectives.</td>
</tr>
<tr>
<td>3.</td>
<td>I did not find the video footage helpful.</td>
</tr>
</tbody>
</table>

**Figure 7(a).** The video footage helped me to understand the process.

**Figure 7(b).** The video footage related to the goals and objectives.

**Figure 7(c).** I did not find the video footage helpful.

*Figure 7(a) - (c). Responses relating to video footage*
Interpreting these results is limited as respondents were not asked to identify themselves as parent/carer or other professional and we also do not have data on whether their experience of music therapy was at the Centre or in an Outreach setting. The process for sharing video differs between the settings; with all parents at the Centre being given the opportunity to view video footage whereas in Outreach settings, parents/carers and other professionals have limited access to video footage and need to arrange this with the therapist.

Of those that had viewed video footage, the results show that the majority of respondents agreed (six out of 17) or strongly agreed (nine out of 17) that it had helped them to understand the therapy process (Figure 7(a)) and that it related to the goals and objectives (Figure 7(b)). Two out of 17 respondents disagreed that the video footage had helped them to understand the therapy process (Figure 7(a)) and one respondent disagreed that the footage related to the goals and objectives (Figure 7(b)). However, the results for the final question suggest that all except one respondent (who gave a neutral response) found the video footage helpful with 12 respondents strongly disagreeing with the statement “I did not find the video footage helpful” and four respondents disagreeing with this statement (Figure 7(c)).

4.4.2.2 Qualitative data

Qualitative data was gathered in two places on the questionnaire. First, a space was provided for ‘other comments’ for each section containing Likert scale responses. Second, at the end of the questionnaire, respondents were asked to add their comments to the following statements:

- The strengths of the current goal setting and review process at Raukatauri are; and
- The changes or improvements I would like to see made to the current goal setting and review process at Raukatauri are.

The qualitative analysis revealed five categories each with a number of themes. The categories are as follows: comments about process; collaboration/supports Individual
Education Plan (IEP); communication and sharing; process links to progress and individualised goals relate to the client. Each category is presented below with direct quotes included to add richness to the data. The areas identified for potential improvement are summarised at the end of the section.

**Category: 'comments about process'**

The themes in this category relate to the way in which people can access and understand the goal setting and review process and were identified as: happy with current process; clarity of process; report length; frequency of reviews; and cost.

The theme *happy with current process* was supported by six respondents who when asked what changes or improvements they would like to see, replied that they could not think of any. Seven respondents commented specifically on the current process as a whole and indicated they felt it was working well and they found it helpful. These responses indicated that we were doing a good job with the goal setting and review process and that people were happy with it.

*Clarity of process* was another theme that was well represented with 30 comments identified in the thematic analysis. Of these 30 comments, 28 indicated that respondents felt the current process was clear and relevant. Phrases such as “clearly set out”, “concise” and “I was impressed with the format and content of the goal setting criteria” were included.

One person commented “I really don’t know what the aim/object is” which may suggest difficulty understanding the goal and objective sheets or a lack of understanding about the purpose of music therapy. Another comment related directly to the size of font and paper used for reports suggesting that a larger font and A4 size paper would be better. This comment relates directly to one of our Outreach settings where reports are prepared on A5 paper at the request of the school.
Finally, another comment queried the clarity of the goal and objective sheet for some parents. This person also commented later in the questionnaire about whether interpreters are available where needed, so the comment may reflect a concern about the use of plain English in the goals and objectives.

These results show that overall respondents felt that process was clear, with reports written to a high standard. Respondents also seemed to like the layout of the goal and objective sheet with several comments about this being clear, relevant and easy to read.

We were interested in finding out people's views about the length of reports that we were producing. Report length varied depending on the setting for which the report was written (Centre or Outreach) and the type of report (assessment, progress, closing). As we did not ask people to identify whether they were a parent or professional, or whether they had experience of Centre or Outreach reports, interpreting the results to this question was difficult.

The comments in this theme revealed a variety of responses. Two respondents felt that the report length was fine. Two others commented that they felt the report was a little too long, although also indicate that they value the detail. One noted: “For us we think that the report may be a little too long, however it’s what therapist name has observed and what she wants to work on for the next six months and we really appreciate her feedback”. Another person stated “it is great to have the detail on record”, but added that feedback from other family members (grandparents) was that the report was “quite long and detailed for them to read”.

The theme frequency of reviews included comments from six respondents. Of these, four were happy with the length of the review period. Two suggested that a more frequent review would be useful and clarified this by stating: “twice/term review might be useful” and “every three months instead of every six”.
Within the review process at Raukatauri, we already have provision to review more frequently if the therapist and/or parent/carer feel it is appropriate. These two responses therefore indicated the need to look at how we communicate this possibility to parents/carers so that they feel able to ask for a more frequent review period.

The theme cost included the following two specific comments: “We wonder if a simplified process would make sessions less expensive”; and “Personally I would not want to see valuable MT time going into more report time. I suspect that a spontaneous approach enables the therapist to ‘go with the child’.”

These comments made us consider how difficult it can be for a parent/carer to understand the processes that support the work that takes place in the therapy room. Are there ways in which we can communicate more clearly the importance of the documentation procedures that support the therapy process? Also, taking into account the second comment, would more information about our thinking help increase understanding about the importance of ‘going with the child’, that this approach is supported by theoretical frameworks, preparation before and reflection following each session?

**Category: 'collaboration/supports IEP'

The themes in this category relate to the way in which the goal setting and review system related to IEP goals and other therapeutic input and strategies. It also includes comments about the importance of collaboration on a practical level. The themes included are: sharing strategies; collaboration; and support IEP/other therapy goals and strategies.

Comments within the theme sharing strategies suggest that respondents had a mixed experience of whether strategies were shared or not. There were six comments included and three of them identified that the reports/goals and objectives included strategies that could be
used at home or in the classroom including: “the comments and descriptions of activities have been useful to carry over into the classroom situation” and “good to have clear strategies that we can work on at home”.

However the other three comments called for strategies to be included “so therapy is extended in all environments” with two people specifically asking for “strategies” and “home friendly activities”.

These comments probably reflect the varied nature of our practice at the Centre and that for some children with whom we work there are very clear strategies that can be transferred to other environments. For others, this process may be less clear. It is possible that parents/carers and other professionals would benefit from more information about the nature of music therapy. It might also be useful to ensure there is opportunity for parents/carers and other professionals to discuss the possibility of sharing strategies outside the music therapy room.

Four comments were included in the theme collaboration. Three of these indicated that respondents appreciated the opportunities to work collaboratively with the music therapist. Experiences such as being able to talk with the therapist on a weekly basis, “bringing others into music therapy sessions to observe” and “involving members of the school team” were all seen as strengths of the current goal setting and review process. This feedback was encouraging as it suggested that we were already working collaboratively in some settings and that this was viewed positively. The fourth comment was a more general comment concerning the potential for collaboration: “Collaboration will be dependent on the parents' willingness/ability to coordinate the services which their child accesses and/or they see the importance of collaborative goal setting”.

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This feedback suggests that people valued the opportunity to work collaboratively with the music therapist. As a team, the possibility of collaborative working was valued highly and we felt it was important to ensure that parents/carers and other professionals knew they could ask about collaborative opportunities.

Nine comments were included in the theme support IEP/other therapy goals and strategies. All the comments related positively to the way in which the music therapy goals and objectives supported IEP and other therapy goals and strategies. Six comments related to the ‘fit’ between music therapy goals and IEP goals. One comment suggested that the music therapy goals could be used to influence the Individual Plan (IP) goals: “I really like the goals and they give me ideas for making IP goals with Group Special Education (GSE) (more positive and relationship focussed than the normal GSE ones)”. Another comment alluded to the process working the other way: “the music therapist is able to take relevant information from the IEP and translate it into music therapy objectives and strategies.”

The results showed a correlation between music therapy goals and IEP goals that seemed to be valued by the respondents. This suggests it may be of benefit for music therapy goals to align with IEP goals in order to ensure consistency across the therapeutic interventions being received by a single child. However, it was also interesting to receive feedback that the music therapy goals could influence the IEP goals and that this may result in goals that are more relational rather than educational or functional.

Category: ‘communication and sharing’

This category includes the following themes: parent is involved; use of video; and communication.

The theme parent is involved included 12 comments that related directly to parents being involved in the review process. The comments were all positive and suggested that parents
Two comments referred to parents’ ideas and values being considered: “Caregivers are fully involved and informed so that individual values and choices are accounted for” and “parents’ ideas and wants/desires are considered”. Several comments also highlighted the involvement of both parents and considered the staff to be “flexible” in accommodating both partners to attend. Another respondent commented that the review meeting enabled her/him to “see behaviour in context and contribute based on my own understanding”.

This feedback suggested that for these respondents the review process worked well and they felt involved. Parent/carer involvement is viewed as an important part of the process at Raukatauri, as parents can provide valuable information to help the therapist contextualise what is taking place in the sessions. It was encouraging to hear that parents and carers valued being involved too.

Comments in the theme use of video include suggestions for sharing the video footage as well as comments about the importance of the video footage. These comments were initially grouped separately, but on further analysis, it was more useful to put them together as it demonstrated both the value of video footage alongside the suggestions for sharing this more widely.

Sharing video footage

Five respondents made specific suggestions for sharing the footage more widely. There are some limitations around interpreting this data as respondents were not asked to identify whether they were parent/carer or professional. This means that their experience of viewing video footage would have varied depending on how much they were involved in the review process. For example, the following comment suggests that the respondent had received a
written report but not had the opportunity to view footage: “I wonder whether some video footage edited together on a disc that accompanies a review – might help further illustrate what is being discussed on paper?”

One person suggested that sharing footage would “enable more mutual sharing of ideas and strategies” while another respondent commented “no sense if parents can't share the video footage with family, friends and others working with the child”.

These comments indicated that the video footage was a powerful tool to communicate what occurs in a music therapy session. However, the sharing of video footage needs to be carefully considered for each individual client. It will be important to look at the information provided about the purpose of the video footage and ensure that parents/carers and other professionals feel able to discuss access to the video footage with the therapist.

**Video footage relates to goals**

Four comments referred directly to the way in which the video footage related to the goals. One person stated that the video footage helped “to see examples of the strategies being implemented” suggesting that the video footage could be used to provide information about what the music therapist is doing in the session. The other three comments concerned the way in which the footage related to the goals and objectives including: “The goals that were set then achieved were displayed easily” and “seeing the footage related to the goals and objectives”. These comments indicate that therapists select specific excerpts of footage that relate to the goals, but also that there is value for the parent/carer and other professional in being able to see the goals, objectives and strategies illustrated in this way.

**Value of video footage**

Eleven comments highlighted the value of watching video footage. Five of these comments related to the enjoyment and pleasure gained from watching the video sessions. The
following two example comments illustrate this: “I find watching my child interacting with the therapist inspiring” and “it is rewarding to watch it, as we can see how much he enjoys it and the benefits he gains”. One person felt that “video footage is crucial”.

The other six comments concerned the way in which the video footage can reveal information about the child. Two respondents commented that they were surprised by what they saw: “I was surprised to see the level of arousal in the student and learnt that he could tolerate more movement than I had previously thought” and “I would not have believed how well my son was listening and interacting for that length of time without actually seeing it for myself”. Another respondent felt that watching the video made “some of the science behind the play become clearer” and also “allows you to read the child's body language from a bird's eye view”.

These comments indicate the value of sharing the video footage in a formal way. When this happens, the music therapist can interpret and explain what is happening and also benefit from the parent/carer or other professionals' observations.

There were a total of nine comments included in the theme communication. One comment referred specifically to the question of whether interpreters were available where needed. This is an important point for the team to consider. Interpreters had been used in the past, yet are not routinely offered. Two comments identified a lack of understanding about the kinds of goals that are appropriate in music therapy, with one respondent stating that “a little more guidance from the therapist would have been helpful”.

Two comments related to the process of sharing reports and completed goal sheets, with one respondent suggesting that music therapy reports and IPs are shared more widely. Another respondent felt it would be useful to see “fully completed goal sheets with parent comments”
and said that it “would be helpful to know what parents think”. These comments show that reports are not always managed copied to people involved in the child’s care.

Three further comments related to liaison and discussion. One respondent commented that it “is difficult to schedule extra time with the music therapist” and another respondent suggested that “an opportunity to speak with another member of staff (10 mins?) about how therapy is going (privately and confidentially) would be helpful”. These comments were contrasted by the third which suggested that there was time for “catch-up conversations, emails, filling out student profiles all help contribute to these (setting goals)”.

**Category: 'process links to progress'

This category has just one theme in it, helps you to see progress, that revealed how the goal setting and review process helps to show progress. Part of the research question asked how the goals relate to the therapy process. The following comments therefore are relevant to this part of the question as they show how progress is identified and communicated.

Eleven comments were included in this theme. The comments suggested that the existing process of goal setting and review related to progress within therapy and that the reporting tools (written reports, video, goals and objectives) communicated this well.

Respondents commented on the review process helping to keep track of progress: “easy to track progress of the student” and “shows how my son is going”. Three respondents commented specifically on the written documents and that these helped “to remind you of how far the child has come since they (the goals and objectives) were set”. Another comment suggested that the success criteria could be used to “gain good knowledge of what the student is actually able to do”. Another respondent seemed to concur with this view and stated: “not that easy to quantify progress usually with these ‘airy fairy’ qualities but the success criteria makes it easy to judge progress”. This suggested that having specific observable success
criteria relating to the client could be helpful in increasing understanding about what the child can do.

This category revealed some encouraging and positive feedback regarding the way in which the review process helped to show progress. There were no specific improvements or refinements that emerged from this category.

**Category: 'individualised goals that relate to the child'**

This category includes comments that relate to the way in which the goal setting and review process is individualised and relates directly to the child's needs: goals are not predetermined/child helps set the goals; relationship/engagement; and student centred/relate to child's needs/individualised.

Five comments are included in the theme *goals are not predetermined/child helps set the goals*. One respondent stated that “goals aren't pre-determined or rigid” and saw this as a strength of the process. Two other comments concurred with this with one respondent stating that therapy is “the child's programme – acknowledge where the child is and set goals to suit”.

Two further comments related specifically to the goals emerging from the therapy process: “In a sense the child helps set the goals because they're based on positive interactions within therapy sessions” and “based on actual experiences with the child in therapy sessions”. These responses suggest that the emergent process of goal setting is valued as it values the child's role in therapy.

The theme *relationship/engagement* included three comments that identified “relationship based goals” as a strength of the current process. The comments suggested that relationship based goals are important and one respondent stated that “with our child, it is actually quite
difficult to set quantifiable and relevant goals. To us it is all about how much he engages during a session and how enthusiastic he is to go”.

The comments here suggested that relationship based goals are valued, but also that it is hard to set relevant goals. Although the respondent does not elaborate on what they mean by “quantifiable and relevant” it is possible that this refers to the more functional goals that are usually found in IEPs.

We were also interested in finding out how well the goals and objectives that are set relate to the client's needs. The comments included in the theme student/centred/relate to child's needs/individualised suggest that the current process enabled the therapist to assess the child's needs and set “realistic/holistic goals” and in the words of one respondent “the therapist has a good understanding of the needs of the child”.

Eleven comments were included in this theme. All the comments were positive about the way the goals and objectives related to the child with some respondents commenting specifically on the therapist's understanding of the client as an individual.

No specific recommendations for improvement emerged from this category. Rather, the comments reinforced the current process as one that related well to the individual client and allowed goals and objectives to emerge from the therapy process itself. These are viewed as strengths of the current process.

4.4.3 Summary of questionnaire findings

The questionnaire findings suggested that the existing goal setting and review process was meeting the needs of parents and professionals well. There was a great deal of positive feedback suggesting that communication was good, goals relevant and clear, and the needs of the child accurately represented in the process.
The numeric data suggested that the current process was achieving its purpose. The qualitative data added depth and richness to the numeric responses and although the overall findings suggested that the current process was satisfactory, the qualitative data revealed some areas for improvement.

The data were discussed by the team and the following points were identified with specific improvements to be implemented in the next stage of the project. The improvements are presented below under each category heading.

'Comments about process'  
The comments in this category were encouraging and suggested that we already had a process most respondents were happy with, that the process was appropriate and worked well. Some refinement, however, could be made in the following areas:

- identify the differences and similarities between Centre and Outreach report length. Are these necessary, or should we have a similar format in both settings?;
- ensure that plain English is used and that parents have an opportunity to ask questions about the report and goals sheet;
- ensure that parents/carers know they can ask the therapist for more frequent review meetings; and
- think about the ways in which we communicate the importance of the documentation (progress notes, reports, goals and objectives) procedures that support the therapy process.

