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“But Does it Go Far Enough?”:

Engaging with the Revised UK Health and Care Professions Council Standards of Proficiency as an Opportunity for Growth in Our Understanding of Emerging Critical Discourse on Disability and Music Therapy

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Abstract

Arts therapists practising in the UK must be registered to the statutory regulator, the Health and Care Professions Council (HCPC), and adhere to their various standards, including the Standards of Proficiency (HCPC, 2023a). In 2023, these standards were significantly revised. This paper shares perspectives on how these revisions relate to emerging critical discourse on disability and music therapy. In relation to the construct of disability, music therapy has historically aligned itself, knowingly or unknowingly, with medically-informed paradigms. However, in recent years this has been questioned through engagement with other perspectives on disability (Cameron, 2014; Davies, 2022; Leza, 2020). Any revisions to the Standards of Proficiency have the potential to reflect these perspectives, impact practices which engage disabled people, and affect ongoing growth within the profession. In this spirit, each author has chosen aspects of these revised standards as starting points for reflecting on the following topics within music therapy: shifting paradigms around disability; disability and pedagogy; collaborative practice and research with disabled people; and the role of anti-oppressive language. We acknowledge the complexity of these issues and aim to raise questions rather than provide answers, inviting our audience to challenge and be challenged as they contribute to the profession.

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Introduction

The seed for this position paper was planted during the European Music Therapy Conference in Edinburgh in May 2022 when Stella and Hilary had a conversation about the growing critique of established narratives of disability within music therapy, specifically from a lived experience perspective. Their interest in exploring this led to inviting Tara and Beth to join further discussions. As a group of music therapy practitioners, researchers, and authors, we have each published literature on anti-oppressive music therapy practices with disabled people (Davies, 2022; Hadjineophytou, 2022; Pickard, 2019, 2020, 2021, 2022a; Pickard et al., 2020; Roman, 2022). We were keen to create something that not only reflected on the UK music therapy profession's current engagement with critical disability perspectives, but invited growth and development: Beth suggested that our individual areas of experience might be woven together with the thread of examining recent revisions to the Health and Care Professionals Council (HCPC) Standards of Proficiency (SoPs), from a critical disability studies perspective.

The Health and Care Professions Council and the Standards of Proficiency

The Health and Care Professions Council is the statutory regulator of fifteen designated healthcare professions in the UK, which includes Arts Therapies (of which Music Therapy is a subcategory) (HCPC, 2023c). Any person practising under one of these protected professional titles is required by law to register to the HCPC and adhere to their various standards, including the Standards of Proficiency. While music therapy professions internationally have their own professional standards or competencies, music therapists practising in the UK are uniquely positioned in that their professional standards are developed and aligned with other allied health professions.[1] The standards are periodically reviewed and updated and following a consultation process, a revised set of Standards of Proficiency came into force in September 2023 (HCPC, 2023a). Significant revisions include:

- An expanded emphasis on equality, diversity and inclusion,
- Further centring the service user,
- Emphasis on registrants' mental health,
- Consideration of digital skills and new technologies,
- Exploration of the importance of leadership at all levels of practice,
- Promotion of public health and prevention of ill-health,
- Active implementation of the standards.

[1] See Pickard (2020) for a more detailed history of the evolution of the HCPC Standards of Proficiency for music therapists, and the potentially outdated positioning relating to disability in their previous iteration. In particular, Pickard critically reflected on the problematic binaries posed in the outgoing iteration, such as "normal and abnormal," "health and sickness," and "health, disease, disorder and dysfunction" (HCPC, 2013; cited in Pickard, 2020), and how these may perpetuate problematic and unquestioned perceptions about disability. Pickard (2020) also proposed that the previous iteration of the standards lacked recognition of social disablement and the impact of disabling environments and systems on individuals. Many of the areas discussed in Pickard's article have been revised and refined in the more recent standards discussed in this article (HCPC, 2023).

Since all registered music therapists in the UK must demonstrate their adherence to these standards, these revisions will, in theory, impact all registered music therapists and their practices. In addition, training programmes across the UK map their provision against the Standards of Proficiency to ensure students are equipped to meet the standards upon qualification (as well as being informed by the Standards of Education and Training) and thus there is an onus upon training programmes to update their curricula in response to these revisions (HCPC, 2017). While there are resources available on the HCPC website to support registrants' engagement with the standards (HCPC, 2024), it will ultimately be practitioners' responsibility to determine how they perceive the revisions and how they will implement these in their practices.

Impact of the Revisions

When we compared the revised standards with their previous iteration from 2013, we noticed a markedly different attitude towards disability, offering us a chance to reflect on the ways in which critical disability discourse has influenced the music therapy profession in recent years (HCPC, 2023b). These conversations ultimately led to our co-facilitation of a roundtable presentation at the British Association of Music Therapy (BAMT) Conference in Leicester in May 2024 (Davies et al., 2024).[2] The attending delegates' verbal feedback during and after this roundtable presentation indicated that this was a timely conversation to be having in the face of such significant changes to the standards and thus expectations of the UK music therapy profession. We offer this position paper as the next step in our collaborative thinking and to invite dialogue around this essential area of the profession.

There might be the temptation to read this paper purely as criticism of the UK music therapy profession and/or of these revised standards; however, this is not our intention, and we observe a distinction between *criticism* and *critique*. Our aim is to share, through the lens of these standards, aspects of the current intersection of music therapy and critical disability studies and how engagement with these standards from the latter perspective opens up possibilities for growth, development, and discussion. Our understanding is that these standards serve as a barometer for the UK profession's development, and so engaging with their content within alternative paradigms invites much-needed critical reflection on where the profession stands, how it perceives itself, and how it chooses to describe itself outwardly.

We will be looking at whether and how the revised standards support emerging critical perspectives on disability within music therapy, which our previous publications have formed part of. Using examples from the standards, we will reflect on ideas such as the centrality of lived experience, alternative paradigms or models of disability, pedagogy and knowledge construction, collaborative and co-produced practices, the language of disability, and the disruption of reliance on expert knowledge bases. We aim to raise questions and encourage reflection rather than providing answers, as we acknowledge that we are only four voices, and change and growth in music therapy must be an active, ongoing process which involves all who work in or engage with the profession. We are also still learning ourselves, through these dialogues and practices. We are acutely aware of the current international context around equality, diversity and inclusion policy, and are mindful of the privilege which enables us to feel safe enough to critically discuss this discourse within our profession in the UK. Throughout, we return to the important question posed by a delegate in attendance at our roundtable presentation in response to revisions relating to disability in the standards: "But does it go far enough?"

[2] A roundtable presentation usually involves a panel of several speakers presenting one-at-a-time on a topic to an audience. In this instance, our panel presentation was followed by a 40-minute discussion with the attending delegates.

Our Collective Positionality

We are a group of four music therapy practitioners, educators, and researchers, trained and living in the UK. Our collective ethnic backgrounds and gender identities represent the dominant profile in the UK music therapy profession (Mains, Clarke & Annesley, 2024) of a young to middle-aged white woman; one of our authors is from a predominantly Middle Eastern ethnic background. In assembling this group, we have made a conscious effort to include the voices of two disabled music therapists and two allies. We recognise the importance of disabled music therapists' lived experience, and we appreciate the allyship of non-disabled music therapists in advocating for, creating space for, and supporting disabled music therapists who face myriad barriers (Pickard, 2022; Pickard & Davies, 2024; Swamy & Webb, 2022). We believe there is an imperative for all music therapists to contribute to the discourse on disability; indeed, as we will elaborate, the revised Standards of Proficiency encourage all practitioners to take responsibility and action.

