Music Therapists' Perceptions of the Effects of Tele-Music Therapy on Client Access

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Abstract

This qualitative focus group study explored how music therapists are understanding and responding to changes in client access since the move toward tele-music therapy spurred by the recent COVID-19 virus outbreak. Coming from a recognition of histories of health access disparity for underserved populations, this study also sought music therapists' perspectives on how specific cultural groups and identities may have been unequally affected in terms of access to tele-music therapy. In this study, a synchronous online focus group discussion was facilitated with six music therapists to explore their perspectives regarding the benefits and challenges of tele-music therapy, particularly in terms of client access, and to explore ways these therapists found to respond to any challenges or disparities in access they encountered. Results suggest that music therapists are finding a complex set of both benefits and challenges in terms of their clients accessing tele-music therapy. Four themes with 18 sub-themes were found: challenges/barriers to access (technology challenges, inequities in access, facility- or population-related barriers, safety concerns, challenges of in-home sessions, and hard choices), bridging the barriers (benefits to specific populations, in-home session benefits, bridging distance, and finding solutions), making music in tele-music therapy (music-making challenges, singing, musical instruments and technology, and musical solutions), and the future role of tele-music therapy (hopes and concerns, preparing for the future, and possibilities.) These findings offer recommendations for the continued use of tele-music therapy even beyond the current pandemic.

Keywords: telehealth access, barriers to access, underserved populations, COVID-19

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Table of Contents

List of Tables and Figures

Tables

Figures

Introduction

Motivation for the Research

For most of the last ten years I have had the privilege of living overseas, traveling with my wife to various countries with her position in the State Department. Several of those countries had experienced many years of extractive colonialism, and we saw the people there working to recover their own cultures and healthy equitable economies. Most striking of all the countries we lived in was India, where the socio-economic disparities between the haves and the have-nots was the largest and most evident. And as a privileged white and economically advantaged American, I was at once insulated from those disparities, and at the same time deeply disturbed by the injustice.

However, I would not have needed to travel so far to see these injustices and socio-economic disparities, which are found right here in our own American experience. During my music therapy internship experience in a hospice setting, I found myself reflecting on the disparities I saw while visiting a variety of nursing homes in the western Virginia area. Though our hospice program was able to reach people of all economic levels, I was disturbed to see clear disparities in the broader level of care and quality of facilities when comparing the higher cost retirement communities with the lower cost nursing homes in the area that we served. Also troubling for me was the fact that the funding for hospice care was dependent on the declining physical health of the client. During the six months of my internship, several clients with whom I worked were discharged from hospice for “failure to decline”, despite their very positive responses to music therapy. It was painfully evident to me that music therapy could continue outside of our hospice program, but only for those who could afford to take on the financial cost themselves.

During my course work in the Master of Music Therapy (MMT) program at Slippery Rock University, all the classes there had a strong emphasis on social justice and equity. Classes such as Social Justice Music Therapy and Systems Thinking in Music Therapy encouraged me to explore how people have been marginalized by economic systems, social systems, and even healthcare systems. Central to this exploration has been an exploration of how our own privileged identities have contributed and continue to contribute to other's marginalization.

Slippery Rock's MMT program is primarily conducted online through synchronous class discussions, and to a smaller extent through asynchronous group discussion boards. Both types of classroom interactions were new to me. I found myself having to work harder to engage and connect with others within the context of group Zoom calls. What was it about the online experience that may be contributing or detracting from group interactions? I also reflected on the individual differences within the group members, and how those may have affected each of our individual levels of engagement and interaction.

Finally, this past fall I completed a three-month advanced practicum experience with a private practice music therapy group. I worked primarily with neurodivergent adult groups, and all sessions were conducted online through Zoom or Facetime. During my participation in these groups, I was able to experience firsthand some of the benefits and challenges of tele-music therapy sessions. I was many times frustrated with the difficulties of just getting myself connected to the online platforms, as well as being confronted with the greater challenge of hearing and seeing everyone within the groups. On the other hand, I could feel the joy and excitement of group members who during these online sessions were able to connect and share of themselves with group members whom they had not seen in person since the early in the COVID-19 pandemic. All these experiences have come together to reinforce questions in my

mind regarding not only the benefits and challenges of conducting tele-music sessions, but also questions as to who may have more difficulty accessing these new options. Thus, given my growing awareness of issues of disparity and inequity, from a concern for who may or may not have access to music therapy, to the current COVID-19 pandemic which has sped the move toward tele-music therapy options for connecting with clients, I decided to explore how access and equity to music therapy were impacted by telehealth services.

Positioning

My personal context is dominated by stories of ease of access. I am a white, middle class, cisgender, heterosexual, educated man born in the 1960's. These identities of privilege have led to a life in which there were very few barriers to my access to anything I needed. As I come to recognize these privileged positions, I am recognizing my responsibility to explore where there are access barriers that others may experience.

As one who is relatively new to music therapy, I have been eager to learn from the experiences of other music therapists. The decision to use focus group discussion as a methodology in this study is partly springing from my interest in hearing real world perspectives of music therapy practice.

And interestingly, as someone heading into my 60's who sometimes is uncomfortably new to navigating the ever-expanding forms of social media, I feel a sense of solidarity with older clients and those with various other sociocultural identities who may struggle with gaining access to online telehealth options.

Literature Review

Barriers that limit access to healthcare services are many, particularly affecting vulnerable populations and further increasing health disparities. Barriers include the maldistribution of healthcare resources, unaffordability of health insurance, and lack of good transportation options. In order to address and reduce health disparities, these and other social and cultural barriers must also be examined. New strategies for better healthcare access, such as telehealth options, may help break down some of these barriers. At the same time, telehealth solutions may present additional access barriers which must be explored. Central to a concept of access is the concern for equitably meeting the needs of different groups of people. Equity involves both the ideas of fairness and social justice. Gulliford (2002) refers to two dimensions of access equity. A horizontal form of equity is concerned with fair access for different groups with the same needs, while the vertical dimension of access equity implies groups with different needs have access to services that are differentiated appropriately. Responding equitably to health disparities between different groups is complicated by a lack of accurate data concerning healthcare access. For example, a 2020 report on home health care visits found that 20 percent of Hispanic patients and 80 percent of Native American patients were misclassified in terms of race, ethnicity and language (Sonnier, et al. 2020). This type of limited, inaccurate patient population data can further perpetuate health disparities, as actual differences in access are more difficult to detect.

Appropriate access to healthcare has been defined as that which enables the client access to “the appropriate care from the right provider, in the right place within a timely manner” (Jolly, 2019, p 71). Others have defined access as “the timely use of personal health services to achieve best possible outcomes” (Institute of Medicine Committee on Monitoring Access to Personal

Health Care Services, 1993, p. 4). In her study looking at barriers to healthcare in the rural U.S., Jolly (2019) points to five dimensions that play a role in determining access: availability, accessibility, affordability, accommodation and acceptability (p. 71). Recognizing that a definition of access to healthcare can be complex, Gulliford et al. (2002) describe two aspects of access, "having access" and "gaining access" (p. 186). Having access simply implies an availability of services, while gaining access involves the actual utilization of services. Gaining access can also involve working through barriers to access, whether personal, financial, or organizational.

Numerous studies have traced disparities in health and access to healthcare. In their analysis of a 2003-2004 National Survey of Children's Health (U.S.), Flores & Tomani-Korman (2008b) found significant disparities, with children in non-English-primary-language households 25% less likely to have a usual source of medical care. In a similar study, Flores & Tomani-Korman (2008a) found that children belonging to minority groups faced multiple health disparities, with less access to healthcare. Specifically, compared to 90% of white people having a usual source of healthcare, only 77% of African Americans, 68% of Latinx, and 61% of Native Americans had a usual source of healthcare (Flores & Tomani-Korman, 2008a, p. e286). In a study exploring racial and ethnic differences in health service access since the Affordable Care Act (ACA), Manuel (2018) found that white people had the largest gains in access to healthcare, while Black adults had the fewest gains. In another study focusing on the impact of the ACA's 2014 Medicaid expansion on low-income, nonelderly adults, Yue, Rasmussen, and Ponce (2018) found that while the general population saw significant gains in health insurance coverage and affordability, white people benefited the most in terms of gains, black people saw less benefit,

and Latinx people of all races saw the least benefit. These differential effects only serve to widen racial/ethnic health access disparities.

Health disparities along racial lines have been a concern for years, while little has changed to this day. Malawa et al. (2021) state that this lack of progress can be explained as "a failure to acknowledge that racism is at the root of these racial disparities" (p. 1). They suggest that addressing racism as a root cause, while "working to change policies, systems, or environments, as opposed to changing people" and repairing historical injustice by "shifting resources, power, and opportunities to racially marginalized groups" (p. 2) will be critical to advancing equitable public health.

In a study examining the effects of the ACA on access to health care among young people, Spencer, et al. (2017) found "incrementally worse" access for young adolescents, older adolescents, and young adults, and the authors point out that roughly 40% of these are low income, and "over a third live in the south, where many states have not expanded Medicaid" (p. 667). Similarly, in a study focusing on older adults, Almeida et al. (2017) show that socioeconomic levels and education have a clear effect on access, where in the U.S., older adults in the highest economic quintile have twice the chance to see a doctor than those in the lowest quintile (p. 2). Concerning health access for rural populations, Jolly (2019) points to a "geographic maldistribution of healthcare providers and services" (p. 71). In urban areas there are 93 primary care practitioners per 100,000 people, whereas in rural areas there are only 55 practitioners per 100,000 people.

