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A change management perspective on the introduction of music therapy to interprofessional teams
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Abstract
Purpose – The purpose of this paper is to demonstrate how a change management perspective contributes new understandings about music therapy implementation processes.
Design/methodology/approach – Narrative inquiry, ethnography, and arts-based research methods were used to explore the experiences of 12 music therapists who developed new services in healthcare settings. These experiences were interpreted using insights from the field of change management.
Findings – A change management perspective helps to explain music therapists’ experiences of resistance and struggle when introducing their services to established health care teams. Organisational change theories and models highlight possible strategies for implementing music therapy services successfully, such as organisational assessment, communication and collaboration with other workers, and the appointment of a service development steering group.
Research limitations/implications – This paper offers exciting possibilities for developing understanding of music therapists’ experiences and for supporting the growth of this burgeoning profession.
Practical implications – There is an important need for professional supervision for music therapists in the service development phase, to support them in coping with resistance and setbacks. Healthcare managers and workers are encouraged to consider ways in which they can support the development of a new music therapy service, such as observing music therapy work and sharing organisational priorities and cultures with a new music therapist.
Originality/value – Previous accounts of music therapy service development have indicated that music therapists encounter complex interprofessional issues when they join an established health care team. A change management perspective offers a new lens through which music therapists’ experiences can be further understood.

Keywords Change management, Organizational change, Health services, Music therapy

Background
Music therapy is an allied health profession that involves the use of music to achieve therapeutic goals in areas such as communication, self-expression, emotional support, physical rehabilitation, and social interaction (Wigram et al., 2002). Within sessions, music therapy clients are supported to participate in music experiences, such as singing, instrument playing, music and movement, songwriting, or music improvisation, within the context of a therapeutic relationship. Music therapists are qualified health professionals who use their knowledge and experience to assess individual clients’ needs and to design, implement, and evaluate appropriate music therapy interventions. Professional requirements vary around the world, but in most countries music therapists need to have completed an undergraduate or masters level degree in music therapy in order to practice.
As music therapy is a relatively new healthcare discipline, most music therapists are required to introduce, uphold, and develop an inaugural music therapy post in a setting where music therapy has no existing history or contextual frame. In starting a new post, most music therapists join a team of more established healthcare professionals, many of whom have never worked with a music therapist before. In addition, many new music therapy positions are introduced on a pilot basis, as part-time or temporary contracts, rather than permanent, full-time posts. These conditions limit the time available for introducing the role of the music therapist to staff and for demonstrating the value of music therapy interventions. The situation is particularly problematic in the Republic of Ireland, the country where our research was undertaken and where there are only approximately 60 music therapists for a population of 4.5 million people (IACAT, 2012). The Irish Health Service Executive (HSE) is yet to formally recognise the profession of music therapy and there are no established procedures under which hospitals can employ qualified music therapists. Music therapists working in Irish hospitals typically rely on charity funding and often need to submit documentation each year to re-apply for the service to continue.

Although the development of new services could be considered part and parcel of music therapists’ professional experiences, there has been little previous reflection on the challenges that arise when music therapy is introduced to an established healthcare team. The demands of start-up are somewhat hidden in published narratives and practice accounts and few authors have explained how their music therapy services became established. The little information that is published suggests that new music therapists encounter isolation (Miles, 2007), role ambiguity (Edwards, 2005; Loewy, 2001; O’Neill and Pavlicevic, 2003), and competition with other health professionals over areas of practice. Edwards (2005) provided a rare reflection on the development of music therapy in a children’s hospital in Australia. She described challenges such as fitting music therapy into a medical context and distinguishing music therapy from existing uses of music, and recalled how she needed to respond to others and adapt her practice to establish a role for music therapy in anxiety reduction and pain management.

This paper focuses on the potential contributions of a change management perspective to furthering our understanding about music therapists’ experiences of joining interprofessional teams. Specific attention is given to the ways in which a change management perspective informs new understandings of music therapists’ experiences of struggle and resistance and suggests possibilities for introducing music therapy services successfully. Although there is an emerging literature on music therapy and interprofessional work (for examples see Darsie, 2009; Magee and Andrews, 2007; O’Kelly and Koffman, 2007; Twyford and Watson, 2008) and music therapists with postgraduate management qualifications have reflected on music therapy’s place within the broader arena of “Arts in Health” (Hartley, 2008; Moss, 2008), management perspectives have received comparatively little attention in music therapy to date. This paper aims to address this gap and to demonstrate how music therapists could be supported by management theory in their efforts to create an identity and sustain a legitimate position within interprofessional healthcare teams.