'Collaboration/Supports IEP'  
The category ‘collaboration/supports IEP’ revealed some positive aspects of the current goal setting and review process. The following areas were identified as needing further
consideration by the team in order to identify whether aspects of our practice could be improved:

- how well do we communicate the nature and purpose of music therapy;
- can we provide further opportunity for parents/carers and other professionals to discuss the possibility of sharing music therapy strategies at home and school? This is not to suggest that we should always provide strategies for use in other environments, but that it should be possible for discussion to take place around whether or not this is appropriate and how it can happen;
- how can we ensure reports are copied as widely as possible;
- create a process for inviting other professionals to view a session (Centre and Outreach) where appropriate, with the parent and client's permission; and
- create a process for inviting others (parent/carer or professional) to work collaboratively in and around the session where appropriate.

'Communication and sharing'

In summary, there were many positive comments concerning parental involvement and use of video footage in this category. The following aspects were identified for further discussion and consideration regarding possible improvements:

- wider sharing of video both with family and school environment;
- providing information on the purpose and use of video footage;
- are parents/carers and other professionals encouraged to discuss the use of video footage?
- benefit of sharing video footage at review meetings (with the therapist there to interpret) may have an influence on the way in which we choose to share video footage in other settings;
- is more information needed about appropriate goals and goal setting processes?
are interpreters available where needed?;

- sharing completed/reviewed goal sheets with teachers;

- sharing of music therapy goals with other professionals; and

- do parents know how to contact therapists?

4.5 Focus group interviews

Following completion of the questionnaire analysis, two focus group interviews were held. The focus group interviews provided an opportunity to further explore the themes identified in the questionnaire analysis and to gain a deeper understanding of parents'/carers' and other professionals' experiences and thoughts regarding the goal setting and review process. To help the participants prepare for the focus group, they were provided with a short summary of the themes identified in the questionnaire analysis (Appendix F). The group interview allowed participants to reflect on one another's comments and experiences and enabled differences and similarities to be explored openly.

The interviews were recorded using a digital voice recorder. At the beginning of each group interview participants were asked to identify themselves for transcription purposes; however, all identities were concealed through the use of codes. Where other people's names were used, such as the name of a child or therapist, these were removed and replaced with NAME or THERAPIST'S NAME.

The focus group interviews were transcribed to allow a qualitative analysis of responses. An initial analysis of each transcript took place with relevant points being highlighted. The highlighted transcripts were passed to participants for review. Both focus groups gave permission for the transcript to also be sent to those who had given their apologies. These people were invited to add their comments. One person responded and the comments were subsequently added to the analysis.
4.5.1 Sampling and group composition

An invitation to volunteer for the focus group interview was sent with the questionnaire. A total of 13 people volunteered for the focus group: eleven parents/carers and two professionals. There was no selection process as the numbers were small enough to enable two focus groups to take place.

The volunteers were offered a choice between two focus groups. From the original list, nine people agreed to attend the groups. However, at the time of the interviews a further three people gave their apologies. Table 4.5 shows the number of participants in each group and the coding used to identify each participant in the transcript.

Table 4.5 Focus group participants

<table>
<thead>
<tr>
<th>Focus group</th>
<th>Participants</th>
</tr>
</thead>
</table>
| Focus group 1 (F1) | 3 parents/carers (P1–3)  
|               | 1 other professional (Prof 1)                     |
|               | Apologies from two parents/carers                 |
| Focus group 2 (F2) | 2 parents/carers (P4-5)  
|               | Apologies from two parents/carers                 |
| Additional written information provided in response to focus group transcript | 1 parent/carer (P6) |

4.5.2 Focus group analysis and findings

A thematic analysis of the transcripts was completed with the aim of identifying statements that corroborated or contradicted the questionnaire findings. Both transcripts were personally typed by the lead researcher which provided intimate knowledge of the contents of the interviews. Each transcript was then read in its entirety and significant statements were highlighted. In addition to identifying corroborating or contradictory statements, any new ideas were also identified.

The focus group findings are presented under the categories that emerged in the questionnaire analysis in order to clearly link the two sets of data. There were no comments relating to the category process links to progress, therefore this is not included.
Focus group category: 'comments about process'

There was general agreement that parents/carers appreciated the review process and felt it was important. One participant (P3) stated that it was difficult to attend review meetings during working hours and school holidays and made the suggestion that review meetings could be held in the evening.

There was little discussion regarding the length of report, with the exception of one participant commenting “I like that yours is short and sweet and it doesn't go on and on” (P5). Another participant (Prof 1) commented on the difference in length between the Outreach and Centre reports and felt that “the length of the report is adequate for the fact that the children are in a group situation”. This participant also made some suggestions about incorporating photographs into reports. While the reports were valued by the participants, there was also a consensus that regular verbal feedback was important: “I think I get more out of talking to the therapist after the session than sometimes this goal setting and everything because I know that she's working on those in her session in a therapist way and its really good that she gets around the problems in so many different ways you know and her spontaneity to do that is really good” (P5).

Of particular interest was discussion about the frequency of review meetings with opinion being divided in both focus groups. One participant specifically identified wanting less frequent review meetings while another participant wanted more frequent meetings. On further discussion, these views seemed to be linked specifically to the process of gaining feedback immediately following the session. Where participants were able to have feedback from the therapist immediately following the session, the need for frequent review meetings was lessened. Conversely for one participant, where feedback following the session was not possible, a lack of knowledge about what was happening in therapy was experienced.
Another participant identified the importance of having a review following the initial shorter assessment period “when you really need it at the start” (P6). Frequency of review meetings was also linked to cost where one participant would rather pay for a therapy session than a review meeting. This participant went on to say that paying for the therapist to attend the IEP meeting would be a good option. Focus group one identified the need for a balance between time spent on reporting and therapy with general agreement that reporting and attending IEP meetings for example should not impinge on the time available for therapy.

**Focus group category: 'collaboration/supports IEP'**

Within the two focus groups there were a range of experiences of collaboration. There were mixed feelings about whether the music therapist should attend IEP meetings. Several participants identified this as useful but also felt that it should not compromise the time delivering therapy. For one participant, the music therapist's attendance at the IEP meeting was particularly valuable on many levels: “To have someone on the same wavelength especially with regards to foundational values like respect for the child, it is like having an ally in the room. Also, important as it is someone who is regularly involved with and knows the child, rather than someone who sees them every few months. They can demonstrate what is possible for the child when trust and respectful values are present” (P6).

Alternatives to the music therapist attending the IEP included one participant who had initiated the attendance of other professionals to the music therapy review meeting in order to share progress. Yet another participant had been asked by the music therapist for permission to do a school observation. These were seen as valuable options for gaining and sharing information about the child and music therapy.

Sharing information was seen as important with the professional in focus group one stating that “other therapists and teachers would learn a lot from seeing what goes on in music therapy” (Prof 1). One participant who was a parent of an Outreach client wanted more
information so they could use music therapy strategies at home and felt that the music therapist should liaise as closely as possible with other staff as “anything that could be helped to integrate it with his other learning would be fantastic” (P4). This comment was supported by the professional in focus group one who felt that music therapy “provides another activity towards the child's [IEP] goals” (Prof 1).

Participant P2 questioned the idea of whether music therapy lent itself to regular homework assignments and felt this went against the nature of music therapy. This participant also stated the value of observing the session and seeing a strategy being modelled: “modelling's always the best way to teach so I guess if I'm getting a good view, if I see what she's [the therapist] doing and if she points out specifically – this is the strategy and this is how it works and then lets me see it, then I can take that and use it” (P2).

Another participant raised the issue of giving negative feedback to the music therapist and suggested that ongoing discussion and collaboration were important in enabling this to happen.

**Focus group category: ‘communication and sharing’**

There was general agreement in both focus groups that parents were involved in the process. Ongoing discussion and regular feedback were valued: “I definitely agree with the positive comments about music therapy being very inclusive of parents, very collaborative and open to feedback” (P6); and “they listen to what you say and can make changes. Therapist has been very very good about anything I have to say she will immediately implement [it in] the next session” (P2).

One participant had a different experience where it was difficult to receive feedback following the session: “Weekly feedback after sessions doesn't work for everyone. I have no idea what's going on and it's really hard to tell me because we're already out the door. I agree
therapist is receptive but we don't actually get a lot of chance to cover a lot of ground” (P3). Another participant in focus group two also wanted more feedback: “I would love to be able to interface with you, just to speak to you. I get your notes in the notebook and that's fantastic, but it's always good to know more” (P4). This participant was the parent of an Outreach client and was able to provide a valuable perspective as someone who does not have the regular opportunity for review meetings that parents/carers of Centre clients do.

Video clips were valued by the participants as they gave the opportunity to see things with their own eyes rather than hear the therapist's interpretation. However, two participants felt it had been even more valuable to view a whole session. There was also some discussion about the possibility of including photographs in Outreach reports, particularly as parents/carers of Outreach clients have less opportunity to view video.

**Focus group category: 'individualised goals that relate to the child’**

The importance of goals being individualised and not predetermined was emphasised in the focus groups: “One of the things I really like about it is that it’s not too, the outcomes are not too defined or preconceived. They're not too specific. I like how it's based on the child's experience within the music therapy” (P1). Furthermore, there was discussion about the importance of the therapeutic relationship and flexibility to follow the child rather than a set of predetermined goals with one participant (P2) commenting that if the therapist worked rigidly to one thing, then an opportunity for growth could be missed. This was echoed by the professional in focus group one who indicated there might be flexibility in the short-term objective: “And so is there room for those objectives to change as you say working in quite a creative manner so is there room for it to be flexible?” (Prof 1).

### 4.5.2.1 New ideas that emerged from the focus groups

There were five new areas of discussion that emerged in the focus group interviews: individualised review process; tendency to not address difficulties; parents not knowing what
goals are appropriate; challenge of capturing goals and therapeutic experience in words; and narrative description in reports.

**Individualised review process**

With the importance of individualised goals already acknowledged as important, discussion in the focus group turned to the need for an individualised review process. In focus group one, the participants recognised that their experiences were all unique and that it was hard to make generalisations about how the music therapist should conduct the goal setting and review process, communicate or collaborate with others. This participant summed it up: “I think it's got to be on a case by case basis, you've seen our three experiences are all so different, so I don't think you need a set list of guidelines on what your therapist will and won't do, I think it has to be on a case by case basis on what the family needs” (P2).

**Tendency to not address difficulties**

Focus group participants valued the strength-based approach of music therapy; however, there were several pertinent comments about the tendency to not address challenges or difficulties that might be occurring in therapy. One participant commented on the tendency in review meetings to focus on progress: “everyone wants to tell me how well he's doing, and I love hearing it, but he's still autistic, there must be something otherwise we wouldn't be here” (P3). This was echoed by another participant in focus group two who suggested that showing video of challenging moments would be useful: “sometimes it'd be good to have it [the video] when he's on a bad day, when he's doing his kind of, this is a session where he's losing it and we worked on some strategies, because it's a behaviour thing with him” (P5). Furthermore, participant P6 agreed with the tendency to focus on positives in meetings at the expense of addressing challenges and stated that “I would like to hear what the therapist is struggling with, and brainstorm ideas about causes and solutions. And vice versa – say what I'm struggling with and how music therapy might help” (P6).
Parents not knowing what goals are appropriate

There was a lively discussion about parents not knowing what was expected or appropriate in terms of music therapy goals. Participant P3 suggested that more guidance from the music therapist would have been helpful and participant P2 said they understood the “big picture of what music therapy was” (P2) but not the specific skills or strategies that a music therapist might use: “We knew what we wanted globally for our son to achieve and we were trying to put together all the therapists to help him achieve those goals but for the music therapist in their unusual niche, we didn't know exactly what the appropriate kind of things were” (P2). Two participants suggested that it would be useful to have a list of goals or areas that could be addressed in music therapy to help guide parents in the process of goal setting.

Challenge of capturing goals and therapeutic experience in words

The challenges of communicating progress in music therapy using words was discussed in focus group one. Participant P1 stated: “I can't see how you can accurately capture what happens in the space of time in half an hour in words, it's just clumsy and impossible, especially with an enigma that is my child to be honest” (P1). The professional in focus group one described the value of using photographs and a narrative description (learning story) to convey an event in a session to a parent and suggested this approach could be used more frequently, especially where parents/carers do not have access to video footage.

Narrative description in reports

Further to the example given above of using a learning story to report on a specific event in music therapy, participant P4, who was a parent of an Outreach client, emphasised that a narrative description would be both relevant and personal: “I'm probably more interested in...a sort of narrative description...I suppose I was wanting more for his personality to come through in the final report” (P4). This is an interesting comment that relates to an increased use of the Ministry of Education's Narrative Assessment approach in Special Education settings.
4.5.3 *Summary of focus group findings*

In summary, the focus group findings corroborated the questionnaire results. The participants seemed to appreciate the opportunity to discuss the issues further. The new areas that emerged from the interviews will inform the next phase of the project.

4.6 *Documentary Analysis*

The team decided to undertake a documentary analysis of client files and a review of report samples. This was an important step in evaluating current practice and led directly into the process of identifying improvements.

4.6.1 *Client files*

*Data collection and analysis*

Data were collected by the whole research team from a total of twelve client files. Both Centre and Outreach files were analysed. Guidelines, which were informed by the effectiveness criteria described at the end of Chapter 2, were provided to guide the data collection (Appendix G). A tally was made of the number of times a document was identified in the analysis. Further analysis of the tally took place to identify trends.

*Summary of findings*

A team meeting took place to discuss the data and interpret the results. The following conclusions were reached:

1. Quantitative data indicated that each of the criteria was accounted for in the client folders that were analysed. This suggests that the existing system was fulfilling the criteria that the team decided was necessary for a high quality assessment and review system;
2. Qualitative data indicated that therapists found it easier to find some of the criteria in their own folders, but more difficult when analysing another therapist’s folder. This suggested that the system may be less transparent to an outsider; and

3. Despite some criteria being found in a number of different documents, there were major consistencies across the client folders, which indicated that there were several documents central to this information being easily available.

4.6.2 Client report samples

During the course of the documentary analysis and as a result of the questionnaire analysis which was taking place concurrently, it was decided to review report samples. We were interested in why and how our reports differed and agreed to share samples. A total of twelve reports were reviewed by the team as described in Table 4.6.

Table 4.6 Type of report samples analysed

<table>
<thead>
<tr>
<th>Type of report</th>
<th>Number of reports reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre assessment reports</td>
<td>4</td>
</tr>
<tr>
<td>Centre progress reports</td>
<td>3</td>
</tr>
<tr>
<td>Outreach progress reports</td>
<td>5</td>
</tr>
</tbody>
</table>

The reports were read by all team members and discussed in a team meeting. The conclusions are presented in Table 4.7.

Table 4.7 Conclusions of report sample analysis

<table>
<thead>
<tr>
<th>Summary of discussion</th>
<th>Suggestions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>File of sample reports</strong></td>
<td></td>
</tr>
<tr>
<td>Positive tone and focus on strengths in all reports;</td>
<td>Useful to keep as samples for therapists, especially new staff</td>
</tr>
<tr>
<td>Important to know who the report is for e.g. parent/professional audience; and</td>
<td></td>
</tr>
<tr>
<td>Need to use plain English.</td>
<td></td>
</tr>
<tr>
<td><strong>Assessment Reports for Centre clients</strong></td>
<td></td>
</tr>
<tr>
<td>Length varies: 1-3 pages (plus attached Goals sheet); and</td>
<td>Add additional heading: Summary of review meeting where the discussion and parents’ views could be summarised (rather than included in the Conclusions).</td>
</tr>
<tr>
<td>Reason for referral: amount of detail included varies.</td>
<td></td>
</tr>
</tbody>
</table>
Progress Reports for Centre clients
- Length varies: 3-4 pages (plus attached Goals sheet);
- Summary of previous report: length/detail varies, but usually concise;
- Includes parts of goals and objectives table with progress (and key) followed by comments; and
- Subheadings may be useful.

Add subheadings to report template as prompt to therapist writing report.

Progress Reports for Outreach clients
- Length varies: partly depending on school requests, from 1 (or 2) x A5 page to 2 x A4;
- Headings from Centre report template sometimes used;
- Sometimes include a photograph; and
- More recent reports tend to include parts of goals and objectives table with progress (and key) followed by comments (cf Centre reports).

School reports can use same template/ headings as Centre reports.

Also discussed the use of a general statement about music therapy (cf that used in consultation follow-up letters) as a way of informing the reader about the approach used.

Add the statement to the following documents:
- introductory letter for outreach parents/carers;
- covering letter for Centre reports; and
- All assessment reports.