Access to Telehealth

Many of these barriers to accessing healthcare can be addressed through the use of telehealth. Telehealth refers to the provision of health-related services through electronic communications and information technologies. Telehealth can involve live interactive videoconferencing (synchronous), store-and forward information and videos (asynchronous), and remote patient monitoring (Marcin et al., 2015, p. 169). Drawing on Shi & Singh's (2019) five dimensions of healthcare access (availability, affordability, acceptability, accommodation, and accessibility) as a way to think through issues of access, I will now focus on the literature related to telehealth access.

Availability of Telehealth

Even before the COVID-19 pandemic, there had been growth in the availability of telehealth as an option for accessing healthcare. This is in part due to an increase in Medicare-approved telehealth services and expanding availability of insurance coverage for telehealth services. Since the outbreak of the COVID-19 pandemic and the resulting physical distancing requirements, rapid steps have been taken toward removing barriers to telehealth access, such as the removal of some cross-state licensure restrictions, adding personal residences to lists of approved telehealth settings, and including telephone and video calls under reimbursable modalities of care (Sonnier et al., 2020). Also, in March 2020 the US government instituted a temporary waiving of various regulations governing telehealth (Torous et al., 2020). Ensurring for more equitable availability of telehealth services even beyond the current COVID-19 crisis will require a focus on policy changes that would ensure payment parity for telehealth services, expansion of access to telehealth to all types of providers, and simplification of regulations for both patients and providers. (Campos-Castillo & Anthony, 2021, p. 124).

Affordability of Telehealth

For telehealth to be accessible, it must not only be available, but also affordable. Some authors have pointed to a disproportionate lack of access to secure broadband internet services and video compatible devices among rural and inner-city populations (Kaplan, 2021). Siefer & Callahan (2020) point out the difference between "not having broadband service available" and "not having a home broadband connection" (paragraph 7). They go on to show that the cost of broadband connection service is more of a barrier to lower income populations, whether rural or urban, with people of color being the least likely to have broadband subscriptions. Other factors affecting affordability of telehealth explored in the literature include unfavorable reimbursement policies (Sonnier, et al. 2020), and costs associated with maintaining HIPAA compliance for telehealth services which may be passed along to the client. For example, for those wanting to use Skype for Business, which is HIPAA compliant, Microsoft offers a Business Associate Agreement (BAA). But an Office365 account must linked to the Skype account to enable the BAA. This can add as much as 35 dollars per month in cost for the provider and the client (HIPAA Journal, 2020).

Acceptability of Telehealth

Several studies have explored the concept of acceptability of telehealth for specific populations. Describing his work in gender-affirming medical care, Kaplan (2021) noted that the shared space of telehealth can help to level the power dynamics between himself and clients. Rather than clients needing to enter the doctor's office, a space that is not theirs, they can instead "create a shared space that belongs to neither and yet both of us" (Kaplan, 2021, p. 76). And while disabled people are 20% less likely to own a computer or smartphone, in 2016 they accounted for 65% of clients using telehealth services, showing a "strong desire… to be a part of

this healthcare technological revolution" (Noel & Ellison, 2020, p.2). Adhering to the "nothing about us without us" approach of disability communities, Noel & Ellison (2020) advocate for inclusive innovations which would include those with disabilities in the development of new technologies.

Other studies have explored how telehealth can meet the needs of persons in group psychotherapy. One such study reports increased and more active engagement in online sessions, as group members became more motivated to look to peers for support during the pandemic (Sasangohar, et al., 2020). The study also conceptualizes the online sessions as more "direct and contextualized interaction" which can increase the "ecological validity and relevance" of therapy (p. 5), as the sessions move out of traditional institutional spaces and into virtually shared home spaces. Another study examining online group psychotherapy focused on establishing cohesion and presence during sessions and recommended being more active and "increasing self-disclosure in online groups to compensate for the challenge of being present and the lack of body-to-body interaction" (Frydman et al., 2021). ,Telehealth and Accommodation

Accommodation in this context is defined as the extent to which providers and health systems situate or adjust to meet the needs of a client or population. Telehealth options can be seen as one accommodation which can respond to healthcare disparities. Fleming et al. (2009) suggest the need for developing telehealth skills specific to the needs of underserved communities. Noting the rising need for telehealth among Black communities since the pandemic, and the longer-term health disparities experienced in Black communities caused by systemic racism, Campos-Castillo & Anthony (2021) point toward the need for leveraging "a broadly defined set of telehealth tools to reduce health care disparities post pandemic" (p.119). Specific telehealth strategies for addressing the needs of diverse populations are being

implemented in the following ways: marketing to specific underserved groups, providing client tutorials, and creating information resources in alternate languages (Sonnier et al., 2020).

Telehealth and Accessibility

When looking at telehealth accessibility, an important question is, "Are we meeting clients where they are?" A response would need to encompass more than just a client's geographical location, but also explore how the client's individual needs and socio-cultural characteristics are addressed. Various studies explore the promotion of equitable telehealth access for vulnerable populations, through a focus on digital literacy and access to technology for low-income, culturally diverse populations (Kaplan, 2021; Sonnier et al., 2020; Torous, et al., 2020).

Telehealth Accessibility for Specific Populations

Other research has focused more specifically on telehealth accessibility for particular groups of people, such as older adults. Older adults are less likely to have access to digital devices, leading to widening gaps in access to telehealth services. Older patients who are also male, less educated, and with lower income (Bommakanti et al., 2020), and those with serious illnesses (Frydman et al., 2021) are even less likely to have access to devices. In addition to needing access to devices, older adults with visual, auditory, or cognitive impairments may need help using new technologies and may benefit from in-home technical help (Frydman et al., 2021).

Additional studies have focused on reaching those living in underserved geographical areas. For rural families, which make up 20% of the US population, there are multiple barriers to accessing healthcare, including geographic challenges, the maldistribution of health services, and

the economic barrier of traveling to service providers (Marcin et al., 2016). Studies have shown that telehealth options can enable patients facing these inequities better access to health care and save time and costs through reduced travel required (Khairat et al., 2019; Noel & Ellison, 2020). Two other studies focus on the advantages of telehealth for disabled clients who live in underserved areas (Zhou & Parmanto, 2019; Noel & Ellison, 2020). And a cross-sectional study of people in Hispanic border communities showed an openness to (and a high intention to use) telehealth, despite most of those surveyed never having heard of it before the survey (Ghaddar et al., 2020).

Client Access to Tele- Music Therapy (pre-COVID)

Before the COVID-19 outbreak, much of the literature around client access to tele-music therapy involved work with military veterans. The US Department of Veterans Affairs (VA) has long been a leader in telehealth, and by 2016 roughly 12% of US veterans served by the VA received some care through telehealth (Department of Veterans Affairs, n.d.). This can be seen as a response to the fact that roughly 24% of US veterans live in rural areas. However, in 2018 only 2% of the VA's creative arts therapies were being accessed through telehealth (Spooner et al., 2018, p. 12). Two separate studies looked at the advantages of providing tele-music therapy options for veterans living in remote locations or where there are no qualified therapists locally, and both suggested accommodations that may be necessary when working with veterans and those with PTSD (Vaudreuil et al., 2020; Lightstone et al. 2015). In a case study of tele-music therapy work with a veteran with traumatic brain injury the client found that accessing sessions from his home to be comforting, allowing him to be more open to new music therapy experiences, leading the researchers to propose that tele-music therapy sessions can promote

greater client autonomy where the client takes a more active role in their own therapy (Spooner et al. 2018).

There are only a few non-veteran related examples from the pre-COVID era that address availability of tele-music therapy. One such study focused on children with hearing loss and their families living where local services are not available (Fuller & McLeod, 2019). And in his thesis focused on the therapeutic relationship in tele-music therapy, Glover (2020) also presented tele-music therapy's possible role in reducing geographical barriers to access such as long commutes to therapy, overcoming financial barriers to access, as well as reducing psychological barriers as clients can access sessions while within the more comfortable setting of their own home, rather than having to visit the therapist in a clinical setting. And in a study examining the use of online songwriting through Skype sessions with an adolescent with Asperger's syndrome, Baker & Krout (2009) found that the client was more highly engaged, more creative in his lyric writing, and more confident in express opinions within Skype sessions than with in-person sessions.

Client Access to Tele-Music Therapy During COVID

Availability

During the COVID-19 pandemic, music therapists continued to provide services to clients, many needing to expand their reach through telehealth modalities. In a June 2020 national survey of music therapists practicing in the US, Fay et al. (2020) found that almost two-thirds responded that they had added tele-music therapy as an option for their clients). This has made possible continuity of music therapy services as well as "enhanced therapeutic outcomes and improved family involvement" (Fay et al, 2020, paragraph 1). In another 2020 survey, Gaddy et al. (2020) found that a majority of music therapists were providing tele-music therapy

options for service since the pandemic. The same survey found that most were providing synchronous tele-music therapy sessions (54%), but other modalities were being provided, including: virtual music lessons (17%), prerecorded songs (16%), and prerecorded video sessions (16%) (Gaddy et al., 2020).