We have had the privilege of resources and opportunities to enable us to access conferences at which these discussions have developed and been presented. We observed that our roundtable presentation at the BAMT conference reached a limited audience who were already conscious of or aligned with most of the ideas we presented; this was compounded by the fact that online participation at the conference was removed at short notice. We have taken the political stance to publish this paper through an open access platform to increase accessibility to its content and challenge the gatekeeping of knowledge (Ikuno et al., 2021; McFerran, 2016). Whilst this paper concerns the UK music therapy profession specifically, we intend that it is useful to an international and interdisciplinary readership, reflecting on possibilities for change and growth in related practices.

We are collectively using the language of the social model of disability, in alignment with the majority of disabled people and disabled-led organisations in the UK (see Disability Rights UK, 2025; Disability Wales, 2025), which posits that disabled people may be more disabled by the society they live in than by their body or their mind: "Impairment is conceptualised as a cognitive, sensory or psychological difference that is defined often within a medical context, while disability is understood as the negative social reaction to those differences. Disabled people are just that; people disabled by contemporary society" (Goodley, 2017, p. 9). We believe that language choices are not neutral and intentionally employ this language in alignment with our values and philosophy. We are also respectful of individuals' language choices, which may differ from this position.

Our collective stance is one of anti-oppression, listening to and learning from people who have faced injustice to inform how we use our respective privileges to help remove barriers to social justice (Baines, 2013, 2021; Hadjineophytou & Apley, 2024; Pickard & Davies, 2024). We recognise where our collective positionality has influenced and limited our areas of focus and acknowledge that future engagement (by both ourselves and other interested parties) with this subject area should actively seek out further diverse perspectives. As we progress through each author's individual contribution to this paper, they will detail further their unique positionality in the first-person voice.

In the next section we echo the format of our roundtable presentation by taking it in turns to explore an aspect of critical disability discourse in music therapy through the lens of the revised Standards of Proficiency. Our ideas are intentionally presented individually rather than collectively, demonstrating that we offer just four of many threads of the discourse, and that there is a natural range of resonance, dissonance and limitation within the scope of our discussion which we hope will be enriched by future engagement. The topics are as follows:

- Hilary: On disability culture and communication,
- Beth: On music therapy pedagogy and construction of knowledge,
- Tara: On engaging disabled people in research,
- Stella: On the power of language.

Hilary: On Disability Culture and Communication

My name is Hilary Davies, my pronouns are she/her and I identify as a white, cis-gender, autistic woman. In my music therapy practice, I currently specialise in working with autistic adults, including recently-diagnosed adults and many with co-occurring conditions such as ADHD, depression and complex post-traumatic stress disorder (PTSD). My current PhD research is looking at the application of the neurodiversity paradigm to music therapy practice and my other research interests include music therapy with adults with profound and multiple learning disabilities (PMLD) and the experiences of disabled music therapists.

My interest in the topic of this paper stems from my own efforts to scrutinise the power dynamics within the therapeutic relationship in order to create more collaborative methods of practice, to be aware of where the areas of privilege and lack of privilege lie within my own identity and how this impacts my therapeutic work, to re-think music therapy practice through the lens of different models and paradigms of disability, and to create music therapy practice which embraces the varied forms of communication and culture created by the disabled and neurodivergent people I work with. My own identity contains some aspects of privilege, and indeed this privilege has enabled me to speak out on disability issues within the music therapy profession in ways in which others may not feel able to do so. However, I have also experienced the minority stress (Botha & Frost, 2020), discrimination and marginalisation that come with being an autistic person in a society which is designed largely for the needs and preferences of neurotypical people, both within the music therapy profession and beyond. Although at first glance I might "pass" as neurotypical, this does not mean that my differences as an autistic person do not create difficulties within both my personal and professional life. Many autistic people, including many people I have worked with as a music therapist, "mask" their autism habitually, seeking to mimic the behaviour of neurotypical people in order to fit in within society (Price, 2022). It is my hope that these changes in the HCPC standards can mark the beginning of a shift towards a music therapy profession where disabled people, whether therapists or people attending music therapy, can feel that they are in a safe and accepting environment where they are able to be their own authentic selves, freely expressing their own forms of communication, culture and behaviour, without feeling that any of these aspects of self-need to be suppressed or hidden.

Communication and Disability Culture

I have chosen to focus on Standard 7.3, which reads as follows:

> 7.3 understand the characteristics and consequences of verbal and non-verbal communication and recognise how these can be affected by difference of any kind, including, but not limited to, protected characteristics, intersectional experiences and cultural differences (HCPC, 2023a)

The standard refers to "difference of any kind" (which of course includes the "difference" that is disability) and goes on to give the examples of "protected characteristics, intersectional experiences and cultural differences." As is pointed out within the footnote to standard 7.3, disability is considered to be a "protected characteristic" under the Equality Act 2010, alongside gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (Equality Act

2010). Many disabled people have multiply-marginalised identities, meaning that they experience multiple forms of discrimination due to different aspects of their identity (Shaw et al., 2012). Crenshaw (1989) explained how the impact of multiple forms of marginalised identity on the individual could be "greater than the sum" of each, and that without considering all aspects of identity the full impact of discrimination could not be understood (p. 140). Despite this, the impact of intersectionality has often been overlooked when considering the lived experience of disabled people (Brinkman et al., 2023). Disability is certainly not the only factor which influences the communication needs or choices of disabled people, and therefore it is important, as this standard hints at, to consider all aspects of a disabled person's identity. Disability can also be viewed as a "cultural difference": the cultural model of disability explicitly situates disability as part of culture and identity (Snyder & Mitchell, 2006), while the concept of autistic culture, and other forms of neurodivergent culture, is an important part of the neurodiversity paradigm (Leza, 2023). However, the idea of disability as culture has thus far rarely been considered within the music therapy literature (Davies, 2019). It is positive that the standard mentions difference "of any kind," which could encourage music therapists to keep an open mind about the causes and reasons for communication differences.

The word "difference" in the standard is significant here, when we choose to apply it to the concept of disability. While the medical model of disability describes disability using words such as "deficit" or "abnormality" (Cameron, 2014), the use of the word "difference" calls to mind more contemporary ways of thinking about disability such as the neurodiversity paradigm (Walker, 2012). The use of phrases such as "social communication differences" instead of "social communication difficulties" can have a huge impact on the way that disabled people, such as myself, feel about how they are perceived.

The previous equivalent standard (8.5 in the previous standards) instead referred to the impact on communication of "factors such as age, culture, ethnicity, gender, socio-economic status and spiritual or religious beliefs" (HCPC, 2023b). It is interesting to note that there is no reference to anything that could be particularly connected with disability in this list. Standard 7.3 in the updated SoPs, however, references disability in its mention of "protected characteristics," and as I have pointed out, a connection between disability, intersectional experiences and cultural differences can also be made. Disability can be a significant factor in communication difference, since the physical, mental and neurological differences experienced by disabled people often affect communication in profound and fundamental ways. When working with disabled people in music therapy, the recognition and valuing of communication differences, rather than seeking to normalise or change the way in which disabled people choose to communicate, is a vital aspect of embracing anti-oppressive practice (Baines, 2013; Winter, 2012).

