Music Therapy New Zealand

TE RŌPŪ PUORO WHAKAORA O AOTEAROA

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Call for Submissions: NZJMT 24 (2026)

Submissions are invited for the next issue of the journal with an open submission date.

Please read the journal policy (below) and download the journal guidelines from: https://www.musictherapy.org.nz/journal

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Journal Policy

The New Zealand Journal of Music Therapy (NZJMT) is a peer-reviewed, open access and print journal, published annually by Music Therapy New Zealand (MThNZ) for music therapists, students, allied professionals, and others interested in music therapy. Our purpose is to raise awareness of music therapy and related approaches in the wider community, and to extend the knowledge and understanding of music therapists.

NZJMT promotes the values of Music Therapy New Zealand:

- Life / Ora: Promoting and working towards sustainability and a balanced, overall wellbeing;
- Reciprocity / Whanaungatanga: Fostering relationships that are connected, reciprocal and inclusive;
- Creativity / Auahatanga: Celebrating our diversity, passion, spark and vitality; and
- Professionalism / Te Taumata: Supporting and advocating for the highest quality, evidenced based ethical practice with integrity and confidence.

A wide variety of submissions will be considered, including (but not limited to): Practice-based, research, theoretical or case study articles about music therapy; less formal, practice-based or autobiographical articles for the Community Voices section; interviews; arts-based elements; student contributions; relevant articles about related fields or allied professions, if clearly relevant to music therapy practice; and book and resource reviews.

Authors and reviewers are asked to consider the relevance of their work to contemporary music therapy practice in Aotearoa New Zealand and to read past issues of the journal and to download the submission guidelines from https://www.musictherapy.org.nz/journal. First person writing is preferred, where appropriate. Note our use of EPICURE and IMRaD checklists for evaluation of articles, and requirements for formatting and referencing.

The journal publishes only original material, except where reprint rights have been sought for an article of particular relevance to music therapy practice here. Articles declined by the journal may be recommended for publication elsewhere, e.g. Music Therapy New Zealand's MusT newsletter.

No payment is made to or by authors or reviewers. MThNZ offers an honorarium to members of the editorial team and some advisers.

Inquiries: journal@musictherapy.org.nz or info@musictherapy.org.nz

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Editorial: A Reflection on Liminal Spaces

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Citation

Cho, H. & Hunt, E. L. (2025). A reflection on liminal spaces [Editorial]. *New Zealand Journal of Music Therapy, 23,* 1-4.

This year's journal brings together a range of contributions; a survey report, a community voices article, and two book reviews. The report presents findings from the 2022 survey of New Zealand Registered Music Therapists, offering valuable insights into the profession. The community voices piece explores innovative applications of technology within music therapy practice, highlighting creative possibilities for the future. The first book review examines *Music Therapy with Autistic Children in Aotearoa* (2022) by Daphne Rickson, a text that resonates deeply with practice in this field. The second review reflects on the second edition of *The Handbook of Music Therapy* (2024), edited by Leslie Bunt, Sarah Hoskyns, and Sangeeta Swamy, through the lens of the reviewer's own learning experience with the first edition.

Throughout the editorial process, from initial communication with authors to publication, there are many reflective moments reminiscent of the diverse rites of passage we all experience. The term "rites of passage" originated with anthropologist van Gennep (1960 [1909]) to describe universal human rituals which typically involve three distinct phases; separation**,** transition**,** and incorporation (also referred to as pre-liminal, liminal, and post-liminal rites). Within the transition phase lies the concept of liminality, a threshold state of transformation. The term *liminality* derives from the Latin *limes* ("threshold") or *limen* ("boundary" or "limit") (Wels et al., 2011). Turner (1969) further explored liminality as a stage where individuals retreat from societal structures, entering a space of "anti-structure," a bottom-up creative response that contrasts with the structured pre- and post-liminal stages characterised by status, power,

and authority. This liminal stage is essential for processing, development and transformation. We recognise that human life is fluid and consists of an ongoing series of rites of passage in many forms.

Music therapist Coombes (2022), expanding on Rudd's (1995) application of rites of passage theory to music therapy, reflects on music therapy as a liminal space; where clients enter sessions in a state of separation, experience transformation through music-making, and then return to daily life with new skills and insights. In this sense, music therapy mirrors the structure of rites of passage. As editors, contributors, and readers, many of us are music therapists. We support clients through their transitions while navigating our own.

Each manuscript we receive also undergoes a rite of passage; from initial submission, through the editorial process, to publication in the journal. From our perspective as editors, this liminal stage is a collaborative and creative endeavour as we work in partnership with authors, supported by reviewers and proofreaders, to polish their manuscripts (see Figure 1).

Figure 1

Word cloud depicting the liminal elements of the editorial process

Figure notes: Formed in the shape of a cocoon, the word cloud includes the following words: Editorial process, author, editor, reviewer, proofreader, dialogue, revise, modify, collaboration, originality, creative, big picture, academic integrity, relevance, fact check, remodel, grammar, polishing, structure.

This year the journal has shifted to an open submission deadline. This has, in part, been in preparation for an online only presence, but also has positive implications to support diverse writers and provide greater flexibility as we all navigate the twists and turns of life. Paired with our writing workshop for emerging writers in August 2025, facilitated expertly by Dr Carolyn Shaw, we hope this will encourage more writers to share their thoughts and experiences with our journal readers. As a result of our open submission policy, we have received a diverse range of manuscripts throughout the year. Some of these remain in their own liminal stages as we work through the editorial process.

Each contribution in this year's journal reflects rites of passage for the music therapists involved. The report on the 2022 survey of Registered Music Therapists may represent different stages in the lives of practitioners in New Zealand. For Hyunah, as a contributor to the survey article, I experienced my own personal rites of passage during the article's development - marriage, relocation to another country, and health challenges - all while collaborating with co-authors who faced their own stages of life. The community voices piece extends traditional forms of therapy by integrating technology, reflecting a crossing of thresholds into new possibilities. The first book review on Rickson's (2022) work can be seen as a testament to her lifelong dedication and experience in the field of music therapy for autistic children; a form of post-liminal reflection on her professional journey. The second book review on *The Handbook of Music Therapy* offers an intriguing perspective on how the reviewer connects the first and second editions to their own evolving journey as a music therapist.

As an editorial team, we strive to honour each person's unique passage, balancing individual diversity and academic convention, whilst supporting one another across thresholds. This year's process has been a profound exercise in valuing both the collective and the self; acknowledging that we are all, in different ways, crossing and re-crossing the liminal spaces of life.

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(2025). New Zealand Journal of Music Therapy, 23, 5-60.

Music Therapy Provision in Aotearoa New Zealand: Findings of a 2022 Survey of Registered Music Therapists

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Keywords

Music Therapy New Zealand; music therapy; workforce survey; service provision; allied health profession

Citation

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Review

This article was independently reviewed by two anonymous peer reviewers.

Abstract

This article reports on a 2022 survey of New Zealand Registered Music Therapists, offering an overview of the current workforce. This builds on previous surveys in 2008 (remuneration) and 2016 (a broader picture of the current workforce). The purpose of these surveys was to inform Music Therapy New Zealand's strategic planning and advocacy for the provision

of music therapy in Aotearoa New Zealand and to inform other communities about work undertaken here. The 2022 survey achieved a response rate of 63%. The findings provide a snapshot of respondent demographics, location, and key facilitators and barriers to extending service provision. Recommendations are made for continued advocacy, clear social justice commitments, professional needs that are not met by the organisation's charitable status, improved communications and member engagement, and the scope and design of future surveys.

Summary (Plain English)

This article is about a survey in 2022 by Music Therapy New Zealand. This group helps people learn about music therapy.

We asked music therapists some questions about:

- Their training and work.
- Where they are from and where they live now.
- What they think about Music Therapy New Zealand.

Their answers will help music therapists and Music Therapy New Zealand make good choices in the future.

Music therapists thought five main ideas were important:

1. Telling people what music therapy is.
2. Making sure that everyone involved in music therapy is treated fairly.
3. Helping music therapists and the public.
4. Improving how Music Therapy New Zealand talks to its members and other people.
5. Choosing questions carefully if we do another survey.

You can learn more about Music Therapy New Zealand on the website: https://www.musictherapy.org.nz.

You can also email any questions to info@musictherapy.org.nz

Introduction: Context of the 2022 Survey

Music Therapy New Zealand[1] (MThNZ) is an incorporated society and advocacy organisation with charitable status[2] (Fletcher, 2016; Music Therapy New Zealand, n.d.-b.). The profession is self-regulated[3] with registration managed by the New Zealand Music Therapy Registration Board, an autonomous group within MThNZ. Surveys implemented by MThNZ aim to provide up-to-date information to support MThNZ to fulfil its charitable purposes, through up-to-data workforce data, and to inform other communities about work undertaken here. The 2022 survey built on two surveys: a 2008 remuneration survey (Twyford, 2009), and a broader 2016 survey (Molyneux et al., 2016).

Internationally, other music therapy organisations have also used workforce surveys to gain an overview of the profession and provide direction. Carr et al. (2017) cautiously recommended a consistent approach to workforce surveys, recognising the diversity among countries but also highlighting commonalities within the international profession. While they provided open access to their UK-based survey, it seemed more relevant for Music Therapy New Zealand to build on our previous surveys.

Recommendations resulting from the 2016 survey analysis related to three broad themes: (1) Music therapy provision and employment; (2) Professional issues; and (3) Diversity. A summary of MThNZ action in response to these suggestions, drawn from Council documents reviewed by the MThNZ Administrator on behalf of Council and the Registration Board, shows positive achievements, work in progress, and alternative action undertaken (Appendix A, Tables A1-A3). Five-yearly surveys were also recommended, to provide updated and comparative information about the music therapy profession. Opportunities for New Zealand Registered Music Therapists (RMThs[4]) to express their views through regular surveys would also highlight issues important to MThNZ members and prioritise the accountability of the organisation and its officers to members and other stakeholders. Suggested revisions of the survey format included refining the questions about employment and self-

[1] https://www.musictherapy.org.nz

[2] See https://not-for-profit.org.nz/difference-charitable-trust-incorporated-society for definition of terms.

[3] In Aotearoa New Zealand, medical and some allied health professions are regulated under the Health Practitioners Competence Assurance (HPCA) Act (2003), currently under review (Ministry of Health, 2025).

[4] The abbreviation RMTh (plural RMThs) has been used here, rather than the official professional designation, NZ RMTh, for the sake of conciseness.

employment in different settings, to clarify where additional advocacy and funding might be required.

The 2022 Survey

Purpose, Design, and Procedures

The purpose of the 2022 survey was to provide an updated picture of the geographical distribution of RMThs, their current scope(s) of practice, and their views on professional and organisational issues of interest to MThNZ. A scheduled 2020 survey was delayed until 2022 by the COVID-19 pandemic.

The 2022 survey adopted the extensive 2016 survey schedule, with some rewording and some additional questions. Development of this survey was led by Helen Dowthwaite, co-author of this paper. Nine sections were included in 2022:

1. Music therapist training and registration;
2. Survey participant demographics;
3. Employment;
4. Travel, hours, and costing of music therapy services;
5. Supervision;
6. Professional development;
7. Membership of MThNZ;
8. MThNZ events; and
9. Additional questions, covering broad sociocultural and strategic topics.

An hourglass survey design began with easy to answer demographic questions, narrowing to detailed questions about employment issues, and finally broader questions seeking feedback about MThNZ. (However, questions about MThNZ were included in both demographic section and feedback about the organisation.) Questions (139 in total, due to splitting topics into smaller items) required predominantly multi-choice or short-form responses, with some items allowing for longer comments - particularly following a multi-choice response. The survey items (without the multi-choice answer options) are listed in Appendix B. An invitation was circulated to all RMThs in November 2022 via email, the MThNZ *MusT* newsletter, and a closed RMTh Facebook group.

The survey was accessed as a Google Form, which automatically collated quantitative data and supporting comments in a spreadsheet. Interim findings were reported to Council (Talmage, 2024) and circulated

to MThNZ members via the monthly *Pulse* e-update for MThNZ members (November 12, 2024). The data were edited to merge duplicate answers, such as *European New Zealander* and *Pākehā*. The qualitative data were categorised and systematically organised.

Ethical Considerations

Ethical values are central to music therapy practice and to the work of MThNZ. All RMThs were invited to participate in the survey. Participation was voluntary, with no impact on professional registration status or MThNZ membership for those who declined to participate. The survey clearly stated that all responses were anonymous and confidential. No identifying information was recorded or attached to the survey responses. As music therapy is a small professional community in New Zealand, additional care was needed to avoid linking comments with named locations that might identify participants.

As co-authors, RMThs, and MThNZ members and officers, we recognise a conflict of interest in designing, implementing and analysing this survey – for example, making assumptions about priority issues and being potential respondents. This conflict was ameliorated through a collaborative approach and the collection of anonymous data. We believe our reporting of quantitative data is objective and accurate but acknowledge the subjectivity of our qualitative analysis. Others might have interpreted this information differently. However, during the writing process the authors shared drafts of selected sections of the analysis and draft article with several experienced RMThs, to inform our interpretation, conclusions and recommendations. (This article respects the anonymity of these colleagues.) Ideally, surveys should be analysed promptly and the findings shared with stakeholders. Unfortunately, the full analysis of this survey was delayed, but the findings remain of interest and value.

2022 Survey Results

The response rate of 63% of RMThs (n=57) was considerably higher than the previous (2016) survey with a 37.33% response rate (n=28). This presentation of the 2022 survey results combines some sections of the survey (described above). We report on: (1) Survey respondent demographics, (2) Employment matters, (3) Professional supervision and continuing professional development, and (4) Feedback about MThNZ. Additional issues highlighted by respondents have been incorporated into these four broad areas. A few questions received either no responses or a high proportion of “Not Applicable” (N/A) selections, and some were

noted as difficult to answer. As such, these items were excluded from the analysis.

Survey Respondent Demographics

All respondents were RMThs (Table 1); the majority (92%) holding full registration and a current practising certificate issued by the New Zealand Music Therapy Registration Board (2022). Provisional registration was held by four respondents, but one practising certificate had lapsed. One preferred not to respond.

Table 1

Current Registration Status of 2022 Survey Respondents

Registration Status	Number of Respondents	Percentage of Respondents
Full registration and current annual practising certificate	52	92.0%
Provisional registration and practising certificate	3	5.3%
Provisional registration but lapsed practising certificate	1	1.8%
Prefer not to say	1	1.8%

Most respondents were located in New Zealand's main centres: Wellington (34%), Auckland (23%), and Canterbury (13%) (Figure 1). Other respondents showed a wide geographical distribution. Any comparison of the 2016 and 2022 distribution must be stated cautiously, as data represents survey respondents rather than all RMThs. However, an interesting observation is the low number of respondents (and probably practising RMTh) in some regions - particularly none in Taranaki, Gisborne, Otago, Southland, or the West Coast.

Respondents were predominantly female (81%) and Pākehā (68%). A large proportion (68.4%) were trained in New Zealand (Figure 2). Others trained in the UK (14%); Australia (7%); and Germany, Ireland, Spain, South Africa, The Netherlands, and the USA (each 1.8%). Graduation dates of New Zealand trained RMThs reflect the development of the Master of Music Therapy programme at Te Kōkī, New Zealand School of Music[5] and immigration of international music therapists (Figure 3). Four respondents began their professional practice overseas before relocating

[5] https://www.wgtn.ac.nz/explore/postgraduate-programmes/master-of-music-therapy/overview?programme=master-of-music-therapy-by-research

Figure 1

Geographical Distribution of Survey Respondents in 2016 and 2022

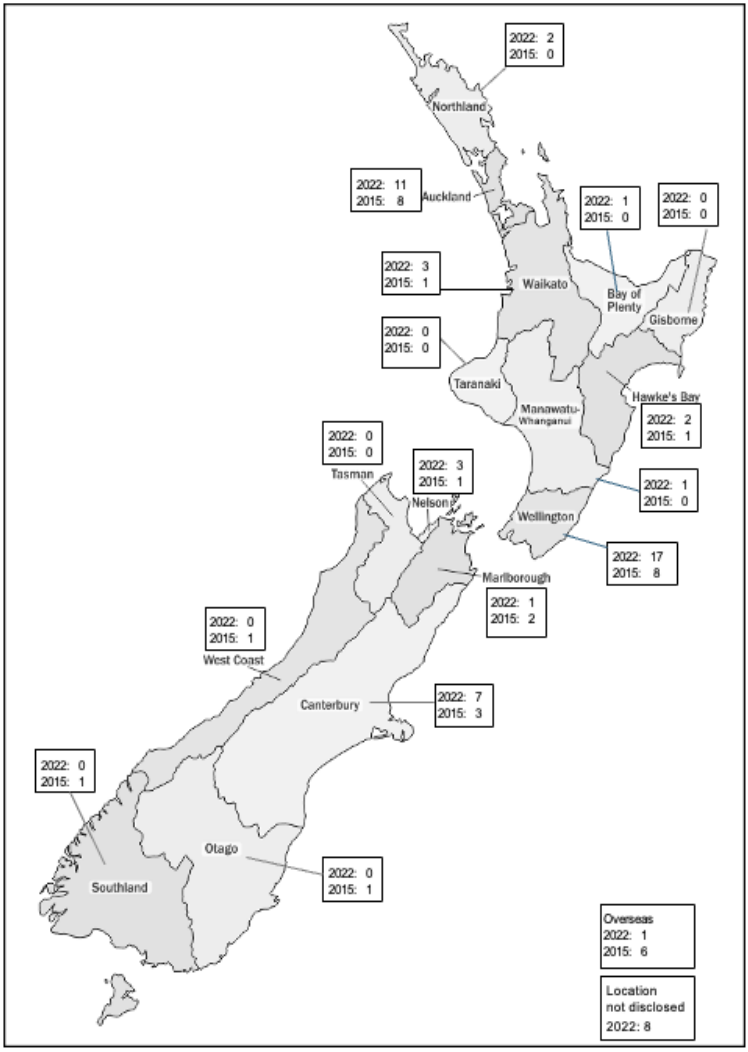

Figure notes: Copyright-free blank map showing New Zealand Regions identified by Stats NZ, retrieved from https://d-maps.com/carte.php?num_car=240254&lang=en

Data from Figure 1 are tabulated in Appendix C, Table C1.

