

Repositioning music therapy service evaluation: a case of five Nordoff-Robbins music therapy service evaluations in neuro-rehabilitation

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Abstract

Service evaluations in music therapy often have local, functional and immediate goals, such as ensuring quality and continuing funding. However, given the amount and type of information collected in service evaluation projects from therapists, clients and those around them, such – often unpublished – projects may constitute a hidden treasure trove of information particularly about the perceived impact of music therapy services. In addition to exploring potentially challenging aspects of service evaluations in music therapy, this article considers how these can contribute to the understanding of music therapy through analysis of five service evaluations. These service evaluations share a common approach (Nordoff-Robbins) and area of work (neuro-rehabilitation) and were informed by sociocultural epistemologies underpinning contemporary Nordoff-Robbins practices. Such epistemologies consider people's everyday experiences and contexts, and encourage an exploration of the music therapy service in its entirety. It is from this perspective that this study explores the impact of music therapy services in neuro-rehabilitation settings as perceived and reported by clients and those around them. Although the perceived impact of music therapy beyond the client has been previously discussed, this seems to have been less emphasised in neuro-rehabilitation settings where the focus tends to remain on the client and their rehabilitation progress. We discuss how the context-sensitive nature of such evaluations can enable the potential for identification of areas of impact that can feed back into practice as well as generate research questions.

Keywords: Service evaluation; impact; Nordoff-Robbins music therapy; neuro-rehabilitation

Introduction

Service evaluations are often associated with pragmatic aims, such as attempts to review a service, ensure quality and inform funding decisions. Within the UK, recent years have seen an increased demand for service evaluation protocols and for convincing evidence of service effectiveness, not only within large organisations and service providers (e.g. the UK's National Health Service), but also as part of the skillset required of UK-registered music therapists, as set by the UK registration body for arts therapists (HCPC, 2013). However, within music therapy service provisions, service evaluations are accorded

limited resources and support for music therapists, many of whom work part-time; and many employers emphasise contact time with clients as the service priority (Cartwright, 2015; Watkins & Tansley-Thomas, 2015). Results of service evaluations (especially in cases of small-scale projects) often remain hidden in the form of internal organisational reports which do not make it to the public arena. Additionally, service evaluations, which are shaped by their functional nature and pragmatic decisions, do not appear to be widely considered within the research community.

This state of affairs – which seems to be present in many countries in addition to the UK – raises various questions and dilemmas. Examples include whether music therapists should relinquish all aspects of evaluation procedures to “evaluators”, who may know little about the nature of the service, in the interest of concentrating on music therapy ‘contact time’; whether music therapists are able to undertake rigorous evaluations given the paucity of support and resources; and how best the service itself might be represented in evaluations. In reconsidering how music therapy might engage with the concurrent increasing demands and limited resources for service evaluations, we explore what can be learnt from such evaluations of music therapy services.

Drawing from an archive of internal unpublished evaluation reports of music therapy services, we – a team that was heavily involved in the original evaluation team – focus on the case of five service evaluation reports that have in common an improvisatory-based service delivery (Nordoff-Robbins music therapy), within settings whose primary focus is neuro-rehabilitation. We collate the reported results and attempt to reposition service evaluation. While acknowledging their limitations, we consider what service evaluations can contribute to emerging dialogues within and around music therapy in neuro-rehabilitation and beyond.

In order to set the context for our evaluative ethos, we first explore the current position of service evaluation and provide a brief review of Nordoff-Robbins literature in neuro-rehabilitation settings. This provides a platform for the current study, which is a retrospective analysis of five service evaluation reports. The presentation of the study findings focuses on the kinds of impact that music therapy is perceived to have by the different participant groups. The study findings speak the language of “impact” and “effectiveness”, while the original reports also convey the individual experiences of music therapy through idiosyncratic personal narratives. The potential tensions between impact-driven effectiveness and services adopting an improvisational interactive stance provide a starting point for our exploration. The paper concludes with a questioning of and reflection on service evaluations’ contribution to future practice and research initiatives. This questioning signals our championing of the humble service evaluation as a source of ideas and inspiration for research and practice development.

Commonly accepted hierarchies of evidence (Evans, 2003; Wigram, Pederson, & Bonde, 2002) communicate at least two messages: that evidence has to do only with research, and that certain research methodologies, such as systematic reviews and randomised

controlled trials (RCTs), are the gold standards of evidence. Critiques of the hierarchy of evidence offered by music therapists and others (Aigen, 2015; DeNora & Ans dell, 2014; Stige, 2003; Wood, 2015) propose many pathways to evidence, such as monitoring, service evaluation, assessment and audit, and these necessitate tailored aims and procedures, with different kinds of participation and interventions (NHS Health Research Authority, no date). We suggest that each pathway can be equally important as long as there is an alignment between its scope, aims, methods and anticipated results. Studies that compare the effectiveness or efficacy of interventions, for example, are a particular way of representing, understanding and testing music therapy. These may be RCTs (and the related Cochrane reviews, see for example Bradt, Magee, Dileo, Wheeler, & McGilloway, 2010) or other between group comparisons (e.g. Nayak, Wheeler, Shiflett, & Agostinelli, 2000). Such studies continue to make advances in testing hypotheses of effectiveness of music therapy for clients. Similarly, case studies that trace clients' journeys through therapy, which often include interaction with those around them, provide valuable insights into the observed effects of music therapy (e.g. Magee, 1999).

We understand service evaluations to be distinct from (and also aligned with) accounts of practice that include case studies and research reports; and distinct from assessments and evaluations that focus on the effects of music therapy on individual clients (Raw, Lewis, Russell, & MacNaughton, 2012). In evaluating the music therapy service as a whole, information needed includes collation of reported perceptions of the service from a range of sources at each worksite (including clients, their families, music therapists and staff). This evaluative information is often combined with monitoring information such as retrospective monitoring figures of sessions delivered and numbers of attendances.

Service evaluations offer a different form of evidence (Public Health England, 2016), whose fit with the kinds of methods touched on above (e.g. RCTs) is questionable for some researchers and employers. Commonly, service evaluations aim to represent the perceived impact of a service and define current care provision. They do not refer to a predefined standard (as happens in audits) and do not introduce a new intervention or control group (as often happens in comparative research studies). Also, service evaluations often depend on self-report and are led by the practitioner(s) within the organisation (Tsiris, Pavlicevic, & Farrant, 2014). These characteristics of service evaluations can, from certain perspectives, raise methodological issues of bias and trustworthiness, and, from other perspectives, be considered naturalistic and multilayered. Other gold-standard concerns about the robustness of service-evaluation evidence are based on the small sample sizes of data collected, the use of data collection tools (that are context-responsive rather than standardised), and the unstable, and at times disparate, data collecting timelines thanks to the practicalities of everyday work lives. In the service evaluations described here, information is often solicited directly by the music therapists and includes individual self-report, including narrative and numeric responses.