**Literature review**

What is organisational change?

Researchers in the fields of management and organisational studies have long examined organisational change in the commercial sector (Dawson, 2003; Shanley, 2007). Dawson (2003, p. 16) defined organisational change as “new ways of organising and working”. This definition is sufficiently broad to capture organisational change initiatives of varying speed, scale, political intensity, and substance. Under this definition, the term “organisational change” could refer to a revolutionary organisation-wide change or to a much smaller scale modification of work practices. Given the focus of the commercial sector, economic forces, such as the need for commercial competitiveness, cost cutting and rationalisation are usually presented as the primary reasons for organisational change (Kotter, 2007; Shanley, 2007). A number of change processes and models have emerged over the past century. These range from models espoused by management “gurus” or...
“celebrity professors” (Dawson, 2003, p. 14) to strategies that have been subject to greater academic reflection and research. A number of theoretical frameworks have also emerged, including ones that emphasise the technical and rational aspects of organisational change and those which pay greater attention to personal and social consequences (Dawson, 2003; Shanley, 2007; Sturdy and Grey, 2003). It has been emphasised that organisational change is highly complex and the assumption that change is always inevitable and desirable has been questioned (Dawson, 2003; Sturdy and Grey, 2003). Since the 1980s, there has also been increasing recognition that organisational change is fluid, dynamic, and processual (Dawson, 2003; Shanley, 2007).

Organisational change in healthcare
Major changes in the ways that healthcare is delivered worldwide have led researchers to take an interest in the effects of organisational change on healthcare workers. While some healthcare writers have shared cases of successful change ventures, such as the introduction of a self-administration of medication programme (Deegan et al., 2004) or a shared governance management structure (Robertson-Malt and Chapman, 2008), negative outcomes of organisational change are also commonly reported. Doherty’s (2009) interviews with acute care hospital nurses in the UK indicated that National Health Service (NHS) reforms of nursing roles had met with mixed success. Although reforms were intended to provide workers with greater empowerment, nurses perceived that changes had intensified their workloads and lessened their ability to care for patients. Nurses expressed concern that their work had become geared toward meeting government targets rather than addressing patients’ needs. In a similar Australian study (Wynne, 2004), organisational restructuring was perceived to be detrimental to patient care. Intensive care unit nurses experienced constant pressure, worked within time and resource constraints, and perceived that they had little input into the changes that affected patients. Furthermore, nurses in the Australian study perceived that they had learned more about imminent changes from the media than from their own hospital management. These studies indicate that organisational change is not always viewed favourably by healthcare workers, especially when change is understood as increased work. It has been proposed that healthcare practices are firmly entrenched and that healthcare organisations are hesitant to adopt change (Deegan et al., 2004; Dulaney and Stanley, 2005). This view is supported by research into the effects of introducing clinical directorates (CDs), new management structures intended to bring together clinical and organisational aspects of care (Braithwaite et al., 2005; Braithwaite, 2006a, b). Braithwaite’s research raised questions as to whether the introduction of CDs had led to alterations in hospital social structures, including changes in the ways that people act and relate in clinical settings. He observed that despite the introduction of CDs, old structuring behaviours continued – nurses talked to nurses, doctors talked to doctors, and positions were formed behind the scenes rather than through the formal hierarchy. Braithwaite concluded that the establishment of CDs had not markedly altered underlying profession-based values, beliefs, roles, practices, routines and relationships. This research about the introduction of CDs suggests that in healthcare, meaningful change may be hard to achieve.

Healthcare researchers have reflected on the ways in which organisational change can lead to disruption of existing routines and shifts in the locations of power within healthcare teams. For example, studies have demonstrated how the introduction of new practices can lead to workers perceiving that they have lost their former expert role (Campbell, 2008; Dulaney and Stanley, 2005). Deegan et al. (2004) observed a situation in which nurses expressed anxiety about the introduction of a self-administration of medication programme, as it meant that they would lose control of the drug trolley. A change to medication regimes, placing power at the disposal of patients, was seen to symbolise a reduction in the nurses’ status. On reading this research, it becomes evident that power and political behaviour are important issues to consider when implementing change in healthcare settings.