The "Double Empathy Problem"

Standard 7.3 requires the music therapist to "understand" and "recognise" communication differences. The very concept of "difference" here could also be seen to be centring neurotypical communication as the "norm" from which neurodivergent and disabled forms of communication deviate. Standard 7.5 goes a little further towards addressing the need to embrace and respond to varied forms of communication in a way which regards them as normal and natural:

> 7.5 modify their own means of communication to address the individual communication needs and preferences of service users and carers, and remove any barriers to communication where possible (HCPC, 2023a)

Damian Milton's "double empathy problem" (Milton, 2012), which looks at cross-neurotype communication between autistic and allistic (non-autistic) people, would be

highly relevant with regard to this standard. However, this theory has rarely been mentioned in the music therapy literature thus far (Davies, 2022; Enoka, 2022; Low et al., 2023 Mossler et al., 2023). If as music therapists we do wish to embrace a neurodiversity paradigm perspective that views autism and other neurological variations as "differences" rather than "abnormalities" (an increasing trend within music therapy literature, see Pickard et al., 2020; Leza, 2020; Davies, 2022; Low et al., 2022; Lehmann-Kuit et al., 2023; Davies & Bakan, 2024), then the "double empathy problem" could certainly offer some valuable guidance.

Milton points out that while allistic people are excellent at socially communicating with each other, they are not in fact particularly skilled at social communication with autistic people: and conversely, autistic people, while experiencing problems with social communication with allistic people, are in fact far more skilled at social communication with other autistic people (Crompton et al., 2020; Milton, 2012). I believe that Milton's situating of communication issues between autistic and allistic people as a compatibility issue brings up some potentially important considerations for music therapists regarding the way in which we create a therapeutic relationship with clients whose communication style may be completely different from our own. One of the frequent issues that I find that autistic adults bring to music therapy with me is communication compatibility issues with the people around them, whether family members or work colleagues, and they often feel like they are the ones having to adapt to the communication style of others, rather than vice versa. When working with me, an autistic music therapist, there can be a sense of relief at our shared understanding and the acceptance, celebration and encouragement of individual forms of communication that I endeavour to bring to my work as a music therapist. In particular, if as music therapists, we find ourselves working in a "cross-neurotype" situation (with a person of a different neurotype to ourselves, for example an allistic music therapist working with an autistic person, or vice versa), perhaps we do need to consider not only how to "understand" and "recognise" communication differences, but also how to respond to, celebrate and learn from each person's unique style of self-expression.

Although the double empathy problem was originally developed with reference to autism, I see no reason why it could not have broader relevance for other forms of neurodivergence and disability. There is certainly further work to be done here, both in exploring the importance of the double empathy problem for work with autistic people in music therapy, and its relevance more broadly for other disabled identities.

Communication Differences

Some communication differences may be quite obvious to the observer, for example in the use of different communication methods by adults with PMLD. I looked at this topic in my Master's research, studying a music and movement improvisation group for adults with PMLD and found that a large number of forms of communication were being used, such as eye contact, movement, proximity or otherwise to other members of the group, non-verbal vocalisations, moving objects and forms of touch. Verbal communication was rarely used within the group, and yet a great deal of effective communication was taking place, often initiated by adults with PMLD who were joined in their preferred forms of communication by the facilitators of the group (Davies, 2019). For example, an adult with PMLD was described as a "poet through touch," who communicated with others with "extremely rich dialogues through finger-tip" (Davies, 2019).

Other communication differences may be less obvious to the observer and yet could be causing an equally significant barrier to communication in music therapy practice. For

example, autistic forms of communication such as stimming[3] and echolalia are frequently misinterpreted and misunderstood by allistic people, and even more subtle communication differences such as dislike / lack of understanding of small talk, or autistic "bluntness" can also cause barriers in communication with allistic people.

Bakan's ethnomusicological work with his Artism ensemble, a musical collaboration between professional musicians and autistic young people, illustrates stimming can be accepted as a valid form of autistic communication (Bakan, 2014). He describes the experience of "Zolabean," an autistic participant in the ensemble who uses both stimming and musical improvisation to communicate and respond to other members of the group:

> It is clear that for Zolabean, neither mode of participation is superior nor inferior to the other; they are just different ways of being engaged, each preferred at different times for different reasons. I embrace both, too, though the matter of the reasons behind Zolabean's choices remains largely a mystery to me. (Bakan, 2014)

Bakan chooses to respect Zolabean's frequent use of stimming while taking part in the group, rather than trying to persuade or encourage her to participate musically or communicate verbally, despite the fact that he freely admits he did not always fully understand Zolabean's communication choices (Bakan, 2014). Both the cultural model of disability and the neurodiversity paradigm recognise the unique characteristics, behaviours and forms of communication of disabled communities, both co-created and as a part of the individual experience of neurological difference or other forms of disability, as part of culture. For example, stimming is recognised as a valuable element of autistic culture. As Amanda Baggs (Mel Baggs) puts it: "In every **flick** of the hand, wobble of the head, the fine detail of our bodies rocking, we each discern the other's environment . . . Our hands are loud" (Baggs, 2012, p. 324).

Pickard's work with autistic young people with profound learning disabilities offers another illustration of a desire to authentically respect and respond to the communication needs and preferences of disabled people in music therapy. She writes:

> It is suggested that by working in a way that removes the hierarchy of the therapist as expert…and the hierarchy of verbal language as a primary medium of communication…there is opportunity for clients to take ownership of a neurodiverse identity and feel valued as a human communicator. (Pickard, 2019)

Final Thoughts

In order to work effectively with autistic and other disabled people in our music therapy practice, we need not only to "understand" and "recognise" communication difference, but to deeply and authentically engage with its value as a natural expression of diverse identities. The standards discussed here provide a starting point, but the music therapy profession can certainly go further, following the examples referred to above (Bakan, 2014; Davies, 2019; Pickard, 2019), in engaging with and celebrating the experiences and communication needs or preferences of disabled people. This could include learning both from the writings of disabled people and from the disabled people we encounter in our music therapy practice.

[3] Self-stimulatory behaviours—repetitive actions such as flapping, spinning or rocking that can have many meanings and functions in autistic self-expression and communication.

Beth: On Music Therapy Pedagogy and the Construction of Knowledge

My name is Beth Pickard and my pronouns are she/her. My engagement with these standards has evolved initially from that of a student and curious newly qualified practitioner's perspective, to an increasingly reflexive and critical educator's perspective, and crucially a researcher's perspective with a focus on critical disability studies. I approach this engagement as a white, cis-gender, female, heterosexual, employed, neurotypical music therapist, and I appreciate that several of these intersecting identities afford privilege in my experience, and may offer both insight and limitations to my knowledge and understanding. My lived experience as a sibling of a sister who has a learning disability shapes my positioning as an ally, and my understanding of the world and subsequently of the profession. However, I acknowledge that I have not encountered the disabling burden of ableism in my own experience, and thus respect and learn from colleagues who generously share their insights to inform activism in this space.

My focus in this publication is largely as an educator, where I contribute a critical disability studies lens to the music therapy curriculum and its development. I am passionate to ensure that students are encouraged to nurture a critical stance across their studies, but particularly in relation to concepts including normalcy and diversity which can be outdated in their representation in the profession's literature. The standards I have selected to focus upon are:

> 12.1 appreciate, and be actively informed by, lived experiences of wellness and illness, as well as the effects of social disablement and exclusion and consider this alongside diagnostic knowledge that is relevant to their profession.
>
> 12.15 recognise different methods of understanding the experience of service users, including diagnosis (specifically mental health and learning disability), and be able to critique these systems of knowledge from different socio-cultural perspectives (HCPC, 2023a).

Through developing an anti-oppressive pedagogical approach (Pickard, 2021, 2022a), I believe there is scope to address both of the standards through learning and teaching practices, maintaining my own engagement with the standards, and enabling students to demonstrate their engagement with these standards, in parallel.