Affordability

Despite the increasing availability of tele-music therapy throughout the past year, there are concerns that the additional costs of accessing telehealth technologies may exacerbate inequalities for lower-income clients. Broadband internet services and related telehealth technologies such as USB microphones can be cost prohibitive for many clients (Sasangohar et al., 2020; Gaddy et al., 2020; Dowson et al., 2021). Even for those that can access internet services and technologies, technical literacy barriers may remain, as telehealth technologies can be difficult to learn.

Acceptability

In a 2020 survey published by the American Music Therapy Association, 75% of the music therapists who responded reported that their clients were responding positively to tele-music therapy services, and that certain clients "are thriving in ways that did not happen when seen in person" (Fay et al., 2020, paragraph 2). In the same survey, clients' family members were noted to be more involved in tele-music therapy sessions. Additionally, the survey reflected benefits for the other healthcare providers in the hospitals and care facilities where tele-music therapy services were provided, where coworkers expressed "joy and gratitude for the connections made through shared musical experiences during a period of increased isolation and stress" (paragraph 2).

During the height of COVID-19, quarantines and physical distancing measures made it difficult to impossible for many to engage in social spaces. Group tele-music therapy sessions allowed groups one way to connect. A study by Sasangahar et al. (2020) looking at the implementation a program of online art and music therapy group sessions in an outpatient psychiatric setting found clients to be receptive and well-engaged, and found the program thriving during the quarantine perhaps more that it would have otherwise. Similarly, as evidenced from survey responses of Neurological music therapists' (NMTs) about their experiences with tele-music therapy during the COVID pandemic, participants viewed certain client groups as perhaps benefiting more from telehealth than from in-person music therapy, those included autistic clients, clients with aphasia, and some mental health clients (Cole et al., 2021). Gaddy et al (2020) found that most music therapists commenting on tele-music therapy viewed it as beneficial, with many remarking on the resilience and adaptability of music therapists, and viewed the COVID-19 pandemic as a potential source of growth for the music therapy profession.

Accommodations

Increasing the use of tele-music therapy is one of the many ways that music therapists have adapted and diversified service options in order to meet the evolving needs that the COVID-19 pandemic brought about. Along with adopting tele-music therapy technologies, music therapists have adapted their therapeutic goals (promoting client access, reducing social isolation during lockdowns), made therapeutic space adaptations, logistical and technological adaptations, adapted working hours, adapted methods and techniques (holding remote or socially distanced interactive concerts), and even adapted the use of musical instruments to include household item percussion and DIY instruments (Kantorová, 2021). Sasangohar et al (2020)

suggested that music therapists who continue to employ tele-music therapy methods will need to be mindful of therapeutic relationship boundaries, the need for flexibility, and the need to consult with colleagues often. They also suggest that working with high-risk patients, such as persons who are chronically suicidal, will require more active planning for client safety, which may involve making emergency contact details available before the sessions, communicating the willingness and ability to contact emergency services, and providing access to inpatient services when needed (Sasangohar et al., 2020).

Digital latency and sound quality issues have both been found to be challenges when making music together online. Latency refers to a time delay between when a sound is created and when it comes out on the other end of the digital divide. The amount of latency can vary depending on the quality of the internet connection, hardware quality, and the video conferencing platform being used. But latency is very difficult to avoid completely, making certain types of dyadic and group online music making very problematic. Sasangohor et al (2020) found that tele-music therapists have needed to make adaptations in music methods used, relying more on receptive music and music composition methods which are not as reliant on synchronicity, and less on dyadic or group improvisations or re-creative music. However, Dowson et al. (2021) found that group music-making and improvisations online are possible, and can work better musically by moving away from musical styles with a strict rhythmic pulse to a more free, arrhythmic musical style such as a soundscape.

Accessibility

Since the outset of the COVID-19 pandemic, it has become more important for music therapists to assess clients for their capacity to access internet-based services. Clients and their caregivers may have barriers to access simply because of inexperience with the internet. In this

case, music therapists may find it helpful to create resources to help these clients navigate online platforms and resources (Knott & Block, 2020). About a third of people in the United Kingdom over the age of 65 were found to be lapsed or "never"-users of internet (Dowson et al., 2021, p.7), and many gave the reason that it is just not needed or that they lack the skills to use it. Dowson et al. (2021) noted the need to assist these older clients who, perhaps due to lock down restrictions, are newly motivated to access online music therapy option.

One of the major benefits of tele-music therapy has been identified as the continuation of services during the COVID-19 crisis. In Cole et al.'s (2021) survey of NMT's experiences, they found that in addition to being able to continue providing sessions, tele-music therapy increased accessibility for remote clients and increased caregiver involvement. Although much needed study has been done regarding accessibility within telehealth practices in general, within the music therapy literature most of the research has focused on the benefits, availability, and acceptability of tele-music therapy options. Research regarding tele-music therapy has also focused on accommodations that have been explored for specific needs of various client groups. With the exception of some studies focusing on rural access to tele-music therapy, there has been little study within the music therapy literature regarding accessibility for specific groups of people. As the music therapy profession continues to respond to the COVID-19 pandemic and to life afterward, there is a need to focus not only on the benefits and availability of tele-music therapy services, but also to focus on possible barriers to access.

Purpose Statement

Since the outbreak of the COVID-19 virus, increasing numbers of music therapists have been engaging in internet conferencing methods in sessions with their clients (tele-music therapy.) Tele-music therapy presents a different set of benefits, as well as challenges, in terms

of client access to music therapy sessions. This research project intended to explore how a sample of music therapists are understanding and responding to these changes in client access. This research project also focused on music therapists' perspectives on how specific groups (cultures, socio-economic groups, etc.) may have been differently affected in terms of access to tele-music therapy. The research questions included:

> What perspectives do music therapists have regarding the benefits and challenges of tele-music therapy in terms of client access?
>
> What are music therapists' perspectives on how specific groups have been affected differently in terms of access to tele-music therapy services?

Method

Theoretical Framework

This study approaches its methodology from an interpretivist, qualitative orientation, which is informed by a set of beliefs about the nature of reality (ontology) and nature of knowledge (epistemology). Interpretive research approaches understand "reality and meaning making as socially constructed" and holds that people "make their own sense of social realities" (Tuli, 2010, p. 100). From an interpretivist perspective, these multiple perspectives of reality are "constructed, interpreted, and experienced by people" within the context of their unique "interactions with each other and with wider social systems" (Tuli, 2010, p. 100). Interpretive research methods can emphasize the following: the understanding of reality through firsthand experiences, the use of context-sensitive data gathering methods such as interviews and focus group discussions, viewing people involved in the study as participants, creating an environment where participants can speak freely to create a more detailed description of a particular

phenomenon, and placing a value on participants being empowered to "make meaning of their own realities" through the process (Tuli, 2010, p.101).

Research Methodology

In this study, I decided to engage a focus group to learn about their perspectives on how specific groups (cultures, socio-economic groups, etc.) may have been differently affected in terms of access to tele-music therapy. Focus group methodology places emphasis on knowledge that is built from the interactions of the discussion participants. Focus group studies are exploratory in nature, and can be used to "generate hypotheses and to explore phenomena" (Ivanoff & Hultberg, 2006, p. 125). The focus group leader works to promote interaction among the participants, creating an open, nonjudgmental environment for discussion. Through the sharing of ideas, the process of listening, and the process of responding in discussion, the focus group discussion can lead to furthering of understanding of a shared experience. The object is not consensus, but to form a "collective understanding" of the participants' various perspectives (Ivanoff & Hultberg, 2006, p. 129).

Rationale for Focus Group

The issues surrounding client access to music therapy and tele-music therapy are complex given the many cultural and situational contexts that clients can inhabit. Individual music therapist's perspectives on client access can similarly vary, depending on the specific groups of people the music therapists serve and the settings in which they practice. Though we have all experienced the common phenomenon of life during the COVID-19 pandemic, we each have experienced it uniquely and in relative isolation, leading to a wide variety of specific experiences and resulting perspectives. To explore the research questions, a focus group methodology

therefore was chosen, in order to bring together individual music therapists' experiences and perspectives. The goal of using a focus group discussion was to allow the participants to further each other's understandings as they respond to each other, and to empower the group to together create a broader understanding. My aim in conducting this focus group discussion was to provide a space where music therapists could together explore the broader meanings of their individual experiences, hopefully leading to further understandings within the profession of how to better provide equitable access to music therapy.

Recruitment Procedures

A purposive sample was used to select music therapists with at least six months experience leading tele-music therapy sessions and preferably five or more years of experience practicing as a board-certified music therapist. These parameters were chosen to ensure that each participant had comparative perspectives of using tele-music therapy methods as well as traditional in-person methods. Calls for participants were posted in two Facebook groups: Music Therapists Unite, and Music Therapists for Social Justice. In order to ensure a diverse group of participants, respondents were directed to a Google poll in which they could identify their gender identity, race, years of practicing music therapy, time practicing tele-music therapy, and the populations with which they work. Participants were then selected for as much diversity of experience and identity as possible. While the aim was to have greater diversity in terms of race and gender, the pool of respondents only included white cisgender women.