Figure 2

Respondent Demographics: Location of Music Therapy Training

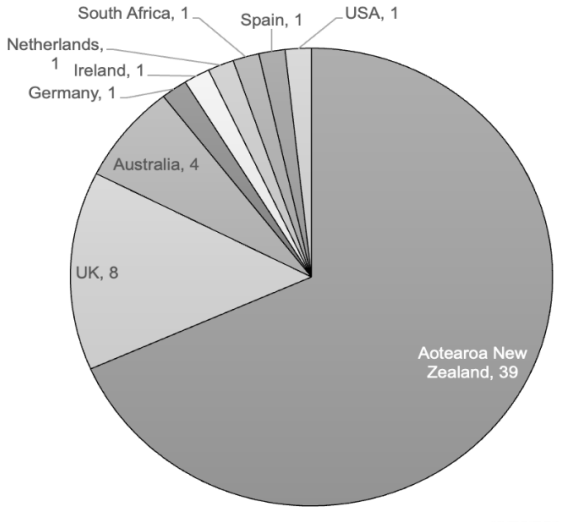

Figure note (image description): This is a pie chart visualisation of the data about training location, included in the previous paragraph.

Figure 3

Respondent Demographics: Year of Graduation

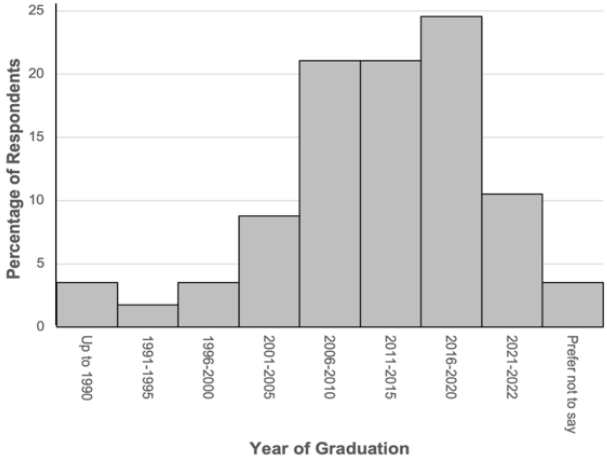

Figure notes: The years are reported in periods of 5 years, other than a final two-year period (2021-2022) and training prior to 1991. Data from Figure 3 are tabulated in Appendix C, Table C2.

to Aotearoa New Zealand. Six held dual registration here and in another country: four in the UK (including one currently based overseas) and one each in China and Germany.

In addition to graduation date, the age, and residency status of practising music therapists are important factors in workforce projections. Some music therapists completed their Master of Music Therapy degree as young graduate students, while others retrain as music therapists mid-career. Figures 4a and 4b display respondent age, further grouped by reported residency status (citizen, resident/permanent resident or working visa) and self-identified gender. While these data do not represent all RMThs, the large proportion of respondents with New Zealand citizenship (68.4%) or residency[6] (17.5%) may suggest a commitment to practising in this country.

Employment Matters

Questions and responses about employment matters focused on five areas: beginning work as a new graduate; scope of and models of practice; hours of work, work-related travel, and costings; other employment; and barriers to practice.

Beginning Work as a New Graduate

Of 53 responses to a question about initial work after graduation, 64.1% reported finding paid work within 6 months, with one even securing work before graduation (Figure 5). A further 9.4% took up to 12 months, with one respondent taking 18 months. Explanations for the large number of "N/A" responses included choosing an alternative career path, not immediately pursuing work, or being unsure of the scope of the question (e.g. full-time/part-time work and self-employment). Consequently, the data should be viewed as indicative, rather than precise.

Music Therapy Employment and Other Work

The survey asked about music therapy work and other forms of employment (Figure 6). For most respondents, music therapy work focused on clinical practice, but for some this included supervision, consultation, research, and tertiary roles as music therapist educators. Several also acknowledged dual careers.[7] Additional (non-music therapy)

[6] Residency visas and permanent residency visas were counted together for the purpose of this analysis.

[7] Importantly, one respondent emphasised that "core roles" for RMThs included research, tertiary music therapy education, and consultation services, as well as direct clinical services.

Figure 4a

Respondent Demographics (Age, Gender, and Residency Status), Part 1

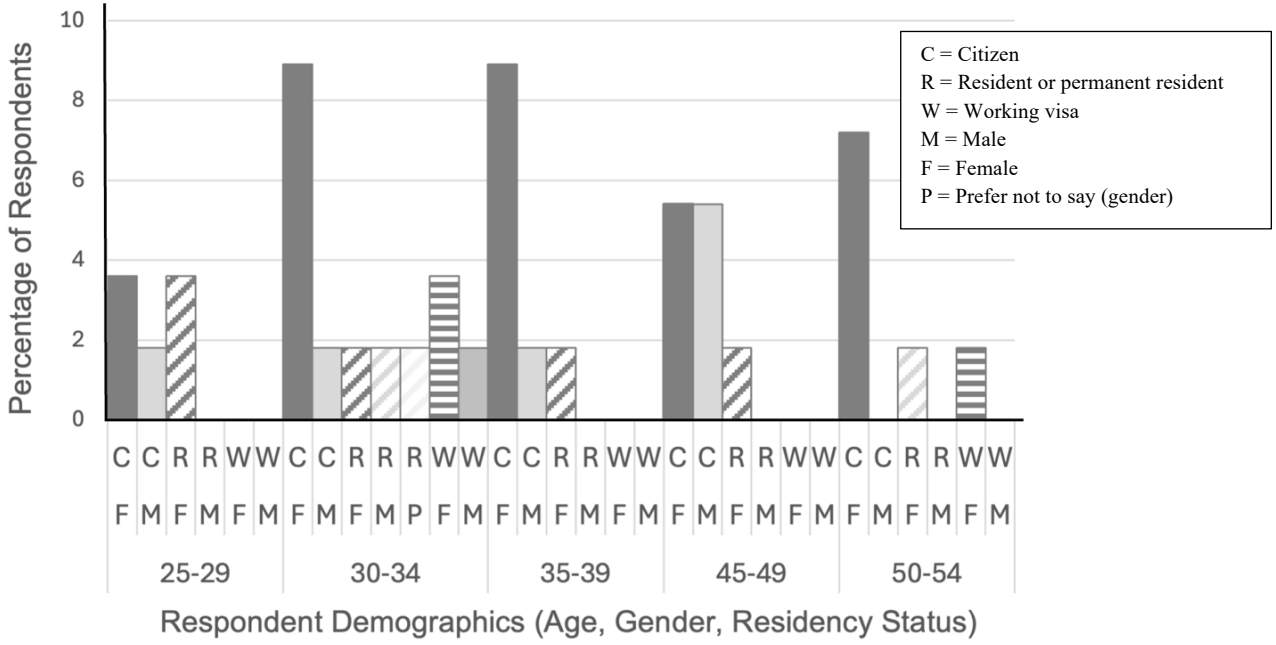

Figure note: Data from Figure 4a are tabulated in Appendix C, Table C3.

Figure 4b

Respondent Demographics (Age, Gender, and Residency Status), Part 2

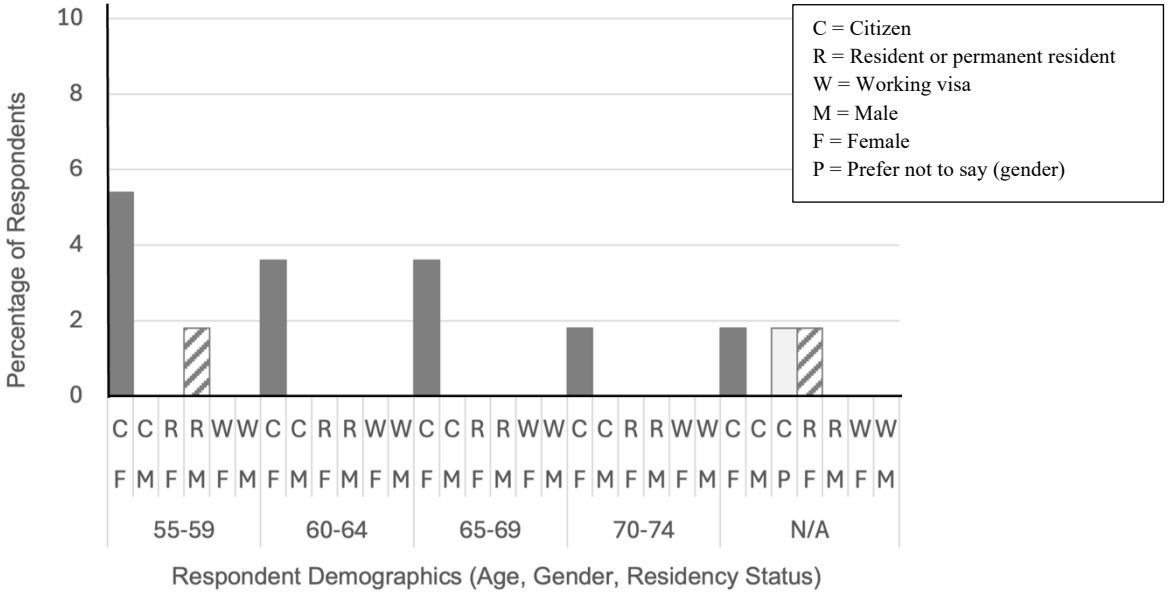

Figure note: Data from Figure 4b are tabulated in Appendix C, Table C3.

Figure 5

Time Taken by New Graduates to Find Work

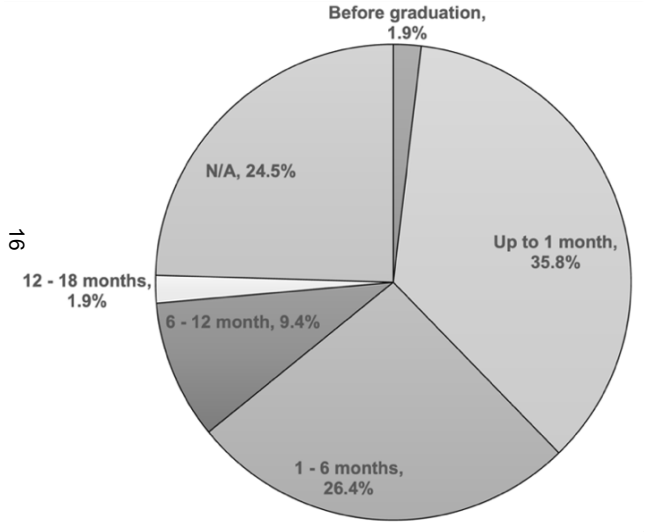

Figure note: Data from Figure 5 are tabulated in Appendix C, Table C4.

Figure 6

Other Employment

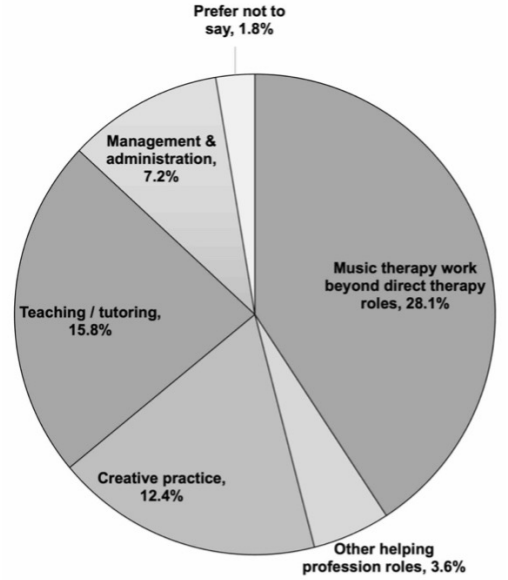

Figure note: Data from Figure 6 are tabulated in Appendix C, Table C5.

work reported by almost half of respondents (n=27, 48.2%) represented four main categories: creative practice (as musician, writer, and/or artist), teaching or tutoring, other helping professions, and management and administration. As some RMThs worked in multiple areas, these figures are approximate. More detailed figures are tabulated in Appendix C, Table C5.

Scope and Models of Practice

To capture a detailed, inclusive picture of professional practice, the survey included both a multiple choice question about workplaces, and open-ended questions about "music therapy model or approach" and "client population". Many respondents reported working across multiple settings and client groups, rather than with a single primary client group, facility or employer. (Consequently, work setting figures exceed 100%). Data analysis considered both settings (Figure 7) and broad descriptions of client groups (Figure 8). More specific population descriptions (e.g. mental health, disability, palliative care) are difficult to report accurately.

The wording of some questions influenced responses in ways that made analysis tricky. For example, one participant recorded "neurological choir" as "workplace" rather than as "model or approach" or "client population". Another highlighted that their work in a university research centre was a clinical and research role that did not sit comfortably within the tertiary education category available. Someone else noted uncertainty about whether to classify their workplace as "community rehabilitation service" or "non-government agency". These issues highlight the challenge of providing meaningful categories. Nevertheless, responses highlighted a wide variety of work settings. Of particular interest are the high proportion of respondents working in schools or early childhood/early invention settings for at least part of their week, with a lower number working for agencies, in healthcare settings, and private practice, and a range of other settings.

The wording of questions (for example, "What communities do you work with? e.g. diagnosis and age groups") resulted in most respondents framing their practice within a diagnosis-focused medical model, as shown in the following responses:

> All ages. Global developmental delay, autism spectrum disorder, foetal alcohol spectrum disorder, cerebral palsy, cortical vision impairment, rare genetic syndromes, shaken baby syndrome, stroke recovery, attention deficit hyperactivity disorder, cancer, [and] acute and ongoing paediatric hospitalisation.

Figure 7

Professional Practice Settings

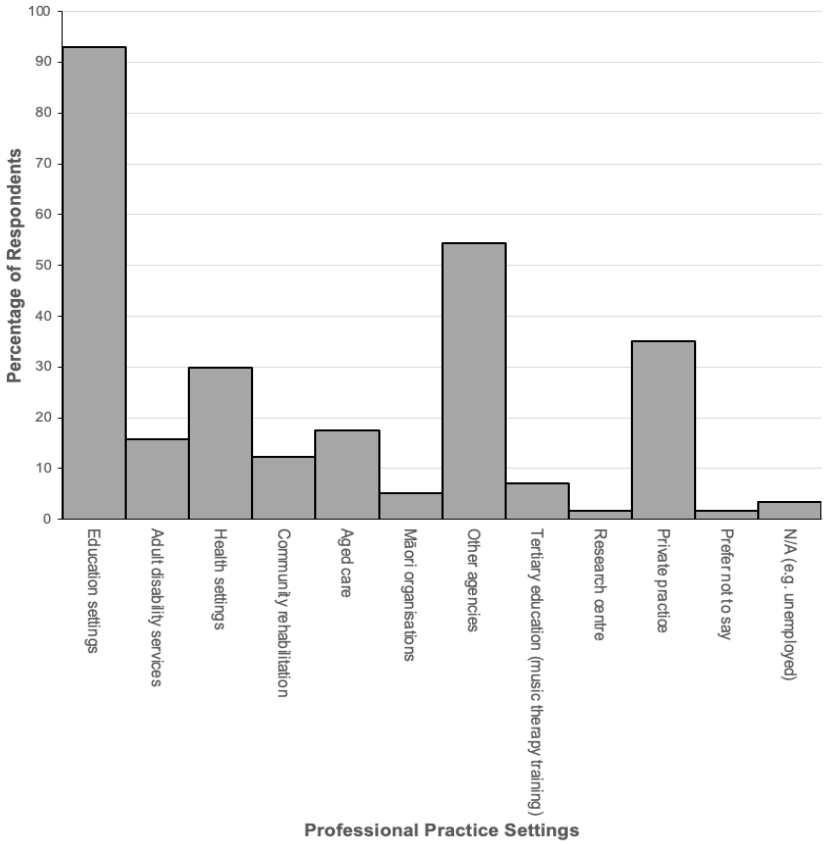

Figure note: Data from Figure 7 are tabulated in Appendix C, Table C6.