I perceive standards 12.1 and 12.15 to be closely interrelated as they discuss the process of knowledge construction and disruption of historical hierarchies of knowledge (Bolt & Penketh, 2016; Dolmage, 2017; Price, 2024). From a pedagogical perspective, these standards are exciting as they firmly enshrine the expectation to value lived experiences and the expertise and insight they offer and consider the way such knowledge complements forms of knowledge more typically privileged in academia (Pickard, 2022b). While there have been historical precedents to ensuring that lived experience informs and guides both pedagogy and practice (see HCPC, 2012; HCPC, 2017, para 3.7), the active language of the revised standards introduces a stronger steer and expectation for both educators and practitioners to attend to this agenda in all aspects of practice. This is a powerful opportunity to ensure that music therapy curricula value expertise in lived experience at all levels of curriculum development and delivery.

Before looking ahead to opportunities to further embed and value expertise in lived experience, it feels relevant to reflect on our (the authors) collective experiences of this concept in music therapy pedagogy to date. Through informal discussions about our own experiences, we identified a lack of explicit engagement with experts by lived experience in the four music therapy programmes we studied during the past sixteen years. While there was some involvement of musicians with lived experience of specific genres and cultures, there was little representation of the lived experience of disablement. We appreciate there may have been involvement from experts by lived experience in aspects

of the programmes which are less visible, or that there was lived experience that we were not aware of, but the fact that the centrality of lived experience was little discussed across four programmes, regions, orientations and timelines feels significant to reflect upon.

In addition, a recent research study about the lived experiences of disabled music therapists in the UK asked participants explicitly about their experiences of teaching relating to disability in their music therapy training (Pickard & Davies, 2024, in press). The results showed a stark contrast between individual experiences. Some participants reported affirmative and aspirational experiences which promoted practitioners' confidence in their disabled identity and "humanised disability." Other participants reported either an absence of lived experience perspectives, or problematic perceptions about the relevance of lived experience: "We learned a lot about the concept of 'lived experience,' however, it was with hindsight always about 'others' and with hindsight I now feel could arguably involve a substantial and questionable degree of 'othering' (them and us) in relating to different client groups." Another participant shared: "I couldn't really understand why my training hasn't included the voices of more people with lived experience—I feel we could give a much better insight into the realities of particular experiences" (Pickard and Davies, in press).

Collectively, we have identified increased attention and opportunities for lived experience perspectives in training programmes and professional activities in recent years and acknowledge a gradual shift in the profession. Looking ahead to the potential impact of the revised standards on pedagogy and subsequent practice, valuing expertise in lived experience could be enacted in a number of ways, including:

- Different forms and modes of collaboration,
- Representation in authorship and knowledge construction,
- Representation in course teams and student cohorts,
- Conceptualisation of people engaging in music therapy and critical reflection.

Different Forms and Modes of Collaboration

There are a vast number of ways in which people with lived experience can contribute to curriculum development. This could involve people who have accessed music therapy or have potential to do so. This could also involve disabled music therapists and other disabled clinicians, challenging a simplistic binary between disabled and non-disabled categories (Shilldrick, 2020) and also disrupting the historical binary between "healthy" therapist and disabled client (Rolvsjord, 2014). Kumashiro (2000) argues that this dismantling of the "self-Other binary" is an important task of anti-oppressive pedagogy, and I would argue promotes valuable empathic understanding for therapists.

The nature of such collaboration can involve co-designing and co-producing curricula, consulting on assessment tasks, collaborating on recruitment processes and contributing to learning and teaching practices. There could also be opportunity for reimagining this collaboration and exploring innovative opportunities.

While professional standards across therapeutic professions advocate for collaboration and co-designing of curricula (BABCP, 2025; BPS, 2024; HCPC, 2023a), as does policy and strategy across social and health care (for example the UK Government 2014a, 2014b; Care Council for Wales, 2017), there is little literature about co-producing therapeutic curricula. There is rich literature about co-production from health and social care education (Beresford & Boxall, 2012; Hardy et al., 2018; Horgan et al., 2020; Redman et al., 2021), as well as music education (Laes & Westerlund, 2018), which can inform and support the development of this agenda in therapeutic studies and music therapy. Co-produced publications also offer specific and important insight (Devlin, Meadows et al., 2024; Devlin, Johnston et al., 2024; Greenstein et al., 2015). At the time of writing, music

therapist and educator at the University of Roehampton, Tessa Watson, is co-leading the Health Education Network for Co-Production (Cadogan et al., 2023), which signals an exciting development in therapeutic programmes collaborating with healthcare programmes in the development of knowledge co-production (Watson & Warner, 2024). It is hoped that best practices from other disciplines can inform developments in music therapy (see for example, Wales PRIME Centre, 2016; USW, 2025).

Representation in Authorship and Knowledge Construction

There is scope and opportunity to invigorate the concept of reading lists and recommended resources to include a range of multimedia sources which can be authored by or centre the experiences of those with lived experience of disablement. Reading lists serve as "representation devices serving to reflect particular perspectives and knowledge" (Schucan et al., 2020, p. 904), and thus are powerful indicators of who is conceptualised as expert and capable of knowledge production. While there are rich debates about decolonising reading lists with focus on race (Burke, 2018; Lindo, 2023) and gender (Tack, 2022), there is also scope to incorporate a wider range of sources to enable students to challenge the ableist reliance on the written and spoken word, and for other forms of being and knowing to be valued and shared (Bolt, 2019; Penketh, 2020; Pickard, 2022b).

There are a range of initiatives underway to promote this agenda, such as the University of South Wales' (2024) "Diversity Curators" and University of Kent's "See Yourself on the Shelf" (Mires-Richards et al., 2020), with a move in the sector to address this agenda through co-production and student partnerships (Gabriel, 2019; Museus, 2014; Thomas & Jivraj, 2020). Within and beyond music therapy, there are more examples of acknowledging expertise in lived experience in relation to mental health or race and ethnicity than there are in relation to disability. This is a challenge to be addressed both within and beyond the profession.

This shift to valuing expertise in lived experience and how it complements other forms of knowledge more traditionally privileged disrupts the entrenched notions of epistemic invalidation (Kuokkanen, 2008) and testimonial injustice (Fricker, 2007). Epistemic invalidation can be defined as the ways in which dominant groups define the valid mode of knowledge production, undermining or excluding oppressed groups who don't have access or opportunity to contribute to this discourse, whilst testimonial injustice is when an individual or group's contribution is given less credibility based on their status as a knower. This is where significant conflict between conceptions of expertise arises, with Stone and Priestley (1996, p. 19) suggesting that disabled people are the "true knowers," or experts, of the experience of disablement, while Mitchell (2016) and Dolmage (2017), amongst others, document the myriad ways that the ableist, systemic injustices of academia devalue the expertise of disabled people, resulting in epistemic invalidation.

Representation in Course Teams and Student Cohorts

Learning about difference, diversity and disability can be embodied by increasing diversity and representation in course teams: engaging more disabled practitioners, whether as tutors, lecturers, supervisors, placement providers, mentors or in other capacities not yet established. There is a parallel here to student recruitment, since until student cohorts are more diverse, and barriers to accessing training addressed, there will not be scope to recruit more music therapists with lived experience: a key issue signalled in the BAMT Diversity Report (Langford et al., 2020). Ableism in academia is an issue beyond the field of music therapy, but one we share a collective responsibility to address in order to increase diversity in student cohorts and course teams in turn, and for the profession to better reflect the communities it serves. This echoes back to the standards' aspiration to

be actively informed by lived experiences of wellness and illness, as well as the effects of social disablement and exclusion, and I posit that this can be achieved in an authentic way by valuing contributions of educators and students with these very experiences.