Table 1

Participant Demographics

Gender	**Race**	**Sexual Orientation**	**Ability**	**Years in the Field**	**Time Practicing Tele-Music Therapy**
Cis woman (n=6)	White (n=6)	Hetero (n=5)	Disabled (n=1)	10+ years (n=4)	6-12 months (n=5)
		Unknown (n=1)	Non-disabled (n=5)	5+ years (n=1)	1-5 years (n=1)
				3 years (n=1)	

The participants practiced in five states and worked in a variety of settings. Participants worked in private practices (3), in university clinical supervision (1), in acute psych settings (2), in schools (2), and a group home (1). The participants also worked with a variety of groups of service users, including veterans, neurodivergent children, persons with traumatic brain injury and PTSD, youth and their families, and residents of senior centers, nursing homes, and substance-use centers.

Data Collection Procedures

After receiving responses indicating their interest in being involved in the study, all participants were sent an informed consent form (see Appendix A). At the same time, they were invited to reflect on perceived barriers and bridges to client access that tele-MT may present, and on how they may see different populations with which they work experiencing these barriers differently. They were also given a sampling of several possible discussion questions. Participants were informed that they would be participating in a live, online focus group discussion through a group Zoom call. Participants were asked to respond to a Doodle poll in

order to schedule a meeting time that would work for all. In mid-April, a ninety-minute online discussion was held with six participants, during which the researcher encouraged group interaction and discussion around a set of three broad questions and an introductory and wrap-up question. (See Appendix B)

Ethical Considerations

Due to the focus group methodology incorporating live interactive group discussion via video conferencing there was a concern for participant anonymity. Participants were given the options of keeping their camera disabled throughout the discussion and using a pseudonym. None of the participants chose these options and were comfortable identifying themselves to other participants. In order to minimize breaches of confidentiality, geographic information that might identify workplaces or specific settings or any information that could directly identify the individual participants was removed from the results section. Demographic information was included but was synthesized with that of other participants to further conceal individual identities. Given the subject of the discussion could partly focus on the challenges of providing music therapy services during what has been a very difficult year for many, there was a minimal risk that the focus group discussion could cause some emotional discomfort. It was understood that, as music therapists, the participants would have access to therapeutic and supervision resources, but in addition the researcher offered to provide access to music therapy supervision if needed.

Data Analysis and Interpretation Procedure

Interpretive research works toward finding a holistic picture of the issue being studied. This involves “reporting multiple perspectives, [and] identifying the many factors involved in a

situation" (Creswell & Creswell, 2018, p. 182). In order to gain a more holistic picture of the data, I began by reviewing the recorded discussion video, and reading and re-reading the discussion transcription with a focus on the participants' meanings and the flow and progression of the discussion interaction. The transcription was uploaded into a qualitative data analysis software program, ATLAS.ti., then the data was coded to identify themes and significant quotes. Through several re-readings of the transcriptions and continued coding, interrelationships between codes were found, and codes were consolidated into broader themes and subthemes. The researcher used member checking to check for validity of the identified themes. The findings were sent to each participant for confirmation and comment on the validity of my interpretations of their narratives.

Results

The purpose of this study was to explore how music therapists are understanding and responding to the benefits and challenges presented in the move to tele-music therapy, particularly in terms of client access to therapy. The focus group participants responded in their discussion to 4 questions regarding general and specific ways they have experienced tele-music therapy affecting client access to the music therapy, both positively and negatively, ways they have responded to possible challenges, whether they have experienced specific groups' access to therapy being affected differently, and whether they have observed access equity gaps widening or narrowing.

Four themes with 18 sub-themes were found during data analysis. The four categories of themes included a) challenges/barriers to access, b) bridging the barriers, c) making music in tele-music therapy, and d) the future role of tele-music therapy. Each theme and sub-theme will be explored in detail in this section, and narrative passages will be quoted to provide richness of

detail to the themes. Quotes will be in italics when given their own paragraph or placed in quotation marks when within a paragraph. Each participant was assigned a letter (a through f) to ensure confidentiality, and any identifying information was excluded. Example quotes from the focus group participants pertaining to each of the 4 themes can be found in Table 2.

Table 2

The Four Themes with Corresponding Example Quotes

Theme	Example Quote
Challenges/Barriers to Access	"We've gone out of our way to help clients as much as possible access devices, whether it's lending materials or finding a local organization that's willing to give them. But it has highlighted a lot of the inequities in our community as far as—and even before the pandemic—the lack of internet access was a problem."- Participant A
Bridging the Barriers	"I've had some feedback from some of my families and clients that, up until now, some of the coping skills or experiences they've had are very generalized. 'And now all of a sudden, there's this bridge between a facility and a family, like I've literally taken these skills home… And there's this powerful connectivity then that my home can be this space for me.' " – Participant D
Making Music	"It's been really positive… because…I never had a music room. I bounced from conference room to conference room, and that meant no drumming. That meant no instruments because I'm disturbing everybody else. With the telehealth I can send people drums. I can send everything I want to do. I can now do." – Participant C

Future Role of Tele-Music Therapy	"… I'm in a school-based program, when students come back full-time, I am afraid that things will immediately go back to normal. And a big concern for that is… there is no normal anymore. It's a completely new normal. We can't go back to the way it was before for myriad reasons. But especially with autistic and disabled kids, you see trauma in very different ways in this past year. And change has been traumatic for everyone involved. And I'm a little nervous… that when we go back to normal, they're going to just erase everything that happened… and assume that the kids will just welcome the consistency and the sameness, which maybe some kids will, maybe some staff will, but a lot of people probably won't." Participant B

Challenges/Barriers to Access

This theme had 53 occurrences and includes codes in which the participants discussed what they saw as challenges or barriers to client access to tele-music therapy. It includes the following sub-themes: technology challenges, inequities in access, facility- or population-related barriers, safety concerns, challenges of in-home sessions, and hard choices.

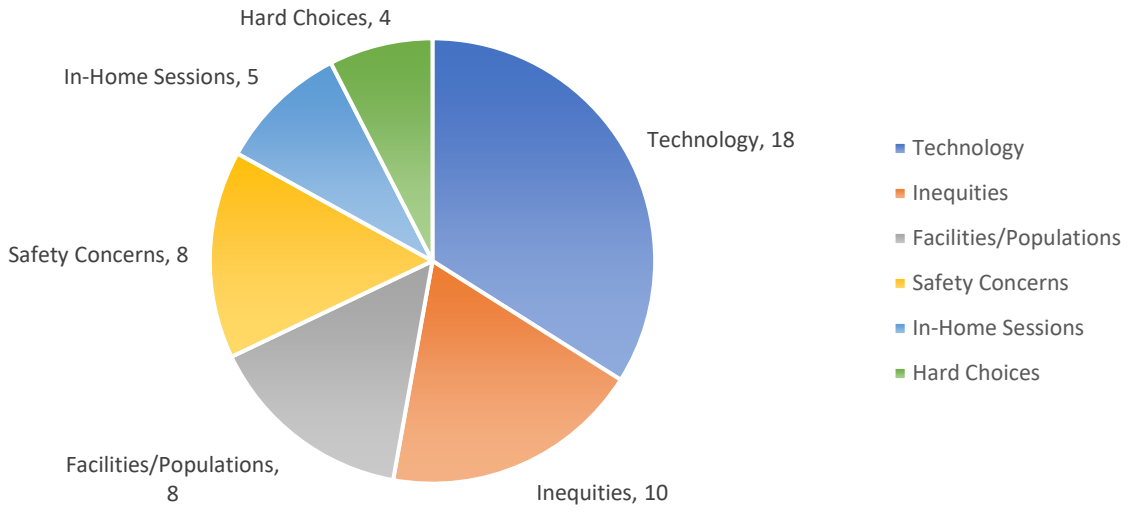

Figure 1. *Challenges/Barriers to Access*. This figure displays sub-themes and number of occurrences found in the category of challenges/barriers to access and includes the codes: technology challenges (18), inequities in access (10), facility- or population-related barriers (8), safety concerns (8), challenges of in-home sessions (5), and hard choices (4).

Technology Challenges. Participants described what they have seen as technological challenges to their clients' access to tele-music therapy. They pointed to unreliable broadband internet access available to rural clients, disparities between suburban and urban clients in accessing needed computers or devices, the learning curve involved for both clients and music therapists in actually using the technology, and audio challenges for the elderly and people with hearing impairments. Participant B pointed to technology access disparities in working within suburban and urban schools, stating:

Some groups of people got access to laptops almost immediately, and some groups didn't. So our suburb, mainly white areas, they immediately had laptops or iPads. But in our cities, in our city schools or the students that I serve there, it was a struggle to make sure they had the proper

equipment, make sure that they could access it if it was their first laptop, and they had to learn how to use it. I had a couple of those situations where we had to coach them through the process of understanding how to use each thing.

Inequities in Access. Participants also pointed to inequities in access for their clients which have existed since before the pandemic, that the pandemic has brought further into the light. The participants discussed their initial and continuing efforts to understand and respond to these inequities, and expressed that "taking a good, hard look" (participant D) at the inequities was "frustrating to witness" (B) and "very rough at the beginning" (A). Participant A described the work of responding to these community inequities in this way:

While [tele-health] has opened doors, in some cases, the lack of connectivity or reliable connectivity has definitely also been a negative impact for some people. We've gone out of our way to help clients as much as possible access devices, whether it's lending materials or finding a local organization that's willing to give them. But it has highlighted a lot of the inequities in our community as far as—and even before the pandemic—the lack of internet access was a problem.