We suggest that, rather than starting from aiming to make general claims about music

therapy's effectiveness, service evaluations have the following characteristics:

- . (1) they look at the whole service and its impact within a work environment as opposed to its effects on individual clients;
- . (2) they are specific to a setting and often carry pragmatic agendas, including service review, funding possibilities or restrictions and alterations to the service (whether developing or restricting it);
- (3) they seek to find out and describe how the music therapy service is seen to be functioning by people who are directly and indirectly involved with it.

In so doing, information from service evaluations can have many uses, including but not limited to: documenting perspectives known well to music therapists but so far underrepresented in research literature; exploring the relationship between documented experiences by music therapists and the perceptions of those they work with; and comparing between accounts of people's views "on the ground" and of those portrayed in research studies. Such uses may in turn offer directions and prompts for future research and assessment initiatives.

Although service evaluations are relevant irrespective of client population or music therapy approach, they seem to be aligned with approaches that prioritise a context-sensitive stance. One such example is the Nordoff-Robbins approach to music therapy within which a range of socioculturally sensitive and oriented practices, research and theories have emerged over the years (Pavlicevic & Ansdell, 2004; Pavlicevic et al., 2015; Powell & O'Keefe, 2010; Procter, 2013; Wood, 2006, 2016). In this context, there has been particular interest in music therapy's ripple effect; the idea that music therapy's impact goes beyond the individual client, to reach families, carers, as well as other staff members. The notion of music therapy's "ripple effect" also acknowledges its impact on the worksite which points towards the impact of the music therapy service within the context of other services and the environment of the organisation as a whole. As Pavlicevic et al. (2015, p. 660) put it:

[the "ripple effect"] as a metaphor conveys the temporal, social and physical contagiousness of therapeutic musicking. The ripple effect contrasts with more traditional music therapy practices that limit their focus to 'the therapist working with the resident [client]' [...].

As the authors explain (Pavlicevic et al., 2015, p. 676), Small's (1998) term musicking is used here to "discard the notion of music as 'object', and emphasise the activity of doing music among and between people, and the corresponding musical-social relationships and networks that musicking activates and animates".

Our service evaluation work has been developed as a way to document, analyse,

understand and communicate the kinds of impact that Nordoff-Robbins services are seen to have. Before reporting on the case of five Nordoff-Robbins music therapy service evaluations in neuro-rehabilitation settings, which will help us illustrate what service evaluations can offer, we focus on Nordoff-Robbins. By outlining some principles of Nordoff-Robbins practice, research and theory with particular reference to neurodisability, we set the wider context within which our evaluative work has emerged.

Nordoff-Robbins music therapy and neurodisability

Nordoff-Robbins (also known as Creative Music Therapy) is one of many improvisational approaches to music therapy practised internationally (Bruscia, 1987; Nordoff & Robbins, 2007; Spiro, Tsiris, & Pavlicevic, 2014). Nordoff-Robbins practices focus on the shared improvisatory music-making by clients and therapist as the primary conduit for the therapeutic relationship (Aigen, 2005; Ansdell & Pavlicevic, 2005; Nordoff & Robbins, 2007; Pavlicevic & Ansdell, 2009). As is also the case in contemporary music therapy frameworks such as community music therapy (Stige & Aarø, 2012), and resource-oriented music therapy (Rolvsjord, 2010), the acknowledgment of “the essential continuity between clinical and nonclinical musical experiences” (Aigen, 2014, p.19) situates the music-therapeutic experience on the continuum of music in everyday life. More recent Nordoff-Robbins literature takes into account people’s everyday experiences of music and health, and encompasses an understanding of musical communities through the lenses of psycho-socio-cultural epistemologies (Ansdell, 2014; Ansdell & Pavlicevic, 2010; Stige, Ansdell, Elefant, & Pavlicevic, 2010).

While it has no neuro-rehabilitation-specific interventions or assessments, Nordoff-Robbins music therapy adopts a stance where musical and social aspects of work, as well as assessment criteria are adapted to each context considering the aims and ethos of the work setting, clients’ conditions and resources, as well as the well-being of clients’ family and staff. The range of foci and stances portrayed in Nordoff-Robbins neuro-rehabilitation work, as this is documented in the literature, is also reflected in the five neuro-rehabilitation contexts reported below. The range of work includes areas such as differential diagnosis (Lichtensztein, Macchi, & Lischinsky, 2014), assessment (Carpente, 2013, 2014), new practice protocols (Guerrero, Turry, Geller, & Raghavan, 2014), and music therapy work with people with multiple sclerosis (Schmid, 2005, 2014; Schmid & Aldridge, 2004), with traumatic brain injury (Gilbertson & Aldridge, 2008) as well as community-focused projects (Wood, Verney, & Atkinson, 2004).

More specifically, Lichtensztein et al. (2014) explore how music-centred improvisational music therapy interventions may be employed as part of a multimodal approach to differential diagnosis between vegetative state and minimally conscious state. Carpente (2014) developed an assessment tool informed by Nordoff-Robbins music therapy practice – the Individual Music-Centered Assessment Profile for Neurodevelopmental

Disorders (IMCAP-ND) – that evaluates musical and interpersonal relationships of individuals with neurodevelopmental disorders in music, and positions such relationships within a social context.

Inspired by Carol and Clive Robbins' early work in the 1980s, when they collaborated with physical therapists in working with children with multiple disabilities (Robbins, 2005), Guerrero et al. (2014) piloted an intervention that focussed on interdisciplinary team collaboration, designed to address the physical, psychological and social dimensions of well-being of adult stroke survivors. Movement rehabilitation was promoted through interactive music-making (employing both improvised and pre-composed music), and this study suggests that music therapy enriched peer support, brought change in motor functioning and participation in activities, created a naturalistic music-making context through group improvisation that drew upon clients' creative strengths, interests and lives/identities prior to their illnesses, and heightened emotional awareness and expression through musical engagement.

Schmid's (2005) study of Nordoff-Robbins music therapy with people with multiple sclerosis identifies patients' needs beyond basic functional and medical care (see also Schmid & Aldridge, 2004). Contact and encounter emerge as essential forms of social interaction in music therapy. As Schmid comments it "[. . .] may come as a surprise that 'contact' is relevant for therapy in a treatment context with a focus on recovery and compensation of cognitive and motor impairments" (Schmid, 2005, p. 169).

In their focus on early rehabilitation of traumatic brain injury, Gilbertson and Aldridge also stress the importance of relationship and mutuality, and describe music therapy as facilitating clients to return as "active human beings within a community of significant others" (Gilbertson & Aldridge, 2008, p. 141). These broadened aspects of music therapy work resonate with Wood et al. (2004) who report on a community-focused Nordoff-Robbins project. Exploring the role of music therapy in people's long-term recovery, beyond their discharge from their medical or rehabilitation unit, the authors make a case for an expanded role for music therapists in and beyond a neurorehabilitation setting. Case study materials including quotes and descriptions of how staff members and clients experienced the work are cited. These are used as part of illustrating how music therapists not only focus on individual clients and their therapeutic goals emanating from their neurological difficulties (e.g. regaining lost motor skills and communicative abilities), but also on their families as well as the staff in the setting; music therapists engage with the wider community, creating musical-community pathways for all.