Conceptualisation of People Engaging in Music Therapy and Critical Reflection

In developing and delivering music therapy curricula, it is vital to consider how difference is represented and how those accessing music therapy are conceptualised. Language is a powerful tool for articulating power dynamics and standpoints, and the language around those engaging in therapy is one example of this (Hadjineophytou, 2022; Rizkallah, 2022). The language of disability is rich and contrasting (Bottema-Beutel et al., 2021; Goodley, 2017), and a critical engagement with the complexities of language, centred on the insights of those with lived experience, can be one of many tools for exploring positionality and conceptualization of difference in music therapy training and practice (as will be further discussed in Stella's section of this paper).

Echoing Hilary's emphasis on the importance of recognising intersectionality in relation to disability, standards 12.1 and 12.15 promote the importance of understanding disabled people as rich, complex and whole individuals: challenging an historical focus on pathology and an absence of recognition of the impact of social disablement and exclusion in the previous standards. This promotes that people engaging in music therapy can be understood as resourceful, whole people with insight and experience, not "broken" patients to be "fixed"; challenging the grand narrative of "weak clients" and "expert therapists" (Rolvsjord, 2014). With this revised positioning, comes an opportunity for music therapy pedagogy to incorporate teaching on systemic issues impacting disabled people in healthcare and wider society (McMahon et al., 2024; United Nations, 2006; WHO, 2022), and to consider the role of music therapy in providing accessible provision and advocating for social justice.

Summary

Considerations for higher education moving forward will be to address necessary systemic changes to enable meaningful engagement with these standards. While it is positive to have professional standards which support and enable advocacy for more diverse representation in course teams and curricula, there are significant changes needed in academic practices to make these aspirations accessible and sustainable. It is important, in the spirit of the social model of disability, to acknowledge that this is a collective, societal issue, not an individual one.

Standards 12.1 and 12.15 have potential to promote a holistic and transformative education for students, preparing them well for their future professional practice (Liasidou, 2014), where through "teaching *with*, and *by*, rather than *about* [disability], we […] may move beyond normalizing understandings and practices of inclusion, towards an expanded notion of professionalism" (Laes & Westerlund, 2018, p. 34). However, it is vital that innovations are authentic and sustainable, not tokenistic or performative (Horgan et al., 2020; Tack, 2022). With the life span of music therapy curricula in the UK largely between two and three years, and processes to affect changes to syllabi and more significant course structures extending beyond that, it feels too soon to understand whether or not the recent revisions have gone "far enough" or what their impact has been on music therapy pedagogy and construction of knowledge to date. I have found the revisions empowering to advocate for further systemic change and maintain hopefulness that they will present a continued challenge to ableist practices in higher education.

Tara: On Engaging Disabled People in Research

> 13.11: engage service users in research as appropriate (HCPC, 2023a)

My name is Tara Roman and my pronouns are she/her. I identify as white, heterosexual and cisgender woman. I am a mother and a HCPC-registered music therapist. I work part-time in a school as a music therapist, and I am also a part-time PhD research student at the University of Roehampton. As someone who does not identify as being disabled my use of language is guided by people with lived experience who are experts in this area. In this paper I will use the language most commonly used in critical disability studies literature which is identity-first language. When writing about my PhD research I use person-first language as this was the language chosen by the children, young people and families involved in the research project. I recognise there is no singular approach, and I respect the choices that individuals make regarding this (Hadjineophytou, 2022).

The revised standards now encourage practitioners to "engage service users in research as appropriate" (13.11), in addition to the existing standard 12.5 "recognise the importance of working in partnership with service users when carrying out research" (HCPC, 2023a). The wording of the new standard is vague and open to interpretation: what does "as appropriate" mean and for whom? Is this regarding service users? Families? Practitioners? Researchers? Ethics committees? Organisations? It could be assumed that the wording "appropriate" means one thing (i.e. appropriate to clients or service users) for both the HCPC and professionals engaging with the standards. I would argue that there are multiple interpretations of what "appropriate" might mean, and that different interpretations can lead to different positions and outcomes. The HCPC website states that "The HCPC's function is to set and maintain standards for those professions, with the objective of protecting the public" (HCPC, 2018). Even though the aim of the HCPC is to protect the public, the standards also recognise that Music Therapists all have their "own values, beliefs and personal biases (which may be unconscious)" (HCPC, 2023a, 5.3). I suggest that arts therapies research, regulated by the HCPC standards, is not neutral, or necessarily harmless or benign, but is carried out by individuals with their own beliefs, biases and values and takes place within a social, cultural and political context.

I have written about this issue previously: "Even though I intend to work as a Music Therapist from a position of wanting to do no harm, this does not make me exempt from the social, cultural and political context" (Roman, 2022, p. 2). This statement is also true for researchers. It is essential that researchers actively consider their positionality and engage in reflexive processes to engage with how their worldview influences the research process (Holmes, 2020). Critically, the revised standards, as currently written, do not require arts therapists to recognise and challenge existing inequalities and systemic barriers to participation in research. It is necessary to actively engage with these issues in order for disabled people to participate meaningfully in research. Additionally, recognising and challenging inequalities and barriers is vital to create inclusive, diverse, accessible and welcoming research spaces (de Haas et al., 2022; Grace et al., 2024). Engaging with ideas about power, accessibility and inclusivity provides opportunities to develop music therapy research in relation to contemporary discourse in critical disability studies.

Power and Empowerment in Research

> [Research] has the potential to empower and/or exploit those who are its subject. In short, the traditional power relations inherent to academic research must be destabilised for inquiry to be in the interests of disabled people's emancipation. (Liddiard et al., 2019, p. 154)

As Liddiard et al. (2019) highlight, academic research can maintain inequalities in power relations, and it can also provide ways to challenge and disrupt them. Issues of

empowerment, equality, accessibility, inclusion and participation are identified in the United Nations Convention on the Rights of People with Disabilities (United Nations, 2006). Article 1 of the convention states: "The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity" (United Nations, 2006, Article 1). Being able to fully and effectively participate in research is a human right. Participatory and inclusive research approaches offer ways to enable disabled people to contribute their knowledge and expertise in research. Participatory research approaches often are concerned with destabilising the assumed roles of researchers and the researched in academic research (Cook et al., 2019), and recognise that many forms, and ways, of knowing can contribute to the co-creation and co-production of knowledge (Cook et al., 2019; Liddiard et al., 2019; Milner & Frawley, 2019; Roman, 2022). Johnson and Walmsley (2003) highlight the importance of developing research questions which should be relevant and meaningful to disabled people. Additionally, if a research project involving disabled people is initiated by a researcher (and not disabled people) the researcher should carefully consider if the research will be of benefit to disabled people. Researchers might ask if their proposed research adopts an ally's stance; for example, actively challenging discrimination and ableism. Johnson and Walmsley (2003) also recognise that disabled people should be able to influence the research process and have meaningful access to research findings.

Barriers to Participation

The revised standards do not require practitioners to recognise or address potential barriers to engagement in research. Requiring current, and future, researchers to recognise and challenge barriers to participation in research is essential to develop inclusive and accessible research practices.