Figure 8

Client Groups Reported by Respondents

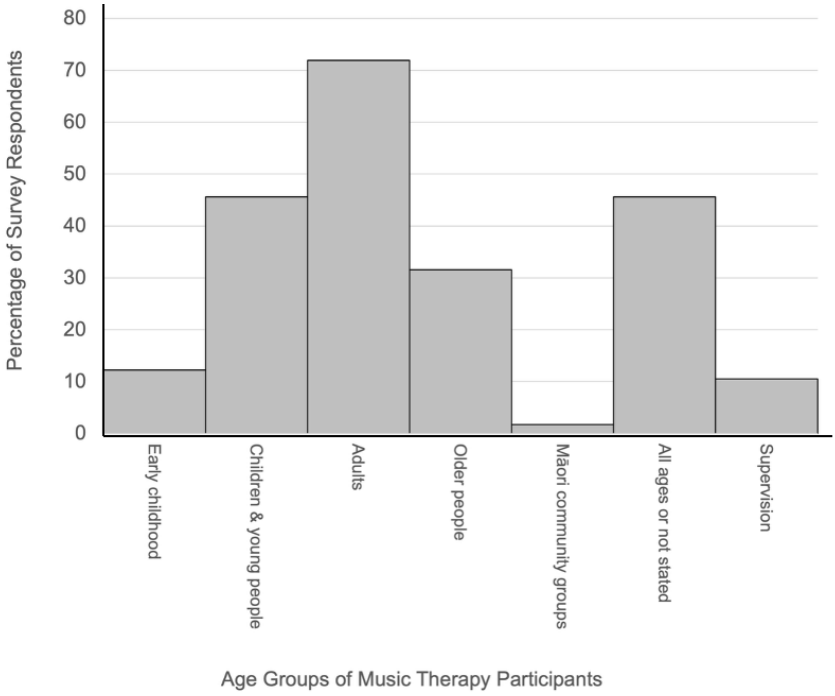

Figure note: Data from Figure 8 are tabulated in Appendix C, Table C7.

> My clients range in age from 3.5 years old to 63 years old with varying diagnoses including: autism, attention deficit hyperactivity disorder, stroke recovery, brain injury, mental health diagnoses, cerebral palsy, Rett syndrome, Down syndrome, Global Developmental Delay, developmental disabilities, [and] sensory processing disorder.
>
> Currently, adult and elder psychiatric and neurological impairment, adult memory loss and dementia, adult autism, attachment issues [with] mothers and babies.

In this analysis, responses have been sorted predominantly by age group, and secondarily by broad domains and a few specific diagnoses (Figure 8). Exceptions include “dementia care” which predominantly affects older people, but respondents might also have been working with clients with

young-onset dementia, diagnosed below the age of 65 (Loi et al., 2023). The client groups or fields of practice served in these settings include disability, neurorehabilitation, medical, and psychosocial needs across the lifespan. A few respondents used terminology that seemed outdated. One referred to clients with “low intellect”, which could be reframed as “(very) high learning needs” or “intellectual disability”. The phrase “special needs” was also used in several responses and remains in common use, in spite of objections from the disability community (CCS Disability Action, 2023).

Overall, 68% of RMThs expressed satisfaction with their current work. However, many shared aspirations for future practice with client groups currently underserved by music therapy, due to funding challenges and/or lack of awareness of music therapy. These included potential clients identified primarily by age (mothers and babies, early childhood/early intervention, children in foster care, youth, and older people) and by need or diagnosis (disabled people, mental health, sensitive claims, neurorehabilitation, HIV, corrections/forensics, and the general population).

Visual representation of this diversity is provided by a word cloud of the descriptors offered by respondents (Figure 9). This visualisation indicates frequency of words and phrases, with increasing font size reflecting higher frequency. This is not a sufficient standalone method of analysis, but offers the reader an overall impression of the ways in which practice has been described. Adopting the terminology used in McFerran et al.’s (2023) mapping of practice, the most common responses include both broad *approaches* (music-centred; Community Music Therapy) and specific *models* of practice (Resource-Oriented Music Therapy; Neurologic Music Therapy; and, less commonly, Nordoff-Robbins’ Creative Music Therapy). Some terms used by respondents that might suggest broad approaches (improvisational; psychodynamic) are only included by McFerran et al. (2023) as descriptors of specific models. Other descriptors draw on interdisciplinary concepts, particularly client-centred and person-centred principles and (less commonly) family-centred, child-centred, and strengths-based values. Frequency counts of qualitative data may also lessen awareness of potentially important issues raised by fewer respondents. For example, few responses referred to contemporary discourses, such as cultural models, post-ableism, and trauma-informed practice, but we cannot assume that open-ended questions have comprehensive responses and that the respondent finds such concepts unimportant.

Figure 9

Word Cloud Depicting Respondents' Reported Practice Models and Approaches

Figure note (image description): A greyscale word cloud depicting frequency of responses through font size.
Tabulated data are provided in Appendix C, Table C8.

These clinical practice data are complex, because of the open-ended question format and multiple descriptors in most responses. Significantly, although few responses specified *eclectic* practice, the multiple descriptors used by many respondents suggest that their work is indeed eclectic or uses multiple methods. Where respondents listed multiple approaches/models, it was unclear whether these were applied in different contexts or were drawn on in all contexts. Nevertheless, the data suggests professional flexibility and theory-informed practice.

Planning and Costing Clinical Services

This section reports on the length of individual and group music therapy sessions, and costs for clients.

Session Length

The length of music therapy sessions varied considerably (Table 2). The most common session lengths were 45 minutes to 1 hour (34.6% of responses) and 30-45 minutes (32.7%); together, these figures indicated that more than two-thirds of sessions lasted half to one hour. A smaller number (11.5%) reported shorter sessions (15-30 minutes). Longer sessions were associated with neurological choirs (1.5-2 hours). The "not applicable" responses (9.6%) suggested that some RMThs facilitate considerably varied session lengths, with a few not currently offering clinical services.

Table 2

Reported Session Length

Session Length	Number of Respondents	Percentage of Respondents
15 - 30 minutes	6	11.5%
30 - 45 minutes	17	32.7%
45 minutes - 1 hour	18	34.6%
1.5 - 2 hours	1	1.9%
Not applicable (not currently pro sessions, or varies)	5	9.6%
Prefer not to say	1	1.9%

Costings: Client Fees for Individual and Group Music Therapy

Questions about client fees elicited a high non-disclosure rate; therefore, the analysis of fees for individual sessions is based on 27 responses (54%). Client fees varied between therapists, between individual and group work, and perhaps between client groups. Charges to clients covered a wide range from $40 to $160 per session. About half of all responses (30% of those who disclosed financial information) were in the range $70 - $100 per session. A small percentage (15%) charged higher rates, possibly reflecting specialisation or experience. Charges for group work were difficult to analyse, as respondents seem to have variously reported individual contributions or the rate for the group as a whole. The wording of this question needs to be clearer in future surveys.

Work-Related Travel

The majority of respondents (n=47, 87%) travelled up to 40 km for work, with some (n=7, 12.5%) travelling a maximum of 5 km. This suggests that many music therapists commute a relatively short distance and work within their own communities. A minority (n=4, 7%) travelled 50 km or more, and in one case up to 120 km. Long-distance commuting may suggest regional disparities in job opportunities, rural employment, or itinerant roles. The survey questions were not precise enough to provide an explanation, and should be revised in future surveys.

Respondents reported different approaches to costing work-related travel. Many charged (or were reimbursed by employers) the current per-kilometre rate recommended by the Inland Revenue Department. A few were reimbursed directly for fuel costs, and others charged a variable rate, depending on distance. Of particular note were many "N/A" (Not Applicable) responses (n=23, 41%), representing many cases where no reimbursement applied. This might reflect employment in one facility, but might also represent a lack of awareness of expense reimbursement processes.

Remuneration

The survey investigated client fees and RMTh remuneration, by both session rate and overall annual income. The data set included 55 survey respondents, of whom 17 (23.2%) chose not to answer questions related to charging. We theorised that non-responses might indicate privacy concerns, variability in pay rates, or non-disclosure clauses in employment agreements and contracts. One response that the rate “varies” might indicate variation between workplaces, project-based work, or fluctuating contracts. Consequently, the following analysis should be

treated with caution as not fully representative of the profession. Due to the wording of survey questions, it is also possible that reported earnings may include non-music therapy work. As music therapy practice may include research, supervision, and tertiary education, these figures may not accurately reflect the remuneration of RMThs engaged mainly in clinical practice.

Nevertheless, the reported rates provide a starting point for considering remuneration. Hourly rates ranged from $20 per hour to $160 per hour. The most frequently reported hourly rates were $30 - $40, $70 - $80, and $100 - $110 (each almost 11% of responses). The highest reported rate, $160, appeared to be an outlier, possibly reflecting a specialised or highly experienced therapist. Of particular concern was a decrease in the minimum hourly rate in comparison with 2008 survey. The lowest rate ($20 per hour) was below the minimum wage of $21.20 at the time of the 2022 survey (Employment New Zealand, 2025).

A greater proportion of respondents reported on their annual income (76.8%). Responses encompassed both employees with an annual salary and the overall earnings of contractors/self-employed RMThs on hourly rates. Roughly one quarter of total respondents earned either $40,000 - $60,000 (27.5%) or $60,000 - $80,000 ($23.2%).[8] Approximately 10% earned $20,000 or less – presumably through part-time work. The small proportion (8.7%) earning over $80,000 may reflect limited opportunities for professional progression and the few senior positions available in public, private, or non-profit agencies or in tertiary training.

A comparison of the 2008, 2016 and 2022 survey suggests rising salaries: $5,000 - $65,000+ (2008), $5,000 - $79,999 (2016), and up to $120,000 (2022). However, these figures are tentative, and questions should be carefully reworded in future surveys. The current data do not adequately show how annual remuneration relates to billable work and non-billable administrative tasks.

Barriers to Accessing and Providing Music Therapy Services

The survey revealed several barriers impacting the provision of music therapy services, related to economic factors, therapist availability, and therapist wellbeing.

A lack of funding reduced or precluded potential services, such as neonatal intensive care units (NICU); support for mothers and babies; early childhood and early intervention; mental health for children, young people, and adults; sensitive claims; care for people with HIV;

[8] We note the overlap of these ranges, which should be avoided in future survey design.

neurorehabilitation; dementia care; palliative care, and corrections.[9] Additionally, the Accident Compensation Corporation (ACC)[10] rarely funded music therapy, limiting access for people who might benefit. The cost of living also posed a financial barrier, with limited family budgets making private therapy unaffordable for many. Collectively, these financial constraints can reduce both the availability and accessibility of music therapy services.

The geographical location of RMThs created an uneven access to services. As reported above (Figure 1), music therapists were not available in all regions. Many also lacked the capacity to increase their workload, as indicated in responses to the survey's open-ended questions. Respondents identified gender disparity in some areas of practice, particularly the greater challenge for women than men to secure roles in corrections services.

Therapist wellbeing sometimes hindered service provision, with some reporting health issues, such as voice problems. Almost half of respondents (46%) reported having experienced burnout, a response to chronic occupational stress (Edu-Valsania et al., 2022). Action to combat burnout included increased attention to self-care; counselling or psychotherapy; and the support of family, friends, colleagues, supervisors, and others with lived experience of burnout.

Supervision and Continuing Professional Development

The New Zealand Music Therapy Registration Board (established in 2000) provides a voluntary system of professional registration, including publication of a Code of Ethics (CE), Standards of Practice (SP), and minimum expectations for professional supervision and continuing professional development (CPD). Reporting on these activities is required as part of the application processes for full registration and for an annual practising certificate. Information and resources are provided on the MThNZ website.[11]

Satisfaction with Registration Matters

Satisfaction rates with the Annual Practising Certificate (APC) renewal process for RMThs and the Code of Ethics (CE) and Standards of Practice (SP) documents were similar, with the majority of respondents either "satisfied" or "very satisfied" (Figure 10). However, approximately

[9] In New Zealand, *corrections* is the term used for prisoners and community-based offenders.

[10] The Accident Compensation Corporation (ACC) is a no-fault accident compensation scheme in New Zealand. For further information, see: https://www.acc.co.nz

[11] For current guidelines and resources, see the webpage: https://www.musictherapy.org.nz/about-mthnz/new-zealand-music-therapy-registration-board-2025/

one-fifth gave “neutral” responses. A few were “dissatisfied” with the APC process, and one respondent was “dissatisfied” with both documents.

Figure 10

Satisfaction with the Annual Practising Certificate Process, Code of Ethics, and Standards of Practice Document

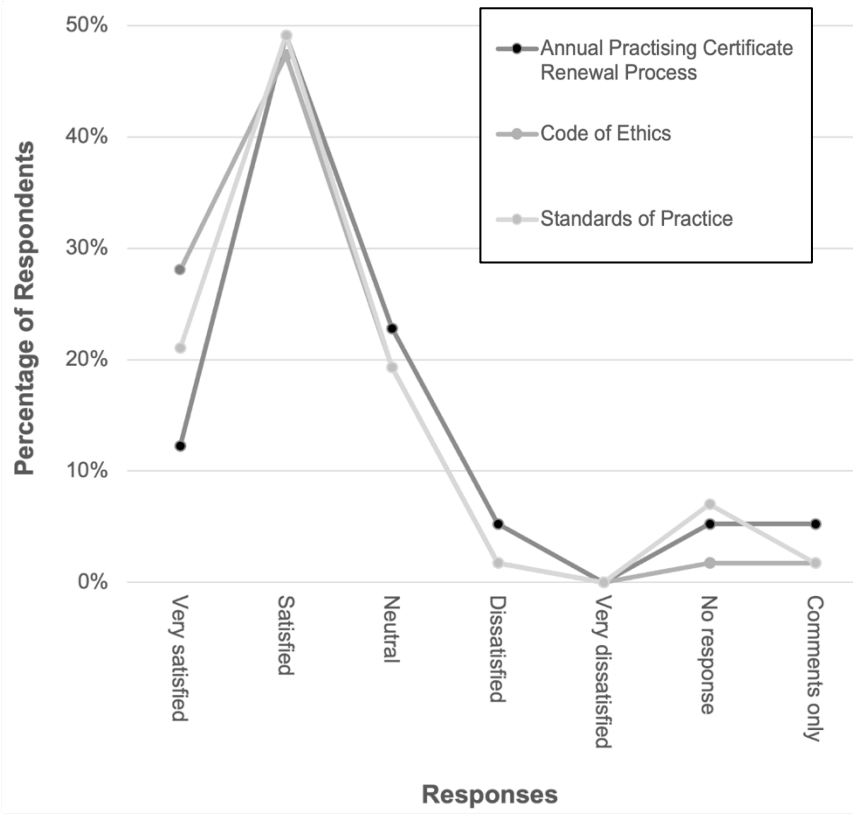

Figure note: Data from Figure 10 are tabulated in Appendix C, Table C9.

Concerns about the APC process related to the length of the form and changes in the form close to the submission deadline. Constructive suggestions included developing a pre-populated online APC form, reducing the need to retype information, and perhaps available during the year for maintaining supervision and CPD logs. One respondent

questioned whether the requirement for the supervisor to review and approve the APC CPD log exceeded the supervisor's scope of practice.

Positive comments about the CE and SP documents included their value in advocacy as well as professional practice: "I reference them in every contract and every meeting when establishing [...] new work and in every in-service/education session as it is a key way to strengthen our status with other professions." One respondent suggested a workshop or webinar offering practical guidance about using the CE and SP in everyday professional practice. Suggestions for future revisions of the documents included greater integration of Te Tiriti o Waitangi; more emphasis on reflexivity in relation to cultural competence; avoidance of cultural appropriation; and guidelines for telehealth practice.

Appreciation was expressed for the work of the Registration Board, for example: "I believe the Registration Board, particularly the Chair and Registrar, are highly responsive to feedback and constantly committed to improving the process."

Supervision

Supervision, which involves meeting with a more experienced practitioner and/or peer(s), is a requirement for music therapy registration in New Zealand. Variation in respondents' supervision arrangements included the choice of individual, peer, and/or group supervision (Figure 11) and the choice of supervisor (Figure 12).

With a minimum requirement of ten hours per year, frequency ranged from weekly to ad hoc meetings. Both in-person and online supervision were common. Some reported challenges accessing their preferred type of supervision, such as group or peer supervision or a supervisor with a specific theoretical orientation.