Facility and Population-Related Barriers. Participants shared varied experiences regarding their work within residential settings such as nursing homes, acute psychological facilities, and veterans' hospitals, where certain facilities were unable to make provision for tele-health access. Participant E described the difficulties in access for her clients in residential facilities:

For some of my [clients] especially, they're just not going to focus on to a screen for any extended period of time, or they didn't have a device that would support it. I would say all except

for one of the facilities that I was in pre-COVID have shut down and just declined to even try the online group set up for fear of it just being too complicated. Those facilities have just lost access to the service.

Safety Concerns. In terms of client safety, participants described both benefits and problematic challenges for tele-music therapy access. These safety challenges and benefits mostly revolved around the phenomenon of clients coming to tele-music therapy sessions from their own home. The benefits will be discussed in a later section. Participants described tele-music therapy services in family-based or community-based settings as non-confidential spaces in which the client may not have the safety to identify authentically or discuss confidentially. Participant D described her concerns about client safety in this way:

In my face-to-face confidential in-person groups, I have a lot of kids who will come out as trans, non-binary, gay, whatever, anything on that rainbow curve… They're not necessarily out to their family. Or they are out to their family, but it's not safe, or they're not accepting, or they're navigating it or whatever. Or they were out to some of their school friends, but not others. So in group, we call them by their name and their pronouns. But now I'm doing telehealth and you're in your living room and you're not out to your grandma, who is your caregiver. So then this child has to basically put themselves back in the closet, right? This child is now choosing, "I either have to out myself to my caregiver in order to receive services in a way that is authentic, or I'm going to have to put myself back in the closet and pretend for the next hour." It's tricky, is an understatement. It's really dangerous.

In-Home Sessions. In addition to concerns about client safety, participants brought out other challenges they have seen when clients access tele-music therapy sessions from their homes. Families and caregivers who were already overwhelmed with the COVID-19 pandemic

were often asked to provide more at-home care for children and loved ones. Participants described caregivers as becoming overwhelmed and experiencing burnout. Participant E pointed to the extra work and attention caregivers often need to provide during tele-music therapy sessions:

Our music therapy sessions served as an hour of respite for caregivers, that now that we're in telehealth, … I need caregivers to basically be my hands, a lot of times to facilitate some of these movement exercises or to move the iPad around so I can see what's happening. Now they don't get that anymore. And so a lot of times, I have had caregivers asking, "Okay, when are we going back in person?"

Hard Choices. Participants also focused on the sometimes-difficult choices involved in providing tele-music therapy access. Given the threat of the spread of the COVID-19 virus, participants found themselves gauging client risk levels and their own risk levels as they were deciding whether to have sessions in person or online or not at all. Participant B related the frustration of having the decisions already made for them by the school in which they practice: *That's so interesting to hear everybody talk about the choices about where to go back to in person and where to maintain telehealth, because at the schools we had no choice. It was, "You're coming back in person, you're doing music therapy."* In addition, given limited resources, difficult decisions needed to be made prioritizing which clients received assistance and to what extent, as Participant C related:

There was a point where, at the private practice, we bought three iPads, and we had to kind of like prioritize who needs it the most. We're like, "Yes, you can have one of our loaner iPads", but it was hush-hush because we don't have enough for everyone because we're not made of money.

Bridging the Barriers

This theme had 26 occurrences and includes codes in which the participants discussed what they saw as the benefits of tele-music therapy in regard to client access, as well as ways that they responded to the challenges to tele-music therapy. It includes the following four sub-themes: benefits to specific populations, in-home session benefits, bridging distance, and finding solutions.

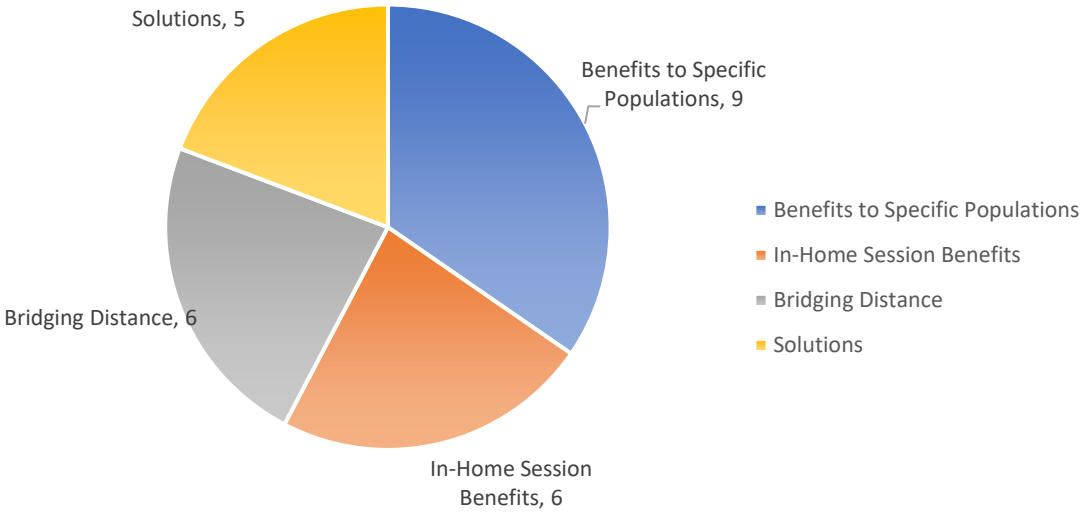

Figure 2. *Bridging Barriers*. This figure displays sub-themes and number of occurrences found in the category of bridging barriers and includes the codes: benefits to specific populations (9), in-home session benefits (6), bridging distance (6), and solutions (5).

Benefits to Specific Populations. Participants pointed to a wide variety of population groups that they've seen as benefiting from access to tele-music therapy. One group which was mentioned included clients who have busy work schedules, as participant C related, "I'm starting to get clients who work and they can go to their car for an hour, take their lunch break, and they can actually get the therapy because they could never come before." Other benefiting groups

mentioned were those in palliative care, young adults who don't yet have driver's licenses, veterans, and neurodiverse clients. Participants also discussed the benefits to neurodiverse children, where tele-music therapy sessions held in the child's home have allowed more freedom to practice with a more humanistic model. Participant B related the following scenario:

If we were doing our thing and then the student decided they didn't want to do it anymore. So, they would turn to pick a different instrument. There'd be a paraeducator behind them saying, "Well, we need to earn our next star. Otherwise you don't get [inaudible]." And it made me just so frustrated, but then that same student who was struggling and didn't want to do anything in a music session with me in person. And I got to see them virtually, they were thriving.

In-Home Session Benefits. Participants shared benefits gained by a client's ability to attend music therapy session from their homes. They described in-home music therapy sessions as adding to the client's sense of comfort and safety, and described the very positive feelings that sharing their personal spaces (and even their pets) would bring. As participant F stated:

The dogs and the cats that have joined therapy have been really wonderful. And I think those, although it's kind of silly, but it adds to safety and that's been something I've cherished just seeing people's spaces, and the kids love to show their rooms and people like to see our spaces. And I think that's been, although it's trite, it's also been really, really valuable.

Participants also pointed to in-home music therapy sessions as an important bridge to the clients' families and to skills transfer. Participant D shared the following:

I've had some feedback from some of my families and clients that, up until now, some of the coping skills or experiences they've had a very generalized [inaudible]. So… "I come to therapy and we do a meditation, or a guided relaxation. We write a song, we do this... and it

happens in your office, in our group room, in your facility. And now all of a sudden, there's this bridge between a facility and a family, like I've literally taken these skills home. And now I'm learning to do those things in my living room. I'm learning to do those things in my bedroom. I'm learning to do those things in my home. And there's this powerful connectivity then that my home can be this space for me."

Bridging Distance. The participants shared ways they have seen tele-music therapy help bridge the physical distance between themselves and their clients. They described the greater accessibility for homebound clients, and they also focused on the greatly reduced need for long commutes to a shared clinical space both for themselves and for the clients. As participant A put it:

We've been able to connect... That 70-mile drive to [the city] can take an hour. It can take three hours depending on traffic. Now, we're able to work with clients and facilities in [the city] that we just wouldn't have been able to work with because of the time commitment, which is really neat. Because there are some populations that we might not have access to because of [our] rural location.

Solutions. Participants discussed ways they and their communities were responding to the challenges of tele-music therapy access. These responses include assisting clients in accessing devices and computers, and employing music-making platforms such as Garageband and Soundtrap to enable on-line musical collaborations. Participants also shared that they found themselves having to re-think and adjust their approaches to sessions, sometimes in significant ways. Participant D explained:

So, there's this massive shift to these groups and a lot more like psychoeducational. We're learning and practicing coping skills, not processing our trauma and navigating our stuff. And that shift has been... Again, are those groups still helpful and supportive to those youth? My data and their assessments say yes, but it also says that we're not doing the same thing anymore. We're in a completely different approach.