4.6.3 Recommendations from documentary analysis

The documentary analysis showed that we were already meeting the majority of the criteria identified for best practice. However, our documentation of this was inconsistent and difficult to identify by someone not familiar with the client. In order to keep our processes transparent and to demonstrate that we were meeting best practice criteria, recommendations were made for reviewing several key documents to make the information more accessible and easier to record.

The review of reports highlighted the individual styles of report writing across the team and, although there were variations in style of writing, key information was consistent. The team all found it valuable to share reports and a recommendation was made to keep a folder with sample reports in that could be accessed by all staff. It was agreed this would be a useful tool for new staff members or music therapy students on placement.
4.7 Reflective journals

At about this stage in the project, the team decided to start keeping reflective journals and did so for the remainder of the project on an ad hoc basis. Originally, reflective journals were going to be used during the implementation phase. However, the team realised that it would be useful to capture their experiences of the current goal setting and review system against which to compare any future changes made. This decision was to prove valuable when it came to planning the changes for the implementation phase.

4.8 Conclusions reached during reconnaissance phase

The conclusions are presented under the headings of the three main research questions. As well as the main research questions, there was a further set of guiding questions that had been proposed at the beginning of the project:

- Is the client making progress?
- Is progress being generalised?
- What does it mean if progress is not being generalised?
- How do we measure the broader value of the session in itself and how do our video recordings contribute to this?
- Does the review system improve our practice?
- How do we use video footage to communicate to parents and other professionals?
- What do the overall reconnaissance results indicate for improvement?

The data collected through the questionnaires, focus group interviews and documentary analysis provided information relevant to the main research questions. The final question was addressed in team discussion which was critical in planning the improvements to be made during the implementation phase. At this stage, we focused on exploring the main issues that had emerged from the data rather than reviewing the data directly in relation to the guiding
questions above. We wanted to stay true to the emergent process of action research and explore the themes that emerged from the data rather than impose our own presuppositions on the data. Results for the main research questions are summarised below.

What is the purpose of the goal setting and review system?

The data collected during the reconnaissance phase helped the team to clarify the intention and purpose behind each stage of the goal setting and review system. As stated in the introduction to this report, goal setting and review of progress is an integral part of music therapy practice at Raukatauri. This process enables therapists, clients and families to understand the direction of therapy and identify progress. It provides an opportunity for the music therapist to give and receive feedback from the parent/carer and/or referrer, including sharing video footage of music therapy sessions. It also provides an opportunity for the therapist to document (in the form of a written report) the client's progress in therapy and to evaluate the emerging strengths and needs in order to plan future therapeutic intervention.

What criteria does the current research/thinking suggest about an effective goal setting and review system?

The literature review revealed an emphasis on SMART goals and objectives in music therapy for the purposes of evaluating and measuring progress. Individualised goals were highly valued, and the importance of setting goals and reviewing progress collaboratively was also mentioned within the New Zealand context. Clear assessment processes were viewed as essential to setting goals and objectives. However, a lack of standardised assessment tools within music therapy, and the challenges in devising these tools, was identified.

When establishing the effectiveness criteria against which to match the existing system, it was essential to evaluate our own responses to the evidence from the literature. Our collective experience as a team revealed dissatisfaction with the use of SMART goals for all clients. While the use of SMART goals represented a straightforward way to collect evidence of
progress and therefore efficacy of music therapy, the team found that SMART goals did not always reflect the nature of therapy for a particular client.

The team wanted a process that reflected the values and approach used at Raukatauri rather than simply adhere to a value system suggested by published articles. Therefore, when establishing the criteria, we felt that a descriptive approach to assessment, goal setting and review, better supported the individualised developmental and improvisational approach at Raukatauri. This was supported further by the questionnaire and focus group findings which revealed a preference for individualised goals that reflected values of respect and collaboration.

**How well does our current system match the effectiveness criteria established?**

The data collected in the reconnaissance phase suggested that on the whole the current goal setting and review system was working well. The questionnaire results were overwhelmingly positive and the documentary analysis revealed that we were indeed meeting the criteria established based on the literature review and the team's experience of best practice. There were however a number of improvements identified from all data sources that could be addressed during the implementation phase. These will be discussed in the next chapter.

Through a meta-analysis of journal entries, the team reflected on the guiding questions for this phase. This process clarified where we were meeting the criteria and where further improvements could be made. Table 4.8 shows reflections from the meta-analysis.

**Table 4.8 Reflections from meta-analysis of journals**

<table>
<thead>
<tr>
<th>Is the client making progress?</th>
</tr>
</thead>
<tbody>
<tr>
<td>This question concerned how well we were able to show the client's progress in the current review system. The team felt that we were able to show progress but were dissatisfied with some of the ways this was reported in the goals and reports. Journal entries showed that the current way of monitoring progress, through a predominance of</td>
</tr>
</tbody>
</table>
SMART goals and a categorisation of; ‘never, sometimes, often, always’ for scoring whether objectives were met each session, presented a frequent challenge and sometimes a source of frustration. Defining the difference between ‘short-term objective’ and ‘success criteria’ was also noted as problematic as both seemed to require observing the same ‘evidence’.

One therapist shared the experience of a parent who had commented on the difficulty of ‘categorising’ their child’s progress against defined goals.

**Is progress being generalised?**

On reflection the team felt that progress may be generalised but that we were not getting feedback about this. Although the goals and objectives template had been designed to allow space for feedback from parents, it was not being used in this way with the exception of a couple for examples where the therapist had specifically requested a staff member provide feedback on the sheet.

Journal entries showed that success criteria were confined to observable change in the music therapy setting only. The team thought it might be possible to gather more feedback on generalised progress if this was prompted at the review meeting with parents/carers or other professionals.

The team also reflected on the value of describing effective strategies in reports that could be used and adapted for use in other environments.

**What does it mean if progress is not being generalised?**

The team agreed that generalisation of progress meant different things for different people. In order to know if progress was being generalised we needed to identify what changes we were looking for and gather data to evaluate this accordingly.

**How do we measure the broader value of the session?**

With the current system, the team felt that the goals and objectives were able to capture a small part of the therapeutic process. We felt we were reporting effectively on these. However, the system did not easily allow for reporting on progress outside of these specific areas. This meant that sometimes the broader value of the session and the benefit on a client’s ‘quality of life’ for example, was not reflected in the report.

**How do our video recordings contribute to parents/carers/other professionals understanding of the broad value of the sessions?**

The team felt that video recordings and enabling sessions to be viewed was an important way of sharing what happens in music therapy. This was supported by the reconnaissance questionnaire findings. However, the team were also interested in whether video could be used more effectively.

**Does the review system improve our practice?**

In general, it was felt that the current system helped the therapist to maintain awareness of the focus of therapy. However, the meta-analysis revealed concerns that the emphasis on SMART goals might impede the improvisatory nature of therapy and interrupt the therapist in meeting the client’s
needs.
During team discussion it was useful to hear that colleagues were also feeling limited by the progress key on the goals and objectives sheets and that SMART goals were not deemed appropriate for all clients.

<table>
<thead>
<tr>
<th>How do we use video footage to communicate to parents and other professionals?</th>
</tr>
</thead>
<tbody>
<tr>
<td>This varied amongst therapists. The ways in which video footage was used include:</td>
</tr>
<tr>
<td>- Sharing footage in six monthly review meetings</td>
</tr>
<tr>
<td>- Inviting parents to view additional footage as necessary</td>
</tr>
<tr>
<td>- Inviting parents/professionals to observe a live session (this happened infrequently)</td>
</tr>
<tr>
<td>- Preparing edited highlights on DVD/CD to share with parents/carers and other professionals</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What do the overall reconnaissance results indicate for improvement?</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Changes to documentation were required.</td>
</tr>
<tr>
<td>- Inviting parents/carers/professionals to view more footage, either live or edited, would be likely to improve their understanding of the therapeutic process and progress towards goals as well as strategies being employed.</td>
</tr>
<tr>
<td>- More prompts for therapists to discuss goals and offer guidance for parents/carers in review meetings were needed.</td>
</tr>
</tbody>
</table>

4.9 Conclusion

This chapter has presented the process of data collection and analysis that occurred during the reconnaissance phase. Overall the findings were encouraging, particularly the questionnaire analysis which suggested a high degree of satisfaction with the existing process. On close examination however, there was still a need to refine the current goal setting and review system into one that reflected the relationship based approach to music therapy used at Raukatauri. The next chapter presents the implementation phase of the project. This phase was informed by the reconnaissance phase findings and aimed to identify, prioritise and implement the changes needed to refine the goal setting and review system.
CHAPTER 5 IMPLEMENTATION PHASE

5.1 Introduction
Following the data collection and analysis of the reconnaissance phase, the process of identifying the changes the team wished to make to the goal setting process began. These changes or improvements were implemented during the period December 2010 to the end of January 2011.

The guiding questions for this phase were:

1. How can we prioritise and plan for the implementation of improvements to the system?
2. How can we track implemented improvements to our goal setting and review system?

There were a range of improvements, some of which had a less direct impact than others. This chapter begins by describing the process of identifying the changes to be made. The implementation of these changes is then presented along with the reflective process in which the team engaged to track the effect of the changes which would inform the subsequent evaluation phase.

5.2 Process for identifying improvements
The process of identifying improvements was a major stage in the research process. The purpose was to look at all the data from the reconnaissance phase and identify the areas where we felt changes could be made. This match analysis was guided in part by the questions that had been posed at the beginning of the project. However, due to the emergent nature of action research, it was important that any changes arose directly from the research data and were not imposed on it by our attempts to answer pre-set questions.
The research team engaged in a series of discussions (both face to face and via email) to analyse the data, identify and prioritise changes to be made in the next phase of the research project. Appendix H shows the plan and time-line for this process. It was a practical decision to have a series of discussions that could fit in with the team's workload. However, on reflection, this process also allowed space for our thinking to develop. The two stages of developing the changes are presented below and are followed by a more detailed account of the agreed changes that were implemented.

5.2.1 Stage one – issues from the questionnaire

A list of issues raised from the questionnaire analysis formed the first stage of this process. After reading through the summary report of questionnaire analysis, the team met to identify areas for improvement as suggested by the narrative comments made by those who returned the questionnaire. Table 5.1 shows the action points the team formulated as a result of identifying areas for improvement. These evolved from meetings on 30 September 2010, 20 October 2010 and subsequent email correspondence.
Table 5.1 Action points emerging from questionnaire analysis

Comments about process

<table>
<thead>
<tr>
<th>Issue raised from questionnaire analysis</th>
<th>Area of improvement</th>
<th>Action</th>
<th>Who</th>
</tr>
</thead>
</table>
| Identify the differences and similarities between Centre and Outreach report length. Are these necessary, or should we have a similar format in both settings? | Team reviewed a selection of reports as part of the documentary analysis | 1. All reports (Centre and Outreach) to use same template/headings.  
2. Keep file of samples for staff reference and staff induction.  
3. An additional heading: **Summary of review meeting** where the discussion and parents’ views could be summarised (rather than included in the Conclusions)  
4. Consider using subheadings in progress reports – add prompts to template | CM   |

| Need to improve clarity of reports and goals and objectives for some parents Ensure that plain English is used and that parents have an opportunity to ask questions about the report and goals sheet. | Team to ensure that plain English is used in all communications. Therapist to be aware of the audience for whom they are writing and that language may be different for a medical professional and a parent where English is a second language for example. | Update Policies and Procedures document to reflect this and include reference to website: [http://www.plainenglish.org.nz/rachels-checklist.php](http://www.plainenglish.org.nz/rachels-checklist.php)  

| Requests for more frequent reviews. | 1. Ensure that parents/carers know they can ask the therapist for more frequent review meetings.  
2. Therapist to discuss frequency of reviews in the review meeting. | 1. Add a sentence to the covering letter for reports stating that parents can request an earlier review.  
2. Add prompt on Review Planning Sheet | CM   |

RT
Think about the ways in which we communicate the importance of the documentation (progress notes, reports, goals and objectives) procedures that support the therapy process (in relation to comments about cost).

| 1. Therapist may have client folder with them in review meeting. |
| 2. Therapist may attend IEP review if appropriate. |
| 1. Add to Policies and Procedures under guidelines for review meetings. |

### Collaboration

| How well do we communicate the nature and purpose of music therapy? | Ensure all introductory letters and reports have explanatory paragraph about music therapy. | 1. Statement about music therapy to be added to assessment report template. |
| Can we provide further opportunity for parents/carers and other professionals to discuss the possibility of sharing music therapy strategies at home and school? This is not to suggest that we should always provide strategies for use in other environments, but that it should be possible for discussion to take place around whether or not this is appropriate and how it can happen. | Therapist to consider including strategies they have found useful in the music therapy context in the conclusion part of the report. For example: strategies that have aided engagement, sustained attention and evoked eye contact. These may be more about quality of approach and engagement rather than specific activities. | 1. Add to Policies and Procedures under guidelines for report writing. |
| Copying reports and goals and objectives sheets as widely as possible. | Therapist to ensure they ask at the review meeting for permission to copy reports to other people involved. | Add to checklist on Review Planning Sheet |
| Inviting other professionals to view a session (Centre and Outreach) with the parent and client’s permission. | 1. Therapist to ensure that parents know they can request an observation on behalf of a person involved in the child’s care. 2. Therapist to suggest an observation where they think it might be useful. | 1. Add to checklist on Review Planning Sheet. |

CM

RT
<table>
<thead>
<tr>
<th>Inviting others (parent/carer or professional) to work collaboratively in the session.</th>
<th>Therapist to consider whether working collaboratively will support the therapeutic goals and objectives when reviewing the client’s progress.</th>
<th>Add to Policies and Procedures under guidelines for review.</th>
<th>CM</th>
</tr>
</thead>
</table>
| Inclusive process | Therapist to inform parents that they may invite other family members and professionals working with their child to the review and request that they inform the therapist prior to the review meeting if others will be attending. | 1. Add sentence to review appointment letter informing parents of this.  
2. Add to Policies and Procedures under guidelines for review meetings that therapist can verbally encourage parents to invite others. | CM CM |

**Communication and sharing**

<table>
<thead>
<tr>
<th>Wider sharing of video both with family and school environment.</th>
<th>Therapist to be aware of making video available where appropriate.</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>What information do we provide about the purpose of and use of video footage?</td>
<td>Check Centre documentation regarding reasons for/use of video to ascertain whether the policy and rationale are clear.</td>
<td>Check information on contract and in Policies and Procedures.</td>
<td>CM</td>
</tr>
<tr>
<td>Do we encourage parents/carers and other professionals to discuss the use of video footage?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| The benefit of sharing video footage at review meetings (with the therapist there to interpret) may have an influence on the way in which we choose to share video footage in other settings e.g. IEP meetings. | Continuum of preferred process:  
- Therapist presents footage at review meeting with time for in-depth discussion  
- Therapist prepares DVD with footage and parent presents at IEP with notes from therapist  
- Therapist prepares DVD with footage and notes that is shown at meeting in the therapist’s absence |  |  |
<table>
<thead>
<tr>
<th>Topic</th>
<th>Details</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>More information at start of therapy about appropriate goals and goal setting process.</td>
<td>Goal setting and asking parents for their hopes and expectations to always be done at consultation meeting. Therapist to identify issues or changes parents/carers would like to see during assessment stage and at assessment review meeting. Therapist then assesses whether this issue can become a goal or focus area to be addressed in music therapy.</td>
<td>CM</td>
</tr>
</tbody>
</table>
| Communicating regularly with parents/carers.                         | 1. Centre clients: where the parent/carer does not bring the child to weekly sessions, therapist should discuss at the review meeting how to maintain regular contact between reviews.  
2. Outreach clients:  
   a. Ensure parents know how to contact therapist  
   b. Therapist to communicate directly with staff or parents regarding specific issues  
   c. Use home/school notebooks  
   d. Ask TAs/staff to communicate where appropriate | CM     |
| Are there interpreters available where needed?                       | 1. Ensure parents know they can request an interpreter if necessary.  
2. Ensure therapists know they can suggest the use of an interpreter if necessary. | CM     |
| Sharing completed/reviewed goal sheets with teachers.                | Ensure reports and goals and focus areas are shared as widely as possible.                                                                                                                                 | CM     |
| Sharing of music therapy goals with other professionals. | 1. See earlier comment about copying reports as widely as possible.  
2. Therapist to ensure they request IP/IEPs or other therapy goals from parents or school to help inform planning of MTh goals. | 1.  
2. Add to checklist on Review Planning Sheet | CM |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>One person suggested making available the opportunity to talk privately with another member of staff.</td>
<td>Is this already covered by the covering letter that is sent with reports?</td>
<td>Check the covering letter.</td>
<td>CM</td>
</tr>
<tr>
<td>Additional points that emerged from discussion</td>
<td>Therapists are reminded that their unique assessment of and intervention with clients is as valid as those conducted by other professionals.</td>
<td>All points: Policies and Procedures to be updated under filing guidelines.</td>
<td>CM</td>
</tr>
</tbody>
</table>
| Client filing guidelines | 1. All correspondence (in and out) to be entered in progress notes e.g. \textit{01.01.01 report received from SLT. Filed in correspondence.}  
2. Review Planning Sheet to be filed correspondence and reports section.  
3. Copy of goals and objectives (table) to be filed with report in correspondence not with measuring sheets. | --- | CM |
5.2.2 Stage two – meta-analysis

A further team discussion (24/11/10) provided an opportunity to reflect on a meta-analysis of the team's reflective journals. The aim of this team discussion and the meta-analysis of journals was to bring together the various data sets from the reconnaissance phase along with the team's reflections regarding their practice. This was a vital step in the process of identifying the changes to be implemented. This discussion addressed a further series of issues and questions including the following, some of which match to the original guiding questions set at the beginning of the project:

- Raukatauri policy on viewing video;
- How do we know if outcomes are transferred to other settings?;
- Individualised monitoring sheets;
- Writing goals and objectives;
- Use of progress key – how do we define each step?;
- What counts as evidence? How do I know?;
- Who is the goal for?;
- Do goals reflect child's enjoyment?; and
- Transparency regarding approach being used in therapy.

