A critical reflection on the Health and Care Professions Council Standards of Proficiency for music therapists: A critical disability studies perspective

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Abstract

This article takes the theoretical and philosophical lens of critical disability studies to critically reflect on the Health and Care Professions Council Standards of Proficiency for Arts Therapists. The discipline of critical disability studies, evolving from disability studies and the disability rights movement, is initially defined before multiple paradigms of disability are introduced as central tenets of these disciplines. The relationship between critical disability studies and music therapy is explored, with reference to seminal publications and the perceptions of music therapy within them. The Health and Care Professions Council Standards of Proficiency are then taken as a source of reflection to attempt to understand the perpetuation of medicalised perspectives in the profession and the potential friction between critical disability studies and music therapy. A selection of the Standards of Proficiency are analysed according to distinct paradigms of disability. Questions are posed to interrogate and contextualise the standards in relation to critical disability studies philosophy. From this critical reflection, a discussion emerges which reflects on the reach of these professional standards and how they might contribute to a continuing, outdated expert-model of music therapy in the United Kingdom. The article concludes by drawing these threads together in a series of recommendations to educators, practitioners and the wider profession.

Keywords

disability; disability studies; music therapy; profession; registration; standards

Introduction

The first aim of this theoretical and reflective article is to introduce the disciplines of disability studies and critical disability studies to Music Therapists and to review the history between these disciplines and the music therapy profession. Building on this discussion, an understanding will be presented of the reasons why potential expert-models or medicalised perspectives continue to permeate the music therapy profession. In order to elucidate this, the article offers a critical reflection on the Health and Care Professions Council (HCPC) (2013) Standards of Proficiency (SoPs) for Arts Therapists in relation to three distinct paradigms of disability. Finally, the article proposes a paradigm shift within music therapy research and practice by highlighting opportunities for reflection, growth and potential change.

The professional regulation of the discipline of music therapy in 1997 by the then Council for Professions Supplementary to Medicine (CPSM) and subsequently the HCPC in 2012 are recognised by many as important milestones in the evolution of the profession (Barrington, 2005, 2008, 2015; Bunt and Hoskyns, 2002; Carr et al., 2017; Karkou et al., 2017; Odell-Miller, 2016). With this professionalisation comes a range of criteria, considerations and context aligned with the regulatory body and allied professions. This process is mirrored in other international contexts, but not with such close alignment to other allied health professions. In Australia, as a self-regulating allied health profession (Allied Health Professions Australia (AHPA), 2017), Music Therapists engage with Competency Standards outlined by the Australian Music Therapy Association (AMTA, 2018). In the United States, the AMTA provides Professional Competencies and Standards of Clinical Practice (AMTA, 2013, 2015) which registrants must evidence, having achieved board certification from the Certification Board for Music Therapists (CBMT, 2020). Similarly, in New Zealand, Music Therapy New Zealand (2012) outlines Standards of Practice to which Music Therapists are expected to adhere to maintain registration.

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The United Kingdom is uniquely positioned among the given examples in the adherence to SoPs developed and aligned with other Allied Health Professions (HCPC, 2013). It should also be noted that the SoPs are understood as a significant but component part of professional apparatus. As such, there are many other dimensions that shape and inform the evolving music therapy profession: from training courses to funding bodies, other HCPC resources (HCPC, 2016, 2017, 2020), systemic processes and increasingly, service user perspectives.

This article takes the theoretical and philosophical lens of critical disability studies (Goodley, 2014, 2017; Watson et al., 2020) as an opportunity to critically reflect on some of the potential implications and connotations of the SoPs (HCPC, 2013) to which registered Music Therapists in the United Kingdom must adhere. The discipline of critical disability studies is defined by Thomas (2007) as 'breaking boundaries between disciplines, deconstructing professional/lay distinctions and decolonizing traditional medicalised views of disability with socio-cultural conceptions of disablism' (p. 53). There are many possible theoretical lenses that could be used to interpret and understand the HCPC (2013) SoPs. With the prevalence of music therapy practice undertaken with individuals who experience disablement in the United Kingdom (Carr et al., 2017), critical disability studies is proposed as a valid perspective to consider in this article.

As is widely recognised in critical disability studies, social constructionism suggests that interactions, language and attitudes can have a significant impact on the lived experience of disablement (Bolt, 2016; Rapley, 2010). It is proposed that music therapy contributes to both neurodiversity discourses (Leza, 2020; Pickard et al., in press; Thompson et al., 2019) and deficiency-based narratives (Bieleninik et al., 2017; Straus, 2014, 2011) in the social construction of disability, through contrasting perspectives evidenced in theory and practice. While there are several rich publications discussing music and disability studies (Howe et al., 2016; Lerner and Straus, 2006; Lubet, 2011; McKay, 2013; Straus, 2011, 2014), there are only brief or sceptical references to music therapy within them.