Participants also spoke of their involvement in community-based responses to inequities in technology access. They shared examples of disparate community organizations pulling together for resource sharing, and of gaining a sense of community as they and their clients together struggled to make their way through the pandemic. Participant A shared what she saw in her community:

And so when this all started, a bunch of us were trying to get laptops to facilities... And so people here like city council members were doing laptop drives, and we were raising money and going into pawn shops and buying computers that were for sale and asking them for discounts and just trying to load up. But it really became like a community imperative that this should not be on the clients and the students, and that it shouldn't be if they cannot get access to these it's "Too bad, so sad." So I did see the community sort of stepping up here to try and get technology or hotspots for internet access into people's hands.

Making Music in Tele-Music Therapy

This theme had 21 occurrences and includes codes in which the participants discussed how tele-music therapy was affecting music-making in sessions, and how they were responding musically. It includes the following four sub-themes: music-making challenges, singing, musical instruments and technology, and musical solutions.

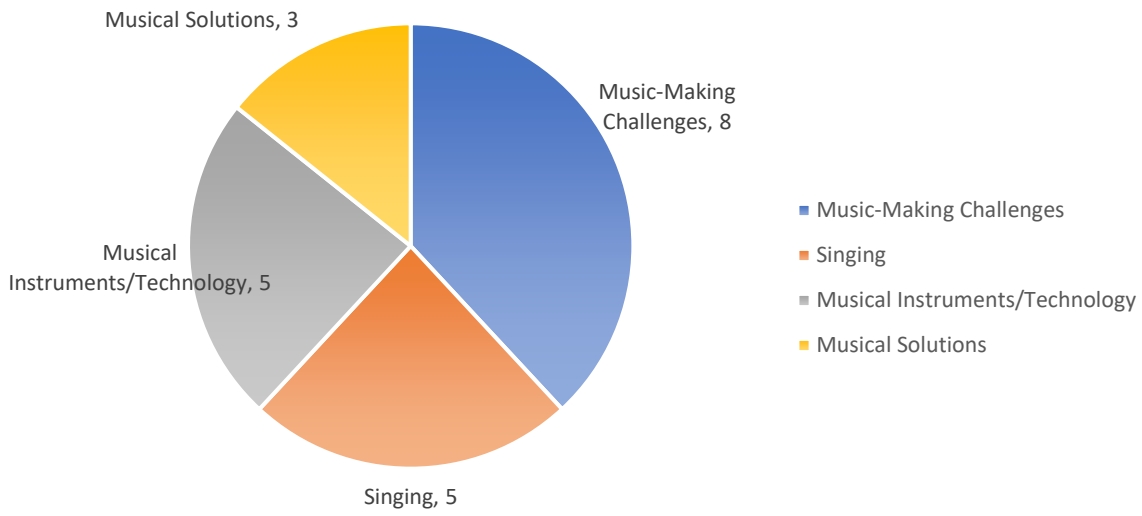

Figure 3. *Making Music in Tele-Music Therapy*. This figure displays sub-themes and number of occurrences found in the category of making music in tele-music therapy and includes the codes: music-making challenges (8), singing (4), musical instruments/technology (5), and musical solutions (3).

Music-Making Challenges. Participants described the various challenges of making music with clients within tele-health sessions. Given that music therapists often bring their own instruments with them to facilities or to client homes, one significant challenge involves the relative shortage of musical instruments available to clients during tele-music sessions. One participant also noted that, even when musical instruments were available during on-line sessions, it would become a challenge for clients who needed the music therapist's physical assistance in handling the instruments.

Participants pointed to a steep learning curve related to gaining fluency in synchronous music making in tele-health sessions. The same type of learning curve was noted in gaining experience making music digitally through digital audio workspaces and other on-line music

making technologies. Participants discussed the challenges that poor sound quality during tele-music therapy session brings to music-making. Chief among these sound issues is time-lag, or latency, which causes the sound signal to be delayed enough to make synchronous music-making very problematic. Participant F describes the challenges of latency:

And when I do live music together, I'm … trying not to pay attention to what's happening. I work with a little boy on singing… but I have to... Sometimes I'm tempted to catch up to him, but I know if I catch up to him, then it will sound off to him. And then I'm like, "Is he singing in time? Is this part of his challenge? Is it the computer?"

Singing. Participants noted that, because of COVID-19 response restrictions, group singing was a good option when meeting in-person. In these situations, in-person sessions relied more heavily on instrumental music-making. However, singing together remained safe and practical part of one-on-one tele-music therapy sessions. Participant B stated:

And [when] I got to see them virtually, they were thriving. They were playing along, they were singing, they were at home with their mom and they were in a safe space. So, that part was really wonderful.

Musical Instruments/Technology. Participants pointed to helpful and new ways that they were able to use musical instruments and technologies within tele-music therapy sessions. One participant described using digital multi-tracking software with clients of all ages in creating referential songwriting projects. Another participant related how tele-music therapy sessions allowed for more flexibility in instrument choices, and how she creatively and proactively found ways to provide musical instruments for her tele-health clients. Participant C went on to say:

It's been really positive… because we have a terrible, terrible space issue. This building was built in 1950, and it's not made for half the things we need now. I never had a music room. I bounced from conference room to conference room, and that meant no drumming. That meant no instruments because I'm disturbing everybody else. With the telehealth I can send people drums. I can send everything I want to do. I can now do.

Musical Solutions. Participants described musical solutions they were using to respond to on-line music-making challenges such a latency. Participants described moving away from synchronous music-making during tele-music therapy sessions. One participant shared that music making in her on-line sessions employed more musical turn-taking, in which the client and music therapists would take turns in sharing music, and in giving feedback or processing the music. Other participants pointed to creating musical collaborations through the use of on-line platforms such as Soundtrap. Participant A shared:

A colleague] was telling me about this really neat model she developed with... I think it's a community organization that primarily serves LGBTQ community and Black and Brown folks. And they were doing tele-health whenever they could, but in between they had collaborative projects that they worked on together whenever they could access it. I forget what the program is, but it's like Google Docs but with a digital audio workspace. So you don't have to all be synchronous. You can add and take things away on your own time and everyone has access to it.

Future Role of Tele-Music Therapy

This theme had 18 occurrences and includes codes in which the participants touched on future aspects of tele-music therapy practice. It includes the following three sub-themes: hopes and concerns, preparing for the future, and possibilities.

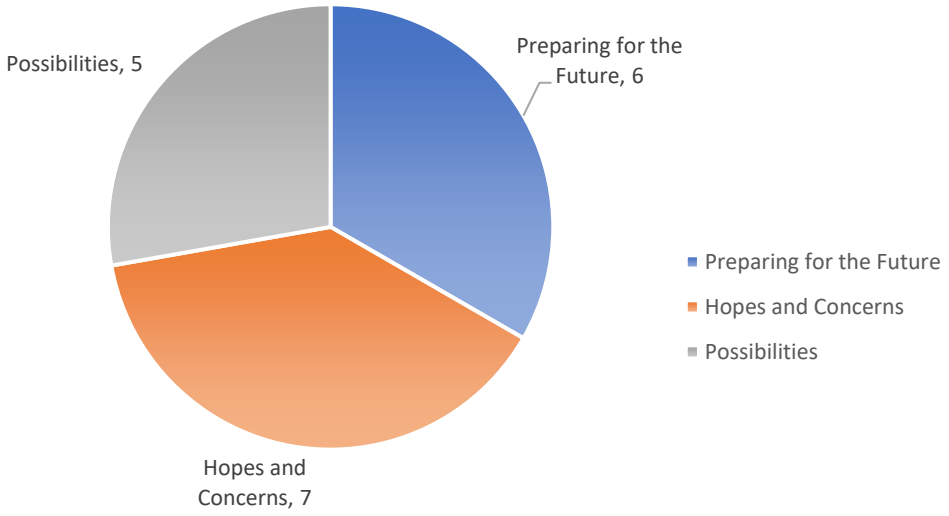

Figure 4. *Future Role of Tele-Music Therapy*. This figure displays sub-themes and number of occurrences found in the category of the future role of tele-music therapy and includes the codes: preparing for the future (6), hopes and concerns (7), and possibilities (5).

Preparing for the Future. Participants discussed how they would like to see tele-music therapy evolving in the months and years ahead in a hopefully post-pandemic world. Some participants questioned to what extent they would continue seeing clients in tele-health. Participants questioned what a return to "normal" life would look like and if it was actually possible. Participants who worked with children or had children of their own pondered what reopening schools would look like and what should be their response. Participants noted the eagerness among practicum students to try new online technologies as they start out in the profession. Participant A shared a vision of a music therapy profession embracing a broader view of what music therapy actually can involve, stating:

…we've been taught that music therapy is less valid, or not real music therapy if we find adaptive ways to meet our client's needs that don't involve weekly synchronous meetings. But our relationships with our clients are still valid, and … it's not not therapy because of that. And so I also hope that in the future, our education, and the new music therapists, but also their professional organizations, aren't gatekeeping and policing what isn't music therapy when board certified music therapists are involved. Because it's still important and valid work, even if it doesn't look the way that it did in the 1950s.