Existing literature on organisational change in healthcare has focused on the introduction of new administrative structures or practices, rather than the introduction of a new professional service.
Additionally, though the implementation of new healthcare roles has been studied extensively (for examples see Bridges and Meyer, 2007; Stanmore et al., 2006; Willard and Luker, 2007), this implementation is not always understood from a change management perspective. As the introduction of a new music therapy service is likely to affect the work of other healthcare professionals, we believe that particular insights may be found through examining music therapy implementation as a type of organisational change. Understanding music therapy implementation in this way stimulates reflection about the ways in which a new music therapy service may entail increased work for other professionals, including disruption to routines and surrendering of professional territory, and require adjustment to change. Furthermore, organisational change theories and models may provide useful strategies for including and engaging other workers in the introduction of a new music therapy service. In the sections that follow, we show how we gained new insights about music therapists’ experiences by applying existing knowledge about organisational change.

Understanding music therapy implementation as a type of organisational change
This paper is based on our research which aimed to explore music therapists’ service development experiences and to identify strategies for implementing music therapy successfully. A total of 11 narratives were collected from music therapists who had developed new services in healthcare settings and ethnographic fieldwork was undertaken in a hospital where a new music therapy service was being introduced. During the fieldwork, the new music therapist was observed interacting with staff in scheduled meetings and corridor stops and interviews were undertaken with six of the music therapist’s interprofessional colleagues.

In total, we collected data from 12 music therapists working in a range of countries (Australia, Canada, Ireland, the UK, and the US) and in a range of healthcare environments, including hospice, mental health, oncology, and paediatric hospital settings. An arts-based research approach was used to analyse the narrative data. A total of 12 poems were written in response to the narratives, which led to the identification of seven common themes (going solo, looking for a home, building relationships, accepting the challenge, insecurity, investment, and development takes time) Analysis of the fieldwork data focussed on the identification of strategies which the music therapist used to implement her new service. A total of six categories of service development strategies were identified: educating, interprofessional working, remaining flexible, generating evidence, investing time and energy, and relying on advocates. (For further detail about the methods and findings see Ledger, 2010a; Ledger, b; Ledger and Edwards, 2011; Ledger, forthcoming.)

At the outset of our research, we assumed that music therapists encounter a unique set of challenges when they introduce their role to an established healthcare team. However, as we became increasingly familiar with literature outside of music therapy, it became apparent that music therapists report similar obstacles to workers who have attempted change in the commercial sector (and others who have worked in interprofessional healthcare teams or introduced new healthcare roles, for example see Bridges et al., 2007). The field of management theory became a rich source of information and we began to conceptualise music therapy implementation as a type of organisational change. This conceptualisation gave rise to new and provocative understandings of music therapists’ experiences as normal rather than unique or unexpected. Here we demonstrate how a change management perspective enhanced our understanding of music therapists’ experiences and revealed possibilities for implementing music therapy successfully. Quotations from the music therapists’ narratives and fieldwork interviews are included to convey particular aspects of their experiences.

Service implementation as challenging
In sharing their service development stories, music therapists in our study frequently recalled aspects that were “hard”, “difficult”, or “challenging”. They used powerful imagery to portray their experiences, such as the imagery of a struggle, a fight, a rollercoaster ride, or a long and difficult
road. They often referred to resistance from other workers and recalled feeling unwelcome, criticised, intimidated, or even bullied. The most common explanation for resistance was that other professionals felt threatened when the music therapist joined the clinical team and entered their domain of practice. This was particularly evident in the narratives of two music therapists who worked with highly vulnerable client groups. They perceived that nursing colleagues were intensely protective of patients and cautious towards unfamiliar interventions and new members of staff. These music therapists’ reflections indicated that resistance to change may stem from a well-meant intention to care for patients, rather than a disliking towards an individual music therapist:

I was told that really it’s not about me, it’s not about what I do, it’s about the needs of the nurses in this unit and how they feel about change and how they are reacting, so it’s all about what they’re comfortable with (Narrative 11).