Taken together, these studies suggest that Nordoff-Robbins music therapy in neurorehabilitation appears to foster an improvisatory, context-responsive and ecologically engaged stance. This observation partly explains why the Nordoff-Robbins approach seems to be naturally aligned with a service evaluation ethos, and it also highlights the complexities regarding the evaluation and representation of the multi-faceted nature of such music therapy practices. What kinds of information might best

make a case for the impact (and effectiveness) of such services, while not compromising the improvisational stance (which spans beyond improvising music with clients)? How might service evaluations engage with such range of foci and stances, and also respond to requests by employers or funders for more standardised units of value and efficacy (at times measurable and at times not)? These kinds of questions inform the current study, which focuses on a case of five service evaluation reports. These evaluations are designed and implemented from within the music therapy services and the organisation where the services are situated.

The current study

This study explores the impact of Nordoff-Robbins music therapy services in neurorehabilitation settings as this is perceived and reported by music therapy clients as well as by those around them (families, music therapists and other staff).¹ This exploration leads to a consideration of how service evaluation can contribute to the understanding of music therapy.

Method

The current study consists of a retrospective cumulative analysis of results reported in five evaluation reports of Nordoff-Robbins music therapy services in neuro-rehabilitation settings. As such, these five reports constitute this study's data set and further details about them are provided below to illustrate the work and processes involved in the production of these reports.

For the purposes of this study, we extracted and collated all the numeric and narrative information related to the perceived impact of music therapy as summarised in each report. In most cases, such information was provided in the results-related sections of the reports.

Numeric information from responses to multiple choice questions was collated in a large database, organised according to the different evaluation respondent groups (i.e. clients, families, staff and music therapists) and grouped thematically. Descriptive statistics were used to analyse the numeric information. On the other hand, narrative information, from respondents' additional comments to their numeric-related responses and open-ended questions, was collated in a separate database, analysed thematically and clustered into larger meaning units. Additional information which featured in the evaluation reports as

¹ The study is part of a larger ongoing study which explores the same question but across a wider number of different settings including, but not limited to, the ones explored here. Ethical approval for the study was granted by the Nordoff Robbins Research Ethics Committee which comprises internal and external experts as well as lay members. Permission for public use of direct quotes, case vignettes and photographs was provided for only two of the sites: sites 4 and 5.

direct quotes and case vignettes did not form part of the data analysis, but was recorded as contributing to the information gathering and conveying. Case vignettes, in particular, helped to 'ground' and illustrate the results in the reports themselves.

Data set: the five evaluation reports

The data set of the current study consists of five evaluation reports regarding the Nordoff-Robbins music therapy services provided in five neuro-rehabilitation contexts in the north of England by the UK-based music therapy charity Nordoff Robbins England and Wales. In all the contexts, people had a range of neurological difficulties including brain injury, stroke, spinal injury and degenerative conditions, while some included clients with other non-neurologic-specific conditions (Table 1).

The music therapy service at each site was provided by a Nordoff-Robbins trained music therapist. In alignment with Nordoff-Robbins music-centred, improvisational principles, the services provided sessions in individual and group format, as well as performance work and open events, as deemed appropriate in each case. Sessions took place in different places within the worksites (e.g. a designated music therapy room, clients' bedside, communal lounge) as appropriate. Some sessions were attended by clients, while others were also attended by family members as well as staff (e.g. rehabilitation support workers).

All reports were produced between 2012 and 2015, and the evaluation projects which led to these reports were designed and implemented collaboratively between the Nordoff Robbins evaluation team to which we belong² and the music therapists on site.

Although the focus of the current study is on the cumulative retrospective analysis of the material given in these reports, we provide here some background information about the evaluation projects leading to these reports. This information explains the processes involved and therefore helps to understand some of the strengths and limitations of the final outputs: the evaluation reports.

All evaluation projects followed a six-phase process (Figure 1) that has been developed as part of our ongoing service evaluation work (Tsiris et al., 2014). In Phase 1, the evaluation team collected background information including information about the service and its aims, the worksite, the clients, as well as the purpose of the evaluation and the target audience (e.g. funders).

² This study was conducted while all authors were working at Nordoff Robbins England and Wales.

Table 1. Overview of the five service evaluations^a.

Site	Profile of worksites				Evaluation respondents				Data collection tools							
	Type of worksite	Client age group (years)	Data collection duration (weeks) (Average = 16.8 weeks)		Sessions	Attendances	Clients	Families	Staff	Music Therapist	Total respondents per site	Questionnaires	Comment slips	Attendance log-sheets	Case vignettes	Total collected tools per site
Site 1	Hospital	11+	22	Data collection duration (weeks) (Average = 16.8 weeks)	189	255	12	6	28	1	47	47	0	1	4	49
Site 2	Residential care	19+	17		100	183	9	3	16	1	29	29	0	1	3	31
Site 3	Hospital	19+	12		59	113	10	1	14	1	26	26	0	1	4	28
Site 4	Residential care	11+	6		39	79	2	0	9	1	12	12	0	1	3	14
Site 5	Residential care	19+	27		161	558	8	4	12	1	25	25	9	1	3	36
			Total	548	1188	41	14	79	4	138	13	9	5	1	158	
											9				7	

^aOne music therapist participant took part in two evaluation projects: sites 3 and 5.