There has been a fraught history between the disciplines of critical disability studies and music therapy, with a relatively small number of seminal publications in this field (Hadley, 2014; Pickard, 2018b, 2019; Straus, 2014; Tsiris, 2013, 2018) After a concise contextual summary of disability studies and critical disability studies, the historical tension between these disciplines and that of music therapy will be briefly explored. To illustrate some of the discussion points further, the HCPC (2013) SoPs will be critically reviewed, analysed and discussed from a critical disability studies perspective in relation to multiple paradigms of disability before conclusions and recommendations are presented.

Disability studies, critical disability studies and paradigms of disability

The discipline of disability studies emerged in the late 20th century as the disability rights movement evolved in the United Kingdom (Oliver, 1983, 2013; Barnes, 2020). Activitsts, practitioners and scholars' aspiration for this movement was a repositioning of the 'problem of disability' from residing within the individual, to a problem of social justice (Oliver, 1983). As Goodley (2017) proposes, 'Disability Studies' most important conceptual leap is the move from the individual to society' (p. 9). Critical disability studies emerged later into the 21st century and is still refining its focus and reach, with varying conceptions and definitions discussed by Goodley (2013):

> If late-twentieth-century disability studies was associated with establishing the factors that led to the structural, economic and cultural exclusion of people with sensory, physical and cognitive impairments, then disability studies in the current century might be seen as a time of developing nuanced theoretical responses to these factors. (p. 631)

A further powerful definition is offered by Shildrick (2020):

> In recent years, the powerful emergence of what has come to be called critical disability studies has added new force to the theoretical impetus already at the heart of the social model [of disability], taking it in innovative directions that challenge not only existing *doxa* about the nature of disability, but questions of embodiment, identity and agency as they affect all living beings. (p. 32)

A notion widely discussed in both disability studies and critical disability studies is that of paradigms of disability and their potential to inform our understanding and experience of disablement. Since this is a tool that will be used in reviewing and analysing the HCPC (2013) SoPs in this article, a brief introduction to this concept will be offered here. This is presented in recognition of the scale and scope of this article and is a tiny portion of a much wider, richer critical debate about the validity and value of discussing disability in these terms (Beaudry, 2016; Smith et al., 2009; Watson and Vehmas, 2020).

Baglieri and Shapiro (2017) define a paradigm as 'an ideology or frame of reference. It is the way one perceives, understands, or interprets a topic or issue' (p. 17). The Medical Model of Disability, arguably the dominant paradigm in our society, conceptualises disability as deficiency. As such, medicalised interpretations of disability situate the construct of disability within the individual, and any 'interventions' seeking to address disability will focus on normalising the 'problem' within the individual, working towards remediation or cure (Goodley, 2017).

In contrast, the Social Model of Disability conceptualises disablement as the barriers faced by individuals when seeking to participate in society (Oliver, 1983, 2013). The Social Model of Disability recognises impairments, whether physical, sensory or cognitive, but posits that these impairments lead to disablement because of the inhospitable nature of

ableist environments, systems and society within which disabled people live (Barnes, 2020; Houting, 2019). As such, disability is positioned within societal structures, and any activity which seeks to reduce the experience of disablement would likely take a social justice approach to challenging the barriers posed by society, rather than seeking to change or 'normalise' the individual.[1] The Social Model of Disability is one of the driving forces of disability studies (Oliver, 1983, 2013; Barnes, 2020), and its influence continues to be debated and discussed in critical disability studies (Goodley, 2013, 2017; Shildrick, 2020).

A third model of relevance to this discussion is a Nordic Relational Model of Disability (Fougeyrollas et al., 2019; Goodley, 2017; Shakespeare, 2013; Traustadóttir, 2004, 2006; Traustadóttir et al., 2013). In this paradigm, disability is situated as resulting from the relationship between the impairment an individual experiences and the environment in which their impairment is embodied. Approaches informed by this paradigm would explore opportunities to work with an individual *and* with their environment or community to address the relationship between the individual and the context.

A final model to consider is the Neurodiversity Paradigm, which conceptualises difference as anticipated and valued diversity, rather than deficit (Kapp, 2019; Milton et al., 2020; Singer, 1999, 2016): 'A harmless neurological difference rather than a pathology' (Kirkham, 2017: 107). There is a growing body of research and practice exploring the relevance and value of this perspective to music therapy (Davies, 2020; Elefant et al., 2020; Leza, 2020; Pickard, 2019, 2020a, 2020b; Thompson et al., 2019).