The music therapists’ experience of service implementation as a “challenge” is consistent with prevailing views about organisational change. Organisational change theories and models portray change as a challenging process, which requires major shifts in workers’ values, practices, roles, and identities. One of the most widely cited organisational change theories is Lewin’s change theory (also referred to as an “Organisational Development” model of change, for examples in studies of hospital settings see Deegan et al., 2004; Dulaney and Stanley, 2005; Shanley, 2007). Kurt Lewin was a social psychologist who believed that people exist in a force field of social, historical, situational, and physical influences. In his view, forces such as values, past experiences, money, and time can create or limit the possibility for change (Cartwright, 1951). Successful change may depend on the presence of driving forces, such as motivation to change, or require the removal of restraining forces, such as limited funding or resources in the case of a healthcare setting (Dulaney and Stanley, 2005).

Lewin presented change as a three-step process. The first step involves “unfreezing”, which is the process of recognising the need for change. The second step is “moving”, in which the change is enacted. Finally, “refreezing” represents the incorporation of the change into the new system. It is possible that the implementation of music therapy requires a process of unfreezing, moving, and refreezing, as music therapy may not fit easily within existing healthcare frameworks of diagnosing and treating disease (Edwards, 2005). Loewy (2007, p. 17) has also explained how the inclusion of music therapy as a psychotherapeutic intervention may challenge medicine’s place as the “primary restorative influence” in healthcare settings.

Some of the music therapists in our study seemed acutely aware that their healthcare organisations possessed long-held traditions, and that previous attempts at change had been unsuccessful. The possibility that historical factors play a role in music therapy development was particularly apparent in one music therapists’ story. She started with a description of events that occurred at the hospital 14 years before the music therapy service even began. She perceived that a long-standing relationship with the hospital facilitated her access as a music therapist, as she was already familiar with the hospital environment, knew, and was known to existing staff.

Surprisingly, few music therapists have openly discussed issues of envy and rivalry towards music therapy within interprofessional healthcare teams, or have considered the dynamic of introducing a non-pharmacological and non-narrative treatment system into a highly complex clinical environment. A future review of this area would be of interest to examine whether the unique nature of music and musical creation processes have a particular impact within treatment systems that focus on pharmacology and verbal therapy as primary means of clinical change. However, in some of the small literature on aspects of envy we could find, Miller (2010) suggested conflict can occur in some adult mental health teams because of the team’s positive view of the service users’ high level of participation in music therapy. She described how the team can develop a view of music therapy as a successful “activity” for participants who struggle to attend scheduled appointments. This can create a conflict for the music therapist who wants to be included in the team as a psychological therapist working towards clinical results. She suggested it can be difficult for music
therapists to promote session attendance as a positive outcome, when they wish to be included in processes of psychological change for the client. A similar experience was recounted by one of our research participants, who recalled being told she was “definitely not a clinician and should not be considered part of the therapists”. These music therapists’ experiences provoke consideration of the possibility that it might be difficult for team members to align with a therapy that has successful participation from service users, so descriptions of the therapy as “fun” and “activity-based” might be easier to tolerate.

The importance of gatekeepers
Music therapists in our study drew attention to specific people who could be perceived as gatekeepers to the development of music therapy services. These people tended to be in positions of power and included managers or trusted and respected members of staff. Some gatekeepers advocated for music therapy at management level, allocated funds to the music therapy service, or introduced the music therapist to further useful contacts. Others helped the music therapist to gain access to patients and to ensure the continuation of the music therapy service. Several music therapists stressed the importance of developing good relationships with managers in particular. They described ways in which they had gained management support, such as only asking for “small things”, demonstrating the financial benefits of employing a music therapist, or helping to promote the organisation. Once management support had been gained, it became possible to secure the necessary funds to continue music therapy service provision.

During the ethnographic fieldwork, interviewees pointed to the support of a medical consultant as critical to the successful introduction of a new music therapy service. They explained how the consultant had seen music therapy implemented successfully elsewhere and supported the initial proposal to introduce music therapy at the hospital. The consultant was seen to hold considerable power over hospital management and interviewees perceived that it was his strong support for music therapy that had led to management approval for the new service. One of the hospital managers explained, “if you don’t have the consultant behind it [music therapy], it’s dead.” Additionally, we observed that the music therapist rarely communicated with hospital management directly and instead used other team members as intermediaries. She later explained that she was hoping other team members would stand up for music therapy and fight for its continuation:

[. . .] in six months time, if there is a threat to pull the plug, every member of the team will turn around and say no, this is something that we want. That’s my aim.