Hopes and Concerns. Participants expressed hopes that we as a profession will continue thinking about access on a broader level, based on the realization that the pandemic brought into view inequities that have long existed. Participants shared hopes that music therapists will be prepared to advocate for tele-health for their clients who may need it. There were hopes expressed also that inequities would continue to be addressed, through expanding community resource sharing, and through providing continued options for on-line music therapy internship placements. Participant E:

I don't think it's necessarily possible for internships to remain completely virtual, but it's lovely to have the option for financial reasons at least, maybe that could be helpful for fewer barriers to entry in our profession.

Participants also expressed concerns relating to the future availability of tele-music therapy. One participant shared that telehealth approval is tied to an emergency disaster declaration in some states, which may not continue past the COVID-19 pandemic. Another participant had concerns as to the reopening of the school systems in which she works. Participant B states:

One concern that I have is, because I'm in a school-based program, when students come back full-time, I am afraid that things will immediately go back to normal. And a big concern for that is, and I've seen this all over the internet… there is no normal anymore. It's a completely new normal. We can't go back to the way it was before for myriad reasons. But especially with autistic and disabled kids, you see trauma in very different ways in this past year. And change has been traumatic for everyone involved. And I'm a little nervous, because of the behavioral way that my school is centered around, that when we go back to normal, they're going to just erase everything that happened, pretend that it didn't happen, and assume that the kids will just welcome the consistency and the sameness, which maybe some kids will, maybe some staff will, but a lot of people probably won't.

Possibilities. Participants shared ideas for making tele-music therapy more accessible and viable in the future. They focused on the need for advocacy aimed toward continued access for clients who have responded well to tele-music therapy. Participants also stressed the need for data to support such advocacy. Participant D stated:

We're going to need data. Like it or not, the powers that be are going to need proof of what we're talking about. So if we're saying tele-health actually makes medical and mental health services more accessible for X, Y, and Z reasons, … we [need to] have data that says that this is effective in these ways, that it's meeting needs in these ways, and that we can show that this needs to be a viable option always, not just during crisis.

Participants also suggested that the music therapy profession could devote resources toward tele-music therapy education, training, and support. Participant A suggested that this could allow tele-music therapy to become a more viable, integral part of music therapy practice, stating:

As an educator, I'm thinking … this has to be part of our curriculum. Future music therapists need to at least have an experience with telehealth that could carry them forward. And then also AMTA and our professional organizations need... I mean, and I was the same way and I admit I was wrong, we really poo-pooed tele-health as a viable modality. And I think we need to rethink that. And there needs to be more support and resources, and not just because it's an emergency situation, but to make it more viable long term.

Discussion

This research study aimed to explore how music therapists are understanding and responding to changes in client access since the move toward tele-music therapy spurred by the recent COVID-19 virus outbreak. Coming from a recognition of histories of health access disparity for underserved populations, this study also sought music therapists' perspectives on how specific cultural groups and identities may have been unequally affected in terms of access to tele-music therapy. Research questions explored music therapists' perspectives regarding the benefits and challenges of tele-music therapy, particularly in terms of client access. The study also focused on ways that therapists found to respond to these challenges and to any disparities in access they encountered.

During the focus group discussion participants shared from their own unique and varied points of view and experiences with tele-music therapy. They described challenges and inequities to access for their clients in residential settings, in the schools, and in their clients' own homes. They expressed the initial emotional challenge of seeing these disparities, while also pointing to specific ways they and their communities were able to positively respond. Participants discussed ways that tele-music therapy was benefiting specific populations which with they worked, including folks with busy work schedules, clients living at a distance, and

neurodiverse children. They also observed that clients accessing sessions from their homes can aid in skills transfer. Participants provided descriptions of the musical challenges presented in tele-music therapy sessions, and discussed musical solutions with which they responded. Participants shared their hopes that tele-music therapy would remain a viable and supported option beyond the needs of the current pandemic, and they pointed to the need for data and research to support continued advocacy for tele-music therapy options. They shared hopes for a broader vision of music therapy which would more actively embrace tele-music therapy options, and discussed the need for continued allocation of professional resources and training in tele-music therapy.

In reflecting on the focus group discussion, I recognize that each participant was bringing with them their own experience of the first twelve months of the COVID-19 pandemic. This was a very new experience during which each had to make major adjustments to their personal and professional lives. In the group discussion they openly shared their lessons learned in creatively and proactively responding to their clients' needs through tele-music therapy. As someone new to the music therapy profession, I was inspired to be a part of that discussion. As the researcher, my goal was to let the discussion evolve and find its own direction, and I was happy to see the participant interactions did just that. I appreciated the depth of responses as well as the thoughtful and open discussion. Each of the participants, and I as well, had been through a difficult and sometimes isolating year, and the support and encouragement the six music therapists brought to each other in our 90-minute discussion was healing to see personally.

The broader healthcare and public health literature point to continued disparities in access to healthcare along racial lines, with white people experiencing the most benefits from the healthcare system and people of color seeing the least (Flores & Tomani-Korman, 2008a;

Manuel, 2018; Yue, Rasmussen, and Ponce, 2018; Malawa et al., 2021). Consistent with these studies, participants of this study pointed to racial disparities, noting that their clients in suburban, mostly white school systems had much easier access to adequate telehealth technology than their clients in urban school systems who were primarily people of color. Participants also focused discussion on access disparities based on socioeconomic levels, which the current pandemic has brought more into focus for them. This is consistent with healthcare literature which has found less access to healthcare across a broad range of age groups for people in lower socioeconomic levels (Almeida et al., 2017; Spencer, et al., 2017).

Participants described their responses to geographic access challenges, which are reflected in the healthcare literature in terms of a maldistribution of healthcare providers and services between urban and rural locations (Marcin et al., 2016; Jolly, 2019). Both the music therapy literature (Lightstone et al., 2015; Vaudreuil et al., 2020; Cole et al., 2021) and broader healthcare literature (Khairat et al., 2019; Noel & Ellison, 2020) suggest that telehealth sessions can increase accessibility for remote clients and bring them savings in cost and travel time. This is echoed in the participants' observations of the ways that tele-music therapy helped bridge the physical distance between themselves and their clients.

Consistent with research calling for policy changes which might ensure more equitable availability of telehealth (Campos-Castillo & Anthony, 2021; Malawa et al., 2021), participants focused on the need for advocacy aimed toward continued tele-music therapy access for clients beyond the current pandemic.

There were some notable ideas shared in our focus group discussion that were unanticipated in the review of the literature. The participants pointed out the benefits to music therapy students of having the option of fulfilling internship or practicum requirements through

virtual sessions. During the current COVID-19 pandemic, many music therapy students, including this researcher, have been able to complete their practicum or internship placements from their own home or dorm room, thereby reducing the financial burden of traveling or relocating for months at a time. Participants suggested that keeping this option open beyond the needs of the pandemic response would remove some of the financial barriers of entry into the music therapy profession and could help level the socioeconomic playing field for new music therapists. Also, while the literature tended to focus on professional, institutional, and government responses to healthcare access disparities, entering into our focus group discussion was an awareness of how local communities were responding these challenges. Participant discussion focused on local communities coming together to work at resource sharing in response to telehealth technology and internet access needs, and in the process building community ties and community health.

In reflecting further on the focus group discussion, I am finding that one aspect of my own experience with tele-music therapy was not touched on in their conversation. During my advanced practicum experience I was not only needing to learn how to better navigate the technological side of making connection through online platforms, but I was also newly navigating connections across cultural differences. Most of the clients I was now working with, individually and in group settings, were people of color, whereas most of the clients I had worked with before in a hospice internship had been white like me. I'm sure I'm not alone in needing to reflect on how to navigate such differences. Though this was not a primary focus of the research question, it may have been instructive to ask the participants how cultural differences within the music therapy relationship may have contributed to challenges of connecting virtually through tele-music therapy.

Limitations of this Study

A limitation of this study is the small sample size of the focus group participants. Though having only six participants involved in the discussion allowed for dynamic interaction, their experiences may not be representative of a broader range of music therapists, nor are the results necessarily generalizable across the diverse field of music therapy.

Despite the researcher's intentions of gathering a diverse sampling of participants, participant demographics were quite homogenous due in part to the small sample size, the recruitment process, and the homogeneity of the music therapy field itself. All of the 6 participants were white, college educated, and identified as cisgender women. One of the 6 participants identified as disabled. This researcher's difficulty in recruiting a broader cross-section of participants may stem from my own white, cis, hetero, ably situated world, which make it harder for me to reach across to invite others of different identities. Also, given that recruiting and sampling was taking place during the height of COVID, certain identities that were hit harder by COVID may have been less ready to devote energies toward participation in this study. This lack of diversity of participants in a study which has as its goal a focus on access inequities for marginalized groups and identities is a significant limitation. The largely privileged sociocultural locations held by the participants of the study (and myself) act to limit our personal knowledge of, and experience with, access barriers, and make it more difficult to recognize the many barriers to access that marginalized folks will face.

As the researcher, my goal during the focus group discussion was to allow the discussion to flow of its own direction without interjecting my own experiences or opinions. Likewise, in the analysis of the data, I sought to keep the focus on the experiences, meanings, and insights brought out in the discussion, with as little focus as possible on my own interpretations and

priorities. This can be a challenge within qualitative studies, and in this case made more problematic by my own identities. Recognizing that my male identity could make it difficult for me to hear and prioritize the voices of women without interjecting my own voice, I committed myself to being self-reflexive about this during the analysis and interpretation of the data. The process of member checking was helpful as well in assuring that I was not misinterpreting their conversation.