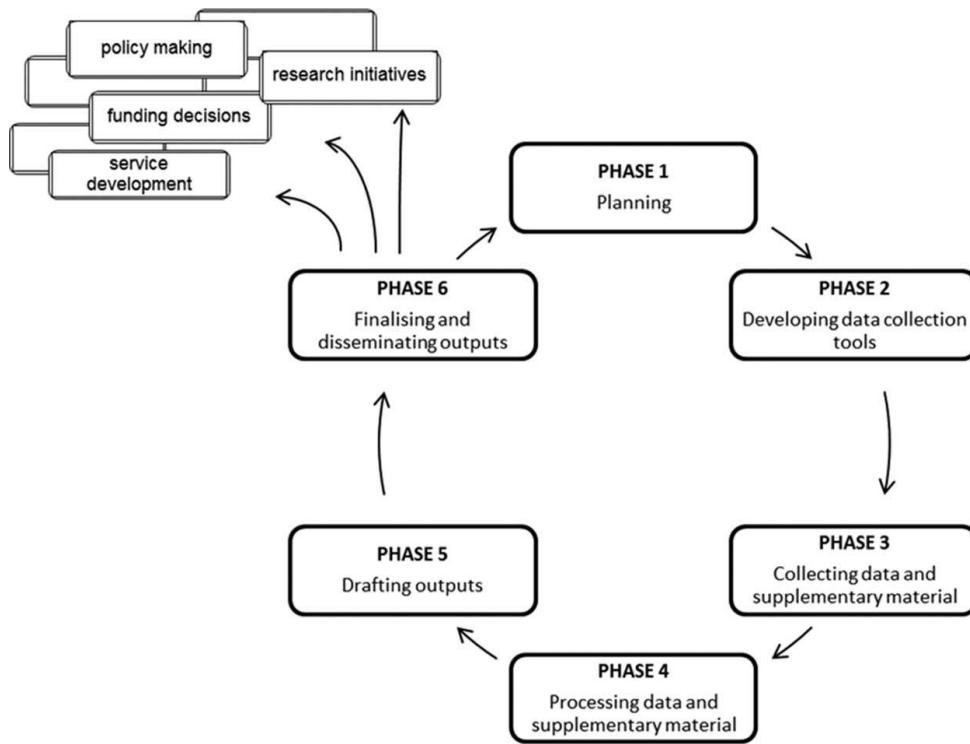


Figure 1. Service evaluation phases (from Tsiris et al., 2014, p. 24).

This information was collected using a pre-formatted form which was completed by the on-site music therapist and their line manager as well as through verbal consultation with the music therapist where necessary. Phase 2 focused on developing the evaluation tools in collaboration with the music therapist and key stakeholders (e.g. managers). This included refining questions and ensuring that tools were aligned with the evaluation and service aims, and that language appropriate for the different participant groups was used. In Phase 3, the music therapist administered the evaluation tools and collected data as well as complementary material. The latter included, for example, illustrative audio-visual material. In Phase 4, collected data was sent to the evaluation team for analysis, and in Phase 5, the evaluation team drafted the evaluation report which was shared for feedback with the music therapist, their line manager and any other appropriate people at the worksite. Finally, in Phase 6, the report was revised, finalised and disseminated in print bound and online format.

For each evaluation project, the data collection tools (Table 2) were drawn from accumulated evaluation resources already assembled and revised over 4 years. The data collection tools were further refined and adapted each time in consultation with the on-site music therapists and key stakeholders (Phase 2).

From the start, therefore, evaluation tools and procedures were collaboratively adapted and negotiated. As a result, over the years, the questions continued to be developed and refined. For example, the increasing emphasis on questions relating to the impact of music therapy on staff and the worksite was triggered by spontaneous responses provided

in previous projects, and retained for subsequent questionnaires. Although clients were not actively consulted on questionnaire design, their feedback and ways of responding informed the development of future evaluations.

Despite the advantages of developing context-responsive data collection tools and retaining a practice-sensitive stance, the parallel aim to retain the primacy of the evaluation focus may well limit the variations and range of information collected.

Table 2. Overview of data collection tools, respondents and data^a.

Data collection tools	Evaluation respondents	Data content and formats
Attendance log-sheet	Music therapists Clients, families, staff, music therapists	Content: Information on clients', families' and staff's attendance to music therapy during the evaluation period. Format: Numeric data from attendance log-sheet.
Questionnaires		Content: Perceived impact of the music therapy service on clients, families, staff and the worksite as a whole; identification of areas for development considering music therapy's fit with other services. Format: Numeric data from multiple choices. Format: Numeric data from Likert scales. Format: Narrative data from open-ended questions
Comment slips	Clients, families, staff	Content: Feedback from anyone who takes part in music therapy regarding their experience of the service. Format: Narrative data from open-ended questions.
Comment slips	Music therapists	Content: Brief vignettes illustrating the perceived impact of the music therapy service within the worksite. Format: Narrative data from case studies.

^aParticipants could complete both questionnaires and comment slips. The figures in the findings section draw only on the questionnaires. The information in the comments slips did not contribute to the figures but as with the case vignettes, they did inform the narrative findings.

In all projects, the music therapist on site distributed and sometimes administered questionnaires (Phase 3), and respondents may have been well aware of the potential link

between the evaluation outcomes and practical matters such as funding needs and the continuation of the service. Although on the whole such evaluation practices bring concern regarding biases or unrealistic expectations arising from the evaluation findings, the need to elicit as rich information as possible, as well as the absence of evaluation support for the music therapists in many workplaces were the determining impulses.

As shown in Table 2, both numeric and narrative data were collected in these five evaluation projects. The main and most consistent sources of numeric data were different sets of multiple choice responses.³ Sometimes respondents were asked to tick from a list of options where both positive and negative statements were included, while at other times they were asked to choose between a positive, neutral or negative option for each statement (for examples of questions, see Table 3). All questions were optional and since respondents could tick as many options as apply in each question, the numeric findings do not add up to 100%.

The music therapists' responses are included in all the reports and also form part of the data set for this study. Their voice is strongly affected by professional, political and financial pressures, and they are likely to be well versed in the kind of information that they would like represented in the final report. Their comments thus carry organisational weight and first-hand experience that could be seen as being loaded with a certain bias. Nevertheless, we include their views here as they have been an integral part of the evaluation reports to date and have informed the way that evaluations have developed over time. Moreover, the therapists' contributions can be critical in identifying, for example, certain weaknesses of the service.

³ Likert scales were used sporadically; thus data deriving from such scales are not reported here.

Table 3. Examples of questions from the evaluation tools. Evaluation tool Example of question

Table 3. Examples of questions from the evaluation tools.

Evaluation tool		Example of question		
Questionnaire for clients (site 4)	Do you find music therapy... (please tick one box for each statement)	Yes	No	Not sure
	helps you to communicate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	helps you interact with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	improves your memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	develops your concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	helps you to express your feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	increases your confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	provides you with opportunities to make choices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	enhances your sense of wellbeing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	improves your mobility / coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	provides opportunities to have fun	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	helps you to relax	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	takes your mind off your medical condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	helps with your rehabilitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	helps you learn how to play music	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	provides a link to your life prior to injury/illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	improves the general mood/atmosphere at [site 4]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	other (please specify):			
	Please comment on your choices above: (optional)		
Questionnaire for family members (site 2)	How does music therapy impact on YOU as family member? (please tick all that apply)			
	<input type="checkbox"/> provides a distraction from my family member's illness			
	<input type="checkbox"/> reduces my anxiety			
	<input type="checkbox"/> increases my anxiety			
	<input type="checkbox"/> provides an opportunity to have fun with my family member			
	<input type="checkbox"/> makes me feel sad when I see/hear what my family member cannot do			
	<input type="checkbox"/> gives me hope when I see/hear what my family member can do			
	<input type="checkbox"/> makes my experience feel more like daily life outside [site 2]			
	<input type="checkbox"/> gives me ideas for interacting with my family member			
	<input type="checkbox"/> has no impact on me			
	<input type="checkbox"/> not sure			
	<input type="checkbox"/> other (please specify):			
Questionnaire for staff (site 3)	Please rate your agreement with the following statements in order to evaluate the impact of music therapy on patients (please circle a number for each statement)			
		strongly disagree	disagree	neither
			agree nor disagree	agree
				strongly agree
	helps communication skills	1	2	3
		4	5	
	provides opportunities for communication	1	2	3
		4	5	
	helps to initiate language	1	2	3
		4	5	
	increases isolation	1	2	3
		4	5	

Table 3. (Continued).