Lewin’s work on change included recognition of “channels”, the routes through which new ideas or practices enter and travel through an organisation. In introducing a change, it may be important to identify gatekeepers who have the power to admit or refuse entry to a channel. Dulaney and Stanley (2005, p. 164) highlighted a need to recognise gatekeepers within both formal and informal power structures of a health care organisation. They described how staff members may exert considerable influence despite little formal power, “by virtue of their longevity on a unit, or their clinical expertise, or their close relationship with those who have formal power”. The ways that music therapists in our study identified gatekeepers seemed to vary. In some cases, the music therapists happened to know influential people prior to starting work and in other cases, the music therapists made useful connections once they entered an interprofessional team. One music therapist reflected that her pre-existing relationship with a well-respected staff member was “an influential component of setting up networks around the hospital and gaining respect, recognition and being taken seriously”. She considered herself “very fortunate” to have this person’s support. Another music therapist explained how she identified important people over time and learned to dismiss the opinions of staff members who had little or no impact on the development of the music therapy service. Her gatekeepers were the other therapists who showed her the most respect and understanding.
The path of change

Lewin’s conceptualisation of change as a three-step process may imply that organisational changes follow a relatively straightforward, linear progression. However, our research indicated that the establishment of a new music therapy service rarely occurs in a predictable, linear fashion. For most of the music therapists in our study, service implementation appeared to be a journey that included both highs and lows and nearly all of the music therapists recalled setbacks in the development of their services. The service development stories we collected were laden with changes, waxes and waners, or ups and downs in the amount of music therapy provided. Music therapists indicated that their services had been affected by such aspects as changes in the economic climate, healthcare policy, and management and clinical staff.

Music therapists recalled a fluctuating pattern of music therapy service development, including setbacks, as well as service achievements. For example, one music therapist presented her service as one that had switched between phases of “growth”, “regression”, and “recovery”. She explained how there was a need to “back track” when changes in staff occurred and how the development of music therapy was delayed by the appointment of four different on-site supervisors in the course of five months. Each time a new supervisor was appointed, she needed to re-introduce the idea of music therapy and wait for the new person to become “comfortable” with music therapy’s inclusion on the ward. At the time of telling her story, she perceived that she was limited to working in just one clinical area and expected that it would be some time before she could branch into other areas of practice.

I feel that I have opened to a new perspective of change for this position. . . it will still be, reasonable that this programme could extend to the hospital as it was ultimately envisioned, however the pace that that will happen is not going to be directed by me. . . it’s just a matter of timing and somewhat surrendering to that, to that process that needs to happen (Narrative 11).

Recent authors have argued that organisational change is less predictable and rational than previous change models suggest. For example, Styhre (2002) drew on what is termed “complexity theory” to explain developments at a Swedish telecommunications company. He tracked a change project at the company for 18 months and noted that attempts to greater empower workers were affected by unanticipated external influences. Although managers initially invested heavily in the creation of a new workplace environment, changes were abandoned when financial problems arose unexpectedly. For example, the company ceased to employ a consultant to provide training on co-workership and leadership. Styhre (2002, p. 349) observed that periods of rapid development were followed by periods of decline and that the plan for change needed to be much more fluid and evolutionary than originally intended. In Styhre’s view, organisational change is “never solely a one-dimensional series of succeeding activities, but is always taking place amidst the turmoil of transient states and interconnected flows of activities”.

An “emergent approach” to change was further advocated by the nursing researcher Shanley (2007). He cited the work of Pettigrew (1990), who proposed that change is complex, occurs over time, and is influenced by multiple, unpredictable variables. Shanley emphasised that the change process can be uncertain, iterative and “messy” (Shanley, 2007, p. 541) and called for greater attention to the role of power and politics in organisational change.