Table 5.2 shows the discussion document used by the team to identify the change or improvement to be made and the accompanying action.
Table 5.2 Discussion document re: improvements to be implemented

<table>
<thead>
<tr>
<th>Issue/question</th>
<th>Area of improvement/change identified</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Policy on observing sessions/sharing video</strong></td>
<td>Useful question to ask is: Who does it serve?</td>
<td>Policy for observation and sharing video to be reviewed.</td>
</tr>
<tr>
<td>Feedback from questionnaire and focus group suggests that parents/caregivers</td>
<td>Is the observation or video sharing for the benefit of client, family, therapist? Does it put anyone at risk?</td>
<td></td>
</tr>
<tr>
<td>would like more access to video of sessions. However as a team there are</td>
<td>For families where observing regular sessions and sharing video is helpful, we can plan for regular</td>
<td></td>
</tr>
<tr>
<td>concerns about not setting a precedent for future work. There may be clients</td>
<td>observations to take place.</td>
<td></td>
</tr>
<tr>
<td>where it is not appropriate to share video or allow an observation. We</td>
<td></td>
<td></td>
</tr>
<tr>
<td>need to maintain the right to advocate for the child's right to privacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>especially where emotional issues are concerned. How do we decide and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>communicate clearly our decision to parents/caregivers to share or not</td>
<td></td>
<td></td>
</tr>
<tr>
<td>share video or to allow an observation or not?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>How do we know if outcomes are transferred to other settings?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents/caregivers rarely complete the comments section on the goals and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>objectives template. What other ways could we get their feedback? Could we</td>
<td></td>
<td></td>
</tr>
<tr>
<td>have a section on “evidence” that we complete together in the review meeting?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Monitoring sheets</strong></td>
<td>Guidelines for using monitoring sheets to include examples of different ways they have been used.</td>
<td>Team to provide examples. Claire to update P+P.</td>
</tr>
<tr>
<td>Therapists are already creating individualised monitoring sheets depending on</td>
<td></td>
<td></td>
</tr>
<tr>
<td>the goals. These might include a rating system related to qualitative outcomes,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a yes/no answer, or other measure. Team agreed that it is useful to adapt the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>sheets in this way to ensure they are relevant to the goals and objectives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>that have been set.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Writing goals and objectives</strong></td>
<td>Folder of examples to be available for team.</td>
<td></td>
</tr>
<tr>
<td>Team agreed that sharing examples of goals and objectives is useful. Also,</td>
<td>Examples to include both SMART and broad objectives.</td>
<td></td>
</tr>
<tr>
<td>remember that useful examples of goals can be found in the IMTAP and SCERTS</td>
<td>Might be useful to state the overall intention/direction of therapy and that goals will guide this</td>
<td></td>
</tr>
<tr>
<td>for those on the autistic spectrum. Objectives might be SMART, but do not</td>
<td>process but won't be adhered to rigidly as this can also limit the potential of the client to grow</td>
<td></td>
</tr>
<tr>
<td>have to be. A useful guideline is that if the therapist can identify clear</td>
<td>within the therapeutic relationship.</td>
<td></td>
</tr>
<tr>
<td>criteria to change, then a SMART objective may be useful. If clear criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>cannot be identified, then a broader objective will be more appropriate.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Use of progress key – defining each step
Team felt that this was important at the reporting stage. Further discussion regarding consistency may be necessary. The Goal Attainment Scoring system may be useful here too which can help identify whether progress is as expected, below or above expectation.

<table>
<thead>
<tr>
<th>What counts as evidence? How do I know?</th>
</tr>
</thead>
<tbody>
<tr>
<td>The following data can be gathered for evidence of progress towards goals:</td>
</tr>
<tr>
<td>1. Data from monitoring sheets</td>
</tr>
<tr>
<td>2. Data from video indexing</td>
</tr>
<tr>
<td>3. Feedback and observations from parents/caregivers and other professionals</td>
</tr>
</tbody>
</table>

Team discussed the way in which evidence is presented and decided that the report template could be modified to identify the evidence more clearly.

<table>
<thead>
<tr>
<th>Who is the goal for?</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is important that the goals are designed to reflect the child's needs. Thought needs to be given to the ways in which the therapist, parent and other professionals impose their own expectations on the child. Nevertheless, the parents' expectations provide a useful reference point for the therapist to work towards, especially with a client group who are not able to articulate their own goals.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do goals reflect the child's enjoyment?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enjoyment may be identified by the parent as a valuable outcome of therapy. This may relate to Quality of Life and should be regarded as a valid goal or objective.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transparency regarding therapeutic approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist to be conscious of the therapeutic approach/method/technique they are using to work towards particular goals. This will of course vary with each client, but the therapist should be able to state the theoretical underpinning, e.g. therapist directed turn-taking to improve concentration; client-centred approach to develop motivation, confidence and capacity to initiate interaction.</td>
</tr>
</tbody>
</table>

An unexpected outcome of this meeting was the identification of a set of points that underpin the approach to music therapy at Raukatauri. The process of defining these underpinning features and values of our approach helped us to examine whether the proposed changes fitted with our values. The features of our approach are presented in Table 5.3 below.

**Table 5.3 Features of the approach to music therapy at Raukatauri**

<table>
<thead>
<tr>
<th>Feature</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness of the developmental stages and milestones that are essential for healthy development</td>
<td></td>
</tr>
<tr>
<td>Awareness that children with special needs may have splinter skills and unusual discrepancies between skills and deficits. Recognition that sometimes it can useful for children to go back and re-learn skills they have skipped over.</td>
<td></td>
</tr>
<tr>
<td>Recognition that sometimes the special skills a child has need to be developed in their own right.</td>
<td></td>
</tr>
<tr>
<td>A client-centred approach and giving choices is important for motivation, developing agency and a sense of self. A client-centred approach also supports the individual to reveal more of themselves.</td>
<td></td>
</tr>
<tr>
<td>An understanding of psychodynamics is important to gain a holistic view of the child and their needs. Within this framework, all behaviour is seen as communication and the therapist pays close attention to their innate and intuitive responses to the child in order to gain insight.</td>
<td></td>
</tr>
<tr>
<td>A music-centred approach is important as it emphasises the universality of the creative process. Music is a human endeavour and is accessible to all as a form of self-expression and communication.</td>
<td></td>
</tr>
</tbody>
</table>

Finally, the discussion centred on the need to revise the goals and objectives template. Several issues were identified relating to the original document. Several team members felt that the *success criteria* were sometimes confused with the *short-term objective* which created a lack of consistency in our goal setting. The team were uncomfortable with the use of the phrase *success criteria* as it did not reflect the strength-based, improvisatory nature of our approach at Raukatauri. There was also a tension around a particular behaviour being identified as ‘successful’ that did not fit with the philosophical underpinning of working in a psychodynamically informed, client-centred way where all behaviour is accepted as communication to be received and understood within a context.
On a practical level, there were several parts of the goals and objectives template that did not work very well. The comments section was rarely completed spontaneously by parents/carers despite therapists sending out goal sheets prior to review and asking for feedback. The team also wanted a section on the template where evidence of progress towards goals could be noted. Furthermore, we wanted a section where areas for development that arose outside of the goals could be noted. Although these were practical changes to the document, there was a deeper philosophical influence here regarding the questions ‘what is knowledge?’ and ‘how do we know?’ We wanted to create a template that could be used to show multiple ways of knowing that progress was being made. This might include: evidence from video footage of the music therapy session; a change noted by a parent/carer or other professional; a narrative of an interaction in the session; and sometimes a measure of progress relating to a rating or scale put in place by the therapist. We wanted to acknowledge that progress was sometimes intangible because as one parent stated in the focus group “I can't see how you can accurately capture what happens in the space of time in half an hour in words, it's just clumsy and impossible, especially with an enigma that is my child to be honest” (P1).

5.3 Implementation plan

The implementation of changes was prioritised into three stages. First, changes were made to our goal setting and review documents where necessary. Second, the team carried out their scheduled review meetings with parents/carers during the Term 4 (T4) break. It was planned to implement the changes as part of our usual practice and so the review meetings were scheduled as normal for both six-monthly progress reviews and assessment reviews. Third, changes to the Policies and Procedures document were made during January 2011.

In order to track the changes made, the following plan was put in place:

1. Team members kept reflective journals during the process of planning goals, review meetings and report writing;
2. Parents/carers who received a written report during this period were informed of the changes made to the system and invited to give feedback; and

3. A check-list of changes to be made to documentation was made to ensure all changes were completed.

5.4 Implementation actions

For the purposes of this report, the actions that were implemented have been grouped into several sections presented below. These are: changes to goal setting and review documentation; changes to related documentation; changes to review meetings; and changes to Policies and Procedures document.

5.4.1 Changes to goal setting and review documentation

There were several areas for improvement that related to the goal setting and review documentation with changes made to the following documents: review planning sheet; goals and objectives table; report template; covering letter for reports; and monitoring sheet for goals and objectives. The changes are described below.

Review planning sheet: From the documentary analysis, the review planning sheet was identified as a key document that therapists used during this process. It was used in the planning stages, during the review meeting with parents and finally at the end of the process as a check-list that all necessary reports and documents had been completed and filed. The main changes to this document were as follows:

- more space to identify relevant video footage;
- prompts to ask parent/carer for feedback, including thoughts and concerns about music therapy;
- more space to note discussion about goals;
- prompts to discuss frequency of review meeting and raise issue of closure;
• prompt to request IEP report and date of next IEP which would lead to whether or not it would be appropriate for therapist to attend;
• space to identify distribution list for report; and
• other reminders to check whether observations are appropriate and if more communication is needed between review meetings.

The changes made to the review planning sheet addressed issues in all categories of the findings from the reconnaissance phase. Appendices I and J show the original and revised documents.

*Goals and objectives table:* Data from the reconnaissance phase revealed that participants in general liked the layout of reports and the goals and objectives table. Feedback from the questionnaire and focus groups also revealed a strong preference for individualised goals that emerged from therapy. In order to reflect broader focus areas, several changes were made to the template.

The title of the document was changed to ‘Goals and focus areas’, which gave more scope for therapists to include broad focus areas and not just SMART objectives. The *success criteria* section was removed as it often caused confusion. Instead of *success criteria*, therapists could use the space titled *short-term focus* to identify changes they might expect to see in therapy. Sharing *strategies* was identified as being important by participants and this section of the table was retained. The *parents/carer's comments* section was removed and it was decided to focus on gathering feedback in face to face meetings or by asking more specific questions.

We also added guidelines to the template to help therapists in the goal setting process. These guidelines emphasised that goal setting was an individualised process and that for some clients and some goals, the use of a SMART objective and a measure of progress might be appropriate and for others, a broader focus area was more appropriate. Finally, the layout of
the template was re-designed to make it compatible with the report template.  This would enable therapists to transfer information from one document to the other more easily. Appendix A shows the original goals and objectives table and Appendix K shows the revised goals and focus areas table.

Report template: Once the goals and objectives table was revised, the report template also had to be revised to reflect these changes. The team agreed that the written report was an important document to inform parents/caregivers and other professionals involved in the child's care about progress in music therapy. Although our reports were well received there were a number of areas that we felt could be improved. We wanted to include a section in the report where evidence of progress could be clearly identified. Although descriptions of progress were included routinely in our reports they were not labelled as such. By labelling these descriptions as ‘evidence’, we also hoped to show that qualitative evidence was as valid as quantitative measures. It was also decided to include a section where areas for development that arose outside of the goals and focus areas could be noted. Finally, a sub-heading titled “summary of review meeting” was added. This enabled us to include discussions that occurred in the review meetings in an appropriate place, rather than under the “conclusions” section. Appendices L and M show the original and revised report templates.

Covering letter for reports: Changes were made to the covering letter sent with reports. In this letter, parents were advised that they could request an earlier review meeting if required and the process for ending therapy was also reiterated.

Monitoring sheet for goals and focus areas: This document was changed to match the format of the goals and focus areas table. It was decided to include notes on the template that would provide guidance for completion. A box titled “evidence” was included with a note that this could include a quantitative or qualitative measure.
5.4.2 Changes to related documentation

Confirmation letter for assessment sessions: An introductory paragraph about the nature of music therapy was added to the letter confirming a client's assessment sessions. A sentence outlining the importance of the review meeting was also added to this letter.

Introductory letter for Outreach clients: The same introductory paragraph about music therapy was added to this letter template along with a clear invitation to contact the therapist with any queries or feedback.

5.4.3 Changes to review meetings

The changes to review meetings were less overt than the changes to our documentation. The research process had required the team to engage in sustained enquiry. The experience of looking critically at our practice and identifying areas for improvement meant that we were more aware of these areas when meeting with parents/carers to review progress. The revised review planning sheet was used in review meetings during the implementation phase. Another change at this time was that more parents were offered the opportunity to view a whole session prior to attending the review meeting. This change relates to the comments about communication and sharing from the questionnaire and focus group data.

5.4.4 Changes to Policies and Procedures document

As a result of changes to our process, the Policies and Procedures document required updating. This was a relatively simple process and was done as part of the annual review of the document.

5.5 Reflexive process

This section briefly describes the two aspects of the reflexive process that was put in place at the end of the implementation phase. This involved journaling by the research team and the designing of an evaluation questionnaire for parents/carers.
5.5.1 Reflective journals

Each team member kept a reflective journal and was encouraged to write in it when engaged in any aspect of the goal setting and review process. This included: preparation for review meetings; writing goals and reports; and reflection following a face to face review meeting.

The team were asked to do a meta-analysis of journal entries every three weeks. This technique was put forward by Eileen in a training session and would aid data collection and analysis in the evaluation phase. Table 5.4 shows the guidelines for journaling.

Table 5.4 Guidelines for journal meta-analysis

<table>
<thead>
<tr>
<th>When</th>
<th>What</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regularly</td>
<td>Team members to make journal entries.</td>
</tr>
<tr>
<td>Every 3 weeks</td>
<td>Use the following questions to analyse your journal entries (meta-analysis):</td>
</tr>
<tr>
<td></td>
<td>• What are the trends/shifts in my thinking?</td>
</tr>
<tr>
<td></td>
<td>• What are the trends/shifts in my emotions?</td>
</tr>
<tr>
<td></td>
<td>• What are the trends/shifts in my responses?</td>
</tr>
<tr>
<td></td>
<td>• What are the trends/shifts in my practice?</td>
</tr>
<tr>
<td></td>
<td>• What’s changing?</td>
</tr>
<tr>
<td></td>
<td>• What’s becoming clearer?</td>
</tr>
<tr>
<td></td>
<td>• What’s becoming less clear?</td>
</tr>
<tr>
<td></td>
<td>• What “aha moments” have there been?</td>
</tr>
<tr>
<td></td>
<td>Write the analysis in the blank third of the page</td>
</tr>
<tr>
<td>Jan 2011</td>
<td>Summarise the meta-analysis in a couple of paragraphs</td>
</tr>
</tbody>
</table>

5.5.2 Feedback from parents/carers

An important part of the reflective process was gathering feedback from parents and carers.

All parents/carers who received a written report during the implementation phase were informed of the changes made to the system and invited to give feedback. This was part of the usual Raukatauri evaluation procedure which involves an evaluation form being sent with every report.
In addition to inviting feedback through the evaluation forms, a questionnaire was distributed to this group of parents/carers asking for specific feedback about the changes. This will be discussed further in the next chapter.