Many respondents (35%) also provided clinical supervision for other music therapists (and sometimes other professionals) and/or students. The authors note that the number of available supervisors has increased following the opportunity in 2023 to complete a MThNZ-hosted Level 5[12] micro-credential supervision course through the New Zealand Coaching and Mentoring Centre.[13]

[12] For an explanation of the Levels of the New Zealand qualifications framework, see https://www.careers.govt.nz/courses/find-out-about-study-and-training-options/qualifications-and-their-levels/#clD_7262

[13] https://www.coachingmentoring.co.nz

Figure 11

Types of Supervision

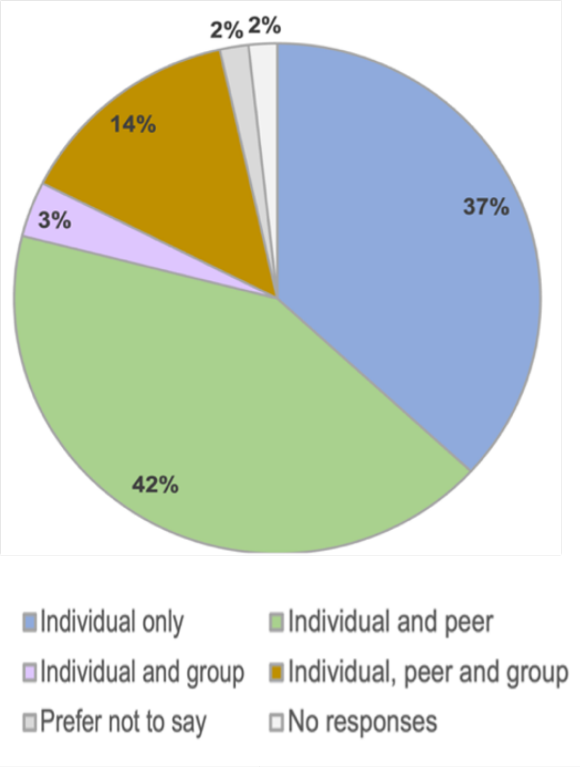

Figure note: Data from Figure 11 are tabulated in Appendix C, Table C10.

Figure 12

Choice of Supervisor

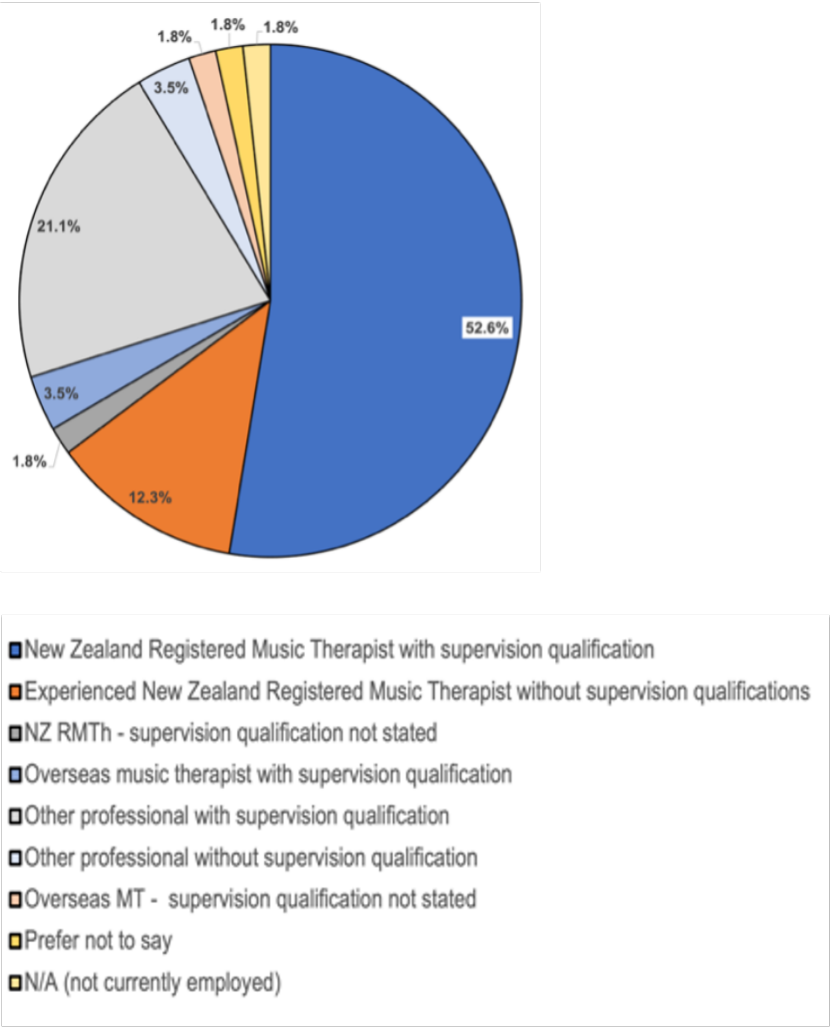

Figure note: Data from Figure 12 are tabulated in Appendix C, Table C11.

Continuing Professional Development

As the Registration Board monitors the range of CPD undertaken, this analysis is brief. Online learning was the most frequently cited form of CPD, highlighting a strong trend toward digital resources and training – for example, some specifically mentioned MThNZ webinars. Workplace learning and collegial support also provided valuable CPD. Some respondents also maintained their musical skills through participation in community music groups. Other activities included personal music lessons, professional reading, and personal research. Respondents seemed to favour interactive or structured group CPD activities, rather than independent projects. Two respondents explicitly stated they did not participate in CPD, with one commenting on their lack of time. However, RMThs are required to undertake CPD in order to maintain their registration and receive an annual practising certificate.

Feedback about Music Therapy New Zealand

Questions about MThNZ focused on membership; MThNZ values; perceived sensitivity towards bicultural, multicultural, and other equity issues; communications and media; events; priority challenges; and feedback about the present survey.

Membership

MThNZ has advocated for music therapy service provision and professional training for more than 50 years (Music Therapy New Zealand & Rickson, 2024). Its status as an incorporated society with charitable status (and not a professional association) provides an array of membership categories - e.g. RMTh, Student, Friend - operating independently of the registration process and incurring separate fees (Music Therapy New Zealand, n.d.-a). Respondents' membership status varied, but only 8.8% of respondents were non-members, while one respondent (1.8%) preferred not to say.

Music Therapy New Zealand's Values

MThNZ has four long-standing values as an organisation, publicised via the website, strategic plan, and journal, and mentioned in the Code of Ethics. However, only a little more than half of respondents were aware of these values (52.6%). More than a quarter were not aware (26.3%), with some unsure (10.5%), preferring not to say (3.5%), and one not responding (1.8%).

Sensitivity towards Bicultural, Multicultural, and other Equity Issues

Motivated by a concern for social justice and equity, the survey investigated satisfaction with the sensitivity of MThNZ towards bicultural issues, multicultural issues, and aspects of diversity more broadly. (This section should also be read in conjunction with responses about the CE and SP documents, above.) The largest proportion of respondents (over 40%) selected "Neutral", indicating that many neither felt strongly satisfied nor dissatisfied. Around 20–30% reported being "Satisfied", while a smaller yet notable proportion (approximately 10–12%) indicated they were "Very satisfied". The spectrum of views expressed in this 2022 survey is the similar pattern of responses in response to these three aspects of diversity (Figure 13).

Responses and additional comments suggest that more work remains to be done as MThNZ continues to emphasise bicultural partnerships, foster intercultural relationships, and advocate for disabled people, the rainbow community, and those with high healthcare needs. One Māori respondent reported negative experiences within the music therapy profession and this organisation, and a tauiwi[14] respondent also highlighted ongoing challenges for RMThs in relation to this sociocultural context: "We need more Māori music therapists, more work on cultural competency in our training and PD, it's an everyday battle to combat institutional racism."

Several respondents commented that diversity was often hidden - for example: "This is never discussed unless we personally know an LGBTQ+ RMTh, but we all have LGBTQ+ clients! Where is the representation on [Council]?"

A very few voices suggested that too much attention is given to these areas, a view out of kilter with the majority of respondents. Others reflected that the organisation is moving slowly in the right direction and made practical suggestions for moving forward together, such as opportunities for RMThs to share their personal and professional experiences, and setting up a working group to align MThNZ with disability organisations and to ensure accessible communications.

[14] Tauiwi is a Māori word, meaning non-Māori people.

Figure 13

Satisfaction with Music Therapy New Zealand's Sensitivity towards Cultural and Equity Issues

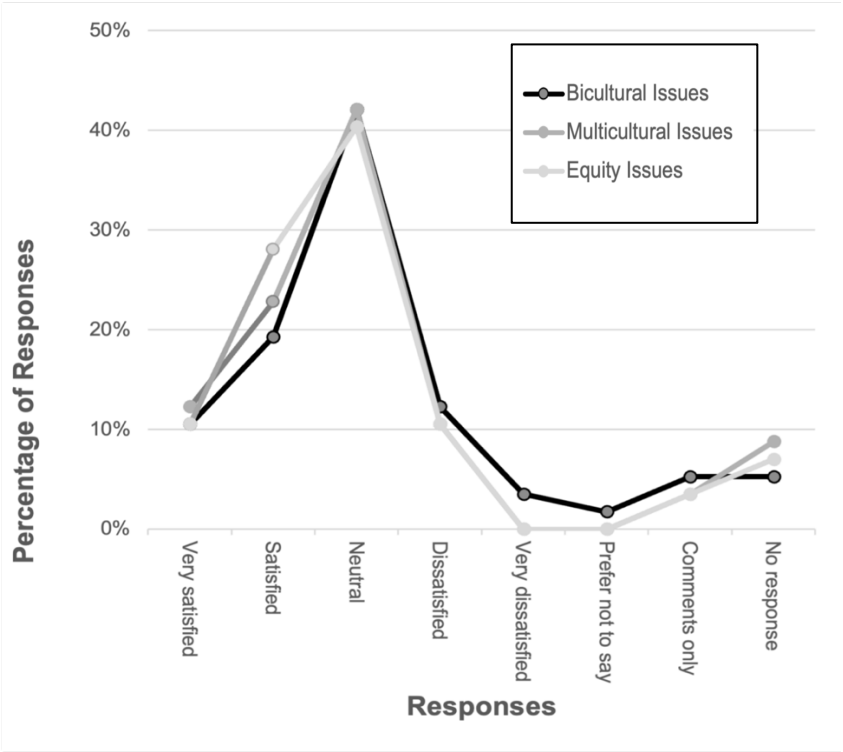

Figure note: Data from Figure 13 are tabulated in Appendix C, Table C12.

Communications and Media

The survey asked for feedback about MThNZ communication and media. This includes a website, website members' area, social media (primarily Facebook, but also Instagram), the *New Zealand Journal of Music Therapy* (NZJMT), and the *MusT* newsletter (resumed after a pause). The high proportion of neutral views suggest that improvements were needed (Figure 14). Several comments acknowledged improvements since 2020, with many advocating improvements to the website and members' area.

Figure 14

Satisfaction with Music Therapy New Zealand's Communication and Media

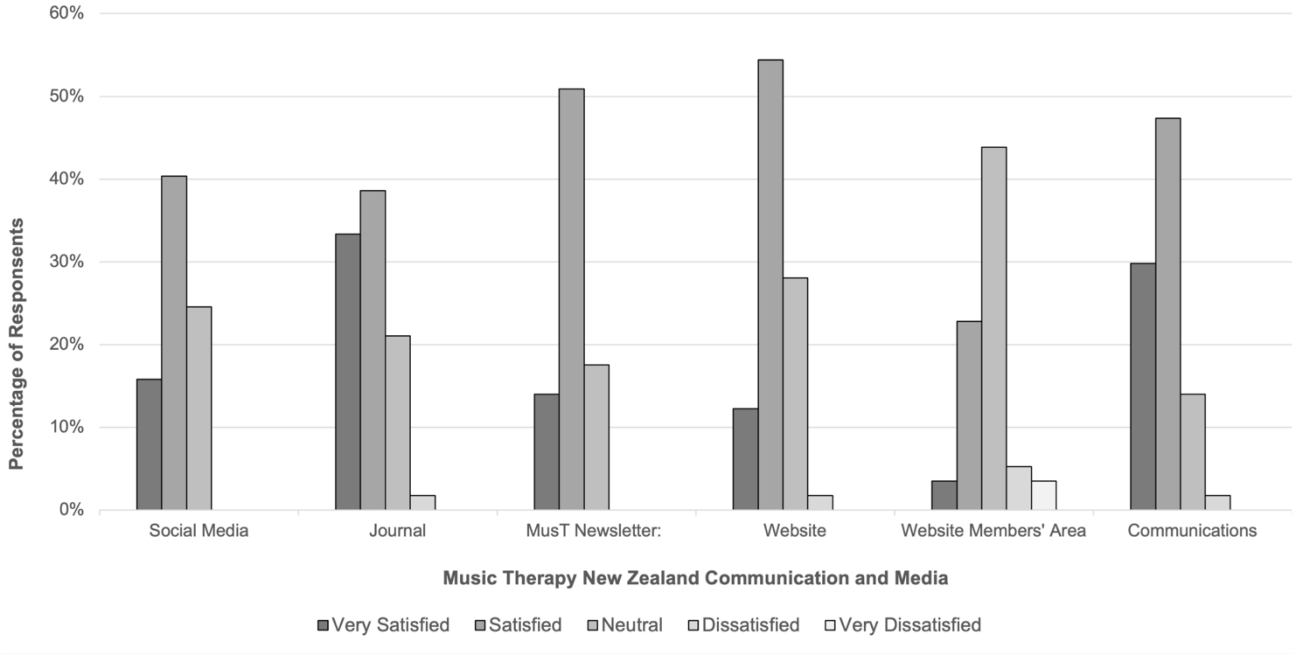

Figure note: Data from Figure 14 are tabulated in Appendix C, Table C12.

Email communication remained essential, rather than relying on social media (a Facebook group) that not all members use. The public Facebook page was valued, with some suggesting more frequent posts and better representation of diverse music therapy practice.

Events

Feedback was positive about MThNZ national and regional events, such as symposia, workshops, and an annual Music Therapy week. Several events have been held since this survey. We note particularly the success of the 2024 50th Anniversary Conference, celebrated in multiple sections of the *MusT* newsletter (Music Therapy New Zealand, 2024).

Priority Challenges for Music Therapy New Zealand

The survey asked RMThs to identify three priority issues for MThNZ to address. Responses broadly referred to professional recognition, advocacy, funding, service provision, support for music therapists, and the time and energy commitment demanded of MThNZ officers.

Feedback about this Survey

We acknowledge that participation in this survey asked for a considerable investment of time. Nevertheless, several respondents commented on the value of the survey. For example: "This survey took way longer than I expected, but I appreciate that you've sought feedback and input and hope it helps. Thanks for all that you do supporting music therapy in NZ – it's appreciated."

Discussion

This article offers an opportunity to reflect on the progress made since the survey's completion in November 2022. Both the 2016 and 2022 surveys were intentionally lengthy, detailed questionnaires initiated for the purpose of capturing a snapshot of the profession and tracking issues related to the workforce and professional issues. In this section, we consider the survey's findings about issues impacting "the provision of music therapy for all who might benefit" – one of the key objectives of MThNZ (Music Therapy New Zealand, n.d.-b). Based on the categorised responses, key themes and patterns were identified to support the interpretation of the data in relation to this topic. Three broad topics were identified: (1) Workforce demographics and service provision; (2) Equity challenges for RMThs, clients, and MThNZ; and (3) MThNZ advocacy and communication.

Workforce Demographics and Service Provision

With a response rate of 63%, this survey does not represent all RMThs active in 2022, but gives an indication of the workforce. Encouragingly, in terms of workforce sustainability, 68% of respondents were under the age of 50. However, the survey suggests that music therapy practice continues to be concentrated in the main centres, Wellington - Pōneke, Auckland - Tāmaki Makarau, and Christchurch - Ōtautahi. Numbers have fluctuated slightly in some other regions; however, some regions seemed to have no music therapy service provision in either 2016 or 2022.

The findings show that eclectic approaches and models of practice continue to be valued - a longstanding philosophy in this country (Music Therapy New Zealand & Rickson, 2024). Unfortunately, questions did not specifically investigate the impact of the COVID-19 pandemic on service provision, and respondents did not raise this issue. A substantial co-authored NZJMT article addressed immediate responses to the pandemic (Talmage et al., 2020), and several other NZJMT articles have noted aspects of the pandemic (e.g. Hernandez, 2024; Johns, 2023; Wallace, 2023). Further inquiries might reveal long-term changes to practice, such as attitudes to telehealth services, as reported in other countries (Clements-Cortés et al., 2025).

The findings suggest two interconnected challenges for music therapy service provision in this country: (1) The challenge for some RMThs of finding sufficient employment, and (2) the challenge of extending sustainable service provision to reach new client groups and more regions of the country. Two initiatives may provide a partial solution. First, MThNZ offers several contestable grants and scholarships, including Ronnie's Fund, established by a private donor, ~~s~~specifically to support regional activities.[15] Secondly, two new music therapy student scholarships have been established through collaborations between the Raukatauri Music Therapy Trust, the Music Helps charitable trust, and a private donor (Raukatauri Music Therapy Trust, 2023).

Additional challenges highlighted by RMThs concerned professional recognition and access to professional development. Music therapy is a self-regulated profession, rather than being regulated under the Health Practitioners' Competence Assurance (HPCA) Act (2003). Issues of professional recognition and regulation were under review at the time of writing this article (Ministry of Health, 2025). MThNZ submitted an organisational response to the public consultation, and we await the consultation findings and government response with interest.

[15] https://www.musictherapy.org.nz/grants/grants-ronnies-fund

A related challenge for RMThs is that MThNZ is an incorporated society with charitable status, rather than a professional association – a structure that suited the early development of the profession with few practitioners but may not fulfil current needs. Many respondents called for increased professional development opportunities, whereas the charitable status requires that the organisation fulfils its publicly facing purposes, rather than acting on behalf of members. While MThNZ has a strong record in organising conferences, symposia, workshops, and webinars open to both a professional and general audience, many RMThs were seeking additional support.