In our research, it was clearly evident that music therapy service development takes time. The music therapists often used adverbs such as “slowly”, “steadily”, “gradually”, “finally”, or “eventually” in the telling of their service development stories. A number of service development aspects were noted to take time, including the securing of funding and adequate resources, gaining acceptance from other staff and building trust, recognising gatekeepers and obtaining access to patients, finding a role for music therapy, and establishing music therapy as an integral part of the healthcare organisation. Several music therapists reflected that in order for music therapy to be accepted, they needed to recognise existing healthcare cultures and build histories of their own. A history of successful music therapy provision was presented as essential for service continuation and
expansion. As one of the music therapists recalled, it took at least six months for her to overturn the “bad impression” left by a previous music provider. Only then was she able to “rest on” her own history.

In some cases, a music therapy service only began after many months or years of protracted negotiations. Where reported, lead in times ranged from four months to several years. For example, the music therapy service studied through ethnographic fieldwork commenced after a preparation time of 20 months. During lead-in times, the music therapists were often required to attend several meetings and to give a series of presentations to support the introduction of a music therapy service. It was explained by two music therapists that it took months for them to gain a meeting with the ultimate decision-maker in the organisation, and for plans to introduce music therapy to progress:

[. . .] some of it was getting to the right people and working through the stepping stones of the political hierarchy in the appropriate fashion. . . Once we saw the president and presented to him, then things moved more quickly. . . because his, his buy-in, um, influenced others’ buy-in (Narrative 11).

Possible strategies for bringing about change

The precise mechanisms through which an organisational change becomes accepted and maintained have eluded clear identification. Buchanan et al. (2005) conducted a review of literature on sustaining organisational change and found that few researchers have addressed this topic. Several explanations for a lack of literature about change sustainability were proposed, including the possibility that periods of change are more interesting to researchers than periods of stability, the need for longitudinal research to address the topic of sustainability adequately, and a prevailing assumption that the ideal organisation is one that is continually undergoing adaptation. On reviewing the small amount of literature available, Buchanan et al. (2005) identified 11 types of factors which may affect sustainability of organisational change: substantial, individual, managerial, financial, leadership, organisational, cultural, political, processual, contextual, and temporal factors. Buchanan et al. (2005, p. 203) were unable to determine the relative significance of any individual factor and suggested that the most important factors are likely to depend on the internal, external, and historical context of the organisation involved. The process of sustaining change was also considered to be dependent on the interplay of multiple factors. They recommended that researchers interested in change sustainability should be “sensitive to context, complexity, ambiguity, uncertainty, competing stakeholders and to the range of potential interlocking influences”.

While it may not be possible to identify the dominant factors leading to change sustainability, studies of hospital organisations have typically emphasised cultural and contextual influences on organisational change (Braithwaite et al., 2005; Dulaney and Stanley, 2005; Viitanen and Piirainen, 2003). Published strategies for achieving organisational change include identifying opportunities for change, communicating and collaborating with others, and appointing change agents.

Identifying opportunities for change

Music therapists in our research described how they identified suitable locations and times for the introduction of their music therapy services. One narrative contributor explained how she detected gaps in the hospital’s service provision and identified ways in which music therapy could make a unique contribution. After a unit manager provided information on existing services, the music therapist took the time to pinpoint areas of the hospital where music therapy could address an unmet need:

I really sat down with the information and looked at everything they were running and where I could possibly fit in, where music therapy could be enhancing programmes and um, yeah, what areas were maybe lacking, or just a bit repetitive, or not creative enough (Narrative 10).
Based on this groundwork, the music therapist proposed a weekly timetable which was met by the manager with approval. Loewy (2001, 2007) has similarly described how she has identified niches for music therapy at Beth Israel Medical Center in New York. She established a role for music therapy after observing that a safer, more cost-effective means of sedation was required for children undergoing medical tests.

Former Harvard Business School professor, John P. Kotter (2007, p. 98) emphasised the need to establish a sense of urgency when leading change in organisations. In his view, employees will be convinced of the need for change when there is a threat, a crisis, a potential revenue drop, a timely opportunity, or when “business as usual is totally unacceptable”. In healthcare organisations, a sense of urgency may be best communicated in terms of a critical need for improving service provision for patients and families (Campbell, 2008). Perhaps this is one reason why Loewy (2007, p. 18) has been so successful in developing music therapy programmes. She continues to enter new areas of practice, through calling attention to “significant lags of service” and expressing requests “through patient need” (Loewy, 2001, p. 9).