Gross (2018) suggests that while more Music Therapists are becoming aware of the Social Model of Disability, 'much of music therapy practice still invests in the medical model of disability, which maintains that disability is an inherent personal flaw in the individual which requires remediation'. This is echoed in the words of Murphy and McFerran (2017) who note that 'outdated expert-models still exist' and 'there is persistence in working from a medical model framework' (p. 311). This article seeks to understand why these arguably outdated models continue to permeate the profession and where the sources of influence of these perspectives may be located.

A wide range of other paradigms of disability are explored in the literature, which could inform and reframe music therapy practices. There are also relevant and important critiques of these most prominent models, illustrating how they can be simplistic and reductive (Anastasiou and Kauffman, 2013; Baglieri and Shapiro, 2017; Beaudry, 2016; Goodley, 2017; Shakespeare and Watson, 2002; Sharma and Dunay, 2016). There are other paradigms of relevance to music therapy work, such as a Recovery Model pertaining to mental health (McCaffrey et al., 2011; Solli, 2015). Baglieri and Shapiro (2017) demonstrate the importance of discussing the paradigms which shape our worldviews, stating that

> Awareness of the paradigms that structure our experiences and reactions to disability can enable us to identify points of conflict. As we identify conflicts between dominant and other paradigms, we can engage in critical reflection in order to locate our own understandings and beliefs and their implications for our own positions to power. Analyses in disability studies propose that in order to act against ableism, we need to shift paradigms. (p. 17)

This is the premise of this article, which, through critical reflection, seeks to propose a paradigm shift to the music therapy profession.

Music therapy and disability studies

Tsiris (2018) presented an eloquent summary of the relationship between music therapy and disability studies in his presentation entitled 'Music Therapy and Disability Studies: A Misunderstood Guest, A Misunderstood Host'. This sentiment recognises that there has been some friction at the intersection between music therapy and disability studies over several years. While there are an increasing number of contemporary publications informed by this perspective (Gross, 2018; Pickard, 2018a, 2019b; Shipsey, 2018; Tsiris, 2018; Metell, 2019), there remains a lack of wider acceptance of these ideas in music therapy pedagogy, literature, research and practice. Tsiris (2013, 2018) was explicitly responding to the publication of Straus' (2011) text which made the following contentious statement about music therapy:

> Music therapy is a normalizing enterprise, bound up with the medicalization and attempted remediation of disability. Of course there is a long history stretching back to classical antiquity of accounts of the power of music to cure or disable. What's new in music therapy is the full impact of the medical model of disability: its practitioners are medical professionals who offer therapy to patients and write up their findings in the form of case studies. They seek to cure, remediate or normalize their patients, and music is their therapeutic tool. (p. 158)

While this statement might appear surprising, inaccurate or unfounded to some Music Therapists, it is possible to trace a clear rationale for this interpretation of the profession when interrogating various dimensions of teaching, regulation and publication in the field of music therapy (Pickard, 2018a; Pickard et al., in press).

A significant contribution to the music therapy and disability studies literature was published in 2014 in a Special Issue of Voices (see Hadley, 2014). Here, a number of international practitioners demonstrated with insight and rigour the potential of disability studies to inform and enrich the discipline of music therapy and to challenge entrenched assumptions and practices (Bakan, 2014; Bassler, 2014; Cameron, 2014; Honisch, 2014; LaCom and Reed, 2014;

Metell, 2014; Miyake, 2014; Rickson, 2014; Rolvsjord, 2014; Straus, 2014). The discussion was vivified again in 2018 when a small number of Music Therapists presented at the inaugural Music and Disability Studies Summit at the University of Leeds, entitled 'Cripping the Muse' (Allori, 2018; Pickard, 2018b; Pickard and Dower, 2018; Shaw, 2018; Tsiris, 2018). Here, Tsiris (2018) developed his exploration of the cross-section at which music, music therapy and disability studies meet.

A critical stance was adopted at the Lancaster University Disability Studies Conference (Pickard, 2018b), considering the construction of normalcy and diversity in music therapy research and practice. Here, the HCPC (2013) SoPs were reviewed as evidence of the potentially medicalised perspective Music Therapists are encouraged to adopt in conceptualising and evidencing their practices, through the influence of the SoPs (HCPC, 2013) on pedagogy and professional practice. At this conference, a case study was presented from diverse vantage points to illustrate the challenge that Ansdell (1999, 2001) termed 'the Music Therapist's dilemma' (p. 2). Building on Ansdell's (1999, 2001) work, the case study demonstrated how translating non-verbal practice into verbal language can shift the perceived intention, ontology and outcome of the work into a medicalised frame (Pickard, 2018a).