5.6 Conclusion

This chapter has presented the changes that were made to the goal setting process as a result of the data analysis undertaken at the end of the reconnaissance phase. In summary, the process of implementation required a number of changes to our documentation and practice. The journals kept by the research team were important to identify changes in practice that were less quantifiable, changes in attitude or approach that had come about as a result of the implementation. This chapter has also described the evaluation procedures that were put in place to inform the next phase of the project - evaluation. Data from the evaluation phase is presented in the next chapter.
CHAPTER 6   EVALUATION PHASE

6.1  Introduction

In the third phase of the project, we evaluated how effective our implementation had been. This was an opportunity to reflect on the changes we had made to the goal setting and review system and to gather feedback from parents and carers who had experienced the changes. Evaluation data therefore came from two sources: parents/carers and the research team. The research questions guiding this phase were:

1. How can we collect data to show the impact of the improvements?
2. How can we record and publicly report on this evaluative data?
3. Can we create best practice guidelines applicable to our work at Raukatauri?

This chapter will begin by presenting the data gathered through the evaluation questionnaire. An overview of the team evaluation process will be given followed by the results. Finally, conclusions drawn from both sets of data will be presented.

6.2  Data collection

The main methods of data collection during this phase were an evaluation questionnaire, individual journaling by team members and team discussion. It was our intention to hold a focus group interview. However, there were no volunteers for the focus group by the deadline and only one person volunteered after the deadline. It was therefore decided not to hold the focus group interview.

6.3  Evaluation questionnaire

The questionnaire (Appendix N) was designed to gather participants views of the improvements made to the goal setting and review process. We wanted specific feedback regarding the changes we had made to the goals and objectives table and written reports. The
questionnaire included a summary of the changes that had been made to each document. The format of the questionnaire was similar to the reconnaissance phase questionnaire which enabled the team to compare the results and see how the changes were viewed by the respondents.

6.3.1 Participant sampling

It was important that we gathered feedback from those who had received the new documents. Purposive sampling was therefore used and the questionnaire was posted or given to all parents/carers who had been sent a report and music therapy goals sheet since the improvements had been implemented.

6.3.2 Return rate

A total of 23 questionnaires were distributed and a total of seven were returned. This is a return rate of 30%.

6.3.3 Questionnaire analysis and findings

The questionnaire findings include both numeric and qualitative responses. There were insufficient qualitative data to make a thematic analysis useful, therefore the numeric data are presented with written responses that support the findings.

Part one: Music therapy goals and focus areas sheet

Respondents were asked to rate various aspects of the new goal and focus areas sheet. Figure 8 shows that all respondents agreed or strongly agreed that the sheet was well laid out and the focus areas were clear and relevant. One respondent commented that it was “good for others involved with the child to be able to glance over and get a good overview of achievements/goals”. These results are similar to those from the reconnaissance phase questionnaire.
Figure 8. Effectiveness of the new goals and focus areas sheet

Figure 9 shows that all respondents agreed or strongly agreed that they understood the strategies used and had been involved in the process of goal setting. When comparing these data with that from the reconnaissance phase questionnaire, it is clear that the respondents to the evaluation questionnaire felt more involved in the goal setting process. Increasing collaboration and parent/carer involvement in the process was an area that the team had focused on during the implementation phase. However, it is also important to note that the sample chosen for this questionnaire did not include any Outreach parents/carers which may have distorted the result here.

Figure 9. Understanding of strategies and involvement in goal setting process
Figures 10 and 11 show how many respondents liked the new layout and how many preferred the old layout. The majority of respondents stated that they liked the new layout. Two respondents strongly agreed with the statement “I prefer the old layout”. One of the respondents qualified this by saying “personally I like to see how well child's name is doing and you have taken out the progress/achieved section.”

Figure 10. Like new layout of goals and focus areas sheet

Figure 11. Preference for old layout of goals and objectives sheet
Part two: Written reports

Respondents were asked to rate the following statements:

- The report includes clear evidence of progress;
- The report is relevant and meaningful to me; and
- The report helps me understand what takes place in music therapy sessions.

*Figure 12* shows that responses in this section were all positive and indicated that the reports communicated evidence of progress. Similar results regarding whether the report is relevant and meaningful were gathered in the reconnaissance phase questionnaire. One respondent did not rate the third statement.

![Graph showing responses to written reports](image)

*Figure 12. Responses relating to written reports*

One of the changes made to the reports was the labelling of examples from the music therapy session as evidence or progress towards a particular goal. The following comment seems to support this change: “I found the most recent report I received from the therapist much easier to digest. It allowed me to better understand short-term focus and strategy in the context of the long-term goal”. Another respondent commented that “specifics are important” when asked to comment on something that was liked about the new report layout. This may
indicate that this parent/carer found it easier to identify specific areas of progress in the new report layout.

**Part three: How does setting goals relate to progress?**

This question aimed to gain an understanding of whether participants related the goal setting process to the progress made in music therapy. When planning the questionnaire, the research team had focused on the original research question of whether changes in the goal setting process improved the outcome for the client. It was hoped that this question would elicit information about this. The responses were all positive and emphasised the way in which the goals helped to focus the therapy and increased the parent's/carer's understanding of the strategies used. The responses however did not reveal any information about whether the changes had improved the process for the client. The following quote is typical of the responses to this question: “Helps me see/understand how what happens in session relates to the goals that have been set. Helps me gauge the progress my child is making towards goals that have been set” and from another respondent: “It gives a sense of focus for something we are working on or towards that can help child’s name in many different ways”. One respondent observed that “Goal setting is a form of check-list for me, it is structured and helps to focus on long-term achievement. Quite similar to SLT and OT process”.

**Additional comments**

Respondents were given the opportunity to make further comments about the goal setting process. Five respondents took the opportunity to comment. Feedback in this section focused on the importance of viewing video and communication with the therapist which reiterated some of the findings from the reconnaissance phase questionnaire.

The importance of the review process was acknowledged, with four respondents commenting specifically that viewing video footage was an important and enjoyable part of this process: “the review process is an important part of music therapy. We all need to know how it is
going – where we are heading. I love viewing the video: goals set – achieved – strategies to improve”. Viewing video was also seen as providing “tangible (sic) examples/evidence of progress”. This comment was echoed by another respondent who stated that “being able to watch videos from previous sessions is great as I sometimes don’t realise how my actions can effect the session as well as small achievements that child’s name has made”. One person commented on the individualised process of setting goals and developing strategies: “I like that goals and strategies are adapted/updated based on my child’s progress”.

Communication was another theme with two respondents commenting specifically that communication was good and parents’ input welcome. Communication with others was also mentioned, with one person stating that “it is nice to have the link between music therapist and other therapists”. Another respondent offered a contrary view and said that “other family members, school teachers and teacher aides should also be involved somehow in the process”, indicating that this was not happening in this particular case.

6.3.4 Conclusions drawn from evaluation questionnaire

The small sample of respondents makes it difficult to generalise the results of the questionnaire data. However it is possible to draw some conclusions. Overall, the results were positive with respondents showing a high degree of satisfaction with the reports they had received. Comments about the new goals and focus areas document were encouraging and suggested that for most respondents, the changes were welcome. Two out of seven respondents expressed a preference for the old layout of goals and objectives with one person commenting specifically on the absence of the 'progress/achieved section'. It is important to note that although this section no longer appears on the goals and focus areas template, progress towards the goal or focus area is clearly marked on the report. This result suggests that it is important to go through both the report and goals and focus areas with parents and carers. The questionnaire results informed the team evaluation which is the subject of the next section of this report.
6.4 Team evaluation

There were three stages to the team evaluation process which involved team meetings and a workshop with our research advisor, Eileen. The stages were: identifying likes and dislikes of the new system and determining any issues with the changed documentation; planning evaluation questions; and a final team discussion to evaluate the impact of the changes that had been implemented.

6.4.1 Stage one – team likes and dislikes

The process used in this team discussion was essentially an unstructured plus/minus/interesting exercise as described by Fletcher, Zuber-Skerritt, Piggot-Irvine and Bartlett (2008). The team were asked to identify what they did and did not like about the changed goal setting process and to identify any areas for further discussion. This process was useful as it had an immediacy that helped the team identify the overall impact of the changes. It also reinforced the iterative nature of action research and the cycles of action, observation and reflection. Table 6.1 shows the results of this discussion.

Table 6.1 Team likes and dislikes

<table>
<thead>
<tr>
<th>Likes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A4 goal sheet – easier to cut and paste goals</td>
<td></td>
</tr>
<tr>
<td>Review Planning Sheet – like the prompts, also shows parents the planning and thought that goes into the review</td>
<td></td>
</tr>
<tr>
<td>Goals/focus areas help focus the music therapist before each session – more than before because they are clearer</td>
<td></td>
</tr>
<tr>
<td>No more confusion re: short-term objectives and success criteria</td>
<td></td>
</tr>
<tr>
<td>Bullet points for evidence is good and also being able to choose which bits to expand on in the report</td>
<td></td>
</tr>
<tr>
<td>Evidence box on goals monitoring sheet feeds into report writing</td>
<td></td>
</tr>
<tr>
<td>Review meeting – easier to formulate goals with parents/carers because of simpler process – no short-term objectives/success criteria</td>
<td></td>
</tr>
<tr>
<td>More time in review meeting spent discussing strategies</td>
<td></td>
</tr>
<tr>
<td>Printing of reports is easier</td>
<td></td>
</tr>
</tbody>
</table>
- Evidence is clearer to see in the report which may help track progress
- Evidence can be concise and easier for parents/carers to see
- Report template same for Outreach and Centre reports
- Flexibility of scale on monitoring sheet is good
- Meeting with Outreach teachers prompted by improvements
- Increased liaison and communication with other therapists – may have been prompted by review planning sheet where we are prompted to ask about copying report to others
- All review meetings are unique and our process enables us to respond to parents’ needs on an individual basis
- Communication with Outreach parents/carers has improved with therapists consistently sending out updated introductory letter – feel that we are communicating more fully the purpose and intention of music therapy

Don’t Like
- Difficult to remember to do covering letter – this prompted discussion about whether to change the way documents are organised on the shared drives and whether to group them in terms of process (e.g. assessment, closing) rather then type (e.g. letter templates, report templates)

Video
- Video is vital in showing progress and reviewing
- Viewing video and regular indexing of sessions helps with planning review and report

Reflections on research process
- Value of doing the journal and meta-analysis

Additional improvements identified
- Bottom tick box re: updating review/goal sheet, on review planning sheet needs to be removed as now redundant
- Headers/footers on report templates need to be changed to Arial
- Discussion re: which font we should use. Should it always be the same?
- Therapist to ensure spacing is consistent on finished reports and to feel free to adjust tables and spacing as necessary
- Additional row for ‘notes’ to be added to bottom of music therapy goals and focus area sheet
- Report template – add a prompt in the evidence box for what to write
- Report template – make sure font size of progress box is consistent
- Closing report template needs to be updated to include tables for goals etc
• Discussion about reorganising computer filing to have documents grouped in terms of process not type of document – to be discussed further
• Replace sample reports in folder with new format
• Make time to share examples of reports and goals as a team
• Add to Policies and Procedures document the recommendation for music therapist to meet and discuss/plan with teachers in Outreach settings

Overall, the team were very positive about the changes that had been implemented. The team liked the changes that had been made to the documentation and felt that the process was easy to use and enabled them to present evidence of progress more clearly. The additional improvements identified served to refine the process further and ensure the documentation fitted the purpose. The team also identified the value of the research process itself, with the journaling being identified as a positive and useful experience. The team had also valued sharing written documents and agreed that making time to do this in the future was important.

6.4.2 Stage two – planning the evaluation questions

The evaluation questions took into account the original research questions and considered the impact of the changed goal setting process on the people involved e.g. therapist, client, parents/carers as well as the impact on the processes of communication and understanding of music therapy. Table 6.2 shows the evaluation questions.

Table 6.2 Evaluation questions

<table>
<thead>
<tr>
<th>Impact of changes on people:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• How has the changed/improved goal setting process impacted on the therapist?</td>
</tr>
<tr>
<td>• How has the changed/improved goal setting process impacted on parent/carer?</td>
</tr>
<tr>
<td>• How has the changed/improved goal setting process impacted on the client? (including generalisation/transfer of skills)</td>
</tr>
<tr>
<td>• How has the changed/improved goal setting process impacted on the clinical team?</td>
</tr>
</tbody>
</table>
### Impact of changes on communication and understanding:

- How has the changed/improved goal setting process impacted on the understanding of progress for caregiver/therapist/client?
- How has the changed/improved goal setting process enhanced the quality of communication between caregiver/therapist/teacher (or any variation of these)?
- How has the changed/improved goal setting process enhanced the quality of collaboration between caregiver/therapist/teacher?
- How has the changed/improved goal setting process enhanced our knowledge of generalised progress?
- How have our amended documents enhanced evidence of the validity of therapeutic intervention regardless of whether progress is generalised?
- How has the changed goal setting process enhanced the use of video recordings?

### Overall impact:

- Overall, what has been the impact of the research
  - for the clinical team,
  - for individual music therapists,
  - for clients,
  - for parents/carers, and
  - for other professionals?

## 6.4.3 Stage three – results of team evaluation

The team evaluation discussion was audio-taped and minuted by a volunteer to enable direct quotes to be captured. The results of the team evaluation are presented below. Comments from team members and journal entries are included.

### 6.4.3.1 Impact of changes on people

This section reports the team evaluation of the impact of the implemented changes on the therapist, parent/carer, client, and clinical team.

### Impact of changes on the therapist

When considering the *impact on the therapist*, the response from the team was overwhelmingly positive. The team liked the new goals and focus areas template and felt that
it was helpful, less confusing and presented evidence of progress clearly. Therapists reported that the template made formulating goals with parents easier and the use of focus areas rather than SMART goals was appropriate for short-term therapy in Outreach settings. The inclusion of strategies on the template was useful as it explained some of the techniques that were used in the session. The revised template supported report writing as the evidence was clearly identified and the monitoring sheets had more of a purpose as the therapist could use them to collect evidence rather than simply to check whether something had happened or not. One team member commented that with the previous system it sometimes felt as if evidence had to be found to support the success criteria. With the revised template, evidence was collected as it emerged and could stand alone as evidence towards the long-term goal rather than to support a hypothesis.

The team identified that with the previous system, the success criteria had been used to provide examples of what was considered progress towards the objective. The new template encouraged us to be less prescriptive about what we expected to see. However, the team also acknowledged that it was important to identify what might be expected and could be viewed as progress. This information could be included under the short-term focus with a statement such as: “I might observe...” and then examples of what might be observed that would indicate progress towards the goal.

There was some discussion about whether the new layout had increased the length of the report and some team members found that they were writing longer narrative descriptions to expand on the evidence given. It was agreed that continuing to share report samples would be useful in the future.

**Impact of changes on the parent/carer**

Feedback concerning this question had already been gathered from the evaluation questionnaire. Raising the question in the team evaluation, however, provided an opportunity
for the team to identify specific feedback they had received during review meetings or other interactions with parents/carers. It was interesting, therefore, that only one parent had commented on the changes and said that they liked the use of bullet points to emphasise progress and felt that this made it possible to see progress “at a glance”. Even on reviewing the evaluation forms, no comments had been made about the changes to the process. While the team were a little disappointed not to receive any feedback, it is also perhaps an indication that people were generally satisfied with the process which was also indicated by the evaluation questionnaire.

Impact of changes on the client

This was an interesting question and raised the issue that we had not considered how to gather data regarding the impact on the client. In fact at the outset of the project, one of the concerns was that we had no way of collecting feedback directly from our clients. We did acknowledge that the video footage of music therapy sessions played a significant role in the goal setting process and for some of our clients may represent their 'voice'. The team felt that a longer time period was needed to assess the impact of the changes on the client.

Impact of changes on the clinical team

There was general consensus among the team that the changes and the research process as a whole had increased their confidence in goal setting. The team agreed that through the rigorous process of the research, they had become more aware of their actions and understanding of goal setting. Through the process of creating something that fitted with the approach at Raukatauri, the team had become more articulate and confident. The team had noticed these changes in the way they interacted with parents/carers and other professionals when talking about music therapy, goals and focus areas, identifying the progress a particular client was making in music therapy and providing evidence of the strategies that were effective for the client. In addition the team felt that there was “less need to double check”
the goals they had written and that the process of sharing reports was useful and should be continued in the future.

6.4.3.2 Impact of changes on communication and understanding

This section reports on changes regarding communication and understanding including: understanding of progress; quality of communication; quality of collaboration; knowledge of generalised progress; evidence of validity; and use of video.

How has the changed/improved goal setting process impacted on the understanding of progress for caregiver/therapist/client/other professional?