Evaluation tool	Example of question				
provides emotional support	1	2	3	4	5
provides a distraction from illness	1	2	3	4	5
provides an opportunity to have fun	1	2	3	4	5
helps patients learn how to play music	1	2	3	4	5
is not pleasant for patients	1	2	3	4	5
provides a normal / everyday activity in a hospital environment	1	2	3	4	5
gives patients something to look forward to	1	2	3	4	5
provides opportunities for creative interaction with others	1	2	3	4	5
provides a link to life prior to hospitalisation	1	2	3	4	5
helps patients to relax	1	2	3	4	5
decreases confidence in communicating	1	2	3	4	5
encourages physical activity	1	2	3	4	5
increases self-esteem	1	2	3	4	5
increases anxiety	1	2	3	4	5

Findings

A total of 476 individual and 72 group sessions (total 548 sessions, see Table 1) took place across the five worksites, and 1188 attendances were recorded (871 clients, 156 staff, 115 family and 46 other people). The differences in the attendance figures relate to the different data collection periods at each site (range: 6–27 weeks; see Table 1). In reporting on the results from the five service evaluations, we position the person with neuro-rehabilitation needs firmly at the centre of the findings, in keeping with our understanding that the skills, roles and experiences of the people within and around healthcare settings are configured around the needs of the client. However, the evaluations gather information from a range of respondents, with a range of roles – the clients, family members, staff and the music therapist – and all are considered to be important. In addition, information is solicited on how all participants experience the influence of music therapy on themselves, the clients (if different), as well as on others; and this is in keeping with our socioculturally informed evaluation stance.

In addition to providing the overall average positive responses across all participant groups, the figures below show the average positive responses for each impact area and give the breakdown per respondent group (i.e. clients [C], families [F], staff [S], music therapists [M]). The overall positive average responses are indicated with the large dotted bars, whereas the average positive responses of each respondent group are indicated with

small boxes. The percentage number is omitted when the average positive responses is 100%. In reading the findings, it is important to clarify that the absence of a positive response does not necessarily indicate a negative or a neutral one. In fact, negative responses were given only in relation to two impact areas and these are reported in the text.

Findings are structured in four sections describing music therapy's impact on clients, families, staff and the worksite respectively. The findings relate to perceived impact of music therapy practice and other aspects of the service (e.g. multidisciplinary collaboration and exchange). Examples of photographs from the original evaluation reports are also included below to give a flavour of how music therapy has been represented in these reports. In reporting the findings, the different sets of experiences and changes perceived by respondents to take place as part of the music therapy service within each context are grouped under a number of "impact areas".⁴

Impact on clients

The majority of respondents report positively on music therapy's impact on clients (see Figure 2). Negative responses, as explained above, were rare but when present are reported in the text.

The highest rated impact areas regarding clients (Figure 2) are described as relating to: communication skills (100%); social skills and interaction (100%); physical activity (98%) (Photo 1); everyday life experience (97%); quality of life (93%); relaxation (93%); confidence (91%). "Everyday life experience", as an example of a perhaps less obvious impact area, refers to music therapy providing an experience more akin to daily life. This seems to be particularly relevant in hospital or other residential settings, and can range from providing distraction/relief from pain or anxiety associated with the client's condition, to reigniting musical interests, stimulating past memories and encouraging the client to consider life beyond illness. Further descriptions of each impact area can be found in a forthcoming publication regarding the larger ongoing study. Music therapy is reported by staff at site 5 to give those who have language loss, such as dysphasic patients, access to the experience of fluent and fluid communication without the need for words.

I believe that it [music therapy] allows patients to express themselves and helps develop communication skills (Work experience staff, site 5).

Music therapy's impact on communication is particularly relevant to clients who are isolated; sessions can offer opportunities for them to become involved in musicmaking in

⁴ These "impact areas" derive from the larger ongoing study mentioned above. Although these areas are subject to further refinement as part of this larger study, they inform our way of presenting the findings of the current study.

a social atmosphere (Photo 2). Indeed, “social skills and interaction” is a dominant impact area both in the numeric and narrative findings. A physiotherapist describes music therapy from within her expertise:

I feel that music therapy is incredibly beneficial within this environment. It allows us to ‘tap’ into patients who have little communication, cognitive ability and motivation to participate within formal physio sessions, and allows us through the medium of music to look at upper limb movement, standing and balance. The patients absolutely love the sessions, and we have seen huge improvements in patients’ mood and motivation, and the general feeling on the ward when music is around is MUCH improved. I feel that we would not be able to achieve such big improvements especially with our cognitively impaired patients if we did not have music therapy (Physiotherapist, site 5).

Music therapy sessions are seen as providing clients with an experience more akin to daily life within a medical environment: providing a link to clients’ lives prior to treatment and reigniting their previous musical interests. Indeed, on two sites, information collected shows that prior to treatment 96% of clients listened to music, 63% went to concerts and 32% played an instrument. Despite the general consensus that music therapy contributes to the development of clients’ learning skills, 38% of clients report that they do not experience music therapy as linked to learning to play a musical instrument. This appears to be in alignment with the focus of music therapy work where “teaching” music in the traditional sense is not a priority (Robertson, 2000). Many of the impact areas and themes regarding clients are illustrated in a case vignette from site 5 (Box 1).

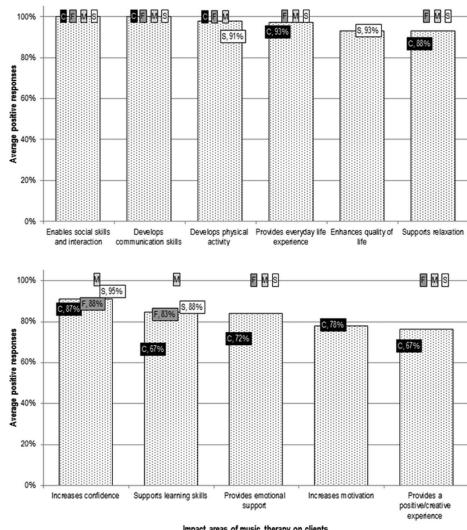


Figure 2. Impact of music therapy on clients (Respondent groups: clients [C], families [F], music therapists [M], staff [S]).



Photo 1



Photo 2

Impact on families

The small number of family respondents ($n = 14$) across the different sites seems to reflect their limited contact with the music therapy services. Indeed, in some cases (e.g. site 4) the music therapist report limited contact with families and this was seen as needing to be addressed. Examples such as performance events were mentioned as ways through which music therapists attempt to engage community members including clients' family, friends and carers.