Equity Challenges

Equity issues are central to contemporary social discourse, particularly in relation to Te Tiriti o Waitangi,[16] racism (Harris et al., 2024; Mana Mokopuna, 2024), changes to disability funding (Awhi Ngā Mātua, 2025; Radio New Zealand, 2025), and reported crises in health care (Gower, 2025), aged care (Dale, 2024), and education (Gillies, 2025). These sociocultural-political issues impact the whole community, including limiting the provision of sustainable music therapy services.

Over half of respondents were neutral or dissatisfied with the perceived sensitivity of MThNZ towards bicultural, multicultural, and other equity issues. These issues do not exist in isolation: our clients and our profession include people who experience increased discrimination or disadvantage due to intersectionality.[17] As an organisation and as professionals, we need to show active allyship.[18]

While this suggests considerable room for improvement, we note recent actions in this area, including new scholarships for music therapy students, a range of grants, and provision of two bicultural workshops for MThNZ members and officers.[19] The 2024 conference celebrated diversity of practice, and a compelling theme was chosen for Music Therapy Week 2025, “Meaningful moments in music therapy – Celebrating diverse communities across Aotearoa” (Music Therapy New Zealand, 2025). Other activities include organisational responses to

[16] Te Tiriti o Waitangi is the Māori text of the 1840 treaty between Māori and the Crown – the version now widely considered the country’s founding document, due to discrepancies between the English and te reo Māori documents (Orange, 2023).

[17] Intersectionality: the interconnection of social identities, such as race, ethnicity, gender, sexuality, and class, that create complex systems of disadvantage and/or discrimination for individuals and groups.

[18] Allyship: active support for the rights of a minority or marginalised group, by people who are not members of the group.

[19] See Appendix A, Table A1.

public consultations, such as recent initiatives related to disability funding, arts access, dementia care, and the regulation of health professions.

Advocacy and Communication

Advocacy and communication with members and the wider community continue to be priorities for RMThs. Continued action is needed to raise awareness of the values of MThNZ and the benefits of music therapy. High levels of engagement with MThNZ are evidenced by membership rates and attendance at symposia and the 2024 conference. However, many respondents noted the challenge of finding time to contribute to MThNZ portfolios or to write for the journal and newsletter. Manageable opportunities for professional writing might include co-authored articles, such as an ambitious article collating responses to the COVID-19 pandemic (Talmage et al., 2020). The MThNZ *MusT Newsletter* could also offer templates for caption stories, i.e. photographs accompanied by a brief description, rather than a full article.

Limitations of this Survey

A survey response rate of 63% provides important data about the music therapy practice and practitioners, but cannot be fully representative of the profession. RMThs who did not participate may have answered the questions differently and may hold different views than the respondents. Nevertheless, the authors believe that the survey has yielded useful information.

Some potential respondents may have been discouraged by the length of this survey and the time commitment required. Some questions could have been more clearly worded to avoid ambiguity and to acknowledge the multi-faceted nature of music therapy practice alongside work undertaken in other fields, such as teaching. A significant omission was the absence of questions about individual and organisational responses to the disruption caused by the COVID-19 pandemic.

In reporting our findings, we have intentionally omitted some data due to a lack of responses; it was unclear whether some questions were deemed challenging to answer or whether the survey length created response fatigue and selective responses. Our rationale was pragmatic: to manage an extensive data set and to focus on key information that seemed most pertinent for RMThs and MThNZ.

The completion and publication of the survey analysis took longer than expected due to limited personnel – most of whom volunteer their time for MThNZ – as well as personal and health-related priorities. Given

these reasons, completing and publishing the survey analysis has been challenging. This unfortunate delay means that responses are no longer current, but do provide comparative data and an opportunity for MThNZ to reflect on progress since November 2022 (the survey date).

Conclusions and Recommendations

The purpose of this survey was to provide a snapshot of the New Zealand music therapy profession, to allow tracking of challenges for the profession, and to listen and respond to feedback from music therapists. Based on our analysis, we offer several suggestions for MThNZ and music therapy in Aotearoa. We acknowledge that much of this work is underway and supported by many in the music therapy professional community. Our suggestions are:

1. Advocate for public and legal recognition of music therapy, as a diverse allied health profession, and for sustainable funding for music therapy services and research;
2. Advocate for music therapy training and support for potential students and new graduates from marginalised communities;
3. Articulate a social justice commitment to Te Tiriti o Waitangi, diversity, intersectionality (multiple factors increasing experience of discrimination), equity, and allyship (support for marginalised or disadvantaged people, by people outside their social group);
4. Recognise that MThNZ, due to its charitable status, serves the wider community, and that the growing profession may need separate representation and support;
5. Update the communications strategy and explore ways to engage more members and community partners in strategic issues, working groups, regional networking, and sharing practice and research through written and digital reporting;
6. Consider the purpose and scope of future surveys, and consider rewording some questions for clarity, if used again; and
7. Consider collecting more comprehensive demographic data in future surveys through a broader, intersectional lens that incorporates aspects such as disability, sexuality, and gender identity.

We emphasise that the survey was conducted in 2022, and the recommendations related to respondents' feedback at that time. MThNZ has already responded to many of these concerns, through activities including:

- Celebrating diversity of practice and practitioners through the 2024 50th Anniversary Conference, project grants, and workshops;
- Engaging with the membership through national and regional hui;
- Responding to government consultations (e.g. the Disability Support Services Consultation (2024)[20] and the Amplify arts consultation (2024);[21]
- Reviewing the MThNZ constitution;
- Grants for innovative projects and funding towards approved regional group activities;
- A short Registration Board survey integrated with the 2024 APC process; and
- Working groups addressing issues such as professional regulation, future surveys, and established portfolios.

These activities chime with the values of MThNZ: Life / Waiora, Reciprocity / Whanaungatanga, Creativity / Auahatanga, and Professionalism / Te Taumata. We hope that this survey report will support and encourage MThNZ, individual music therapists, and partner organisations to continue to advocate for music therapy service provision.

Acknowledgements

Music Therapy New Zealand thanks all survey respondents. This investment of your valuable time has made an important contribution to the breadth and depth of data collected. As a diverse profession, we value all perspectives. Your responses and comments will help to inform Music Therapy New Zealand's strategic planning.

The authors thank Barbara Lewis (Music Therapy New Zealand Administrator), Stephen Guerin (Council Chair), and Jen Glover (New Zealand Music Therapy Registration Board Chair) for assistance in documenting the impact of the 2016 Music Therapy New Zealand survey. The authors thank colleagues who have read and commented on drafts of this article.

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Appendix A
Responses to Recommendations from the 2016 Survey Analysis

Table A1

2016 Survey Recommendations regarding Music Therapy Provision and Employment, and Resulting Action

Recommendations		Action
a.	Develop online profiles for Registered Music Therapist members of Music Therapy New Zealand	Profiles are now included on the Music Therapy New Zealand website: https://www.musictherapy.org.nz/find-a-therapist
b.	Advocate for music therapy to be recognised and included in District Health Board pay scales.	Note, the 20 District Health Boards were disestablished in June 2022 and replaced by Health New Zealand, Te Whatu Ora
c.	Offer workshops related to advocacy and presentation skills, establishing provision/positions, and grant applications.	Written documents rather than workshops have offered guidance. See Item 2(a).
d.	Review the present and potential roles of the Music Therapy New Zealand regional groups.	Regional groups have continued to develop with the support of local coordinators and Council.
e.	Consider the establishment of a Music Therapy New Zealand research fund.	A dedicated research fund has not been established, but some research funding has been allocated through other grants (https://www.musictherapy.org.nz/grants).
f.	Monitor the impact of Music Therapy New Zealand grants.	Grant recipients are required to submit a report to the Project Grants Group, which is usually published in the MusT newsletter.
g.	Monitor the growth of the profession, in collaboration with the New Zealand Music Therapy Registration Board.	The Registration Board maintains records of Registered Music Therapists.
h.	Review the remuneration questions in the surveys to date, to ensure relevant data collection (e.g. GST).	This recommendation was excluded from the 2022 survey, due to the greater focus on scope of practice and feedback about Music Therapy New Zealand.

Table A2

2016 Survey Recommendation regarding Professional Issues, and Resulting Action

Recommendations		Action
a.	Provide self-employment / private practice guidance, including small business skills workshops and an information sheet.	The Professional Resource Pack was revised as Guidelines for Business when Working as a Music Therapist (2023) and subsequently Guidelines for Business Standards with accompanying flowchart.
b.	Consider the role of the music therapy Standards of Practice in the annual registration process, in collaboration with the New Zealand Music Therapy Registration Board.	A two-day Registration Board meeting (July 2019) reviewed all documentation, aiming to simplify forms and ensure alignment with the Standards of Practice and Code of Ethics documents. A further document - Process and Guidelines for Registration and Renewal of Annual Practising Certificates - reminds music therapists of their responsibility to maintain standards of practice. All Registered Music Therapists have signed the professional Code of Ethics.
c.	Ask the Registration Board to ensure that registration information clarifies the status of music therapy as a self-regulated profession in New Zealand.	While the Registration Board documents do not specifically record that music therapy is a self-regulated profession, in New Zealand, it is clear that there is a rigorous process for registration, managed by the Registration Board on an annual basis. The members' area of the Music Therapy New Zealand website highlights organisational membership of Allied Health New Zealand (AHANZ, https://www.alliedhealth.org.nz), which provides information about which professions are self-regulated, regulated under the Health Practitioners Competency Assurance (HPCA) Act, and recognition of music therapy by ACC (https://www.acc.co.nz).
d.	Continue to monitor the possibility of registration under	Work is ongoing in this area.

	the Health Practitioners Competence Assurance (HPCA) Act, through liaison with Allied Health Aotearoa New Zealand (AHANZ) and related professional organisations.

Table A3

2016 Survey Recommendation regarding Diversity, and Resulting Actions

Recommendations		Action
a.	Continue to advocate for diversity of professional practice, rather than prioritising any particular group, context or approach.	Music Therapy New Zealand and the Registration Board do not advocate any particular model of practice. The value of kaupapa Māori for Indigenous Registered Music Therapists and participants is acknowledged and encouraged. The separate scope of practice of taonga puoro practitioners and healers is recognised as another allied profession.
b.	Consider making bicultural and multicultural partnerships a strategic priority.	A bicultural workshop, facilitated by Hone Hurihanganui was offered to all members in 2022 (https://www.engaging-well.com) A workshop was provided for Council members and portfolio holders in 2023, facilitated by Heather Came (https://www.heathercameassociates.com) and Wiremu Woodard.
c.	Review the organisation's and profession's understanding of disability issues.	This forms part of a review of the Standards of Practice for New Zealand Registered Music Therapists.
d.	Ask the Registration Board to consider amending application forms to allow more space and specific prompts for applicants to list other music therapist / other professional accreditation, registration and memberships; and to consider requesting applicant consent for these data to be collated anonymously, for the purpose of developing knowledge about the profession and stakeholders.	Currently, only ethnicity data can be collected; this is included in revised registration forms. Subsequent to the 2022 survey, but before its complete analysis, the Registration Board initiated an optional survey in 2023 as part of the registration and annual practising certificate (APC) renewal process, for the purpose of better understanding the current profession and to support advocacy. This survey included a clear declaration of consent. The Registration Board continues to maintain a register of all music therapists and a summary of the total hours worked by music therapists who complete the annual APC form.

Appendix B
2022 Survey Questions

Section 1: Music Therapist Training and Registration

1. What is your current registration status in New Zealand?
2. Are you Registered as a Music Therapist in another country? If so, where?
3. What is your current Music Therapy New Zealand (MThNZ) membership status?
4. If you are not a member of MThNZ, what are your reasons for this?
5. Why did you choose to be a member of MThNZ?
6. In which institution (including country) did you complete your training to be a music therapist?
7. What year did you graduate?
8. When qualifying, was your first role as a NZ Registered Music Therapist (NZ RMTh) a paid position (in New Zealand)?
9. When you first graduated, where did you work (e.g. organisation/self-employed), how long did you remain in this position, and was it in New Zealand or overseas?
10. When you first graduated, how long did it take for you to find a paid role as a NZ RMTh in New Zealand?
11. List all of your professional qualifications or accreditations.
12. List all other affiliations or memberships.
13. Are you undertaking any further study within a tertiary institution? If yes, please give details here.

Section 2: Demographics

1. Country of birth.
2. In what region are you located?
3. Current location.
4. Gender.
5. Age group.
6. Ethnicity.
7. Residential status in New Zealand.

Section 3: Employment

Note, full-time work is 30 or more hours per week.

1. Are you currently working as a NZ Registered Music Therapist (NZ RMTh) delivering music therapy?
2. If some of your work is as a NZ RMTh, what is/are your other job role(s)? i.e. researcher, lecturer, teacher, consultant
3. If you are not currently working as a NZ RMTh, what is your job title?

4. Current employment status as a NZ RMTh?
5. Where do you work? [A list of types of facility was provided.]
6. What models/approaches do you use?
7. What communities do you work with? e.g. diagnosis and age groups?
8. What communities would you like to work with and what are the barriers to working in these areas?
9. Are you happy with your current employment situation?
10. If no, what would you like to change?
11. If yes, what gives you job satisfaction?
12. Have you ever experienced burnout as a NZ RMTh?
    (Defined as physical, emotional, or mental exhaustion accompanied by decreased motivation, lowered performance, and negative attitudes toward oneself and others.)
13. If so, where and how did you receive support?

Section 4: Travel, Hours, and Costing

1. How far do you usually have to travel to work from home, on average?
2. Do you charge travel expenses and/or travel time?
3. How much do you charge for travel and/or travel time?
4. How many hours of music therapy sessions do you provide per week on average? (contact-time only)
5. How many hours of non-contact time do you carry out per week on average? (e.g. reports, preparation, administration)
6. What is the average length of your individual music therapy sessions?
7. If you are self-employed, what is the average cost for an individual session?
8. What is the average length of your group music therapy sessions? (contact-time only)
9. If you are self-employed, what is the average cost for a group session?
10. What is your hourly rate (before tax)?
11. Or, what is your annual salary (before tax)?
12. If applicable, what type of pay scale are you on?
    (District Health Board, Ministry of Education Therapist Scale, etc.)
13. What is the length of your employment agreement?
    (permanent, fixed-term)
14. How did you establish your main job?
15. How do you create/find more work?

Section 5: Supervision

Note, a summary of types of supervision was provided.

1. What type(s) of supervision do you receive?
2. If you receive individual supervision, how often do you attend?
3. If you receive peer supervision, how often do you attend?
4. How many individuals attend this peer group (on average)?
5. If you receive group supervision, how often do you attend?
6. How many individuals attend this group supervision (on average)?
7. If you do not receive supervision, what are your barriers?
8. Is your main supervisor… [choice of professionals].
9. Do you receive supervision in-person or online?
10. Do you have difficulties accessing supervision?
11. Are you happy with the quality of supervision you receive?
12. If yes, please state why.
13. If no, please state why.
14. Do you provide supervision for NZ RMThs?
15. If so, do you have any formal supervision training?
16. If yes, please list your supervision qualifications.
17. How many NZ RMTh supervisees do you see?
18. Are you currently working with non-NZ RMTh supervisees?
19. Are you currently working with Music Therapy Student supervisees?
20. If yes, how many?
21. Are you remunerated for this work?

Section 6: Professional Development

Note, brief examples were provided of the classifications of professional development used by the New Zealand Music Therapy Registration Board.

1. How satisfied are you with the ability to source Music Therapy-Specific Training and Development for your Continuing Professional Development (CPD) record for your MThNZ registration?
2. Where do you most often source professional development opportunities for Music Therapy-Specific Training and Development?
3. How satisfied are you with the ability to source Other Training or development for your CPD record?
4. Where do you most often source Professional Development opportunities for Other Training or development?
5. How satisfied are you with the ability to source Musical Activities relating to Music Therapy Practice for your CPD record?
6. Where do you most often source Professional Development Opportunities for Musical Activities relating to music therapy practice?
7. How satisfied are you with the ability to source Other Professional Development for your CPD record?
8. Where do you most often source any Other Professional Development

Opportunities?

9. How satisfied are you with the application process for the renewal of your Annual Practising Certificate?
10. What could the New Zealand Music Therapy Registration Board do to improve this process?
11. Are you aware of MThNZ's Code of Ethics and Standards of Practice documents?
12. How satisfied are you with the relevance of these documents to your practice?
13. How satisfied are you with the relevance of these documents to music therapy in New Zealand?
14. Do you have any other comments relating to the MThNZ Code of Ethics and Standards of Practice documents?