There were several comments concerning increased clarity around the goal setting process. One team member stated: “we better understand the goals and focus areas that we are writing and therefore have a better understanding of progress” while another therapist said: “My clarity in what I expect to see as observable outcomes has aided my ability to monitor and therefore convey progress to others more effectively”.

One team member expressed concern that in the Outreach setting there was no evidence available of whether or not reports or goal sheets had been read. On further discussion, it was felt that in Outreach settings, the music therapist should seek opportunities to discuss the report and goal setting documents with the other professionals involved. This could involve asking teachers at the goal planning stage and also when sharing video at team meetings which has started to happen in one particular Outreach setting.

How has the changed/improved goal setting process enhanced the quality of communication between caregiver/therapist/teacher (or any variation of these)?

In general the team felt that as their understanding of the goal setting process was clearer, so the quality of communication had improved. The use of video was discussed and several therapists had made the decision to ask a parent to view an entire session prior to the review
meeting. This experience seemed to increase the parent's understanding and encouraged them to ask more questions and give more feedback during the review meeting. One therapist reported verbal feedback from a parent who had observed many of the child's music therapy sessions. The parent explained that the opportunity to view the sessions had enabled her to observe how the music therapist interacted with the child which had had a positive impact on how she interacted with the child at home. For this parent, viewing sessions had enabled music therapy to become more about the 'how' rather than the 'what'. The subsequent review meetings meant that parent and therapist could together discuss the 'why' of what was taking place. Another team member identified a similar experience where a parent had observed most of the assessment sessions and had tried using a similar interpersonal approach with the child at home which had been successful.

The team identified an increased focus on encouraging parents/carers to talk about their concerns and ask questions about the therapy process. The team agreed that that parents/carers do not have a list of ready-made goals to bring to music therapy, but may have concerns. It is the therapist's job to work out what is relevant and bring the discussion around to how music therapy can help. The new review planning sheet may have contributed to this happening more readily as it includes a prompt to ask for parents/carers concerns.

Communication had been enhanced by the therapist feeling more confident to ask targeted questions and the potential for asking parents to give written feedback was also raised. One team member described a modified review process that had been implemented for two parents who were unable to attend a review meeting. After giving the parents some written feedback about the client's progress, the therapist asked the parents for comments and observations and observed: “They've written much more than anticipated...Something about giving them time to do that, rather than perhaps being put on the spot in the review meeting.” The therapist also reflected that “parents want some indication about what the music therapist thinks” and that they are more likely to contribute when the therapist has shared their thoughts. The
changes therefore had increased the potential for gathering relevant feedback from parents/carers.

How has the changed/improved goal setting process enhanced the quality of collaboration between caregiver/therapist/teacher?

There were several responses to this question that identified increased sharing of strategies and discussion with staff in Outreach settings. One team member observed that she had “paid more attention to explaining strategies to Teacher Aides so they can assist in sessions more effectively”. Another team member found that having focus areas instead of SMART goals had encouraged more discussion with teachers. This discussion was seen as collaborative because it focused on “doing parallel things in the therapy room and classroom. Perhaps supporting each other, trying new things...a sense of moving in the same direction, even if not working together”.

The team agreed that changes to the review planning sheet had helped to increase the amount of contact with other therapists. The revised planning sheet includes a prompt to ask for details of other therapists involved and to agree who the music therapy report should be sent to which has had the positive impact of increasing communication and the possibility of collaboration.

How has the changed/improved goal setting process enhanced our knowledge of generalised progress?

It was acknowledged that the amount and clarity of feedback had increased, however, the team felt that there was insufficient information to answer this question. The team agreed that we might be able to gather information about changes a child had made outside of music therapy, but that it would always be difficult to attribute the change directly to music therapy. There were some clear examples where parents had benefited from observing music therapy sessions which had enabled them to interact differently with the child, which could be said to
create a more enabling environment for the child to interact. However, whether generalisation has occurred remains open to interpretation.

**How have our amended documents enhanced evidence of the validity of therapeutic intervention regardless of whether progress is generalised?**

This question was pertinent to some of our clients who are close to the end of life. One team member reported that the broader focus areas enabled more relevant goals to be set for some clients that were reaching a palliative stage of life. The therapist reflected: “a SMART goal for the child to be awake all session is not necessarily realistic, yet to have a focus area for monitoring alertness without making assumptions of progress is valuable in itself”. The focus area allowed the value of the therapeutic intervention to be realised and acknowledged the fact that for some clients, the idea of *making progress* was unrealistic.

Other responses referred to the increased emphasis on presenting evidence from music therapy sessions. One therapist commented that “the changes have encouraged us to cite changes directly from the monitoring sheets, examples from particular sessions”. The team also agreed that the use of the word ‘evidence’ was significant with one team member commenting: “I think that simply labelling a box as evidence is really important, claiming that word and showing what is valued by us, by parents, the client, by what the client does in the session and framing that as evidence”. This links to the comments from the reconnaissance questionnaire and focus groups about the value of narrative accounts of learning experiences and the importance of valuing a single account of a significant event.

**How has the changed goal setting process enhanced the use of video recordings?**

One of the major changes to the use of video was the increased invitations for parents/carers to view an entire session in preparation for the review meeting. It was hoped that this preparation for the parent/carer might reduce the amount of video footage some therapists attempted to show in a review meeting. Another team member expressed a similar view that
“the balance of talking and explaining with watching and experiencing the clip is difficult”. Watching an entire session gave the opportunity for the parent/carer to observe the “routine and foundation moments within music therapy”.

The team agreed that there had been many discussions about the use of video as a result of the research project. The need to consider confidentiality for the child is always important but in our work with young children, particularly those at an early developmental stage, the importance of involving the parent in the work was seen as significant. One team member commented “it is important not to shut [parents] out. Openness about the music therapist's relationship with the child is important, and for the child to know that the music therapist has a relationship with their parent is important”.

The changed goal setting process seemed to place more emphasis on the appropriate sharing of video across a range of settings. Therapists were more open to parents/carers viewing sessions and also agreed there was value in preparing video clips to be shared at IEP meetings for example. Sharing video footage was seen as an opportunity to share progress made within music therapy, demonstrate the strategies used and also to invite feedback on more challenging aspects of engaging or interacting with the client.

6.5 Overall impact

The team reflected on the overall impact of the research process and agreed that it had been a positive experience. It was agreed that the research process had encouraged open discussion which had a positive impact on the team and our work as clinicians. The team agreed that the workshops with Eileen had been beneficial and her comments about the strength of our team work had been valued. The new process was effectively capturing and documenting our work more clearly. For some team members, the changed review planning sheet, easier goals and focus areas sheet and inviting parents to view sessions prior to the review meeting, meant
slightly less time was spent preparing for reviews. One team member identified feeling “more confident in my collaborations with parents and professionals”.

One team member reflected that participating in the project had made her look back on the action research project she did as a student music therapist and that she had realised how much she actually knew about the methodology. For the research leader, the overall impact had been a valuable learning experience about engaging in collaborative research. This had included: encouraging participation; having clear leadership when needed; knowing when to ask for help; and how to best utilise the knowledge and expertise within the team.

At the outset of the research, we anticipated some positive changes to the goal setting process. We also hoped that the research would increase our capacity to work collaboratively. What we did not anticipate however was that the research would go to the heart of our practice and encourage us to look at the fundamental practice of music therapy and our approach to it.

6.6 Conclusion

This chapter has presented the data collected through the evaluation phase with the purpose of evaluating the impact of the changes that had been implemented. The next chapter will discuss the results of the research within the context of the whole project.
CHAPTER 7 DISCUSSION

7.1 Introduction

This study consisted of three phases of investigation: a reconnaissance phase to gather information; an implementation phase in which changes were implemented; and finally an evaluation phase to evaluate the impact of the changes that were introduced. Chapters three, four and five presented the main findings from each phase. This chapter discusses the main outcomes of each phase, summarises the impact of the outcomes on our practice and addresses the limitations of a smaller scale action research project.

7.2 Reconnaissance phase

The first set of research questions in this study concerned the nature of the goal setting and review system at Raukatauri and asked what the current thinking and research suggested about an effective goal setting and review system. The data collection methods used in this phase were:

- literature review;
- effectiveness criteria;
- questionnaire;
- focus groups; and
- documentary analysis.

The reconnaissance phase enabled the team to clarify the purpose of the goal setting and review process and to critically examine the existing process prior to identifying and prioritising improvements or changes. In clarifying the purpose of the goal setting and review process, the team agreed that the process needed to reflect the Raukatauri values: creativity; open communication; professional integrity; empathy; and respect.

Findings from the literature review revealed a variety of approaches to goal setting and review and assessment was identified as a vital precursor to any goal setting. While some reference
was made to SMART type goals (Berger, 2002; Wheeler et al., 2005), there were also references to individualised goal setting processes (Nordoff & Robbins, 2007, Wheeler et al., 2005). The literature also suggested that the type of goals and objectives used were dependent on the theoretical orientation of the therapist and the approach to music therapy (Bruscia, 1998).

The reconnaissance phase findings revealed that the clinical team believed strongly in the need to set goals and review progress collaboratively with parents/carers and other professionals. This was also supported by the literature review (Bruscia, 1998; Rickson, 2007). Central to the goal setting process was the belief that goals should be flexible, individualised and emerge from therapy rather than being predetermined. This was supported by data from the reconnaissance questionnaire and the literature review (Nordoff & Robbins, 2007; Wheeler et al., 2005; Loewy, 2000).

Findings from the reconnaissance questionnaire were encouraging. Overall, respondents felt the process was clear and relevant and particularly liked the opportunity to view video footage of sessions. The challenge of capturing the therapeutic experience in words was raised, as was the tendency at Raukatauri to focus on positives.

There were a high number of comments in the questionnaire and focus groups about video footage. This prompted much discussion among the research team about the way video footage was used and suggested that video footage was a significant tool in being able to show and promote understanding of what takes place in music therapy. It is interesting to note that video evidence was not identified in any of the literature regarding goal setting from the field of music therapy. It was referred to as a medium used to enhance learning stories for children with special needs both in early childhood settings (Erb, 2008) and music therapy (Jourdan, 2010) as part of the narrative approach to assessment described by the Ministry of Education (2009).
It was interesting to observe that the process of establishing the effectiveness criteria had raised concerns among the research team about the criteria being reductionist. This reflected the very focus of the research project. Our concerns about goal setting had included the possibility that goal setting could reduce the creative process of music therapy to a check-list that had the potential to limit the client and the therapeutic outcomes. We were seeking a process that was robust and enabled us to set not only individualised goals, but also to engage in an individualised process of goal setting with each client and their family. Recognising that each client and family have unique strengths and needs, we wanted a process that reflected these. It was also important to acknowledge that the findings from the reconnaissance questionnaire and focus group analysis revealed a high degree of satisfaction with the existing goal setting and review process. It was therefore not surprising that our improvements focused on changes to our documentation, as our documentation was the key place for recording the goal setting process as it unfolded.

The main outcomes of this phase were: the effectiveness criteria; reconnaissance questionnaire findings; focus group interview results; and documentary analysis. These informed the improvements that are discussed next.

### 7.3 Implementation phase

The research questions for the implementation phase concerned the process of prioritising, planning and tracking the implementation of improvements to the goal setting system. The literature review informed a set of effectiveness criteria against which the clinical team compared the existing goal setting process. This comparison, and the reconnaissance data, formed the basis for team decisions regarding ways in which the current system could be improved.
The process of planning improvements took place through a series of team discussions and it was clear that making changes to our documentation would enable information to be more easily accessed and accountability to be more consistently recorded. Changes were made in several places including: goal setting and review documentation; letter templates; review meetings; and the Policies and Procedures document.

The process of identifying the improvements or changes to be implemented was a crucial stage in the project and enabled the team to refine the process to one that reflected the values and philosophical underpinning of the work undertaken at Raukatauri. This required the team to identify the main features of the approach to music therapy at Raukatauri. This was an unexpected outcome, although on reflection, could have been anticipated following the literature review which clearly identified the goal setting process as being dependent on the therapist's orientation and approach (Bruscia, 1998; Wheeler et al., 2005).

During the implementation phase, the team engaged in review meetings, goal setting and report writing. The changed documentation was used for each aspect of the process and feedback was invited from parents/carers.

Although the main changes during this phase were those to our documentation, the clinical team had a heightened awareness of certain aspects of the goal setting process that had been prominent in our discussions. This heightened awareness included aspects such as: the use of video in the review process; communicating with parents/carers; gathering feedback from parents/carers and other professionals; and creating space for thinking about challenges both inside and outside the therapy room.

The main outcomes of this phase were identification of the main features of the approach to music therapy at Raukatauri and changes to our documentation.
7.4 Evaluation phase

The research questions for the evaluation phase concerned analysis of the impact of the improvements. Data was collected via an evaluation questionnaire, reflexive journals and team discussion.

Evaluation questionnaire results showed that respondents felt more involved in the goal setting process which was encouraging. However, this interpretation is made cautiously due to the small sample size and the fact that the respondents had all experienced the goal setting and review process at the Centre and did not include Outreach parents/carers or other professionals. It was interesting that the evaluation questionnaire results identified the use of video as central to the process and suggests that this is the most effective way of communicating the purpose and benefits of music therapy for those that responded.

The research team discussion and reflexive journals revealed that the new goals and focus areas template was helpful, less confusing and presented evidence towards progress clearly. The team identified an increased emphasis on sharing video across a range of settings, both at the Centre (review meetings and observation of whole sessions) and in Outreach settings (sharing video clips with staff).

Team reflection identified that describing music therapy strategies in reports and on goals and focus areas sheets, was important. This helped parents/carers and other professionals to understand what was taking place in music therapy. The removal of the success criteria was a significant change that helped to bring the goal setting process in line with the improvisational approach to music therapy at Raukatauri. Previously, the client's progress was measured in relation to the success criteria that were pre-defined by the therapist. The new system focused on collecting evidence from the session that related to the broader focus area. In this way, the template supported both intended and unintended outcomes of music therapy, which is
identified as a strength of narrative assessment as described in the Ministry of Education Guide (2009). This change meant that the therapist could focus on collecting evidence from the session that related to a particular goal or focus area rather than collecting evidence to support predetermined criteria.

7.5 The impact of the research project on clinical practice

This project originated from a desire to improve the process of describing, documenting and tracking the progress of clients in music therapy at Raukatauri. We had a system and a template that was satisfactory, but that failed to enable the real essence of the therapeutic work to be captured. The overall impact of the research has been the refinement of the goal setting and review process that reflects Raukatauri values, is individualised and fits with the developmental and improvisatory approach to music therapy at Raukatauri. The project also increased the clinical team's research capability and represented an accessible, relevant and collaborative approach to undertaking research.

The project also impacted on our practice in a number of other ways including: increased confidence; increased sharing of strategies; more effective communication and collaboration; more effective sharing of video footage; and increased openness about the challenges in music therapy practice. These are discussed below.

The team members identified that the research project had increased their confidence in the goal setting process. Therapists felt more able to articulate and communicate the purpose and intent of goal setting, with parents/carers and other professionals.

The research results showed that some parents/carers wanted more strategies to help with transferring skills to other settings. When the team discussed this, it became clear that what was needed was not necessarily a list of activities that the parent/carer or other professional could use, but a clearer understanding of the nature of the therapeutic relationship that
facilitates a response or interaction from the client. Therapists are now empowered to decide how best to convey this, whether through sharing video footage or through providing a narrative description of the strategy used. The results from the focus groups revealed that sharing information regularly and modelling how to interact with the client was a powerful way of sharing strategies.

The research promoted increased communication and collaboration in Outreach settings, including opportunities to share video footage. This impact enabled more staff to contribute to the goal setting process, ensuring that goals and focus areas are meaningful and relevant for each individual. It also increased understanding of the purpose and intent of music therapy.

There has been a significant impact on the way in which video footage is shared in our practice. Prior to the project, selected video clips were shared in review meetings with parents/carers and occasionally at IEPs or other meetings with professionals. Compilations of clips were sometimes made for parents to keep, and occasionally parents were invited to view a whole session, with a small number of parents viewing more frequently. We were aware that watching the video footage was important. However, the research project has further highlighted the significant role that sharing video footage plays in increasing a person's understanding of progress within music therapy. The team have embraced the potential for using video footage and live viewing of sessions more frequently as a communication tool. This also addressed the need for increased sharing of music therapy strategies. Not only can parents/carers and other professionals observe what the music therapist does, but, more importantly, they can observe how it is done. This process may help the parent/carer or other professional create a facilitating environment for the child in other settings which in turn may have a positive impact on the child's ability to generalise skills gained in music therapy to other settings.
While there are clear benefits to sharing video footage more widely, the team are also aware of the need for caution and therapeutic boundaries in this area. There is a need for a clear decision making process regarding the purpose of sharing video footage. Music therapy is a therapeutic process that takes place over time and is facilitated by the establishment of a trusting relationship between the client and therapist. It is necessary to balance the need to share information with the client’s right to privacy which may differ for work with different client groups e.g. children with developmental disabilities and children with mental health difficulties. Therefore, an individualised decision making process is vital and the therapist must take into account the benefit of sharing the video or inviting a parent to view a session, against the potential risk to the course of therapy.