> *Who can be a giver of knowledge?*
>
> To be wronged in one's capacity as a knower is to be wronged in a capacity essential to human value. When one is undermined or otherwise wronged in a capacity essential to human value, one suffers an intrinsic injustice. The form that this intrinsic injustice takes specifically in cases of testimonial injustice is that the subject is wronged in her capacity as a giver of knowledge. (Fricker, 2007 p. 44)

Fricker's concept of testimonial injustice is a good place to start thinking about barriers to participation in research. Do we consider disabled people as knowers? Do we take seriously disabled people as givers of knowledge? People with profound and multiple learning disabilities remain a marginalised group who are consistently excluded from engaging in research (Cluley, 2016; de Haas et al., 2022). Traditional research practices can act as barriers for disabled people, and wrong them in their capacity as a giver of knowledge. Employing traditional or normalised research conventions or methods without serious consideration of these potential barriers, risks that existing inequalities and injustices will be reflected in research processes (Milner & Frawley, 2019).

Disabled people can be actively excluded, for example through participant eligibility criteria or passively excluded due to inaccessible project design such as the recruitment procedures, consent forms, or research tasks themselves. Research tasks often require that participants can use written or verbal language to participate. Preference for verbal or text-based modes of communication exclude other forms of communication as a means to contribute to the co-creation of knowledge within research (Cluley, 2016; de Haas et al., 2022). When inclusive research practices are limited to traditional research practices people who have communication differences and diverse ways to share their knowledge,

understanding and expertise about their lives and experiences are excluded from research (Cluley, 2016; de Haas et al., 2022; Hamilton et al., 2017; Milner & Frawley, 2019). Rather than expecting disabled people to adjust to traditional research conventions, the onus should be on researchers to diversify research practices. For examples of research which aims to be inclusive, accessible and participatory please see Devlin, Meadows et al., (2024) Grace et al., (2024), Metell, (2019), Noone (2018), and Warner (2005).

Informed Consent

Research eligibility criteria often requires that research participants aged 16 and over are able to give informed consent to participate. If a person is assessed as being unable to give informed consent then they are not eligible to take part. The Mental Capacity Act (UK Government, 2005) legislation requires researchers to provide a rationale for including people assessed as lacking capacity in research. Researchers have to argue 1) why people assessed as lacking capacity should be included in the research and 2) why the research cannot effectively be carried out only with people who have capacity. These safeguards are in place to protect vulnerable adults under the central ethical principle of beneficence (Marshall et al., 2012) but in practice can end up excluding large groups of disabled people from research. Consequently, this means that many disabled people are not represented or are unable to directly contribute to the research studies about their lives and experiences. This exclusion results in an absence of their knowledge and expertise in public discourse: "People with profound intellectual and multiple disabilities are yet to belong in any meaningful way to the inclusive research movement(s) […]and are often excluded from research altogether" (de Haas et al., 2022, p. 1). A related issue is the potential barriers to co-authoring research due to the concerns, processes and procedures of ethics review boards. Delvin et al. (2024) highlight the many and significant barriers to co-produced and co-authored research with people with lived experience and expertise due to concerns about risk, perceptions of vulnerabilities, and ideas about who can be an author in a peer reviewed journal:

> These barriers have included (but are not limited to): (1) reluctance to approve research involving stakeholders who the IRB [ethics review board] considers "vulnerable" (e.g., Aldridge, 2019; Boxall & Ralph, 2010), (2) challenging the competence of disabled co-researchers, particularly those with intellectual disabilities (e.g., Smith-Merry, 2019), and (3) unfamiliarity with the methods and values inherent to research co-production (e.g., Strnadová et al., 2020). And, even if such research is approved, peer-reviewed journals may not permit stakeholders to be identified by name as coauthors, creating another equity barrier (e.g., Nind & Vindha, 2012; Sarna-Wojcicki et al., 2017, p. 142).

Radical Research Spaces: Inclusivity, Accessibility and Belonging

The revised standards should go further in demanding that practitioners create radical research spaces. When thinking about participation in research rather than focusing on what a person cannot do, researchers should be required to consider the constraints or barriers of a chosen research method or practice and ask if this research could be done differently to support participation (Cluley, 2016).

> The way forward is likely to be an inclusive research culture that can accommodate 'being with' as core to its research approach. This will enable the voices of people with profound intellectual disabilities to inform the research in creating intersubjective knowledge together. (de Haas et al., 2022, p. 1)

The idea of "being with" someone (de Haas et al., 2022, p. 7) will be a concept familiar to many music therapists. De Haas et al., (2022) describe how the concept of being with "could be key" to doing research inclusively (p. 7). Being with involves noticing, valuing, responding and waiting to enable a shared and meaningful interactive space to be co-created in the space between the people involved. This interactive space can involve gaze, touch, movements, gestures, breathing, sounds and music. This involves a co-operative and collaborative view of research (de Haas et al., 2022) where the researcher and participants work together in an embodied and relational way (Grace et al., 2024). Adopting an embodied, situated and relational conception of research creates opportunities for diversity of voices and stories to be shared and heard.

> By taking seriously the possibility of people with profound intellectual and multiple disabilities being active agents within research, we reject the commonly accepted assumption that research is an inherently intellectual pursuit and therefore only accessible to people in proportion to their presumed intellectual capacity. In working with people with profound intellectual and multiple disabilities, we are attempting to hear from people previously excluded from knowledge-making and considering knowledge outside predetermined acceptable sources. This incorporates using all our senses, our bodies and our capacity to hold and narrate stories for and with people who communicate without words. (Grace et al., 2024, p. 10)

Engaging service users in research is a necessary first step, but not sufficient, to challenge inequalities and barriers to participation in research. The ideas of "being with" and the embodied research spaces described by Grace et al. (2024) and de Haas et al. (2022) provide a guiding principle from which to explore, develop and create new possibilities for inclusive, accessible, collaborative, and creative music therapy research. Research spaces which welcome diverse forms of knowledge and ways of knowing are essential so that music therapists and service users can collaborate to share and co-create knowledge about music therapy.

Stella: On the Power of Language

My name is Stella Hadjineophytou (she/they) and I am a British woman of predominantly Middle Eastern descent in my late twenties. I have educational and health privileges which have afforded me stable employment as a full-time music therapist with Nordoff and Robbins (UK) yet have experienced some marginalisation by way of racial and financial discrimination and through being dyspraxic and dyslexic. Awareness of the push and pull of privilege and marginalisation in my life has motivated me to deepen my understanding of social justice frameworks and of critical disability perspectives, so that I might be more proactive in my allyship. I work in Glasgow, Scotland, primarily with disabled children and young people at an Additional Support Needs school. I am particularly interested in the power of the language of disability to affect unconscious perceptions and actions in music therapy, and music therapists' agency in challenging or enabling systemic social injustice (Hadjineophytou, 2022; Hadjineophytou & Apley, 2024). My decision to research and write about these topics comes from a strong personal drive; I do not receive financial support or time towards these activities.

My contribution to this paper is to highlight the revised standards' lack of critical engagement with the language of disability in arts therapies. There has in recent years been increased attention on how language shapes unconscious bias and systemically codes injustice into music therapy with disabled people, looking beyond basic terminology and deeper into the construction of so-called clinical discourse (Devlin, 2018; Grundy, 2024; Hadjineophytou, 2022). Pickard (2020) highlights the oppressive potential of discourse in

relation to the Standards of Proficiency, which can "shape and colour [music therapists'] approach to practice" and lead to disabled people "being Othered…and marked as different and potentially deficient through these language choices" (p. 5-6). Grundy (2024) cautions that, "we need to be aware of the forces that shroud the therapeutic encounter, being aware of the potentially oppressive and covert power dynamics that hide within the act of writing, and the meanings that texts might assume once produced" (p. 73). I have previously explored how critical disability discourse has influenced music therapy discourse, applying this to my trainee placement therapy delivery with a young woman called Kirsty (Hadjineophytou, 2022).