Section 7: Music Therapy New Zealand Membership

1. Are you satisfied with the level of communication you receive from MThNZ?
2. What would you like to change about MThNZ's communication?
3. Are you aware of MusT?
   [Note for readers of this article, MusT is the MThNZ newsletter.]
4. Do you read MusT?
5. Are you satisfied with the content of MusT?
6. What would you like to change about MusT?
7. Have you contributed to the content of MusT in the past? If no, what are your barriers?
8. Are you aware of the New Zealand Journal of Music Therapy (NZJMT)?
9. Do you read the NZJMT?
10. Are you satisfied with the content of the NZJMT?
11. What would you like to change about the NZJMT?
12. Have you contributed to the content of the NZJMT in the past? If no, what are your barriers?
13. Are you aware of the member's area on the MThNZ website?
14. How often do you use it?
15. Are you satisfied with the content of the member's area?
16. What would you like to change about the member's area?

17. Do you visit the MThNZ website?
18. Are you satisfied with the content of the MThNZ website?
19. What would you like to change about the MThNZ website?
20. Do you follow MThNZ on social media? (Facebook and Instagram)
21. Are you satisfied with the content of MThNZ social media?
22. What would you like to change about MThNZ social media?

23. Are you aware of the MThNZ Membership benefits?
24. How satisfied are you with the MThNZ membership benefits?
25. What would you like to change about the membership benefits?
26. Are you involved in any MThNZ portfolios?
    (e.g. Regional Group Co-ordinator or Special Interest Groups)
27. If you would like to be more involved, what would you like to do?

Section 8: Music Therapy New Zealand Events

1. Are you aware of Music Therapy Week?
2. How satisfied are you with this event?
3. What would you change about the Music Therapy Week event?
4. What other events would you like MThNZ to do?
5. Do you usually attend MThNZ symposiums/workshops?
6. In general, how satisfied are you with the quality of MThNZ symposiums/workshops?
7. What would you like to change about MThNZ symposiums/workshops?
8. Do you usually attend the Annual General Meeting (AGM)?
9. What would you like to change about the AGM?
10. If there is anything MThNZ can do to improve our events, please tell us.

Section 9: Additional Questions

Brief information was provided regarding the Health Professionals Competence Assurance (HPCA) Act (2003).

1. Do you believe that MThNZ should apply for Music Therapy regulation under the Health Professionals Competency Assurance (HPCA) Act?
2. If yes, please state why this would be of benefit.
3. Would regulation have any negative impacts on music therapy and/or individual NZ RMTh?
4. Would you like to be involved in a scoping project for HPCA regulation application? (i.e. discussion meetings)
5. As an organisation, how satisfied are you with regards to our overall sensitivity to bicultural diversity?
6. Would you like to add any comments?

7. As an organisation, how satisfied are you with regards to our overall sensitivity to multicultural diversity?
8. Would you like to add any comments?
9. As an organisation, how satisfied are you with regards to our overall sensitivity to diversity? (e.g. LGBTQ+, diversity, and disability)
10. Would you like to add any comments?
11. Are you aware of MThNZ's four values?

12. How satisfied are you that MThNZ fulfils these values?
13. Do these values fulfil your own personal and professional values as a NZ RMTh?
14. Please add more detail here.
15. In your opinion, what are the current top three challenges facing NZ Registered Music Therapists?
16. In your opinion, what are the current top three challenges facing MThNZ?
17. Are you considering changing your profession as a NZ RMTh in the next 3+ years?
18. If there is anything else you would like to add, please comment here.

Appendix C
Tabulated Data from Figures in this Article

Tabulated data are provided as an alternative to figures in this article, particularly for screen readers.

Table C1

Tabulated Data from Figure 1: Geographical Distribution of Survey Respondents in 2016 and 2022

Region	No. of 2016 Respondents	No. of 2022 Respondents
Northland	0	2
Auckland	8	11
Waikato	1	3
Bay of Plenty	0	1
Taranaki	0	0
Manawatu-Whanganui	0	1
Gisborne	0	0
Hawke's Bay	1	2
Wellington	8	17
Tasman	0	0
Nelson	1	3
Marlborough	2	1
West Coast	0	2
Canterbury	8	11
Otago	1	3
Southland	0	1
Overseas	0	0
Location not disclosed	0	1

Table C2

Tabulated Data from Figure 3: Respondent Demographics: Year of Graduation

Year of Graduation	Number of Respondents	Percentage of Respondents
Up to 1990	2	3.5%
1991-1995	1	1.8%
1996-2000	2	3.5%
2001-2005	5	8.8%
2006-2010	12	21.1%
2011-2015	12	21.1%
2016-2020	14	24.6%
2021-2022	6	10.5%
Prefer not to say	2	3.5%

Table note: Data are presented in 5-yearly periods, other than "Up to 1990" and (due to the survey date) "2021-2022"

Table C3

Tabulated Data from Figure 4: Age, Gender, and Residency Status of Respondent

Age	Gender	Residency Status	No. of Respondents	Percentage of Respondents
25-29	F	C	2	3.6%
	M	C	1	1.8%
	F	R	2	3.6%
	M	R	0	0
	F	W	0	0
	M	W	0	0
30-34	F	C	5	8.9%
	M	C	1	1.8%
	F	R	1	1.8%
	M	R	1	1.8%
	P	R	1	1.8%
	F	W	2	3.6%
	M	W	1	1.8%
35-39	F	C	5	8.9%
	M	C	1	1.8%
	F	R	1	1.8%
	M	R	0	0
	F	W	0	0
	M	W	0	0
45-49	F	C	3	5.4%
	M	C	3	5.4%
	F	R	1	1.8%
	M	R	0	0
	F	W	0	0
	M	W	0	0
50-54	F	C	4	7.2%
	M	C	0	0
	F	R	1	1.8%
	M	R	0	0
	F	W	1	1.8%
	M	W	0	0
55-59	F	C	3	5.4%
	M	C	0	0
	F	R	0	0
	M	R	1	1.8%
	F	W	0	0
	M	W	0	0
60-64	F	C	2	3.6%
	M	C	0	0
	F	R	0	0
	M	R	0	0
	F	W	0	0
	M	W	0	0
65-69	F	C	2	3.6%
	M	C	0	0
	F	R	0	0
	M	R	0	0
	F	W	0	0
	M	W	0	0
70-74	F	C	1	1.8%
	M	C	0	0
	F	R	0	0
	M	R	0	0
	F	W	0	0
	M	W	0	0
N/A	F	C	1	1.8%
	M	C	0	0
	P	C	1	1.8%
	F	R	1	1.8%
	M	R	0	0
	F	W	0	0
	M	W	0	0

Table notes:
F= female
M = male
C = citizen
R = residency or permanent residency visa
P = prefer not to say
W = working visa

Table C4

Tabulated Data from Figure 5: Time Taken by New Graduates to Find Work

Time taken to Find Work	Number of Respondents	Percentage of Respondents
Before graduation	1	1.8%
Within 1 month	19	35.8%
1 – 6 months	14	26.4%
6 - 12 months	5	9.4%
12 – 18 months	1	19%

Table C5

Tabulated Data from Figure 6: Other Employment

Employment Roles		Number of Respondents	Percentage of Respondents
Music therapy work beyond direct therapy roles	Clinical supervisor	4	7.0%
	Consultant	3	5.3%
	Researcher/research student	4	7.0%
	Tertiary music therapy educator	4	7.0%
	Music therapist role but teacher contract	1	1.8%
Other helping profession roles	Child & family therapist (full-time)	1	1.8%
	Dispute resolution practitioner	1	1.8%
Creative practice	Musician	4	7.0%
	Taonga puoro practitioner	1	1.8%
	Artist	1	1.8%
	Writer	1	1.8%
Teaching roles	Teacher or tutor	7	12.3%
	Workshop facilitator	2	3.5%
Management & administration	Business owner/ entrepreneur	1	1.8%
	School management team	1	1.8%
	Manager, charitable trust	1	1.8%
	Administrator	1	1.8%
Prefer not to say	Unknown	1	1.8%

Table C6

Tabulated Data from Figure 7: Professional Practice Settings

Type of workplace		Number of Respondents	Percentage of Respondents
Education settings	Early childhood / early intervention	12	21.1%
	Primary schools	22	38.6%
	Secondary schools	17	29.8%
	Specialist schools (5-21 years)	2	3.5%
Adult Disability Services		9	15.8%
Health Settings	Hospital unit	4	7.0%
	Mental health facility	10	17.5%
	Palliative care facility	3	5.3%
Community rehabilitation services	Community rehabilitation service	6	10.5%
	Neurological choir	1	1.8%
Aged care facilities		10	17.5%
Māori organisations		3	5.3%
Other organisations	Government agencies	6	10.5%
	Non-government agencies	9	15.8%
	Not-for-profit organisations	15	26.3%
	Music therapy business with community contracts	1	1.8%
Tertiary	Music therapy training	4	7.0%
Research centre		1	1.8%
Private practice		20	35.1%
Prefer not to say		1	1.8%
N/A (unemployed)		2	3.5%

Table C7

Tabulated Data from Figure 6: Client Groups Reported by Survey Respondents

Areas of Practice	Percentage of Respondents
Early childhood	12.27%
Children & young people	45.61%
Adults	71.93%
Older people	31.58%
Māori community groups	1.75%
All ages or not stated	45.61%
Supervision	10.51%

Table C8

Tabulated Data from Figure 9 (Word Cloud): Frequency Respondents' Descriptions of Music Therapy Practice

Descriptors	Frequency
Humanistic	14
Client-centred	12
Community Music Therapy	11
Improvisational	9
Music-centred	9
Resource-oriented	9
Neurologic Music Therapy	7
Person-centred	7
Psychodynamic	6
Strengths-based	5
Creative Music Therapy (Nordoff-Robbins)	4
Ecological	4
Child-centred	3
Developmental	3
Eclectic	3
Family-centred	3
Post-ableist	3
Trauma-informed	3
Group work	2
Holistic	2
Play-based	2
Te Whare Tapa Whā	2
Active	1
Affirmative	1
Anthroposophical	1

Descriptors	Frequency
Anti-oppressive	1
Approaches and models created within my own work	1
Child-led	1
Collaborative teamwork	1
Consultation	1
Culture-centred	1
Ecologically oriented	1
Group singing with instruments	1
Holistic assessment	1
Individual	1
Insight-Oriented Receptive	1
Neurosequential Model of Therapeutics	1
Orff	1
Participatory	1
Patient-led	1
Psychoanalytic	1
Psychodynamically informed	1
Re-creation techniques	1
Relational	1
Rhythm-based	1
Skill-sharing	1
Songwriting	1
Student-led	1
Te Wheke	1
Vocal Psychotherapy	1

Table C9

Tabulated Data from Figure 10: Satisfaction with the Annual Practising Certificate Renewal Process, Code of Ethics and Standards of Practice

Responses	Annual Practising Certificate	Code of Ethics	Standards of Practice
Very Satisfied	12.3%	8.8%	19.3%
Satisfied	49.1%	47.4%	49.1%
Neutral	22.8%	19.3%	19.3%
Dissatisfied	5.3%	1.8%	1.8%
Very Dissatisfied	0%	0%	0%
No Response	5.3%	1.8%	7.0%
Comments Only	5.3%	1.8%	1.8%

Table C10

Tabulated Data from Figure 11: Type of Supervision

Types of Supervision	Number of Respondents	Percentage of Respondents
Individual only	21	36.8%
Individual and peer	24	42.1%
Individual and group	2	3.5%
Individual, peer, and group	8	14.0%
Prefer not to say	1	1.8%
N/A (not currently employed)	1	1.8%

Table C11

Tabulated Data from Figure 12: Choice of Supervisor

Supervisor's Profession and Supervision Qualification	Number of Respondents	Percentage of Respondents
New Zealand Registered Music Therapist with Supervision Qualification	30	52.6%
New Zealand Registered Music Therapist without Supervision Qualification	7	12.3%
New Zealand Registered Music Therapist - Supervision Qualification Not Stated	1	1.8%
Overseas Music Therapist with Supervision Qualification	2	3.5%
Overseas Music Therapist without Supervision Qualification	0	0%
Overseas Music Therapist - Supervision Qualification Not Stated	1	1.8%
Other Professional with Supervision Qualification	12	21.1%
Other Professional without Supervision Qualification	2	3.5%
Other Professional - Supervision Qualification Not Stated	0	0%
Prefer Not to Say	1	1.8%
N/A (Not currently employed)	1	1.8%

Table C12

Tabulated Data from Figure 13: Satisfaction with the Sensitivity of Music Therapy New Zealand Towards Bicultural, Multicultural, and other Equity Issues

Responses	Bicultural	Multicultural	Equity
Very Satisfied	10.5%	12.3%	10.5%
Satisfied	19.3%	22.8%	28.1%
Neutral	42.1%	42.1%	40.4%
Dissatisfied	12.3%	10.5%	10.5%
Very Dissatisfied	3.5%	0%	0%
Prefer Not to Say	1.8%	0%	0%
Comments Only	5.3%	3.5%	3.5%
No Response	1.8%	8.8%	7%

Table C13

Tabulated Data from Figure 14: Satisfaction with Music Therapy New Zealand Communications and Media

Responses	Communications & Media Publications					
	Communications	MusT Newsletter	Journal	Website	Website Members' Area	Social Media
Very Satisfied	29.8%	14.0%	33.3%	12.3%	3.5%	15.8%
Satisfied	47.4%	50.9%	38.6%	54.4%	22.8%	40.4%
Neutral	14.0%	17.5%	21.1%	28.1%	43.9%	24.6%
Dissatisfied	1.8%	0.0%	1.8%	1.8%	5.3%	0.0%
Very Dissatisfied	0.0%	0.0%	0.0%	0.0%	3.5%	0.0%
Prefer Not to Say	3.5%	3.5%	1.8%	0.0%	3.5%	1.8%
Comments Only	0.0%	0.0%	0.0%	0.0%	5.3%	1.8%
No Response	3.5%	14.0%	3.5%	3.5%	12.3%	14.0%
Very Satisfied	29.8%	14.0%	33.3%	12.3%	3.5%	15.8%

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Memories & Melodies: Using a Portable Recording Station to Create a Christmas Album with Older Adults at Aged Care Facilities in Auckland

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Keywords

Music therapy; therapeutic recording; older adults; dementia care; music production

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Review

This article received a single open review.

Abstract

This article presents a practice-based exploration of how two music therapists used sound recording equipment as a therapeutic tool in music therapy sessions across two aged care facilities in Auckland. Over a 10-week period from 4th October to 6th December 2024, sound recording equipment was integrated into music therapy sessions at the facilities with clients recording vocals alongside a range of instruments including guitar, ukulele and percussion. The therapists aim to share their recording process and, by drawing on their reflective practice, offer insights into the psychological benefits observed for clients.

Figure 1

Christmas album cover painted by a volunteer at one of the facilities.

Figure notes: A piece of art created by one of the volunteers at one of the facilities. The artwork is of a gold, red and blue star, situated above the words “The Selwyn Foundation Christmas Album”.

Album link:

https://tiny.cc/fusw001

In July 2023, the Raukatauri Music Therapy Trust received a grant from the New Zealand Community Trust to purchase a portable recording station for use in its music therapy services across Auckland. The recording station included a RØDE NT1-A condenser microphone with shock mount, pop filter, and XLR cable; a Focusrite Scarlett Solo 3rd Gen USB audio interface; Behringer HPM1100 multipurpose headphones; an Alesis V25 MKII USB-MIDI controller; M-AUDIO BX3 studio monitors; a RØDE PSA1 microphone stand; and a STORFEX height-adjustable desk with wheels to ensure accessibility and portability. Although not included in the original grant, an iPad and a Lightning to USB 3 Camera Adapter

enabled connectivity between the recording station and the iPad app, GarageBand.[22]

Following the acquisition of the recording equipment, two music therapists from the Trust implemented its use within group music therapy sessions across two aged care facilities. Over a 10-week period (4 October - 6 December 2024), residents participated in structured sessions involving individuals living with dementia as well as residents without a dementia diagnosis.

During these sessions, the therapists recorded participants performing individually, capturing vocals as well as instrumental contributions on guitar, ukulele, and percussion. The incorporation of recording technology enabled participants to engage more fully in the creative process, while also preserving musical outputs for therapeutic reflection and continuity.

Figure 2

Portable Recording Station at Raukatauri Music Therapy Centre
(Photo credit: Oliver Lowery, 2025)

Figure notes: A makeshift portable audio recording station. GarageBand is open on an iPad. There is a microphone and pop filter attached to a moveable desktop stand, stereo headphones, MIDI keyboard, studio monitors and audio interface.

Background

Awareness of the impact of music on older adults has steadily grown over the years. Documentaries such as *Alive Inside* (Rossato-Bennett, 2014) and *Our Dementia Choir* (BBC, 2019) have shone a light on the meaningful role music can play for this population, highlighting how music

[22] GarageBand is a free digital audio workstation (DAW) used for recording and producing music, available exclusively on Apple devices.

can stimulate memory, improve mood, and support social connection. Furthermore, the documentary *Oceania Healthcare – I Love Music* (Film Construction, 2017) has helped grow public awareness and understanding of music's role in aged care within Australasia. In this film, residents were provided with personalised playlists pre-loaded onto MP3 players. The documentary showed that listening to favourite songs from the past, particularly music connected to earlier life experiences, could trigger long-term memories, increase sociability, and enhance emotional wellbeing.