Music therapists in our research also recalled how they needed to wait for “the right time” to introduce new services. One music therapist reported that further developments became possible when managers were satisfied with the music therapy service and the performance of a recent music therapy student. She explained how she recognised an opportunity to gain a second music therapy post after a successful music therapy student placement, when managers were satisfied with the music therapy service, and at a time when other allied health staff were being employed. She believed she had approached managers at precisely the right time, as her proposal for the second post was accepted.

Another music therapist recognised that her colleagues were not yet comfortable with the music therapy service and that further time was needed before the service could expand. She shared her plans to expand her music therapy service, but explained that it was not the right time to put her plans into action. A change in staff had recently occurred and she doubted whether existing staff were ready for additional change. She stated that she needed to show staff that she understood their culture and needs, before attempting to introduce additional services. In her view, the pace of the service development would not be directed by her, but by what she called the “comfort of the culture”. She accepted that growth would be slow and was waiting for a time when staff were more comfortable and familiar with music therapy.

Dulaney and Stanley (2005) stated that change begins with careful assessment of an organisation’s readiness for change. Before implementing a change, they recommended examining a hospital’s history of adopting changes and exploring ways in which other recent changes have unfolded. It is possible that tacit values and cultures are in operation in hospital settings and that these are only revealed when a change is introduced. For example, Jane (second author) established a highly successful music therapy programme in a children’s hospital in spite of initial fierce opposition from many of her co-workers. It was only after some four or five years it became apparent that the culture valued people under pressure who were able to “survive”. In turn, support from key people who were also ‘survivors’ seemed to be fundamental to her acceptance as an important figure in the institution.

These examples indicate that it can take time for music therapists to understand the teams and organisations which they have entered. To be successful in a start-up venture, a music therapist may need to be patient and to recognise and seize opportunities as they arise.

Communicating and collaborating

Descriptions of organisational change in hospitals have often stated that communication and collaboration are keys to successful change implementation (for examples see Deegan et al., 2004; Dulaney and Stanley, 2005; Wynne, 2004). The basic premise is that workers are more likely to accept and sustain changes if they are actively involved in the change process and have opportunities to voice their concerns (Deegan et al., 2004). Nearly all of the narratives we collected
emphasised a need for music therapists to build relationships with other staff. Words like “collaboration”, “co-operation”, “negotiation”, and “networking” frequently appeared in the music therapists’ stories.

Our research indicated that it may be important to develop a music therapy service that is responsive to the culture of the organisation and to the needs of patients, families, and other staff. It was evident that music therapists had learned about organisational cultures and needs in various ways. Some gained knowledge through observation, some entered formal discussions with management and staff, and some developed an understanding through attending team meetings. Of the music therapists, two learned that they needed to meet staff on an informal basis. They described how they “spent time” getting to know staff, sharing meals, and listening to others’ perspectives on how music therapy could address their needs. Their experiences indicated that it was important to listen to others’ perspectives on how music therapy could help them in their work:

> During my first days in the service I was given some advice that has stayed with me ever since. The first words of wisdom were, “drink lots of tea and listen to people” (Narrative 1).