This study took place within a context of a multifaceted and ever-evolving pandemic which affected us all in many various ways. This research focused on client access to tele-music therapy during a time of lockdowns and the lifting of lockdowns, when facilities and schools were closing and reopening again, and while clients and music therapists were struggling to find ways to respond to a difficult, new, and ever-changing situation. Much has changed and people's situations have evolved much in the several months since our focus group discussion took place. Given the complex and changing nature of peoples' experiences during this time, generalizing from one small focus groups' experience may seem problematic. Despite this limitation, I hope that the shared understandings brought out in the group discussion can lend an important puzzle piece to a broader understanding of client access to tele-music therapy.

A final limitation of this study is that while music therapists' perspectives were sought out in regard to their clients' access to therapy, the voices of those clients were not directly heard. Though the perspectives of the music therapists are valuable in themselves, further research which prioritizes the voices of the clients will further deepen any perspectives gained in this research.

Recommendations for Future Research

As mentioned above, as we seek a more complete picture of client access to tele-music therapy, research is needed which centers the experiences and perspectives of music therapy clients themselves. Qualitative research studies could be conducted utilizing interviews or surveys with music therapy clients exploring their experiences in tele-music therapy sessions and any barriers to telehealth access that they have met with. And based on my reflections above, there could be further explorations into how we navigate cultural differences within tele-music therapy, particularly looking at client perspectives. Quantitative studies will be helpful as well in gaining understandings of the demographics of who is accessing in-person music therapy sessions as compared to tele-music therapy sessions. In line with the participants' call for continued availability of online music therapy internship options, research may be needed to explore how tele-music therapy supervision has impacted access to supervision. As also stressed by participants in this study, in order to advocate for continued availability of tele-music therapy services for our clients, more data will be needed to show the effectiveness and accessibility of tele-music therapy.

Conclusion

During the past year and a half, music therapists have needed to respond to the sudden changes brought on by the COVID-19 pandemic. Shutdowns and social distancing measures caused many music therapists to begin exploring telehealth or tele-music therapy options for their clients. The results of this study suggest that music therapists are finding a complex set of both benefits and challenges in terms of their clients accessing tele-music therapy. This focus group discussion has implications for music therapy practice at an organizational level in terms of a call for more support and resources aimed at equitable access to tele-music therapy, and at

an individual practice level in terms of opening ourselves as music therapists to new ways to connect with underserved clients, not just temporarily during a pandemic, but as longer term options for greater access. My aim in conducting this study was to provide a space where music therapists could together explore the broader meanings of their individual experiences of response to the pandemic. Here at the end of 2021, as the worst of the pandemic seems to be fading, my hope is that this and further studies may lead to deeper understandings within the profession of how we can provide more equitable access to music therapy, whether through more traditional formats or through the use of tele-music therapy.

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Appendix A

CONSENT TO PARTICIPATE IN RESEARCH

Music Therapists' Perceptions of the Effects of Tele-Music Therapy on Client Access

Susan Hadley, Ph.D, MT-BC; susan.hadley@sru.edu

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Invitation to be Part of a Research Study

You are invited to participate in a research study. In order to participate, you must be a board-certified music therapist with at least 5 years of clinical experience, who also has at least 6 months of tele-music therapy experience. Taking part in this research project is voluntary.

Important Information about the Research Study

Things you should know:

- The purpose of the study is to explore how music therapists are understanding and responding to changes in client access due to shifts toward tele-music therapy. If you choose to participate, you will be asked to participate in an (1) online focus group discussion. This will take up to 90 minutes.
- There are no anticipated risks or discomforts from this research. There is a minimal chance that the experience may cause some emotional discomfort.
- The study will potentially benefit the participants by providing further insight and perspective into their own professional practice.
- Taking part in this research project is voluntary. You do not have to participate, and you can stop at any time. Please take time to read this entire form and ask questions before deciding whether to take part in this research project.

What is the Study About and Why are We Doing it?

The purpose of the study is to explore how music therapists are understanding and responding to changes in client access due to shifts toward tele-music therapy. Since the outbreak of the COVID-19 virus, increasing numbers of music therapists are engaging in internet conferencing methods (tele-music therapy.) We intent to explore the various benefits and challenges that tele-music therapy presents in terms of client access to music therapy sessions. This research project will also focus on music therapist perspectives on how various groups (cultures, socio-economic groups, etc.) may have been differently affected in terms of access to tele-music therapy.

What Will Happen if You Take Part in This Study?

If you agree to take part in this study, you will be asked to reflect on perceived barriers and bridges to client access that tele-music therapy is presenting, and on how you see different populations with which you work experiencing these barriers or bridges differently. You will be then asked to discuss your reflections with 4 to 7 other participants of the focus group. The researcher will facilitate the discussion with the participants via Zoom in a focus group format, for a 75 - 90 minute, one-time session. The research will facilitate the discussion by asking open-ended questions such as: "In what ways have you experienced tele-music therapy affecting client access to sessions (positively or negatively?)" and "Can you describe how you've seen any particular population groups that are being affected differently in terms of access?" At this time, only one meeting is expected; however, if the need for an additional meeting arises, the researcher will be in communication with the participants about this. The discussions will be recorded using the recording interface of the video conferencing platform. The recorded data will be transcribed and then deleted and destroyed. The transcription will not include the participants' name, but may include demographic information about the participants.

How Could You Benefit From This Study?

You might benefit from being in this study because reflection and group discussion may provide further insight and perspective into you own professional practice.

What Risks Might Result From Being in This Study?

There are no anticipated risks or discomforts as a result of participating in this study. There is a minimal chance that the experience may cause emotional discomfort. Discussions surround inequitable access to resources may cause some minimal emotional discomfort. As therapists, we understand that you have access to therapeutic and supervision resources, and we can provide access to music therapy supervisors, if needed.

How Will We Protect Your Information?

We plan to publish the results of this study. To protect your privacy, we will not include information that could directly identify you. We will protect the confidentiality of your research records by keeping videotapes of the interviews in a password-protected folder on our password-protected computer(s). They will be transcribed and then destroyed. Interview transcriptions will contain your demographic information but not your name. At the conclusion of this study, we may publish the findings. Your name and any other information that can directly identify you will be stored separately from the data collected as part of the project. No names will be included in publications or presentations. Your demographic information may be included but will be synthesized with the demographic information of other participants to further conceal your identity.

What Will Happen to the Information We Collect About You After the Study is Over?

We will not keep your research data to use for future research or other purposes. Your name and other information that can directly identify you will be deleted from the research data as part of the project.

How Will We Compensate You for Being Part of the Study?

There is no compensation for this study. It is completely voluntary.

Your Participation in this Research is Voluntary

It is totally up to you to decide to be in this research study. Participation in this study is voluntary. Even if you decide to be part of the study now, you may change your mind and may withdraw from participation at any time. If you decide to withdraw before this study is completed, any data collected during your participation will be destroyed. You do not have to answer any questions that you do not want to answer.

Contact Information for the Study Team and Questions about the Research

You may contact Susan Hadley at susan.hadley@sru.edu, or David Landes at dgl1003@sru.edu, if you have questions about this research.

Contact Information for Questions about Your Rights as a Research Participant

If you have questions about your rights as a research participant, or wish to obtain information, ask questions, or discuss any concerns about this study with someone other than the researcher(s), please contact the following:

Institutional Review Board
Slippery Rock University
104 Maltby, Suite 008
Slippery Rock, PA 16057
Phone: (724)738-4846
Email: irb@sru.edu

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. Please print this email attachment, sign, and scan this document and return it via email to the coresearcher, David Landes. You will be given a copy of this document for your records. We will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact us using the information provided above.

I understand what the study is about and my questions so far have been answered. I agree to take part in this study. I understand that I can withdraw at any time. A copy of this signed Consent Form has been given to me.

_____ _____ _____

Printed Participant Name Signature of Participant Date

By signing below, I indicate that the participant has read and to the best of my knowledge understands the details contained in this document and have been given a copy.

_____ _____ _____

Printed Name of Investigator Signature of Investigator Date

Audiotape/Videotape Release Form:

We request the use of audiotape/videotape material of you as part of our study. We specifically ask your consent to use this material during the study, as we deem proper. Regarding the use of your likeness in audiotape/videotape, please check one of the following boxes below:

I do ____

I do not ___

give unconditional permission for the investigators to utilize audiotapes/videotapes of me.

_____	_____	_____
Printed Participant Name	Signature of Participant	Date

Appendix B

Focus Group Discussion Questions

Introductory Question: briefly introduce yourself, describe your music therapy practice, and how you've been making use of tele-health methods in sessions.

1. In what general ways have you experienced tele-music therapy affecting client access to the music therapy sessions (positively or negatively?)
2. What specific benefits and/or challenges does tele-music therapy present for client access in your experience, and in what ways are you responding to the possible challenges?
3. Are you finding that specific groups are being affected differently in terms of access to tele-music therapy services? (by age, ability, social/cultural identities, economic levels?) And have you seen any access equity gaps narrowing or widening for under-represented groups?

Wrap-up question: Do you have any more thoughts about how you've seen your clients' access to sessions affected by the shift toward telehealth during this past year?