The findings revealed that some parents found it difficult to identify appropriate goals for music therapy and wanted more guidance. This finding has impacted our practice by increasing our awareness of the issue and the need for the therapist to guide the parent through the process. We also identified the need to provide opportunities for parents to express concerns about their child's progress in music therapy. In the evaluation phase, the team gave feedback that they were more comfortable with sharing challenging moments from sessions and inviting feedback and ideas from parents about how to move forward. This impact highlights the importance of open communication and collaboration to find ways to meet the client's needs.

The research process required team members to share examples of clinical reports. This was seen as useful and the team agreed that a folder of sample reports would be a good resource. While this has not directly impacted clinical practice, it enabled therapists to compare examples of clinical writing and to support the induction of new staff and students.

The final impact of the research is the development of a set of best practice guidelines for goal setting and review at Raukatauri. These are presented in Chapter 8.
A wider impact of the project has been a significant increase in research capability amongst the clinical team. This was one of the expected outcomes of the Lottery grant. The team agreed that this project has been relevant to everyday practice. The action research methodology has been accessible and the clinical team's reflective and analytic skills (outside of the music therapy room) have increased. There are clear parallels between the action research process and music therapy which have helped the team embrace the research process so fully. It is expected that the clinical team will look for further opportunities to research their practice.

7.6 Limitations

One of the limitations of this study was the narrow scope of enquiry. As the aim of the project was to examine the goal setting and review system at Raukatauri, the team's efforts were focused on our own practice. Gathering information from other music therapists within New Zealand would have provided the potential to gain a broader understanding of how goal setting and review was being used in practice. Although a limitation, this narrow focus ensured that the team gained a deep understanding of their own practice and were able to make relevant and meaningful improvements.

A further limitation of the study was the lack of information collected about participants. During the questionnaire analysis and when planning the improvements, it would have been useful to know if the respondent was a parent/carer or other professional and if their experience of music therapy was at the Centre or through Outreach. Furthermore, the small sample size for the evaluation questionnaire presented a challenge when trying to generalise some of the findings.

This was a practice-based research project that focused exclusively on music therapy practice at Raukatauri. The project therefore was of great value to the research team, participants and
clients at Raukatauri, but may be of limited value to people external to the organisation. The location of the project restricts any generalisability of detailed findings. The broader outcomes of the project, however, are likely to be of interest to other music therapists using a similar approach to music therapy who are faced with the need to collect evidence to demonstrate progress.
CHAPTER 8 CONCLUSION

8.1 Introduction

This chapter presents the best practice guidelines that emerged from the project and an overview of the implications for future action. Finally recommendations for future research in this area are presented.

8.2 Best practice guidelines

The following best practice guidelines have emerged from the research project and reflect the thorough and robust investigation by the clinical team. The guidelines consist of a series of statements regarding the actions and thinking required for a meaningful and collaborative goal setting and review process. The guidelines will have relevance for other music therapists wishing to address goal setting in a similar way.

- Goal setting and review is a reporting tool to help describe, plan and support aspects of progress in music therapy.

- Goal setting starts with an assessment of strengths and needs. The approach to assessment is individualised and the therapist can use a range of tools to assist in understanding the client's responses. The assessment is holistic and attention is paid to the whole child, their communication, intentions, interactions, verbal and non-verbal gestures, affect and emotions, musical patterns, themes and preferences.

- The goal setting and review process is individualised depending on the needs of each client and their family. The therapist can consult with other therapists in team meetings, individual and group supervision to help decide an appropriate process for each family. Where a face to face review meeting is not possible, the therapist can consider using a modified review process where written feedback is given to the parent/carer with a request for them to add their comments.
The goal setting and review process reflects the Raukatauri values of: Creativity; Open communication; Professional integrity; Empathy; and Respect.

A collaborative approach to goal setting is used – the goals and focus areas template is a starting point and it is through discussion, planning and reflection with those involved that relevant and meaningful goals can be agreed for the individual.

Goals and focus areas stay close to the experience of the individual in therapy and are based on the client's needs not the needs of the therapist or the funding body.

The therapist uses the monitoring sheets to identify what might be viewed as progress towards a particular goal or focus area. The evidence collected on the monitoring sheet may include a quantitative measure or a descriptive, qualitative measure.

Evidence might include: evidence from video footage, a change noted by a parent/carer or other professional, a narrative of an interaction in the session and sometimes a measure of progress relating to a rating or scale put in place by the therapist.

A descriptive approach to assessment, goal setting and review enables the therapist to effectively demonstrate the client's progress towards agreed goals as well as providing the opportunity to identify both intended and unintended outcomes of treatment.

Sharing video footage is a significant way of sharing information.

Implications for future actions/recommendations
The recommendations below have been derived from areas identified in the research process as needing further enquiry.

1. The question of how clients can contribute to the goal setting and review process needs to be addressed. At the present time, some clients attend review meetings and are invited to contribute to goal setting. The research team are interested in how the client’s opinions can be voiced.

2. The best practice guidelines advocate a holistic assessment process that may draw on existing assessment tools. Further investigation is needed to identify appropriate and relevant assessment tools that can be used at Raukatauri.

3. It was not possible to answer the question regarding whether or not progress is generalised. This is an area that needs further study.

4. It was identified that a longer time period was needed to fully assess the impact of the research project on the client. This will be done over time as the clinical team continue to engage in the cycles of observation, reflection and planning that are integral to music therapy practice and action research.

8.3 Future research

This research concentrated on investigating the goal setting and review process at Raukatauri. It would be interesting to see other facilities undertake similar projects. The findings could then be compared which would enable findings to be generalised more widely.

Of particular interest were the questions raised around the significance of sharing video footage. Further research into how video is used to enhance communication and provide evidence of progress in music therapy would be beneficial.

Finally, there is scope for further research involving parents/carers and other professionals. This could focus on measuring the efficacy of music therapy in relation to the goals and focus
areas that are set. The use of narrative assessment or goal attainment scaling could be implemented and evaluated to identify if either are a useful method for consistently evaluating progress.

### 8.4 Conclusion

The intent of this project was to investigate the goal setting and review process at Raukatauri with the aim of creating an improved collaborative process. Initial findings suggested the existing system was satisfactory and relevant, but also identified some potential improvements. For the research team, the project presented an opportunity to align the goal setting process with the Raukatauri values and approach to music therapy.

Action research was an appropriate research methodology for this study as it mirrored the process of observation, reflection, planning and action that is inherent in music therapy practice. It also offered an opportunity to work collaboratively both as a team and with the parents/carers and other professionals involved. This collaboration ensured that the improvements to be implemented were meaningful and relevant to everyone involved.
REFERENCES


Cooper, A. C. (2006). *Insights from music therapy assessment: Single session encounters with children and young people who may be blind or low vision, and who may have additional or complex needs*. Master of Music Therapy, New Zealand School of Music, Wellington, NZ.


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Research.


Appendix A: Original goals and objectives table

<table>
<thead>
<tr>
<th>Music Therapy Goals and Objectives</th>
<th>Date:</th>
<th>Reviewed:</th>
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<tbody>
<tr>
<td>Name:</td>
<td>DOB:</td>
<td>Music Therapist:</td>
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<tr>
<th>Long Term Goals</th>
<th>Short Term Therapy Objectives</th>
<th>Success Criteria:</th>
<th>Strategies</th>
<th>Progress (see key)</th>
<th>Parent/Carer Comments</th>
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Appendix B: Reconnaissance questionnaire

Collaborative goal setting and reviewing in music therapy for children with special needs.

Questionnaire
This questionnaire aims to gather information about your perspective of the goal setting and review process currently used at the Raukatauri Music Therapy Centre (RMTC). Please refer to the Information Sheet for further information about the research project and who to talk to if you have any questions.

All information gained from this questionnaire will be treated in the strictest confidence, and will be available to the research team at RMTC and research advisor, Eileen Piggot-Irvine, Associate Professor (Action Research at Unitec).

The questionnaire should take about 10 minutes to complete. Please complete and return by Monday 28 June 2010. A stamped addressed envelope for returning the questionnaire is included.

Instructions:
Each statement is evaluated on a 5 point scale where the highest scoring is given a score of 5 (strongly agree) and lowest a score of 1 (strongly disagree). Participants are asked to tick the box that most closely aligns with their evaluation of that statement. Please tick only one box and not across more than one box. If you feel unable to complete an evaluation for a particular statement please leave it blank.

SCALE:
1= strongly disagree
2= disagree
3= not applicable / can’t comment
4= agree
5= strongly agree

Thank you for taking the time to complete this questionnaire and contribute to our research project.

Please return completed questionnaire in the pre-paid envelope.

You are invited to participate in a focus group as part of this research project. Please complete the accompanying detachable return slip should you wish to volunteer to be involved in a focus group interview.
PART ONE  Goal setting
Have you received a goal and objective sheet (blank sample enclosed) within the last six months?

   YES [ ]   NO [ ]   DON'T KNOW [ ]

If you answered Yes, please complete the rest of the questions in this section. If you answered No or Don't Know please go to Part Two.
Please think back to the last goal and objective sheet (blank sample enclosed) you received from the Raukatauri Music Therapy Centre (RMTC) and answer the following questions.

<table>
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<tbody>
<tr>
<td>1. The goal and objective sheet is well laid out.</td>
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<td>2. The goals and objectives are clear and relevant.</td>
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<td>3. The success criteria are easy to understand.</td>
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<td>4. The success criteria are relevant.</td>
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<td>5. I have been involved in the process of goal setting.</td>
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Additional comments:

PART TWO  Written reports
Have you received a written report within the last six months?

   YES [ ]   NO [ ]   DON'T KNOW [ ]

If you answered Yes, please complete the rest of the questions in this section. If you answered No or Don't Know, please go to Part Three.
Please think back to the last written report you received from the RMTC and answer the following questions.

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<tr>
<td>1. The report is written in language I understand.</td>
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<td>2. The report is relevant and meaningful to me.</td>
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<td>3. The report relates to the goals and objectives.</td>
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<td>4. The length of the report is too long.</td>
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<td>5. The length of the report is just right.</td>
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Additional comments:
PART THREE  Video footage

Have you had the opportunity to view video footage relating to the report?

YES ☐  NO ☐  DON’T KNOW ☐

If you answered Yes, please complete the rest of the questions in this section. If you answered No or Don’t Know, please go to Part Four.

<table>
<thead>
<tr>
<th>1. The video footage helped me to understand the therapy process.</th>
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<tbody>
<tr>
<td>2. The video footage related to the goals and objectives.</td>
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<tr>
<td>3. I did not find the video footage helpful.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please state in what ways you found the video footage helpful or unhelpful:

PART FOUR

Please comment on the following statements:

- The strengths of the current goal setting and review process at RMTC are:

- The changes or improvements I would like to see made to current goal setting and review process at RMTC are:

Please continue on a separate sheet if necessary.
Title of Research project:
Collaborative goal setting and reviewing in music therapy for children with special needs: An action research project to improve practice and measure efficacy.

My name is Claire Molyneux and I am Head of Clinical Services at the Raukatauri Music Therapy Centre. I am seeking volunteers for a research project that we are undertaking at the Centre.

Aim of project
The aim of the project is to evaluate the current process of goal setting and reviewing that we use at the Centre and to collaboratively implement changes that lead to improved and more effective practice. Following the implementation, the improvements will be evaluated and an effective model of collaborative goal setting and review will be established that is relevant and meaningful for the children, families and other therapists alongside whom we work.

It is anticipated that the project and its findings will be written up and submitted for publication in an appropriate academic journal and may be presented at conferences.

Research team
The research team will consist of the following people:

- Claire Molyneux, Head of Clinical Services and Lead researcher for this project.
- Marie Bagley, Registered Music Therapist.
- Alison Cooper, Registered Music Therapist.
- Russell Scoones, Registered Music Therapist.
- Rebecca Travaglia, Registered Music Therapist.
- Eileen Piggot-Irvine, Associate Professor (Action Research) Unitec and Research Advisor for this project.

Your participation
I request your participation in the following ways:

- I will be collecting data using an anonymous questionnaire which you will find enclosed with this information sheet. The questionnaire should take no more than 10 minutes to complete.
- I will be conducting focus group interviews and will be seeking volunteers to participate.

If you would like to participate in the research, please complete and return the questionnaire. Your completed questionnaire will be an indication of your consent to participate.

You will also find an invitation to participate in a focus group to be held on Thursday 3rd March at 7.00pm. The group should last no more than 1 hour. Should you wish to do so, please complete the detachable form and return it with your questionnaire.
Withdrawing from the research project
If you change your mind and decide you do not want to be involved in the research project, then you can withdraw by contacting me (Claire Molyneux) on (09) 360 0889 and informing me of your decision. You need to do this within six weeks of completing the questionnaire or participating in the focus group. After this point, I will not be able to remove your data from the research project.

Your privacy
You will not be identified in any written reports or presentations relating to the project. I will be recording the focus group interviews and will provide a summary of findings for you to check before data analysis is undertaken.

The data collected from the questionnaire and focus groups will be stored in a locked cabinet at the Raukatauri Music Therapy Centre and will be available only to the research team identified above.

If you have any queries about the project, you may contact the following people:

Research Advisor: Eileen Piggot-Irvine, Associate Professor (Action research) Unitec. Phone: (09) 815 4321 ext 8936. Email: epiggotirvine@unitec.ac.nz

RMTC Director: Anne Bailey. Phone: (09) 360 0889. Email: anne.bailey@rmtc.org.nz

Yours sincerely

Claire Molyneux
Head of Clinical Services

UREC REGISTRATION NUMBER: (2009-1047)
This study has been approved by the UNITEC Research Ethics Committee from 15 March 2010 to 14 March 2011. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through the UREC Secretary (ph: 09 815-4321 ext 7248). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
CONSENT FORM
Please complete and return with questionnaire

3 June 2010

From: Claire Molyneux

Re: Research Project at the Raukatauri Music Therapy Centre

TITLE OF RESEARCH PROJECT:
Collaborative goal setting and reviewing in music therapy for children with special needs: An action research project to improve practice and measure efficacy.

I have been given and have understood an explanation of this research and I have had an opportunity to ask questions and have had them answered. I understand that my name will not be used in any public reports. I also understand that if I participate in the focus group, I will be provided with a transcript (or summary of findings) for checking before data analysis is started and that I may withdraw myself or any information that has been provided for this project up to the stage when analysis of data has been completed (six weeks after participation in the focus group).

I agree to take part in this project.

Signed: ________________________________

Name: ________________________________

Date: ________________________________

Please complete and return with your questionnaire in the pre-paid envelope.

UREC REGISTRATION NUMBER: 2009-1047
This study has been approved by the UNITEC Research Ethics Committee from 15 March 2010 to 14 March 2011. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through the UREC Secretary (ph: 09 815-4321 ext 7248). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
Collaborative goal setting and reviewing in music therapy for children with special needs.

Invitation to participate in a focus group

You are invited to take part in a focus group in which the themes raised in this questionnaire will be discussed further. The purpose of this group is explained in the Information Sheet accompanying this letter. We aim to hold two focus groups each with 8 members with the intention of having a group with a mix of parents/carers and other professionals. The focus group members will be presented with the opportunity to comment on the goal setting and review system, to add depth to the themes raised in the questionnaire.

Depending on the number of volunteers, there will be up to two focus groups held at the Raukatauri Music Therapy Centre during Term 4 2010. You will be invited to attend one of the groups. The groups will take no more than 1 ½ hours.

If you would like to volunteer to be a member of a focus group, please complete this return slip. To preserve anonymity for the questionnaire, the return slip will be separated from the questionnaire and placed in a separate box on receipt by the Centre Administrator.

NAME:

ADDRESS:

PHONE:  EMAIL:

1. Are you:  
   - a) parent/carer of child who receives music therapy at RMTC.  
   - b) professional with a connection to a child who receives music therapy at RMTC.

2. How long have you been involved with the RMTC?
   - a) 0 – 2 years  
   - b) more than 2 years
Appendix F: Summary of questionnaire themes provided to focus group participants

Collaborative goal setting and reviewing in music therapy for children with special needs: An action research project to improve practice and measure efficacy.