Evidence-based research continues to highlight the significant impact music can have on older adults. Neurologically, music stimulates various areas of the brain, engaging auditory, cognitive, motor, and emotional functions across both cortical and subcortical regions - many of which remain relatively intact with age (Särkämö, 2018). This neural engagement helps explain the wide range of physical and mental health benefits associated with music participation. For example, one study found that listening to upbeat music not only increased emotional arousal but also improved working memory in older adults, suggesting that music can support cognitive function by enhancing mood and alertness (Vincenzi et al., 2022). Additionally, playing musical instruments has been shown to boost fine and gross motor skills, encourage cooperation and focus, and improve mobility, balance, strength, and rhythmic coordination (Thompson et al., 2009).

Historically, the integration of music technology within care home environments has been relatively limited, however in recent times its use has proved beneficial. A pilot study exploring music interventions for people with dementia found that higher levels of engagement with both traditional and technology-based music therapy were associated with significantly reduced agitation and apathy compared to lower levels of use (Dahms et al., 2021). Furthermore, Hebert and Scales (2018) and Thomas et al. (2017) posit flexibility as a key strength of technology-based music therapy, noting that it can be tailored to individual needs and provide autonomous, on-demand access to music, even for those who may not be able or willing to join group sessions. Shah et al. (2024) suggest that incorporating technology into music therapy can unlock new creative pathways, enabling the production of high-quality musical output and further enhancing self-expression.

Weissberger (2014) facilitated a song writing and recording group at a residential and community-based centre for (mostly) over 65-year-olds with varying diagnoses. The author states that, "by using technology in a creative group process we can invite members to experience some of these modern tools and promote inclusion and a sense of belonging" (p.

281). Furthermore, Weissberger (2014) proposed that using GarageBand with adults with physical disabilities helped normalise their surrounding world and kept them engaged. As a result of recording various songs, clients seemed able to "step outside of their illness, if just for a moment, and form new memories while retrieving old ones" (p. 280).

The therapists anticipated that recording vocals and instrumentation with this population would come with various challenges. Veering away from traditional music therapy activities such as spontaneous improvisation and songwriting meant the sessions would be much more structured, making it crucial that the project was underpinned by a reliable and safe relationship between music therapists and clients. Research supports the importance of establishing a therapeutic connection and involving the same music therapist(s) throughout the entire recording process (Grocke et al., 2009; Grocke et al., 2014).

Leading up to the commencement of the project, the therapists had been working in their respective rest home settings for approximately two years. During this time, a relatively low client turnover allowed the therapists to gradually build therapeutic rapport and establish a solid foundation in anticipation of the project's implementation. Comparable findings are reflected in a study by Silverman (2022), in which the music therapist worked with the participants for four years facilitating songwriting sessions prior to recording their songs. Similarly, the therapists involved in the current study each had over three years of professional experience working with the elderly population, further supporting clinical decision-making and the development of strong therapeutic relationships throughout the project.

Soshensky (2011) highlights the therapeutic and social value of creating permanent artistic products such as CDs, suggesting that a positive aspect of music being part of the entertainment industry is that clients can be perceived as artists engaging in something "culturally idealized" (p. 27). This reframing has the potential to shift perception of people living with disabilities, offering moments where identity can be viewed beyond diagnosis or care needs. Similarly, Sadnovick (2014) introduced a recording studio into music therapy sessions with inpatients at a psychiatric unit, eventually producing CDs at the end of the recording process. Sadnovick (2014) noted that producing a CD was a useful way for clients to connect with friends and family while inside the unit. More recently, Kirkland and Nesbitt (2019) utilised cloud-based storage, allowing clients to access and share recordings produced in music therapy sessions with friends and family. These approaches align with the aims of the current project, which sought to offer clients an opportunity to express themselves creatively while producing something meaningful to

share with whānau and wider audiences. In the project at hand, both physical CDs and digital distribution via Bandcamp were used to share the album, making it accessible to family and friends both locally and abroad.

Finally, the therapists sought to assess whether recording could serve as the primary therapeutic focus of a session. Examples of recording being used in this way are rare, as the process is "routinely perceived as a necessary adjunct to facilitating therapeutic programming as opposed to the concept that it has the potential to be a key component to music therapy" (Kirkland & Nesbitt, 2019, p. 5). Furthermore, the authors concluded that, "It may be time to reconsider the voice as a primary instrument in music therapy and to rediscover its benefits and joys through recording." (p. 7). The current project provided a good opportunity to explore how recording and technology could be integrated as central elements in music therapy sessions.

Summary

Several studies support the use of studio recording in therapeutic settings (Grocke et al., 2009, 2014; Kirkland & Nesbitt, 2019; Sadnovik, 2014; Silverman, 2022; Soshensky, 2011; Weisberger, 2014). While the literature on recording in music therapy is growing, much of it centres on younger populations or community-based projects. To date, there appears to be a lack of research specifically addressing the therapeutic use of recording specifically with older adults in rest home or dementia care settings. Of the literature reviewed, only Weissberger (2014) explored song recording with older adults, albeit in a community-based group with varying diagnoses and cognition levels.

Considering their shared clinical caseloads, one of the therapists in this study, who had previous experience recording adolescent and adult populations in music therapy sessions, determined that producing an album of Christmas songs could be a hugely beneficial project for groups at two separate aged care facilities within the same organisation. The therapists had seen the benefits of music therapy in aged care settings during their daily practice and wanted to work collaboratively towards a project that showcased moments of joy and musical skill while exploring whether recording music in sessions could serve as the focal point of music therapy. Clinical goals included developing client social interaction, building confidence, and increasing comfort with technology, all while creating a celebratory, tangible item for group members and whānau to cherish long-term.

Table 1

Project Procedure Table

Week	Procedure	Details
1	Project Planning	Define goals, design creative processes, prepare materials (record demo tracks)
2	Ethics & Consent	Obtain participant consent
3–8	Recording Sessions	Facilitate and record songs
9	Mix & Master Music	Edit, mix, and master recorded music ready to be burned
10	Listening Party	Host a session to share and reflect on the music created / hand out physical CDs

Figure 3

Christmas Album Track List
(Cover credit: Liz Avila. Angel drawn by group member.)

Image description: A track listing for the album, titled “The Selwyn Foundation Christmas Album” and acknowledging “Lavender Cottage & Ivan Ward”. To the right of the track listing is a drawing of an angel. Underneath are logos for the Selwyn Foundation and Raukatauri Music Therapy Trust and a QR code.

Pre-recording

The success of the project relied heavily on clients’ familiarity with the songs. In one facility, due to the intimate nature of the small group setting, the members voted on their recording tracks, with the aim of offering autonomy over the process. Conversely, in the weeks leading up to recording at the other facility, the music therapist catered for a much bigger group by playing a variety of songs and assessing familiarity before choosing the most well-known songs accordingly. The track listing

consisted of songs in the public domain such as *Silent Night, Jingle Bells, Away in a Manger, O Come All Ye Faithful* and *We Wish You A Merry Christmas.* The therapists acknowledged that Christmas songs are rooted in Christian tradition and express Christian beliefs, which carried the possibility of excluding some individuals. However, there were no objections from the group members, and no one was excluded from participating in the recordings, as the songs selected were either voted for or chosen based on familiarity.

Consent for participation was obtained primarily through signed letters from whānau, with some clients also providing their own signatures. All clients verbally consented prior to the project and again before each recording session. Furthermore, bringing speakers and headphones to each session for recording artists to listen back to their musicianship allowed space for autonomy and governance over recordings. This proved crucial, as some clients chose not to include their recordings in the process after listening back. Members were reminded that they were able to remove themselves from the project at any time.

Permission to publish the album on Bandcamp and share it with potential media outlets, such as radio, was obtained through formal consent letters, and further affirmed through verbal confirmation with residents both during and following the recording process. The album was made freely available for streaming and download, with an optional donation feature. All contributions were directed toward funding new therapeutic initiatives within the facility.

Recording

The two facilities differed in how their sessions were structured; one operated as a day centre for clients, while the other accommodated clients residing there full time. Although many of the clients in both settings had dementia, this was not universal. The clients at the day centre were recorded individually, whereas the clients at the residential facility recorded songs individually in small groups of six.

The therapists aimed to use the recording equipment in the simplest way possible to explore and demonstrate accessibility and ease of use for other music therapists interested in using a recording station with their clients. Tracks were recorded through GarageBand, a free app on the Apple App Store. While the music therapists initially explored live group recording, they decided that recording individual tracks over a pre-recorded demo (with click track) would be most effective, given the individualised needs of the participants. The individually recorded tracks were then layered up and roughly mixed by the therapists. Instruments

played by residents on the album ranged from ukulele and guitar to various percussive instruments such as djembe, drums, and shakers.

The therapists agreed that great care needed to be taken during the recording process, both in supporting clients emotionally and in guiding them with the equipment. The music therapists discussed the project with participants, provided a step-by-step explanation of how the recording process would go, and clarified where the recordings would be used when finished. The therapists explained each part of the recording equipment, including microphone and pop shield, and demonstrated how the headphones would be used to help them hear themselves. The therapists also agreed that, if a member seemed unsettled or unhappy, careful attention would be given to explain and settle them, with constant reminders that they could remove themselves at any stage.

When the clients listened back to their own singing and playing, the therapists had not anticipated any negative client response, and upon reflection, they have since seen this as a valuable part of the learning process. When clients did hear their recordings and were unhappy with what they heard, due care was taken to facilitate these emotions and offer opportunities to re-record, play different instruments or remove their recording altogether.

Recording artists who recorded tonal instruments, such as guitar, were the first to record, with other instruments and vocals being recorded later. The therapists, having already built a strong relationship with the members, felt confident in responding to client needs throughout the process. This responsiveness was essential during sensitive moments, such as re-recording sections, encouraging members to increase volume, and generally ensuring emotional and physical comfort.

Flexibility During the Recording Process

In one case, a resident expressed their interest in recording a ukulele part after the instrumental and vocal tracks had already been recorded. They preferred to play in the key of C Major, but the pre-existing recordings were not in this key. To make this possible for them, the entire GarageBand project was transposed to accommodate their preference. From there, the resident was able to record a ukulele part successfully in a key that was achievable for them. Afterward, the project was shifted back to its original key to mix and master. This proved that, despite it being preferable to follow orthodox recording steps, modern music technology allowed for more flexibility when required.

Post-recording

The music was mixed and mastered by the therapists over several sessions. The main goal was to create a mix that was clear, polished, and highlighted the residents' individual abilities at certain points throughout each recording. This was achieved by soloing individual vocal stems throughout a song to showcase their skillset and/or having residents play instruments themselves. During the mixing process, each project was exported from GarageBand on the iPads and imported into Logic Pro X on a personal MacBook Pro owned by one of the therapists. This allowed the therapists to use a more powerful and industry-standard digital audio workstation (DAW), which included valuable stock audio plugins on Logic Pro X (e.g., Chorus, Tremolo, and EQ) as well as several external plugins from Waves V13 (e.g., H-Reverb, H-Compressor, and R-Vox). The two audio plugin engines were used in combination to create clear and polished vocal and instrumental mix chains for each track. During the mastering process, emphasis was placed on ensuring each track was clear across the mix and at a consistent, listenable level throughout the entire album. When reviewing the technical elements of the project, including the recording, mixing and mastering of the songs, both therapists admitted that, without pre-existing knowledge of music technology, additional training may be needed when undertaking projects of a similar scale.

The tracks were burned to compact discs and distributed to group members and whānau. There was a listening party for each facility where the groups listened back to their recordings. Furthermore, clients and whānau were also able to listen to two tracks on the radio when the music therapists were invited to discuss the project on Radio New Zealand.

Outcomes

The therapists observed significant psychological benefits among participants at both facilities. Many members appeared to develop newfound confidence in their musical abilities, which seemed to contribute to enhanced self-esteem and a greater sense of personal accomplishment. The project seemed to foster a noticeable increase in social connection, particularly during the listening parties held at the conclusion of the project. Some members commented positively about their singing and playing and many sang along when listening back to their recordings. The therapists observed many smiles among group members and noticed that they were grateful that they were able to take home a CD. Several months after the release of the album, a participant shared with a therapist during a music therapy session that he had been delighted to have recently rediscovered the CD in his home, showcasing

the lasting impact of the project. The therapists finally noted observable benefits for whānau, who were able to experience their family members singing and playing instruments while receiving something they could physically take home and listen to.

Conclusion

The therapists set out to create a Christmas album with group members from two aged care facilities showcasing and celebrating the musical skills of the members involved. They observed that participants displayed a strong sense of accomplishment when sharing their music during the listening parties and became increasingly comfortable with the technology each week. The therapists reflected that the project highlighted how the process of recording music can serve as a central therapeutic focus within music therapy sessions, rather than merely a supplementary activity.

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(2025). New Zealand Journal of Music Therapy, 23, 73-77.

Book Review

Music Therapy with Autistic Children in Aotearoa, New Zealand / Haumanu ā-Puoro mā ngā Tamariki Takiwātanga i Aotearoa (2022)

Daphne Rickson (Palgrave Macmillan Cham)

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Citation

Hannah, R. (2025). [Review of the book Music Therapy with Autistic Children in Aotearoa, New Zealand / Haumanu ā-Puoro mā ngā Tamariki Takiwātanga I Aotearoa, by D. Rickson.] *New Zealand Journal of Music Therapy, 23*, 73-77.

Music Therapy with Autistic Children in Aotearoa, New Zealand / Haumanu ā-Puoro mā ngā Tamariki Takiwātanga i Aotearoa summarises a research project in which commentators reflect on ten individual music therapy case studies. The impetus for this research began several years earlier, in response to barriers to accessing music therapy due to perceived lack of evidence. Findings from an exploratory study indicated that "those who witness music therapy in action develop more understanding and appreciation for what can be achieved, and can be readily convinced of its importance" (Rickson et al, 2015, p. 30). Therefore, this study asks: "How is music therapy with autistic children (tamariki takiwātanga) in New Zealand (Aotearoa) perceived by family members and other autism experts?" (p. 63). This question is of interest to me as a music therapist who has worked for a number of years with autistic children in the UK and NZ. How might the commentators, with no prior knowledge of music therapy, respond to the case studies provided?

Dr Daphne Rickson is well known in New Zealand and internationally as a music therapy practitioner, researcher, author and educator. She was the recipient in 2023 of the Lifetime Achievement Award by the World Federation of Music Therapy, recognising her significant contributions to the field of music therapy through practice, teaching and research, and in

2022 was appointed Officer of the New Zealand Order of Merit (ONZM) for services to music therapy. This 2022 text is based on research undertaken in 2018, when funding enabled ten music therapists around New Zealand to offer music therapy sessions to tamariki takiwātanga who had no previous experience of music therapy for up to a year. On completion of the therapy, each therapist provided a case study in 'narrative assessment' form (used by teachers in New Zealand schools to document learning progress for students, especially those with additional learning needs; Ministry of Education, 2009). They also included audio or video examples where possible. Each case study was then reviewed by a team of commentators made up of a mix of family members, teachers or other professionals who knew the child well (individual to each case) as well as six autism experts who did not know the children and reviewed all ten cases. Commentators provided both qualitative descriptions and completed a Likert scale questionnaire in response to the case studies. This data was then collated and analysed by Rickson to draw out common themes from the responses.

The initial chapters (1-5) serve as an introduction to the research project, including a thorough introduction to autism through both medical and neurodiversity lenses and a literature review of research in music therapy with autistic children. The literature review is comprehensive, covering both smaller qualitative and larger quantitative studies from around the world published since the year 2000 and reflecting on the difficulties of capturing statistically significant proof of effectiveness in larger studies. The project and its predecessor, a survey of music therapists working with autistic children in New Zealand in 2015, are then outlined.

Chapters six to fifteen cover the ten individual case studies. Each one begins with some background information on child and therapist then includes: a summary of the music therapy process in the form of 'learning stories'; a summary of commentators' descriptive / qualitative responses to the work; comparison between qualitative responses and the Questionnaires; a brief summary from the music therapist (not seen by the commentators); and reflections from the researcher. The children range in age between five and ten years old. The work happens in a variety of settings (schools, homes, therapist's studios) with a variety of key aims or goals, mostly focusing on social interaction, communication, and relating to others. Therapy lasted between five months and a full year. Narrative assessment format was chosen to allow therapists to select meaningful moments from the work after it was completed and allow the therapy to unfold in a natural way without research study prerequisites. The music therapists each provided a number of 'learning stories' (or short vignettes). These give us a glimpse into the therapy, however the

focus of each chapter is the responses from the commentators: The qualitative responses are quoted in excerpts and similarities are highlighted. As a reader, whilst I enjoyed each unique case study presented, I felt at times there was a disconnect between the description of the music therapy process and the responses, as the brief summary we are given is of course very different from what the commentators had read, heard and seen. I wished at times to have a fuller picture of the therapy from the therapists' point of view or more context as to what was presented to commentators.