From an American perspective, key developments in this field include the continuing work of Shiloh (2019; Leza and Shiloh, 2019; The Musical Autist, 2020; Shiloh and LaGasse, 2014) and influential presentations by Aigen on the topic of Music Therapy and Neurodiversity (Aigen, 2017). Leza (2019, 2020; Leza and Shiloh, 2019) is also presenting rich and stimulating discussion to move this agenda forward further. Leza (2020) discusses the controversial appointment and subsequent resignation of Lee Grossman as Executive Director of the AMTA as a significant event in the evolution of the Neurodiversity Movement's influence on music therapy:

> Grossman's public statements had historically placed him as a pathologizing agent in autism advocacy, and his reputation as an anti-vaxxer preceded him. Music therapists across the country quickly began to raise a furor. Discussions on social media exploded, complaints were registered to the AMTA board, and some members chose to resign their membership. In hindsight, Grossman's hire may have been just the needling the music therapy profession required in order to take the next steps in becoming true allies and advocates for the neurodivergent and Autistic community. (Leza, 2020: 213)

Leza challenges the dominant discourse of the music therapy profession, proposing a 'neuroqueering' of the field: 'disrupting any stigmatizing and oppressive "standards of practice" by inviting the neurodiversity paradigm *in* and leaving the pathology paradigm *out*' (Leza, 2020: 215). Using similar language, a recent issue of Voices includes several articles which challenge the dominant, normative discourse in music therapy and offers recommendations for addressing this issue (Baines et al., 2019; Fansler et al., 2019; Metell, 2019).

In Europe, these themes were further explored at the 11th European Music Therapy Conference in Aalborg, Denmark, where a collective of international Music Therapists considered in a roundtable forum how the discipline of music therapy could be enriched and informed by an understanding of the Neurodiversity Movement (Thompson et al., 2019). Again, the HCPC (2013) SoPs were reviewed and discussed, within an international context, and the potential perpetuation of deficit-based interpretations of diversity further highlighted. These ideas were further refined and explored at the World Congress of Music Therapy (Elefant et al., 2020), and a publication of these ideas is forthcoming (Pickard et al., in press). In addition, the most recent meeting of the British Association of Music Therapy (BAMT) Autism Network took the Neurodiversity Movement as its focus for a rich day of discussions and debate (Ashworth, 2020; Davies, 2020; Pickard, 2020b), as did a newly convened professional Facebook group in September 2020 (Acanfora, 2020; Gottschewski, 2020; Pickard, 2020a).

It could be suggested that there is gathering momentum in interrogating the current ontology of music therapy practice, enshrined in the HCPC (2013) SoPs. This article seeks to build on this momentum and highlight opportunities for reflection, growth and potential change.

The HCPC (2013) SoPs for music therapists

As a registered, allied health profession, all UK Music Therapists must adopt, adhere to and evidence the SoPs for Arts Therapists as outlined by the HCPC (2013). A core set of SoPs are outlined for all Arts Therapists, and a specific number of music therapy–specific standards are also included (HCPC, 2013). The SoPs selected for analysis and discussion in this article relate to all arts therapies, and therefore the discussion is relevant across modalities. The SoPs discuss a wide range of practice areas, from health and safety to research, and music skills to service user voice. HCPC (2018) describes the SoPs as follows:

- they set out the threshold standards we consider necessary to protect the public (unique to each of our registered professions);

- they set clear expectations of our registrants' knowledge and abilities when they start practising;

- registrants must continue to meet the standards of proficiency that apply to their scope of practice;

- HCPC approved programmes equip graduates to meet these standards;

- they outline what service users and the public should expect from their health and care professional;

- we use them if someone raises a concern about a registrant's practice. (HCPC, 2018)

HCPC (2018) outlines the process for developing and refining the SoPs which includes a process of continual review as well as a periodic review every 5 years. This review includes liaison with professional bodies, such as the BAMT, and a public consultation, which was completed in October 2020 (HCPC, 2020). A critical disability studies lens could also be applied to this process of review: considering which voices are welcome, heard, privileged and prevailing in the development and maintenance of these standards.

The HCPC SoPs in the context of paradigms of disability

For the scope of this article, a small selection of SoPs have been highlighted for reflection, based on their prominence in relation to the discipline and philosophy of critical disability studies. These standards will be presented in relation to the Medical, Social and Nordic Relational Models of Disability, and the fit between the standard and the paradigm further contextualised.