It is therefore interesting and perhaps concerning for the wider profession that the revised standards omit any critical engagement with language. For instance, Section 7, subheading "communicate effectively," lists nine standards, none of which raise the importance of language choice (HCPC, 2023a). Interestingly, the topic of language is addressed in the preface to the standards, though only with regards to the terminology used within the standards themselves, rather than within the wider profession:

> We…recognise that the use of terminology can be an emotive issue. Our registrants work with very different people and use different terms to describe the groups that use, or are affected by, their services. Some of our registrants work with patients, others with clients and others with service users. The terms that you use will depend on how and where you work. (HCPC, 2023a)

This paragraph preludes the conciliatory tone of the standards, offering a clue as to why the topic of language is not reengaged with later on. Whilst I agree that language is context and choice dependent, I would hope for the UK music therapy profession's regulatory body to encourage critical engagement beyond diplomacy and surface-level terminology. In my opinion, this would mean moving beyond a position of generalised inoffensiveness and instead holding professionals accountable for raising their consciousness on the power of language to affect perception and action in therapy. Furthermore, describing language as an "emotive issue" undermines its very real power to affect lives and dismisses how terms such as "patients," "clients" and "service users" might be received by those they are applied to. This is curiously at odds with the HCPC's effort to revise the standards in line with critical socio-cultural understandings of disability. A consequence of overlooking the importance of language is that professionals are not required to reflect on its use.

Making the Unconscious Conscious

I recently attended an internal Nordoff and Robbins training session on "Writing," where we listed all our daily writing tasks, from emails to reports and session notes. The exercise helpfully drew attention to how much we variously write, talk, think, listen and read about our work through language. Three of the Standards of Proficiency address clinical writing (in the broadest sense of the word) directly:

> "4.3 make reasoned decisions to initiate, continue, modify or cease treatment, or the use of techniques or procedures, and record the decisions and reasoning appropriately."
>
> "9.1 keep full, clear and accurate records in accordance with applicable legislation, protocols and guidelines."
>
> "13.5 undertake and record a thorough, sensitive and detailed assessment." (HCPC, 2023a)

These standards highlight the impact of record-keeping on the therapeutic process yet miss a link to critical engagement with language. This gives permission by omission for music therapists to continue using language unthinkingly and even use it to rationalise

potentially harmful decisions. What does it mean to record reasoning "appropriately," or to keep "accurate" records? Who is defining accuracy and what happens if two people have different interpretations of this? What does it mean to be "sensitive"? How can this be regulated without clear guidance? What guidance might we wish to see?

This very language here can be taken as an example of how language is not simply a preference, but a representation of thought. Ambiguous, "professional" language such as "appropriate," "accurate" and "sensitive" tells us very little about what is actually appropriate, accurate, and sensitive; simply saying it does not make it so. By leaving these qualifiers undefined, it becomes up to the therapist's discretion to determine their meaning. From this critical perspective, it seems that these standards are no longer actual "standards" as they do not outline any tangible qualities; instead they are simply utopian hopes and dreams (as it is worth pointing out that no therapist, regardless of their reflective capacity, could claim to write or speak about their work in a completely appropriate, accurate, and sensitive way due to the nature of subjectivity).

This is not to say that there is any one right way of using language we should expect to see in these standards, but rather that these standards should encourage critical reflection with language and not overlook its influence. Grundy (2024) calls for "more reflexivity regarding the role of the music therapist's self and intersubjective elements within the writing" (p. 66) and considers that "clinical writing potentially has a powerful impact on the therapy process as a whole" (p. 73). Perhaps this might be a more suitable starting point for a professional standard for music therapists' use of language?

So, why is this important? In short, it is recognised that interrogating language use can be a tool in fostering anti-oppressive practices and disrupting systemic linguistic codes (Bricher, 2010; Cameron, 2014; Grundy 2024; Hadjineophytou, 2022; Ziegler, 2020). Walker (2021) argues that healthcare practitioners using language which promotes an individualised, rather than social, understanding of disability "are reinforcing a social paradigm that harms [their] clients" (p. 140). For some music therapists this has meant confidently moving away from deficit-based language inherited from the pathology paradigm and the dominant medical model of disability, towards language rooted in socio-cultural understandings of disability (Cameron, 2014; Leza, 2020). For others, this has meant utilising the inferred delineations of institutionalised language to recognise and not shy away from different roles and power dynamics, for example in terms such as "patient" and "expert" (Rizkallah, 2022). Regardless of one's position, any endeavour to use language thoughtfully and intentionally is challenged by ongoing, changeable systemic and cultural coding of language in the contexts and settings of music therapy work, which influences, informs, or restricts music therapists' reflective capacity. This is because ultimately, music therapists' perspectives and ways of seeing the world have significant implications for how they determine the therapeutic needs of others (Devlin, 2018; 2024).

Grundy (2024) encourages music therapists to engage with unconscious bias through language use, stating, "we cannot escape an unconscious editing and interpreting of everything that happens in the music therapy encounter, and it is especially important for inclusive practice that we unceasingly try to uncover and work on our own biases and assumptions" (p. 68). This undoubtedly challenges practitioners who may find it difficult to accept their role in systemic oppression, especially as this might feel at odds with their desire to be part of a "helping profession." In this vein, music therapists who believe they are using "right" language, perhaps as used in their training or by the institutions they work in, might consider that any discourse reflects the biases of its creators. In fact, it could even be damaging to think of there being a "right" language, as the process of uncovering and informing our assumptions and perspectives requires a constant state of questioning what is "right"; an approach I have previously described as being "unknowing and inexpert" (Hadjineophytou, 2022).

An Example: Sam

My own efforts to interrogate this aspect of my practice have focused primarily on exploring the written descriptions of music therapy work. I first looked at various models of language, which were informative but seemed to change constantly: within my first four years of practice, I have already seen many terms come and go. Consequently, I decided to look beyond the jargon and labels to the actual meaning of the text I was composing. This developed into an "unknowing and inexpert" approach to language (Hadjineophytou, 2022), which invites the writer away from concrete, singular understandings of events, instead focusing on tangible qualities, questions, and possibilities within therapeutic encounters.

In our presentation at the BAMT conference, I presented fictional session notes with "Sam" to demonstrate these different ways of using language and their implication for the therapy (Davies et al., 2024). The context is that Sam is a seven-year-old autistic boy who is attending his first music therapy session at school:

> Sam is known to struggle with transitions. Sam refused to come into the music therapy room today. Our session took place in the corridor using voice and ukulele and lasted five minutes before Sam wanted to leave. The music focused on guiding Sam into the room through lyrics ("we're going to the music room"). Sam did not engage in playing or singing. I left space in the phrases for Sam to strum the ukulele on the word "room," but he did not seem to understand the invitation, showing a low awareness of phrase structure. Sam will need a stronger motivator to enter the music therapy room next week and so I will have a discussion with the class teacher about what we could use.

I then presented these notes in comparison with an alternative version which seeks to move away from deficit-based language (highlighted in bold) and towards a more curious perspective (Table 1):

Table 1. Comparison of Notes.