While a relatively low number of family members attended music therapy regularly, their evaluation responses, together with those from staff, suggest that they find music therapy beneficial for themselves (Figure 3). Rated almost equally are areas to do with their relationship with their relative (client) (88%), the positive or creative experience, and the

emotional support (both 83%) that they experience in music therapy. Music therapy is seen as providing everyday life experiences and relaxation by fewer respondents (both 33%).

Box 1. Case vignette (site 5).

Kathleen has had a diverse and rich musical life. She began learning the piano at 6 years of age and was still playing and singing regularly at 70. Her vast experience included playing the piano at her local church accompanying a fitness class before the war as well as playing songs from favourite artists such as Frank Sinatra and Reginald Dixon. Kathleen loved the classics but was also proficient in the style of swing. She also enjoyed listening to music, particularly that of Salvation Army Bands and other marching music.

At 94 years of age, Kathleen was admitted to hospital experiencing symptoms similar to a stroke: slurred speech, right-sided weakness and low facial muscle tone. Kathleen was able to verbally communicate but found it hard to articulate and find the correct words. She also experienced some sensory impairment and reduced sensation in her right side. This added to her growing frailty due to her age which had left her hard of hearing and unable to see clearly. Due to these circumstances, Kathleen became increasingly isolated in her own room, finding it difficult to interact and communicate with others. During her stay, various infections and difficulties left her feeling tired and withdrawn. However, she was keen to attend individual music therapy when the opportunity arose. Despite her obvious frailty and weakness, Kathleen participated throughout. She enjoyed playing the keyboard again, creating improvised “duets” with the therapist. Not only did this utilise her weaker side, it provided the opportunity for a purposeful and shared activity and helped Kathleen reconnect with her past musical experience. Music therapy sessions needed some degree of flexibility. Sometimes the sessions would happen in the therapy room but often, the therapist would visit Kathleen’s bedside as she was unable to walk and sometimes too tired to be hoisted into a wheelchair. The beauty of music is that it can accommodate different spaces and by working in this way, Kathleen did not have to miss out on her sessions and her progress and achievements could be witnessed and heard by others. Staff began to stop and observe the sessions commenting on her progress and interaction.

The sessions became meaningful, nostalgic and a purposeful shared activity for Kathleen during her stay. She always looked forward to them and said: “I’ve enjoyed playing the music as it has brought a lot of happy memories back to me. – music is a great healer”. Kathleen also enjoyed listening to prerecorded music from her younger days and the therapist would accompany her as she sang to songs such as “We’ll Meet Again” and “Show Me the Way to Go Home”. Her enjoyment of these songs meant that she was motivated to use her voice and they served a great purpose for helping her regain a sense of flow in her speech. Music therapy helped Kathleen reconnect with her identity and healthy, creative self. She relived memories and explored what she was still able to do, what she was able to contribute within a shared musical experience rather than living in the experience of loss which her condition had created.

Narrative findings also show that music therapy is seen to improve relationships between families and their relatives (i.e. clients) and enhance a sense of pride and hope. This includes providing opportunities for positive bonding, creative interaction, shared fun and self-expression, as well as for witnessing and celebrating their relatives' achievements and capabilities. A rehabilitation assistant (site 5) reports that participation in music therapy provides family members with a "sense of achievement for patient and family". In addition, music therapy is described as helping families to learn new ways of interacting and understanding their relative, and provides ideas and skills for use of music and interaction beyond the session time.

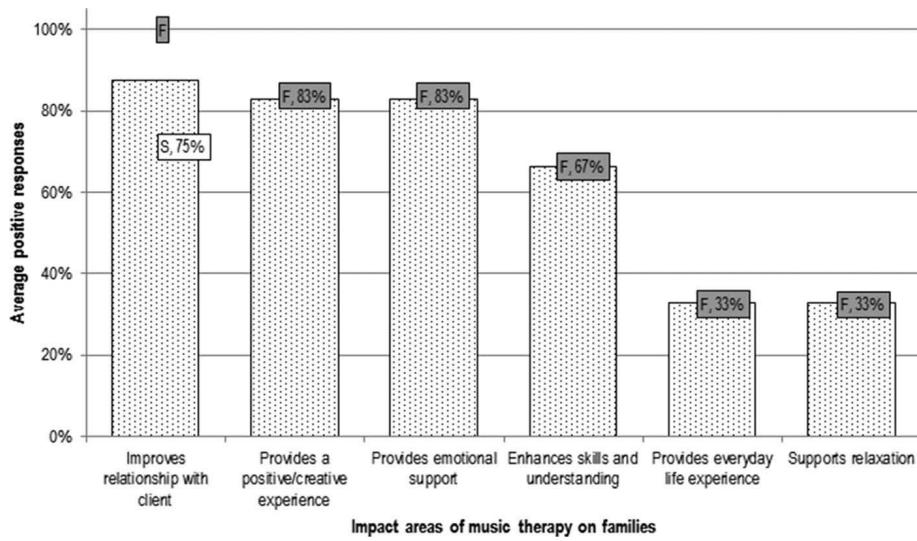


Figure 3. Impact of music therapy on families (Respondent groups: families [F], staff [S]).

Some family members report that they continue (after the music therapy sessions) to use some musical techniques – following the music therapist's advice – to maximise the benefit of the work. [...] [music therapy] gives family members ideas for interacting with their family member (Evaluation report, site 3).

Impact on staff

Staff form the largest respondent group (Table 1), and together with clients, their responses feature prominently with regard to the impact of music therapy on themselves (Figure 4).

Music therapy is reported as promoting positive interaction not only between staff (team building), but also between staff and clients, their families and visitors. In addition to offering opportunities for fun and creative activities, music therapy is seen as helping to develop staff members' understanding of clients and raises awareness of their ways of relating with them. Staff respondents also suggest that music therapy offers them ideas for working, relating and communicating (musically or non-musically both during and beyond sessions) with clients as well as for managing their behavioural needs.

[Participating in music therapy sessions] allows me to develop relationships with my patients. They see me in another light. [It] enhances my occupational therapy role. Patients trust me more and respond to me better (Occupational therapist, site 5).

I believe that [music therapy] helped me to communicate with patients who are unable to communicate verbally (Work experience staff, site 5).

According to the narrative data, music therapy reduces work-related stress, and improves staff motivation and productivity. Taking all the data together in relation to the impact of music therapy on enhancing skills and understanding, and particularly on its contribution to broadening staff members' perceptions of clients, negative responses account for an average of 3% of the responses. Looking more closely we see that staff members are the only respondent group that contributes to that percentage. No explanation regarding these ratings was provided by the respondents.