The Medical Model of Disability

A number of the HCPC (2013) SoPs adopt particularly medicalised language, focusing on deficiency and situating disability within the individual. The first example is taken from SoP 13.1 which suggests that registrants must

> Understand the structure and function of the human body, together with knowledge of health, disease, disorder and dysfunction relevant to their profession. (HCPC, 2013)

This SoP offers a terminology laden with medical model implications and connotations, such as 'disease, disorder and dysfunction'. While it is accepted that this language is necessary and appropriate when understanding medical diagnoses that are frequently experienced by participants in music therapy practice, such as mental health challenges, cancer and brain injury, among others, applying this language and thinking to the experience of disablement could be highly problematic. For example, it is unclear where on the spectrum of 'health, disease, disorder and dysfunction' (HCPC, 2013) that learning disability, neurodivergence or autism might be conceptualised. Furthermore, a participant with profound and multiple learning disabilities (PMLD) may use a mode of communication and engagement with the world that might be complex to understand at first; however, this is not necessarily disordered or dysfunctional. Further research is required to understand the impact of deficit-oriented language on the framing and approach of therapists' practice and clinical decision-making. Knowledge of diverse experiences and presentations of both health and illness are imperative. However, this could be phrased in language that provides scope to understand the myriad of presentations of both health and illness, and the potential of the therapist's positioning to be a barrier to understanding individual participants' health, as well as an asset to understanding other participants' illness.

A continuation of medically and individually oriented language is presented in SoP 13.15, suggesting that registrants must

> Know about:
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> - human development;
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> - normal and abnormal psychology;
>
> - normal and abnormal human communication and language development;
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> - mental illness, psychiatric assessment and treatment;
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> - congenital and acquired disability;
>
> - disorders of social functioning;
>
> - the principal psychotherapeutic interventions and their theoretical bases;
>
> - the nature and application of other relevant interventions. (HCPC, 2013)

The use of the binary of 'normal and abnormal' is problematic from a critical disability studies perspective and enforces an artificial, ableist separation between different ways of being and communicating (Hehir, 2002; Pickard, 2019). If a Music Therapist perceives a participant with a learning disability as having communication and language development that is 'abnormal', this may shape and colour their approach to practice, communication and forging relationships. This language results in participants with learning disabilities being Othered (Goodley, 2014) and marked as different and potentially deficient through these language choices. If autism is conceptualised and understood as a 'disorder of social functioning', and literature supporting this perspective consumed to develop one's understanding of and alignment with the SoPs, this will significantly inform a Music Therapist's approach to social interaction with participants. There is an absence of emphasis here on knowledge of diverse forms of communication and language development, and experiences of social functioning which may not adhere to the psychological 'norm' but are valid and valued ways of being and communicating in the world. The binary between 'normal' and 'abnormal' sets an expectation and hierarchy between these two extremes, with potential connotation of normalisation as a valid aspiration. This is highly problematic from the perspective of the Neurodiversity Movement and the Autistic community (Kirkham, 2017; Mottron, 2017; Pickard, 2020a, 2020b; Pickard et al., in press; Winter, 2012). A further consideration is the language used to construct the music therapy practice and its relation to participants in music therapy. If music therapy's practice is conceptualised as an 'intervention' that is 'applied' to service users, a particular and potentially problematic power dynamic is implied.

SoP 13.16 suggests that registrants must

> Recognise methods of distinguishing between health and sickness, including diagnosis, specifically mental health disorders and learning disabilities and be able to critique these systems of knowledge from different socio-cultural perspectives. (HCPC, 2013)

Understanding a learning disability as a diagnosis, distinguished between health and sickness, speaks of a specific portrayal and engagement with normalcy and diversity in the music therapy profession. The conflation of learning disability with sickness echoes Parsons' (1964) ideology of the 'sick role' and the anticipated and expected conformity associated with an individual embodying this deviant role, discussed in the context of disability studies by Goodley (2017). While the ability to 'critique these systems of knowledge from different socio-cultural perspectives' is advocated (HCPC, 2013), there is a lack of clarity on whether this could include challenging these labels and binaries or whether there is more of an expectation to understand different cultural and social interpretations of health and illness, which may further embed a deficiency-based discourse. If Music Therapists do not perceive learning disability through this medicalised lens, a revision or addition to this SoP should be posed.

The Social Model Of Disability

Some of the HCPC (2013) SoPs recognise that the environment and context in which the work occurs may enable or disable the participant, echoing the ethos of the Social Model of Disability. These SoPs encourage the Music Therapist to identify and reflect on any barriers that may be presented through the context and provision. SoP 2.5 suggests that registrants must 'Know about current legislation applicable to the work of their profession' (HCPC, 2013).

An example could be the evolution of the Equality Act (2010) and Convention on the Rights of Persons with Disabilities (CRPD) (UN General Assembly, 2008) which communicate to practitioners the legislative dimensions and implications of their provision. For example, the Equality Act (2010, p. 10) denotes that if the 'practice . . . puts a disabled person at a substantial disadvantage in relation to a relevant matter in comparison with persons who are not disabled', practitioners should 'take such steps as it is reasonable to have to take to avoid the disadvantage'. This standard could be interpreted to encourage Music Therapists to take responsibility for engaging with discussions and advances in the field of critical disability studies, which informs legislation and may significantly inform their engagement with the participant in music therapy.