An in-depth analysis of thematic findings, based on data from the commentators, follows in chapters 16-23. Chapters 17 and 18 explore how commentators consistently perceived music therapy to support regulation, social communication and relationships. Commentators perceived sessions across case studies to support children by creating a safe and trusting relationship, establishing rapport, offering motivating and engaging activities, responding skilfully and playfully to build connection which in turn reduced anxiety and built confidence in children. Examples of commentators' responses illustrate the themes throughout. Chapter 19 covers goal setting. There is more of a mixed response from commentators on whether the goals set were appropriate and whether timely progress was made. The chapter has a thoughtful discussion around the complexities of goal setting. Goals were generally broad, and possibly clarified as the music therapy process unfolded. The nature of collaborative and child-centred work can feel at odds with formally defined and measurable goals, and while more precise goals can enable concisely reported outcomes, this can mean missing the full and rich picture of what is happening in sessions. However, in this book, goals are perceived as helpful by both therapists and commentators to communicate what is happening and define focus for sessions.

Chapters 20-22 consider themes around common methods and approaches the therapists used and the choice of sessions to be mostly individual (only one case study involved paired working with several peers from school over the course of sessions). I found the discussion around inclusivity to be thought-provoking. Working with individual children, withdrawing them from class for their sessions, was certainly the norm of my working experience in the UK whereas the focus in NZ on inclusive classrooms perhaps means broadening the way music therapists are trained and work. Generalisation of skills and sustainability of progress are considered in chapter 23. Here there was a marked difference between commentators unfamiliar with the individual children (who were unclear whether progress had been seen and sustained outside of

therapy) and those commentators who knew the children (the majority of whom felt there had been generalisation of skills beyond sessions).

The epilogue highlights the many ways that the findings from this research align with the recommendations of the New Zealand Autism Spectrum Guideline. In the same year as Rickson's publication, the Guideline published a third update which includes the recommendation: "Music therapy can enhance social communication skills and should be considered for children and young people on the autism spectrum" (Whaikaha, 2022, p. 30). The epilogue also considers music therapy as an evidence-based practice, and how qualitative synthesis approaches in research practice, such as the cross-case analysis in this project, are increasingly recognised, as are the limitations of traditional randomised control trials.

This book is a valuable and captivating account of a significant and innovative research project. While the commentators held varying opinions in response to many of the questions asked, this reflects the complex and rich data captured. It was heartening to read that the commentators were, overall, impressed by the strengths-based and child-centred approaches used by the music therapists and that they were able to appreciate the way that the music therapists engaged with all forms of expression offered by the children to build the trusting therapeutic relationships which are at the heart of our work. I did observe a small but significant number of errors in proofreading and page number references which was frustrating. The lack of any child's voice is noted in several places throughout the text as being disappointing. Narrative assessment in theory encourages participating children's (and other) voices but no therapists chose to include input from children in this research. Perhaps, as Rickson notes (p. 344), more explicit encouragement was needed at the outset.

Overall, I would highly recommend this book for music therapists in New Zealand and overseas who work with autistic children, as well as for educators, parents and family members who are interested in the process of music therapy. In the introduction, Rickson says the research was born from a "call for more evidence to underpin the potential employment of music therapists to work with takiwātanga in NZ" (p. 9). I certainly hope that it will continue to strengthen the case for more support and funding for access to music therapy.

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Book Review

The Handbook of Music Therapy: Second Edition (2024)

Edited by Leslie Bunt, Sarah Hoskyns & Sangeeta Swamy (Routledge)

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Citation

Cheong-Clinch, C. (2025). [Review of the book The Handbook of Music Therapy (2nd ed.) edited by L. Bunt, S. Hoskyns & Sangeeta Swamy.] *New Zealand Journal of Music Therapy, 23*, 78-84.

It has been more than 20 years since I read the first edition of *The Handbook of Music Therapy* in the months leading up to my decision to study music therapy at the University of Queensland in Brisbane, Australia. In 2000, I completed a Research Master of Education which investigated the relationship between music literacy and textual literacy (Cheong-Clinch, 1999), a study borne out of genuine curiosity – spurred by anecdotal stories from elated parents whose primary aged children's literacy skills had seemingly improved after attending a year of music lessons with me. As I continued my work using music to support early childhood learning and literacy development in schools, it never failed to amaze me that children of all abilities enthusiastically engaged in singing and rhythmic games. One day a parent asked me, "Are you a music therapist?" to which I replied that I was not. On another occasion, a teacher asked me the same question - then another parent, and so on. This question piqued my curiosity (again) to find out about music therapy.

When reading this second edition, I am reminded of how the first edition stirred such a sense of awe in me – about the work of music therapy and the people who practise it – and how it motivated my desire to study music therapy and be part of the growing music therapy profession and community in Australia. Thus, it is through this lens that I approach the second edition. In this updated edition, Leslie Bunt and Sarah Hoskyns have been joined by Sangeeta Swamy. I appreciate the authors' transparency in articulating how they identify and position themselves – Bunt as Cornish, British European and male; Hoskyns as British

European, heterosexual, female, mother and permanent New Zealand resident; and Swamy as second-generation Indian immigrant, middle-class, queer, neurotypical, non-binary woman from the United States.

As in the first edition, this second edition takes the reader right back to 'how it began', through the experiences and contributions from the Elders - Carolyn Kenny, Cheryl Dileo and Denise Grocke. I would first like to pay my respects to these Elders. Carolyn Kenny was Professor of Indigenous Studies and Human Development at Antioch University. As a music therapist and Indigenous scholar, Carolyn's transformative work highlighted the aesthetics and mystery of music therapy. She was an invaluable mentor and role model for many music therapists until she passed away in 2017. Cheryl Dileo is well known internationally and nationally through her work as a clinician, educator, researcher and leader at Boyer College of Music and Dance, Temple University. She has made an extensive contribution to medical music therapy, and has published a series of systematic literature reviews published by the Cochrane Library. Denise Grocke, long recognised for her incredible vision and contributions to the foundation and growth of music therapy and Guided Imagery and Music in Australia. She is well-known internationally through the World Federation of Music Therapy and the International Consortium of Music Therapy Research (initiated by Tony Wigram, Aalborg University, Denmark, and hosted originally at the University of Melbourne). The wisdom of these Elders resonates throughout Part I of the *Handbook,* grounding the readers in the foundations and context of the field, and how music therapy practice and research have crossed many important and exciting thresholds.

This edition is updated to reflect more recent practices, and to respond to key developments in the 21st century – most notably the growing emphasis on cultural and theoretical perspectives and approaches to music therapy. Prospective music therapy students, as well as interested readers and professionals will find these chapters both valuable and inspiring, particularly in their exploration of the values, principles, and qualities integral to being a music therapist. These discussions align closely with contemporary thinking on cultural and contextual awareness, safety and ethics, and reflective and collaborative practices.

Reading Part I of this second edition has prompted me to reflect on the development of music therapy in Australia, as well as my own growth and career as a music therapist, researcher and now educator. In in the first edition, words such as "creeping" and "growing" were used to describe the development of music therapy more than 20 years ago. By contrast, Chapter 2 of the second edition conveys a sense of the growth and an increased international public awareness across continents and

heightened understanding of music therapy as a profession, in teaching, learning and research. Positive contributions in the form of personal stories and lived experiences of music therapy are now widely accessible, appearing regularly across social media, news articles, films, and documentaries.

While there is increasing acceptance and understanding of music therapy in fields such as aged care and disability, there remains an ongoing need for advocacy and for rigorous evidence to further legitimise our practice. A poignant example of this can be seen here in Australia: throughout much of 2025, music therapy has undergone a comprehensive review under the National Disability Insurance Scheme (NDIS). During this process, the Australian Music Therapy Association worked tirelessly and collaboratively with key advocates and academics to provide evidence to the government and the NDIA. In October 2025, this constructive work culminated in long-awaited recognition of music therapy as a funded and legitimate allied health profession, ensuring participants retain access to vital supports. Yet, funding for music therapy in other sectors of care – such as youth mental health – continues to waver, despite growing calls for innovative, youth-friendly therapeutic ways to engage young people.

I reflect on my own experience as the first music therapist in an acute adolescent mental health inpatient unit at a major hospital on the outskirts of Brisbane nearly 20 years ago. Music therapy, alongside attachment and affect-focused approaches to care, was introduced to the inpatient unit as part of a 5-year seclusion and restraint initiative within the National Mental Health Strategy. I have seen music therapy at work, right from the start, and at its most effective, where data from this initiative aligned with key performance indicators for the inclusion of music therapy in the adolescent inpatient service. The outcomes demonstrated improved therapeutic alliance between young people and ward staff, a marked decline in seclusion and restraint episodes, enhanced staff skills, and higher staff retention, both in annual evaluations and over a 5-year period.

In my own music therapy practice, I have had the privilege of witnessing the profound therapeutic connections forged with vulnerable young people during an acute hospital admission, especially as we work together to use music as both a developmentally appropriate and constructive coping resource that can support them into later adulthood. A growing body of research underscores the value of music therapy in adolescent mental health (Bibb & McFerran, 2018; Geretsegger, et al., 2017; McCaffrey, et al., 2018). The literature consistently highlights that engagement with music is a natural coping strategy (Frydenberg, 2008) and, even “second nature” (Cheong-Clinch & McFerran, 2016) to young people in their everyday lives. Yet it appears to be an uphill battle to

establish music therapy as a youth-centred service to address the "global crisis of youth mental health" (McGorry et al., 2025). Reviewing the second edition of this *Handbook*, coincides with the celebration of the Australian Music Therapy Association's 50th anniversary in recent months. I feel both honoured and humbled to have been part of the evolution and maturation of our profession here in Australia. More importantly, I am inspired to reaffirm my commitment and passion to continue this journey alongside my colleagues here in Australia and around the world. I am dedicated to working to ensure that the value of music therapy is enshrined in legislation, recognised as a consolidated allied health profession, aligned with relevant policies. I also aim to ensure it is supported by stable and ongoing funding, and made accessible and equitable to people of all ages and walks of life.

Part II of the *Handbook* offers a rich range of music therapy practices through chapter contributions from music therapy specialists in the fields of autism, adult learning disability, forensic psychiatry, neurology, immigration and dementia. These chapters have been updated with new and revised musical examples to deepen the illustration of music therapy practice, providing a wealth of resource to students, music therapists and other professionals. Swamy's chapter about music therapy with immigrants is a particularly relevant and timely addition, addressing work with individuals and families affected by mass migrations and shifts in immigration policy, as highlighted in their introduction. This contribution is both appropriate and topical, encouraging ongoing reflection and discourse on cultural and contextual awareness in music therapy practice.

The question of how one might begin to learn, observe and listen in music therapy is a valid and thought-provoking question, as explored in Part III: Learning and Teaching. References to music therapy training and research across Africa, Asia, Australasia, Europe and the Americas highlighted the global expansion of the music therapy profession, giving this section a distinctly international perspective. New directions in the cultural psychology of music are discussed, including decolonisation and discussion of music therapy practice in non-Western countries as well as an emphasis on musical consciousness, aesthetics and connections to cultural identity. These contributions explore how individuals connect, listen, borrow, and relate to music, as well as engage in self-reflection about learning, playing and hearing. While the acknowledgement of indigenous cultural and traditional practices, research, and the use of music and sound for healing and health in these cultures is present, this important area could have been explored in even greater depth.

In light of our awareness of the dominance of the White European lens, I had hoped to hear from music therapists in countries beyond the UK, US

and New Zealand about their music therapy approaches to practice, teaching and learning. What are the experiences of music therapists who are themselves part of the recent migratory trend? How do international non-western music therapy students navigate studying in Western countries (Pankaew & Silverman, 2025; So, 2017)? How do Western trained music therapists transition back to their non-Western countries of origin to continue their own professional music therapy practice, teaching, and mentoring (Seah & McFerran, 2016)?

Whilst the authors acknowledge that this second edition is by no means comprehensive, much of the content and context of the *Handbook* remained predominantly western-centric, with the exception of Chapter 6 on culture and intersectionality, and cross-cultural work in Chapter 9. I had hoped to have read more inclusion. Over the past 20 years of my own music therapy learning and practice, I have witnessed the growing interest in the field through the increasing number of domestic and international students studying here in Australia, many of whom return to their home countries (mainly in Asia). In my more recent role as a teaching specialist in the Hong Kong delivery of the Master of Music Therapy course at the University of Melbourne, I am committed to ensure our music therapy programme remains contextually, culturally, musically and practically relevant for students in Hong Kong. The absence of the Asian music therapy perspective and discourse in the Handbook is a significant oversight, especially given the growing interest in music therapy practice and education in Asian countries such as India, Thailand, Singapore, Taiwan, and Hong Kong in recent years, as well as China (since the 1980s and 90s; Wu, 2019), Korea (Hwang & Park, 2006) and Japan (Ikuno, 2005). Reflecting on my own journey into music therapy, the second edition of the *Handbook* could benefit from a more inclusive approach that acknowledges the increasing diversity and global scope of the field.

Part IV of this edition aptly returns the reader to interviews with the Elders, who offer their evaluation of the profession from their perspective as international leaders, mentors, and researchers. Parts I and IV bookended this edition, framing it with ‘how it began’ and ‘where is it going’. The Elders offer wise guidance for the next generation of leaders, mentors and researchers, not only in countries where the music therapy is well established, but also in countries where the profession is still developing. Their reflections serve as a timely reminder to nurture the energy and enthusiasm of music therapists, promote interdisciplinary dialogue, and maintain a responsibility to train and develop therapeutic skills, even in the context of 21st century demands for efficiency and pragmatism. Like me, many future music therapy students, practitioners,

interested professionals, and readers will likely feel a sense of awe and inspiration from engaging with this edition of *The Handbook of Music Therapy*.

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Theses and Publications Alert 2025

Emily Langlois Hunt & Hyunah Cho
Co-Editors, New Zealand Journal of Music Therapy

Introduction

This annual listing highlights music therapy theses and scholarly writing by New Zealand Registered Music Therapists beyond this journal. Many congratulations to these authors.

PhD Thesis (2025)

Talmage, A. C. (2025). *Voices in harmony: Development of a handbook for neurological choir facilitators through practice-based action research* [Doctoral thesis, University of Auckland]. https://researchspace.auckland.ac.nz/items/ce299e18-e6e5-488d-904a-55ce1dfd2bac

Master of Music Therapy Theses (2025)

Bishop, K. (2025). *Head, Shoulders, Knees and Toes: Using music therapy approaches to support and enhance the development of gross motor skills in children who are blind or have low vision.* [Master's Thesis, Te Herenga Waka - Victoria University of Wellington]. Open Access Te Herenga Waka - Victoria University of Wellington. https://doi.org/10.26686/wgtn.29232239

Byrne, S. (2025). *Playlists in Music Therapy: Using participant-selected playlists to inform student music therapy practice.* [Master's Thesis, Te Herenga Waka - Victoria University of Wellington]. Open Access Te Herenga Waka - Victoria University of Wellington. https://doi.org/10.26686/8JCB-YEKF

Gude, A. (2025). *Connections between Rudolf Steiner's concept of the threefold human being and some approaches to music therapy*. [Master's Thesis, Te Herenga Waka - Victoria University of Wellington]. Open Access Te Herenga Waka - Victoria University of Wellington. https://doi.org/10.26686/9C9X-CNY2

Harrison, A. (2025). *From advocacy to access: The shifting focus of a student music therapist performing community-based research*. [Master's Thesis, Te Herenga Waka - Victoria University of Wellington]. Open Access Te Herenga Waka - Victoria University of Wellington. https://doi.org/10.26686/7HND-JG0X

Joy, L. (2025). *Voice, youth, transitional education, and mental health: Singing our way to wellness*. [Master's Thesis, Te Herenga Waka - Victoria University

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Niu, S. (2025). *Using the violin in music therapy sessions when working with young people age 6-21: Living with visual impairments*. [Master's Thesis, Te Herenga Waka - Victoria University of Wellington]. Open Access Te Herenga Waka - Victoria University of Wellington. https://doi.org/10.26686/wgtn.28449047

van den Berg, J. (2025). *Nature connection in music therapy with neurodiverse high school students: How did I integrate nature as a co-agent in my student music therapy practice with a neurodiverse learning support high school community?* [Master's Thesis, Te Herenga Waka - Victoria University of Wellington]. Open Access Te Herenga Waka - Victoria University of Wellington. https://doi.org/10.26686/Z9P2-AP09

Publications (2025)

Cho, H. (2025). Life journey of Korean music therapists in New Zealand. J*ournal of Global and Area Studies. 9*(4), 55-91. https://doi.org/10.31720/JGA.9.4.3

Cho, H., Johnson, H., Barak, Y., & Fitzgerald, R. (2025). Perceptions of music therapy amongst academicians and healthcare providers in universities and university-affiliated health services in New Zealand. *Music and Medicine, 17*(2), 114-121. https://doi.org/10.47513/mmd.v17i2.959

Davis, B., Kalenderidis, Z., Thompson, G., & **Shaw**, C. (2025). Music therapists' lived experience as a radical resource: Moving beyond traditional views on divergent bodies and minds. *Voices: A World Forum for Music Therapy*, 25(2). https://doi.org/10.15845/voices.v25i2.4216

Low, M. Y., & **Rickson**, D. (2025). Music therapy, Autism, and Neurodiversity. In M. Viega, A. dos Santos, & B. Wheeler (Eds.), *Music therapy handbook* (2nd ed., pp. 221-235). The Guildford Press.

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