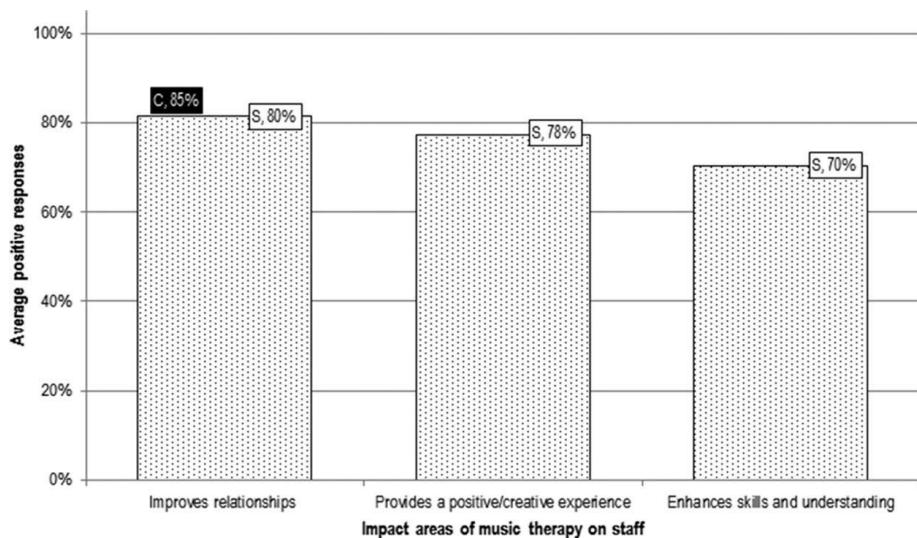


Figure 4. Impact of music therapy on staff (Respondent groups: clients [C], staff [S]).

Impact on the worksite

Overall, respondents report positively on music therapy's role within the respective worksite (Figure 5). The respective music therapy services are seen as building positive interactions between people (89%), a good fit with the ethos and the other services of the worksites (88%), and as contributing to a positive working environment (87%).

Staff, in particular, experience music therapy as bringing a sense of hope and community spirit. They report that music therapy helps to promote a positive mood and atmosphere, and improves the worksite's soundscape.

More particularly, music therapy is experienced by many as influencing the atmosphere of the worksite. Critically, this view is shared by 90% of clients, suggesting that clients

themselves value music therapy as also making a difference to their environment. A staff member comments:

It's a pleasure to hear the music throughout the unit (Assistant psychologist, site 4). The music therapy service is seen as complementing and contrasting with other services offered, and helps clients to engage in them.

[...] Colin now has much more increased attention and his mood is generally brighter. His fatigue appears to disappear during his music [therapy] sessions and his motivation within music [therapy] has transferred to his daily routine which now contains much more structure and activities that all contribute to his rehabilitation (Music therapist, site 5).

Drawn from five service evaluation reports, this presentation of the findings leads to a two-part discussion. We initially discuss these findings in relation to other existing literature and we reflect on some methodological issues. This leads into some broader concluding reflections regarding service evaluations and their potential place in music therapy.

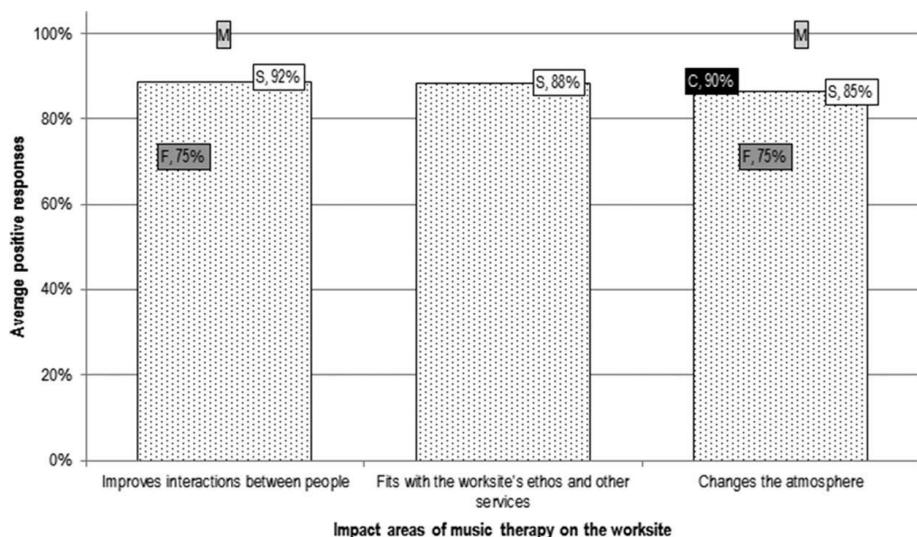


Figure 5. Impact of music therapy on the worksite (Respondent groups: clients [C], families [F], music therapists [M], staff [S]).

Discussion

Reflections

The findings summarised the impact of music therapy services perceived by a range of people within five neuro-rehabilitation worksites. The similarities underlying the current study (i.e. the evaluative stance, the music therapy approach (Nordoff-Robbins) and the delivery settings (neuro-rehabilitation)) provide a relatively homogenous basis for the

consideration of service evaluations' potential contribution to other initiatives in music therapy within and beyond neuro-rehabilitation (e.g. Magee & Stewart, 2015; O'Kelly & Magee, 2013).

Unsurprisingly, the highest proportion of positive responses is about music therapy's impact on clients (total average 94%, Figure 2). This aligns with the primary focus of the work settings, the music therapy services and the evaluation approach: that the client is at the heart of the work. The total average positive responses regarding music therapy's benefit to families (66%), staff (77%) and to the worksite as a whole (88%), while lower than those regarding clients, resonate with descriptions of the social reach for the music therapy service – whether or not this is intended by the work setting or the service delivered (Wood, 2016).

The disparities in perception between the four respondent groups (clients, music therapists, families and staff) relate to a number of potential situations. For example, lower rates of positive responses about music therapy's impact on families may well be linked to the families' limited contact with music therapists. However, such disparities in perception may suggest that even if the overall findings point towards music therapy being of benefit (or at the very least making a difference) to others beyond the clients themselves, there may be little or no acknowledged awareness or understanding of this "ripple effect" by the various respondent groups. This may be especially so where music therapy (and other) services are delivered in workplaces that are explicitly client-focussed and client-specific (see also Spiro, Farrant, & Pavlicevic, 2015).

The disparities between the respondent groups raises a broader question concerning the nature of respondents' familiarity both with the music therapy service, and their familiarity with the person administering the evaluation questionnaires, especially where this was the music therapist delivering the service. The nature of respondents' familiarity with the service illustrates complexities around bias which are well understood (and addressed) in those evaluation and research methodologies that explicitly control for bias and conflict of interests. The evaluation findings here present instead the multiple and complex sets of respondents' relationships and experiences with no attempt to control the accompanying methodological risks. The findings highlight the inevitable everyday workplace instabilities and fluidities, and we are well aware of the complications that such methodological choices presents in reporting these. These are part of the methodological challenges that this paper seeks to explore rather than repair.