There are examples within the SoPs which recognise the systemic considerations which may inform or oppress experiences of health and illness. An example is SoP 13.8 which suggests that registrants must 'understand the psychological and cultural background to health, and be aware of influences on the service-user therapist relationship' (HCPC, 2013). This could include challenging the assumption that learning disability is allied with ill-health, or that ill-health is necessarily a by-product of disablement. 'Influences on the service user-therapist relationship' could include the norms perpetuated by the media and culture to Other disabled people (Baglieri and Shapiro, 2017; Ellcessor and Kirkpatrick, 2017; Ellis and Goggin, 2015; Goodley, 2017; Matthews, 2009) and the potential of the therapist to either perpetuate or challenge this oppression. Continuing this thread of ensuring the therapist is aware of these potential cultural influences and dynamics, SoP 3.3 suggests that registrants must 'Understand both the need to keep skills and knowledge up to date and the importance of career-long learning' (HCPC, 2013). In contrast with the earlier SoPs which could be considered deficit-oriented and aligning with the Medical Model of Disability, this standard places the burden of responsibility with the Music Therapist for ensuring that their understanding and conception of ideas influencing the work are contemporary and informed. This recognises that the Music Therapist could be disabling the participant if their approach or skills were

not up-to-date or if they had not engaged in career-long learning to ensure the continued relevance and optimum validity of their work.

In continuing the Social Model's emphasis on society's potential to enable or disable, SoP 9.5 suggests that registrants must 'Recognise the role of arts therapists and the contribution they can make to health and social care' (HCPC, 2013). This standard highlights that Arts Therapists are part of a wider system of health and social care provision, and that this role and its relationship to others are not fixed or static. By encouraging awareness of the nature and scope of this role, there is potential to reflect on both enabling and disabling elements of music therapy practice. The contribution Music Therapists can make to health and social care could be to highlight ableist communicative environments that are prevalent in wider society and can be challenged or reframed in the music therapy room or to highlight the value of less privileged forms of communication, being and relating (Hehir, 2002; Nind and Strnadová, 2020; Pickard, 2019; Rickson, 2020).

The potential of all the SoPs highlighted in this section to promote a Social Model interpretation of disability and, as such, to challenge oppression in music therapy practices relies on the Music Therapist's commitment to critical reflection in their practice, as advocated by SoP 11.1 (HCPC, 2013).

The Nordic Relational Model of Disability

Some of the HCPC (2013) SoPs could be best equated with a Nordic Relational Model of Disability (Goodley, 2017; Traustadóttir, 2004, 2006), recognising that the fit between the participant's experience and the opportunities they are afforded will result in their enablement or disablement in the music therapy work. An example of this can be seen in SoP 5.1 which suggests that registrants must 'Understand the requirement to adapt practice to meet the needs of different groups and individuals' (HCPC, 2013). This standard acknowledges that there is not one way to practise music therapy and that there is a requirement of the Music Therapist to be aware of the fit between their approach, the environment or context in which the work occurs, and the participants involved. This highlights the necessity to be informed by the views, beliefs and actions of participants and requires Music Therapists to be receptive to the voices of disabled participants who could inform and develop disabling aspects of practice (Metell, 2019).

SoP 5.2 is an example which could relate to experiences of both the Music Therapist and the participant in music therapy, where registrants must 'Understand the need to take account of psychological, social, cultural, economic and other factors when collecting case histories and other appropriate information' (HCPC, 2013). This invites reflection on a further important consideration: the lack of diversity in the music therapy profession (Anderson, 2018; Baines et al., 2019; Hadley, 2013) and the positioning of the SoPs to assume that the participant and the therapist do not share experiences of disablement (Gottschewski, 2020; Kalenderidis, 2020; Shaw, 2018; Thompson, 2020). The potential of this SoP to relate to participant and therapist could be made more explicit to demonstrate the potential for influences on both sides of the therapeutic relationship to inform the work (Hadley, 2013). While it could be argued that these factors will be influential much beyond collecting information and case histories, it is encouraging to note the potential recognition of factors influencing both partners in the therapeutic relationship to inform the trajectory and potential success of the work.