Summary of questionnaire results
The questionnaire results suggest that the current goal setting and review process is meeting the needs of parents and professionals well. There was a great deal of positive feedback suggesting that communication was good, goals relevant and clear, and the needs of the child accurately represented in the process.

The quantitative data suggested that the current process is achieving its purpose. The qualitative data added depth and richness to the quantitative responses and it is from this data that the main areas for improvement of the process have been identified.

As a team we need to think about the following points, whether they are priorities and if so, how we can meet them.

Comments about process
- Identify the differences and similarities between RMTC and Outreach report length. Are these necessary, or should we have a similar format in both settings?
- Ensure that plain English is used and that parents have an opportunity to ask questions about the report and goals sheet.
- Ensure that parents/carers know they can ask the therapist for more frequent review meetings.
- Think about the ways in which we communicate the importance of the documentation (progress notes, reports, goals and objectives) procedures that support the therapy process (in relation to comments about cost).

Collaboration
- How well do we communicate the nature and purpose of music therapy?
- Can we provide further opportunity for parents/carers and other professionals to discuss the possibility of sharing music therapy strategies at home and school? This is not to suggest that we should always provide strategies for use in other environments, but that it should be possible for discussion to take place around whether or not this is appropriate and how it can happen.
- Copying reports and goals and objectives sheets as widely as possible
- Inviting other professionals to view a session (RMTC and Outreach) with the parent and client’s permission
- Inviting others (parent/carer or professional) to work collaboratively in the session.

Communication and sharing
- Wider sharing of video both with family and school environment
- What information do we provide about the purpose of and use of video footage?
- Do we encourage parents/carers and other professionals to discuss the use of video footage?
- The benefit of sharing video footage at review meetings (with the therapist there to interpret), this may have an influence on the way in which we choose to share video footage in other settings.
- More information at start of therapy about appropriate goals and goal setting process
- Ensuring there are interpreters available where needed
- Sharing completed/reviewed goal sheets with teachers
- Sharing of music therapy goals with other professionals
- One person suggested making available the opportunity to talk privately with another member of staff

Appendix F: Summary of questionnaire themes provided to focus group participants
Appendix G: Guidelines for documentary analysis

Guidelines for completion

- Select a case file.
- Check each criteria in turn and identify what evidence is present in the case file that shows the criteria has been met. Use the following question to guide you: Does this document reveal the criteria?
- Use the following code to identify where the evidence is located. There is no need to write down that the information is not included in a particular place unless you feel it is significant e.g. in the example below, it is significant that parent's comments are included on the RPS and not the GOS.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Descriptor</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goals are discussed collaboratively with the family/carers.</td>
<td>Family/carers are given an opportunity to ask questions and discuss the goals. This might be formal (review meeting) or informal (feedback after a session), verbal or written feedback. In collaborative outreach work, the feedback from parents/carers might take place through other professionals e.g. teacher.</td>
<td>RPS – parent comments included. Not included on GOS SR – parent feedback included in report</td>
</tr>
</tbody>
</table>

- Be specific e.g. record of telephone conversation with parent.
- Here is an example:

Please feel free to make further comments on a separate sheet of paper if there is insufficient room in the boxes.
- After completing this for one of your own cases, ask a colleague to peer review the same case.
- You can write your comments either by hand or on the computer whichever is most convenient.

NB: After feedback from the team and further thought, it seems more appropriate to keep the documentary analysis within a qualitative framework. Therefore I have not included a rating scale to rate how well each criteria has been met as this is at odds with the criteria we are evaluating. However, you may wish to make a value judgement and recommendations for improvement which can help to guide us in the next stage of the project.
Appendix H: Research plan for Term 4 2010

Completion of reconnaissance phase and start of implementation phase

Here are the action plans for completion of the documentary analysis and the questionnaire analysis as drawn up by the team on 30 Sept 2010 with Eileen

**Questionnaire Analysis plan**

<table>
<thead>
<tr>
<th>When</th>
<th>What</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>T3 hols and Wk1 T4</td>
<td>Claire to email team with summary of questionnaire analysis. Marie to email team with summary of discussion on 30/09/10 Team to read through and check whether there are any gaps not covered.</td>
<td>Claire Marie Team</td>
</tr>
<tr>
<td>Wk 1 &amp; 2</td>
<td>1. Team print out copies of reports to share (RMTC &amp; Outreach) 2. Team make specific suggestions for improvements</td>
<td>Team</td>
</tr>
<tr>
<td>27 Oct</td>
<td>Team meeting to discuss and confirm improvements to be made</td>
<td>Team</td>
</tr>
<tr>
<td>Wks 4 - 6</td>
<td>Claire to circulate improvements identified so far Team to add further suggestions on the document and also volunteer for changing/reviewing documents as appropriate</td>
<td>Claire Team</td>
</tr>
<tr>
<td>24 Nov</td>
<td>Team meeting to discuss further</td>
<td>Team</td>
</tr>
<tr>
<td></td>
<td>Improvements implemented: T4 Outreach/RMTC reports and Jan break reviews and reports</td>
<td>Team</td>
</tr>
<tr>
<td>Jan 2011</td>
<td>Evaluation of improvements</td>
<td></td>
</tr>
</tbody>
</table>

**Documentary Analysis plan**

<table>
<thead>
<tr>
<th>When</th>
<th>What</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>T3 hols and Wk1 T4</td>
<td>Finish case study analysis</td>
<td>Team</td>
</tr>
<tr>
<td>Wk 1</td>
<td>1. Results collated and sent to team 2. Team to analyse – looking for gaps and trends</td>
<td>Rebecca Team</td>
</tr>
<tr>
<td>27 Oct</td>
<td>Team meeting to discuss and confirm improvements to be made Improvements written up and circulated</td>
<td>Team Rebecca</td>
</tr>
<tr>
<td>Wk 4 to end of Jan 2011</td>
<td>Improvements implemented: T4 Outreach/RMTC reports and Jan break reviews and reports</td>
<td>Team</td>
</tr>
<tr>
<td>Jan 2011</td>
<td>Evaluation of improvements through reflective journal and reassessment of documentation?</td>
<td></td>
</tr>
</tbody>
</table>
Analysis of written reports

<table>
<thead>
<tr>
<th>When</th>
<th>What</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wk 1 - 2</td>
<td>Team print out copies of reports to share (RMTC &amp; Outreach)</td>
<td>Team Team</td>
</tr>
<tr>
<td></td>
<td>Team to read copies of reports</td>
<td></td>
</tr>
<tr>
<td>27 Oct</td>
<td>Reports discussed and themes/trends identified</td>
<td>Team</td>
</tr>
<tr>
<td>Wk 4 - 6</td>
<td>Alison to write up points from discussion on 27 Oct</td>
<td>Alison</td>
</tr>
<tr>
<td>24 Nov</td>
<td>Team to discuss changes/improvements to be made to report templates</td>
<td>Team</td>
</tr>
</tbody>
</table>

Guidelines for Journal meta-analysis

<table>
<thead>
<tr>
<th>When</th>
<th>What</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regularly</td>
<td>Team members to make journal entries.</td>
</tr>
<tr>
<td>Every 3 weeks</td>
<td>Use the following questions to analyse your journal entries (meta-analysis):</td>
</tr>
<tr>
<td></td>
<td>- What are the trends/shifts in my thinking?</td>
</tr>
<tr>
<td></td>
<td>- What are the trends/shifts in my emotions?</td>
</tr>
<tr>
<td></td>
<td>- What are the trends/shifts in my responses?</td>
</tr>
<tr>
<td></td>
<td>- What are the trends/shifts in my practice?</td>
</tr>
<tr>
<td></td>
<td>- What’s changing?</td>
</tr>
<tr>
<td></td>
<td>- What’s becoming clearer?</td>
</tr>
<tr>
<td></td>
<td>- What’s becoming less clear?</td>
</tr>
<tr>
<td></td>
<td>- What “aha’s” have there been?</td>
</tr>
<tr>
<td></td>
<td>Write the analysis in the blank third of the page</td>
</tr>
<tr>
<td>Jan 2011</td>
<td>Summarise the meta-analysis in a couple of paragraphs</td>
</tr>
</tbody>
</table>

Focus group

<table>
<thead>
<tr>
<th>When</th>
<th>What</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Nov</td>
<td>Email proposed dates to focus group volunteers</td>
<td>Claire</td>
</tr>
<tr>
<td>Wk 5</td>
<td>Confirm date of focus group</td>
<td>Claire</td>
</tr>
<tr>
<td>Wk 9-10</td>
<td>Focus groups complete and data to be analysed</td>
<td>Claire</td>
</tr>
</tbody>
</table>

Tasks for November meeting:
1. Team to summarise meta analysis of journals (before the meeting) to draw out experiences, themes, etc around goal setting and review. This information will inform the review of documentation.
2. Discussion and review of:
   a. Goal and Objective sheet
   b. Measuring sheet
   c. Success criteria
   d. Front Sheet
Appendix I: Original review planning sheet

Review Planning Sheet

Parent’s thoughts about music therapy:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Music therapist’s thoughts:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Clips of video to identify potential areas to work on and success areas

Date:  
Session:  
Time:  
Reason:

Date:  
Session:  
Time:  
Reason:

Date:  
Session:  
Time:  
Reason:

Date:  
Session:  
Time:  
Reason:

FORMULATION OF GOALS

Suggested goals:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Further Discussion:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

To Parents:  
Cover Letter  
Report  
Goal Sheet  
Service Evaluation Form

Folder:  
Blue copy of Cover letter/Report/Goals  
Update Front Sheet  
Create Measuring Sheets  
Update (paper/comptr) goal sheet review date

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Appendix J: Revised review planning sheet

**Review Planning Sheet**

Venue:
Date:

Client Name:  
D.O.B:
Attendees:

**Parent's thoughts/concerns/feedback about music therapy:**

**Music therapist's thoughts:**

**Clips of video to identify potential areas to work on and success areas:**

<table>
<thead>
<tr>
<th>Date:</th>
<th>Session:</th>
<th>Time:</th>
<th>Reason:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
GOALS AND DISCUSSION

Suggested goals:

Further Discussion:

ADMINISTRATION

<table>
<thead>
<tr>
<th>Contact Details</th>
<th>Correct or Updated</th>
<th>CORRECT</th>
<th>TO BE UPDATED:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of next review meeting (frequency/closure)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IEP Requested/Date of next IEP</td>
<td>YES NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permission to distribute to other professionals involved with child.</td>
<td>YES NO</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reminders:
- Observations for parents/caregivers and professionals available (if appropriate)
- Communication between reviews (If appropriate) TELEPHONE EMAIL LETTER

Signed: _________________________________ (RMT) Date: _______________

To Parents:
- Cover Letter
- Report
- Goal Sheet
- Service Evaluation Form

Folder:
- Blue copy of Cover letter/Report/Goals
- Update Front Sheet
- Create Measuring Sheets
## Appendix K: Revised goals and focus areas table

### Music therapy goals and focus areas

**Date:**

**Name:**

**DOB:**

**Music Therapist:**

<table>
<thead>
<tr>
<th>Long-term goal</th>
<th>Short-term focus</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(may be specific objectives or broad areas for development)</td>
<td></td>
</tr>
</tbody>
</table>

This information will be copied on to the monitoring sheet and used as a basis for the next progress report.

(Delete this text box!)

---

**Notes:**

---

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Music Therapy Progress Report
PRIVATE AND CONFIDENTIAL

<table>
<thead>
<tr>
<th>Name:</th>
<th>D.O.B:</th>
<th>Report number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Date of referral:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Start of therapy:</td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td>Sessions to date:</td>
<td></td>
</tr>
</tbody>
</table>

Reason for Referral / Summary of previous report *(delete as appropriate)*

Summary of Sessions / Developments *(delete as appropriate)*

Conclusions and Recommendations / Summary of individual music therapy goals *(delete as appropriate)*

The next review meeting will be scheduled for xxxx xxxx.

Registered Music Therapist

Cc:

Encl: Goals and Objectives
Evaluation form
## Music Therapy Progress Report

**PRIVATE AND CONFIDENTIAL**

<table>
<thead>
<tr>
<th>Name:</th>
<th>D.O.B:</th>
<th>Report number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Date of referral:</td>
<td>Start of therapy:</td>
</tr>
<tr>
<td>Date:</td>
<td>Sessions to date:</td>
<td></td>
</tr>
</tbody>
</table>

### Reason for Referral/Summary of previous report (delete as appropriate)

### Summary of Sessions

### Report of Goals and Focus Areas

<table>
<thead>
<tr>
<th>Long Term Goal</th>
<th>Short Term Focus</th>
<th>Strategies</th>
<th>Progress (Achieved/Progressing/ Little progress)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Evidence:**

*Comments on above (can include narrative description, strategies that are effective and ideas for how to develop the goal further)*

**PLEASE DELETE TEXT BOX**

<table>
<thead>
<tr>
<th>Long Term Goals</th>
<th>Short Term Focus</th>
<th>Strategies</th>
<th>Progress (Achieved/Progressing/ Little progress)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Evidence:**

*Comments on above*
Summary of review meeting

Conclusions and Recommendations

The next review meeting will be scheduled for xxxx xxxx.

Therapist’s name
Registered Music Therapist

Cc:

Encl:  Goals and Focus Areas
       Evaluation form
Appendix N: Evaluation questionnaire

Collaborative goal setting and reviewing in music therapy for children with special needs.

Questionnaire
The Raukatauri Music Therapy Centre is currently doing some research to improve our goal setting and review process. The first part of the research project included gathering information from a questionnaire and focus groups. Following analysis of this information, we have made some changes to our goal setting and review process. This questionnaire is to evaluate the effect of the changes we have made. You have been selected to complete the questionnaire because you have attended a review meeting or been sent a report in the last six weeks.

Your completion and return of this questionnaire is taken as an indication of your consent to participate in the research project. Please refer to the attached Information Sheet for further details of the project and who to talk to if you have any questions.

All information gained from this questionnaire will be treated in the strictest confidence, and will be available to the research team at RMTC and research advisor, Eileen Piggot-Irvine, Associate Professor (Unitec).

The questionnaire should take about 10 minutes to complete. Please complete and return by Friday 25th February 2011. A stamped addressed envelope for returning the questionnaire is included.

Instructions:
Each statement is evaluated on a 5 point scale where the highest scoring is given a score of 5 (strongly agree) and lowest a score of 1 (strongly disagree). Participants are asked to tick the box that most closely aligns with their evaluation of that statement. Please tick only one box and not across more than one box. If you feel unable to complete an evaluation for a particular statement please leave it blank.

SCALE: 1= strongly disagree
        2= disagree
        3= not applicable / can’t comment
        4= agree
        5= strongly agree

Thank you for taking the time to complete this questionnaire and contribute to our research project.

Please return completed questionnaire in the pre-paid envelope or to Jo Clark, Administrator at RMTC.

You are also invited to participate in a focus group as part of this research project. Please complete the accompanying detachable return slip should you wish to volunteer to be involved in a focus group interview.
PART ONE  Music therapy goals and focus areas sheet (blank sample enclosed)
This document replaces the goal and objectives sheet. Our research has shown that individualised goals are valued and a strength of music therapy is that the goals are not predetermined. The new goals and focus areas sheet has been changed to allow space for both specific objectives and broad areas for development.

Please think about the sheet you have received and answer the following questions:

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The goal and focus areas sheet is well laid out.</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. The goal and focus areas are clear and relevant.</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I understand the strategies used.</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I have been involved in the process of goal setting.</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I like the new layout of the goals and focus areas.</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. I prefer the old layout.</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

One thing I like about the new sheet is:

One thing I don’t like about the new sheet is:

Additional comments:

PART TWO  Written reports
Our research has shown that a range of information in the report is valued, including specific examples of what happens in music therapy sessions. Written reports have been changed to allow space for the therapist to give specific evidence of progress towards goals and focus areas as well as narrative examples of interactions in music therapy sessions.

Please think about the most recent report you received and answer the following questions:

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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</thead>
<tbody>
<tr>
<td>1. The report includes clear evidence of progress.</td>
<td>☐ ☐ ☐ ☐ ☐</td>
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<td>2. The report is relevant and meaningful to me.</td>
<td>☐ ☐ ☐ ☐ ☐</td>
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<tr>
<td>3. The report helps me understand what takes place in music therapy sessions.</td>
<td>☐ ☐ ☐ ☐ ☐</td>
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</tbody>
</table>

One thing I like about the new report layout is:

One thing I don’t like about the new report layout is:

Additional comments:
PART THREE
We are interested in how much the process of setting goals relates to the progress made in music therapy.

Please comment on the following statement:

- The goal setting process helps me understand the progress made in music therapy because:

Finally, if you have any further comments about the goal setting review process, including review meetings, viewing video and the written documents, please write them below:

Please continue on a separate sheet if necessary.