Original session notes	Alternative session notes
Sam is known to **struggle** with transitions.	Sam does not enjoy transitions to new spaces.
Sam **refused** to come into the music therapy room today.	Sam was offered the option to enter the music therapy room. He chose to stay in the corridor, communicating this in his body language and positioning (shaking his head, turning away, staying in the corridor).
Our session took place in the corridor using voice and ukulele and **lasted five minutes before Sam wanted to leave**.	Sam appeared settled and engaged in a five-minute session in which I used ukulele and voice.
I left space in the phrases for Sam to strum the ukulele on the word "room," but **he did not seem to understand the invitation, showing a low awareness of phrase structure**.	I offered Sam the ukulele to strum at the ends of phrases and Sam chose not to play. Perhaps I was not clear in my invitation, or Sam did not enjoy me coming so physically close to him. I will bring Sam his own instrument next time to present the invitation differently.

This is not to suggest that the alternative session notes here are completely aligned with an anti-oppressive perspective or that this is even possible to achieve. Rather, this exercise serves to show the power of language (beyond specific labels) in forming an understanding of disabled people and their therapeutic needs, as well as an example of working towards a more unknowing and inexpert discourse.

Summary

At this juncture, I theatrically relate the impetus for our writing this paper to the subject of language. The HCPC's very need to revise the language of the standards proves language's power to encode systemic and unconscious biases and acknowledges language's role in the oppressive treatment of disabled people in music therapy. This, in and of itself, is an argument for future revisions of the standards to engage with the topic of language beyond tokenistic acknowledgement of terminology. Rather than simply being "recognised" or seen as an "emotive issue," I hope to see more active consideration of music therapists' language use in relation to emerging critical understandings of disability.

But Does it Go Far Enough?

We have found the revised standards to be a useful starting point for reflecting on the UK music therapy profession's engagement with emerging critical discourse on disability. We recognise a significant reform to the standards in favour of anti-oppressive practices, pedagogy and research compared to the previous iteration of the standards. However, we join our voices to the question posed by the delegate at our roundtable presentation: "But does it go far enough?"

Many of the delegates who actively chose to attend our presentation voiced the opinion that the revisions were "too little, too late" in matching the shift in critical disability discourse within UK practice. Several delegates expressed that many practitioners would find the revisions to be relatively conservative whilst others would find many of the concepts new or challenging, highlighting the range of work that the standards may fail to represent. The delegates reflected that perhaps the revised standards were carefully positioned to sit in the middle of this dispersion and wondered if this was helpful for the profession. Since then, we authors have reflected on the potential for the badge of HCPC registration to be worn in such a way that these standards become "weaponised"; indeed, some practitioners may feel that their ongoing registration to the HCPC means they are automatically fulfilling its professional requirements and need apply little further thought to the matter. We have also reflected on how the ambiguity of some of these standards might make it easier for practitioners to keep any scrutiny regarding the inclusivity and accessibility of their practice at arm's length.

We add to this reflection that the UK is one of few countries who have formal standards for regulated music therapy practice, and that they may be perceived differently in other international contexts. We also recognise that the roundtable discussion only involved those who actively chose to attend and engage with this topic, most likely due to an existing interest or alignment in perspective, as well as those with the resources and opportunity to attend an in-person conference, which would have limited the diversity of perspective on the issue (Coombes, 2024; Hadjineophytou, 2024). We are aware that for many, the revised standards will be received as a positive and welcome development for the UK profession and therefore requiring little further thought: however, we caution against complacency and argue that continuous critical engagement is needed to keep our profession reflective, forward-moving, and open to change.

We intentionally crafted this paper not as a single voice but as four contrasting voices of a collective, to demonstrate the nuance, breadth, and scope of discussion that is

emerging in the profession in response to this topic. As we have been informed and nourished by each other's contributions, we have found resonance and dissonance in our reflections on the revised standards. As a collective we are united by a belief that simply acknowledging unconscious biases is not enough; one must come face-to-face with and challenge the discomforts of their contributions to oppressive practices in order to make active change. The HCPC suggests that they have revised the standards with this in mind, detailing in the preface: "We have also made changes to the wording of the standards to move registrants away from a passive understanding of the standards and towards active implementation of them" (HCPC, 2023a). We question whether or not this has been achieved and what implications this might have for those affected by their implementation. We have all identified a tendency for these revised standards to sit in a safe space of acknowledgement, awareness, and recognition, which perhaps mirrors or encourages similar passivity within the professional population. In each of our contributions we have challenged this passivity, in varying degrees, in favour of greater critical engagement. We feel that holding these nuanced opinions under the umbrella of anti-oppressive practice is a reminder of the importance of individual perspectives and situated knowledge.

Conclusion

We hope to have demonstrated how the UK music therapy profession's regulatory standards might represent and/or inform its engagement with emerging critical discourse on disability. We perceive the latest revisions to the HCPC's Standards of Proficiency for Arts Therapists to be in general a positive step forward for the UK music therapy profession's engagement with disabled people in practice, pedagogy, and research, though we have also outlined ways in which these standards may misrepresent, undersell, exaggerate, and influence on-the-ground practice. Our emphasis on thinking critically about the reasons and implications for this has been in pursuit of growth and development within the profession, and ultimately, in pursuit of justice for disabled people who are in various ways engaged with the music therapy profession.

We align ourselves with those who have expressed that the music therapy profession is in a strong position to be pioneering and forward-thinking in its approach to challenging dominant structures and narratives (Baines, 2021; Davies, 2022; Hadjineophytou & Apley, 2024; Procter, 2001). However, we caution that this is not an intrinsic trait of music therapy, and that constant reflection and reimagining are key in moving the profession forward with authenticity, rather than tokenism. We therefore invite music therapy practitioners, theorists, educators, and researchers to reflect more deeply on the standards that define their practice and, in doing so, join with Jessica Leza (cited in Annesley, 2024) in asking "What might music therapy look like in a system in which the acceptance, inclusion and accommodation of every sort of body mind represents an unquestioned baseline—not an exceptional thing?"

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We would like to acknowledge our colleague David Limmer, who was initially part of these discussions and was due to present alongside us. David planned to share his perspective as a disabled music therapist and present on the topics of accessibility and building collaborative approaches to music therapy with disabled people. Unfortunately, the late withdrawal of the option to attend the 2024 BAMT conference online that was initially promised meant that David was unable to attend, and he did not feel comfortable remotely participating in a roundtable about the issues faced by disabled people for a conference he and others were unable to be a part of.

About the Authors

Stella Hadjineophytou is a music therapist working for Nordoff and Robbins in Glasgow, Scotland, and a doctoral student at Nordoff and Robbins/Goldsmiths, University of London. Stella has experience of delivering music therapy in a wide range of settings, including care homes, psychiatric care, educational institutions, and with victims of trafficking. Stella is interested in writing about and researching disability and access in music therapy practice. Stella is currently the Co-Chair of the Scottish Music Therapy Trust.

Beth Pickard is a senior lecturer and supervisor at the University of South Wales, as well as a freelance researcher, consultant, music therapist and inclusive music practitioner. Her research and practice is heavily informed by critical disability studies: exploring how disability is socially constructed, interpreted and represented across disciplines and pedagogy.

Hilary Davies is currently studying for a PhD at the Guildhall School of Music and Drama, looking at neurodiversity-paradigm informed music therapy with autistic people. She also works as a music therapist in private practice with autistic adults, and as a guest lecturer at several universities. Hilary has an MA in Music Therapy (with Distinction) from the Guildhall School of Music and Drama, and previously studied at the University of Cambridge (Gonville and Caius College). She is the founder and coordinator of the BAMT Support Network for Disabled Music Therapists.

Tara Roman is a music therapist and a PhD research student at the University of Roehampton. Tara's PhD research explores what children and young people with disabilities and their families think is important about music therapy, and how music-making works for them in music therapy. Tara's research and practice focuses on working collaboratively with children and young people and their families.

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