Another SoP which could be read to acknowledge that both the communication skills of the participant and the response from the Music Therapist will contribute to the success of the communicative exchange is SoP 8.3 which states that registrants must

> Understand how communication skills affect assessment and engagement of service users and how the means of communication should be modified to address and take account of factors such as age, capacity, learning ability and physical ability. (HCPC, 2013)

This places responsibility on both parties to consider and be aware of their contributions and enables reflection on how the questioning and the answers can be influential in gauging a participant's experience. While the emphasis on difference is predominantly placed on the participant, in considering their 'age, capacity, learning ability and physical ability', the onus on the Music Therapist to be responsive and adaptive acknowledges that without this modification, the Music Therapist could contribute to the inaccessibility of the experience, thus resulting in disablement. Refreshingly, one reading of this SoP could be that it is the responsibility of the Music Therapist to adjust their communicative approach to enable the participant (Pickard, 2019) by 'shifting the imbalanced burden of adapting away from [disabled] individuals' (Woods, 2017, p. 1094). While such practices and beliefs are anecdotally discussed and respected within the profession, there is a lack of this positioning within published music therapy literature and research. A further reading could be that neurodivergent therapists themselves have expertise in developing accessible communication strategies that should be celebrated, valued and disseminated more widely throughout the profession (Acanfora, 2020; Gottschewski, 2020).

This discussion point relates well to the CRPD's (UN General Assembly, 2008) definition of disability, which conceptualises disability resulting 'from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others' (p. 4). It is particularly interesting that this definition incorporates 'attitudinal barriers' (UN General Assembly, 2008: 4), which could arguably be fuelled or reinforced by some of the earlier SoPs when applied to diversity, disability and disablement.

Discussion

While these examples are not exhaustive or definitive, and there are many more SoPs of relevance and interest to this discussion (HCPC, 2013), it is hoped that this initial exploration has sparked some questioning and critical reflection on the potential of the HCPC (2013) SoPs to perpetuate medicalised, deficiency-based narratives of disablement and diversity. While a process for consultation and review exists, could it be that there is a need for provocations to encourage transformative debate about the essence of this framework and its application? Straus' (2014) interpretation of music therapy as 'position[ing] itself squarely within the medical model of disability' (no page number) may not be familiar or accurate to many UK Music Therapists who may engage in enabling, affirmative and social-justice-informed practices. However, when reviewing the HCPC (2013) SoPs through this lens, as well as other music therapy literature, it is not difficult to understand why such an interpretation of the profession could arise. As Rolvsjord (2014) asserts,

> The most detrimental consequence of the therapist's location in ableist culture is that the therapist may in fact be dis-ableing. As disturbing as this suggestion might be, it is crucial to consider to what degree the therapist contributes to the demoralization of the client through her/his good intentions of 'fixing' the client. (No page number)

There have long been opponents to a medicalised approach within music therapy, with advocates like Procter (2002) stating that Music Therapists

> Must not merge entirely into a medicalised professional hierarchy: to empower and enable, wherever we work, we need hearing minds and radical hearts. And if that means being regarded as mavericks and naïve, then so be it. (p. 106)

A wealth of research and practice documents the social dimensions of music therapy beautifully (see Ansdell, 2015, for example). A recent conference at Nordoff Robbins in London which welcomed international Music Therapists (Ansdell, 2019; Dopierala, 2019; Flower, 2019) entitled 'The Social Value of Music' (Nordoff Robbins, 2019) further shifts the focus of music therapy practice from a medicalised to a social context. As Fansler et al. (2019) advocate in their recent article discussing queering music therapy pedagogy,

> We explore ways in which pathology and diagnosis favor [sic] dominant communities. We explore systemic understandings of 'the problem' or 'the symptom'. We avoid 'interventions' in favor [sic] of centralizing the ever-evolving, expanding, and constantly-becoming relationship of therapist, client, music. And we ask what it means to identify as a therapist. Through all of this, we explore the subjugation of clients and approach the 'therapeutic relationship' as human-with-human rather than fixer-to-damaged or helper-for-those needing help. (p. 14)

Another consideration is that, anecdotally, there are reports of much practice in the United Kingdom which aligns with this social-justice-informed, anti-ableist ethos. The question therefore becomes why is such practice not reported on or evidenced in the literature, and is there a disconnect between the outward-facing perception of the profession and the reality of work on the ground? If 'professional journals have a legitimating and sanctioning role in the development of disciplinary knowledge, as well as professional practices and identities' (Tsiris et al., 2014: 4), is there a responsibility to ensure a congruence between practices on the ground and the nature and focus of reporting in the professional literature? Conversely, one could ask why practitioners working in the field of learning disability or disablement more broadly are potentially less likely to contribute to research and literature, and whether there is a hierarchy of focus and interest in publishing practices or within the disciplinary community. Could ableist practices be affecting these voices from being heard or feeling valued, or is there a divide between this work and research or writing about it, returning to Ansdell's (2001) Music Therapist's dilemma.