The findings are indicative of an improvisational stance that engages musically with whoever is in the music therapy room (or in the corridors and other places where music therapy can take place) at that time. Based on this, the possibility seems to exist for people around the client to be directly influenced by live interactive and spontaneous music-making; and for this to contribute to a sense of organisational well-being (as also discussed in Wood et al., 2004). This finding echoes Powell and O'Keefe's (2010) report on Powell's work in residential care settings for people living with dementia. Powell uses

the analogy of weaving threads in describing how music therapy helps to connect people in the sessions and also in the worksite.

Finally, we are aware and mindful of the limited presence of negative and critical comments about the service; and this is despite the reframing of questions and rating tools along our own journey of developing these. While this may be flattering to the service provider, surely a wholly positive outcome weakens any evaluation endeavour, as well as the service itself. Given that the evaluations considered here are informed by our stated improvisatory and ecologically informed evaluation stance, it may well be that these kinds of inferences and interpretations signal a particular methodological take on the findings; and this prompts the second part of the discussion, which concludes this paper.

Repositioning service evaluation

Throughout this paper, we have made a case for retaining, and entering into, the methodological challenges that are apparent in service evaluations. These become evident when the functional demands of employers and funders for evidence collide (or misalign) with pragmatic evaluation methodologies that seek to prioritise a representation or portrayal of the service being delivered. Instead of seeing service evaluations as based on weak methods, flawed instruments, biased data collection or facile data analysis and interpretation, such misalignments, we propose, are rich and informative. As well as informing service development and funding decisions, service evaluations can contribute to practice and future research initiatives by, for example, posing further questions and generating hypotheses (Pavlicevic, Tsiris, & Farrant, 2012). For example, the current study could inspire several research areas including in-depth analysis of multi-disciplinary perceptions of music therapy in neuro-rehabilitation (contributing to existing research, such as Magee and Andrews, 2007) and of music therapy's impact on developing relationships between different groups of people around the service (e.g. families and staff) (e.g. Melhuish, Beuzeboc, & Guzmán, 2015). Although this study is based in the UK, its potential implications can be – perhaps in different guises – relevant to other contexts. Likewise, different aspects of service evaluation might be prioritised in different evaluative contexts. Age group, cultural background, previous musical experience of evaluation participants, as well as inpatient vs. outpatient music therapy provision might form the basis for further and potentially comparative analyses.

Our evaluative stance remains: we seek to consider the entire service, with its complications, everyday messiness and instabilities. We seek to consider and report on how the service engages with, and impacts on, the entire ecology of the workplace, broadening outwards from individual clients who remain at the heart of the service delivery. The services represented in our case cluster espouse an improvisational stance that engages musically with whoever is in the music therapy setting at that time. This stance, described as music therapy's "ripple effect", offers improvisatory, spontaneous engagements with possibilities for a broader ripple of musical influence in the work

setting (Pavlicevic et al., 2015; Powell, 2006; Powell & O'Keefe, 2010; Wood et al., 2004).

This broadened improvisational attitude also invites a reconsidering of the notion of “impact”, which we have used and retained throughout the presentation of our study. The notion of impact prevails in contemporary evidence-led discourses and often indicates an instrumental ontology where music therapy is seen as a “tool” or activity that effects change in (or on) people and places. Our evaluative stance, however, is underpinned by an integrative (rather than instrumental) view of impact. Thus, we understand the service to be woven into the everyday work setting, with all of its resources, needs, structures and demands.

It could be argued that “impact” jars with the integrative stance advocated both in practice and evaluation here, but in our attempt to reposition service evaluation, we propose a different approach: we invite and value people’s experiences and views about the service from the entire setting, based on the understanding of the sociocultural and collective nature of personal experience and change. Thus, rather than separating the person from their social-cultural network within the neuro-rehabilitation setting for the purposes of evaluation, we understand that the person, their social network and the worksite are parts of the wider phenomenon (Ans dell & Pavlicevic, 2010). To put it differently: organisational well-being is reflected in the person and the sociocultural milieu is integral to the therapeutic alliance; as such the ongoing engagements in, and witnessing of, music-making by staff and families contribute to a sense of organisational well-being.

It could well be argued that the very act of soliciting opinions and perceptions about “the service”, removes the music therapy service from its everyday, integrated realities, and that this action of removing and separating it, alters its nature. If this is so, then, what is being represented through evaluation? And, given the funding and employment necessities for music therapy services which require convincing outputs and outcomes, how useful (or capricious) are these kinds of ontological and theoretical deliberations?

As Magee (1999) highlights, meaningful “achievements” in music therapy can often be difficult to communicate as clearly identified “outcomes” within a rehabilitation setting.

The social and emotional needs of the client are often seen as being less important than the more visible functional needs and certainly appear more difficult to measure objectively. [...] Music therapists, as part of the multidisciplinary team, are having to question and examine the value of their service within a medical model setting, where treatment is costly and the medical stability of the client has to have priority (Magee, 1999, p. 20).

While the person needing neuro-rehabilitation (that may include attending to their social, emotional and functional needs) remains the music therapist’s primary responsibility,

Magee advocates an attending to additional needs which touch on the client's wider social-musical system. This raises the possibility of a more distributed, and possibly more inclusive, therapeutic focus which can be more complex to document and report.

These kinds of considerations suggest the need to remain alert to aspects of the service that may be complicated and rich, unstable and dynamic, rigorous and inflexible. We need to retain our questioning, whether or not work settings insist on the more distant, measurable, statistically convincing findings; and whether or not service evaluations espouse stances that are idiosyncratic, context-specific and (apparently) more representative of the service. Remaining alert to such considerations may well help us to develop a reflexive and questioning stance towards the entire range of evidence and impact-related endeavours in music therapy.

We may seem to be suggesting that socio-culturally informed service evaluations are the exclusive domain of practices which are informed by socio-culturally sensitive epistemologies. On the contrary: we would posit that such service evaluations may also be useful in contexts where neuroscientific epistemologies inform the music therapy service being delivered, such as Neurologic Music Therapy (e.g. Thaut, 2000) or Cognitive Behavioural Music Therapy (e.g. Madsen, Cotter, & Madsen, 1968). Moreover, and conversely, music therapy assessment instruments (that may take an instrumental view of practice) can be used to great effect in socioculturally informed music therapy work in order to gauge the impact of the work on the individual.

In conclusion, we propose a repositioning of the 'humble' service evaluation. Even if it is closely connected to service development and commissioning needs, and is often shaped by funders' agendas, we propose that service evaluation offers insights that can take into account functional, emotional and social aspects of the service delivered, and that these insights can have implications beyond the service itself. When based on a rich and complex musical-social-cultural ontology, the service evaluation (which is often considered to be 'duty' and 'drudgery') can help to (re) imagine questions; and these re-imaginings can influence research initiatives.

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