This offers an interesting perspective when reflecting on Mark Jordan's words, cited from the 1989 Annual General Meeting of the Association for Professional Music Therapists (APMT) on the prospect of professionalisation and registration: 'We are a small profession, and if our voice is to be heard we must continue to speak with one voice. There is plenty of room for differences of opinion, but no room for divided policies' (APMT, 1989: 2; cited in Barrington, 2015: 120). As the cyclical process of consultation, evaluation and refinement of the HCPC (2013) SoPs continues on its 5-yearly cycle, is it time to consider a more contemporary, united voice in music therapy? With the ever-increasing richness and insight of a maturing profession, it is imperative that the HCPC (2013) SoPs represent our diverse, dynamic and inclusive practices. This could be an opportunity to redefine the paradigm through which Music Therapists in the United Kingdom conceptualise, approach and understand practice, by formalising this commitment in the professional registration and documentation. The increasing momentum in neurodiversity-informed perspectives in music therapy (Davies, 2020; Leza, 2020; Pickard, 2020a, 2020b; Pickard et al., in press) and beyond (Kapp, 2019; Milton et al., 2020; Rosqvist et al., 2020) would suggest the need for an increased recognition of this paradigm in the professional standards.

In a recent publication representing a diversity of approaches to music therapy practice in the United Kingdom with autistic participants, Coombes and Maclean (2019) invited Music Therapists to conceptualise the HCPC (2013) SoPs as a 'second skin . . . provid[ing] support that is strong and flexible. Rather like skin itself, it is a semipermeable membrane

which allows for the to-ing and fro-ing of fresh ideas' (pp. 356–357). This enabling analogy acknowledges that the HCPC (2013) SoPs can be perceived as flexible and responsive and not permanently fixed. Could this be a call to action for a rich contribution to future evaluations of the SoPs to ensure they are reflective of contemporary perspectives and practices?

Conclusion and recommendations

As Edwards (2017) acknowledges, 'the practising music therapist works within a system that includes contact with co-workers, clients, carers, and families, and within institutions or structures that are informed or maintained by policy, legal, and financial frameworks' (pp. 847–848). The macro-level, systemic structures such as the HCPC (2013) SoPs inevitably directly inform the micro-level, relational work with participants and their families, and as such require diligent reflection on their influence and focus. As noted in the introduction, the HCPC (2013) SoPs are also but one professional apparatus among many that shape and inform the profession.

While there is much rich and respectful music therapy research and practice in the United Kingdom and beyond, in reporting about this work and articulating within and beyond the profession, 'outdated expert-models still exist' and 'there is persistence in working from a medical model framework' (Murphy and McFerran, 2017: 311). While this could in part be due to the complexity of translating non-verbal material into a verbal domain (Ansdell, 2001; Pickard, 2018a), there are several examples, such as the HCPC (2013) SoPs and high-profile research studies (Bieleninik et al., 2017), which encourage, instil and perpetuate a deficit-based interpretation of difference, diversity and disability.

In conclusion, the following recommendations are proposed and ongoing, critical dialogue on this topic is invited and encouraged. First, critical disability studies could further inform music therapy curricula (Fansler et al., 2019; Pickard, 2018a). This could enable future generations of practitioners and researchers to critically reflect on their own positioning and privilege (Gross, 2018; Hadley, 2013), as well as the power their practice has to perpetuate or challenge societal interpretations of diversity (Baines et al., 2019). It is necessary for current and future generations of practitioners to appreciate the importance of engaging with the politics of disablement (Oliver and Barnes, 2012) and the potential of the discipline to contribute to oppression, disablement, manipulation and Othering, as well as empowerment and citizen participation (Rolvsjord, 2014; Stige, 2006).

Further directions may be for the language of the profession and the professional association (BAMT, 2017), as well as the HCPC (2013) SoPs to be reviewed and revised to reflect a more neutral understanding of diversity and to move away from deficiency-based narratives with potential to disable and disempower participants in music therapy. Finally, through increased co-production, participatory action research and evaluation, participants in music therapy could be enabled and empowered to have a greater voice and action in the shaping of the profession and its professional regulations.

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Note

1. The term 'disablement' is used intentionally to represent 'those times when the relationship between the environment, body and psyche excludes certain people from becoming full participants in the social world' (Goodley, 2017: 10). This word choice firmly positions disablement as something that is *done to* disabled people by society, rather than something residing *within* them.

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Author biography

Beth Pickard is a music therapist, senior lecturer and PhD student at the University of South Wales. Her music therapy practice is aligned with a strengths-based interpretation of disability, informed by her research in critical disability studies. Beth's research explores how disability is socially constructed, interpreted and represented across disciplines and pedagogy.