A change approach that has received recent attention in healthcare is Studer’s (2004) Hardwiring Excellence approach (Spaulding et al., 2010). Studer’s approach uses straightforward language rather than management terminology and the primary focus is on human resources and human capital. To Studer, the central elements of individual motivation for change include purpose, worthwhile work, and making a difference. He presented several “must have” leadership actions to support and reward workers and add momentum to the adoption of change. These include engaging and seeking feedback from other workers, writing thank you notes, and offering encouraging or supportive words at crucial times. Studer’s consideration of the personal aspects of change may be of special interest to music therapists, who frequently enter small established interprofessional teams. Many music therapists have undergone training in psychodynamic theory and thinking and may find a psychoanalytic perspective useful for developing their new roles and understanding their interactions with new practitioner partners. Diamond (2012, p. 20) has explained that a psychoanalytic perspective to change management provides a framework in which organisations are treated as “experiential and relational”. Real change requires altering intersubjective structures, and working relationships, and productive recreations”. Diamond suggested that in organisations “Defensive routines become automatic and commonplace [and] these structured and sometimes mechanistic environments grow to be comfortably familiar, taken for granted, and unconscious to their participants” (Diamond, 2012, p. 5). This observation suggests that a new music therapist may not only be required to identify a suitable role for music therapy, but also to develop an awareness of how the defensive routines of the organisation are manifest. From this perspective, collaborating with others may be helpful for learning the functions of an organisation. Through working together, music therapists and other team members may come to recognise unconscious processes at work. The music therapist who took part in the fieldwork was observed to be particularly adept at communicating and collaborating with other members of her interprofessional team. She not only provided information about music therapy through formal presentations, distribution of research papers, and in team meetings, but also listened to others’ perspectives of how music therapy could meet the needs of patients and the organisation. On many occasions, the music therapist was observed seeking others’ professional opinions, discussing patients’ conditions, and exchanging observations and treatment ideas. She explained how she was attempting to create a music therapy service to match the particular hospital context, rather than implementing fixed ideas about music therapy. She remained open to suggestions from interprofessional team members and tried to fit in with existing systems where possible. This included exploration of new approaches and practices that were very different to those which she had employed in her training and previous work. While most of the music therapists in our study had provided some sort of formal education to staff, the general consensus was that it was more effective to educate others about music therapy by inviting them to sessions and including them in the music therapy process. Almost all of the music
therapists recounted situations in which they had invited other staff in to observe or to assist with music therapy sessions. Once included, staff could see the benefits of music therapy for themselves. The narratives included descriptions of how team members were moved when patients smiled, laughed, sang songs, or cried in the music therapy sessions they attended. Music therapists perceived that they had gained support for their new service when staff observed patients’ improved mood, heard positive feedback from patients or family members, or when music therapy made it easier for other staff to carry out their own treatment procedures. Commentators have observed that an organisational change is more likely to be accepted when workers can see a clear benefit of the change for themselves (Dulaney and Stanley, 2005; Spaulding et al., 2010). During fieldwork interviews, the music therapists’ co-workers identified many ways in which they had benefited from collaborating with the music therapist in conjoint sessions. They recalled how music therapy had helped them to achieve their own therapy goals and had opened up new treatment possibilities. Music therapy was welcomed as a “creative” contribution, which was more engaging than existing interventions. Some described how they had been inspired to develop new skills and approaches and encouraged to seek further interprofessional work with team members other than the music therapist. One interviewee explained that it was unusual that the music therapist was so “open” to others’ observations and feedback, as other staff members tended to be “protective of their profession and their knowledge”.

It was noted that the addition of a music therapy service gave other workers a renewed sense of hope when they were working in difficult and complex situations. Other therapists described how reassuring it was to see patients benefiting from music therapy at times when patients were seen to make little progress in the therapies they themselves were providing. This phenomenon has also been noted by other music therapy researchers. Magee (2005) proposed that music therapy engenders hope when a patient’s progress in rehabilitation is slow and O’Callaghan and Magill (2009) found that hospital staff who had witnessed music therapy perceived that they were part of an organisation that valued good quality care.

**Appointing change agents**

Leadership from one or more change agents may be necessary for workers to become involved in implementing change. In hospital settings, a steering group has often been formed to plan and implement an organisational change, to educate other workers and garner support for the change, to evaluate and communicate change outcomes, and to persist when the change process becomes arduous (Campbell, 2008; Deegan et al., 2004; Dulaney and Stanley, 2005). Although several music therapists in our study reported that support and advocacy from other staff members had been crucial to the development of music therapy services, none mentioned the formation of a formal steering group to introduce the service and the new role of the music therapist. This was in contrast to the approach taken to introduce a new recreation therapist position at the hospital where the fieldwork was undertaken. The introduction of this position was led by a steering committee of clinicians, managers, and financial employees. In interviews, it became apparent that the recreational therapy service received strong managerial support and the new position was to be funded by the hospital trust. This led us to wonder whether the new music therapist could have benefited from the appointment of a similar steering committee, particularly as several interviewees questioned whether they were asking for music therapy in the “right way”.

**Discussion**

Our intention in writing this paper was to demonstrate how a change management perspective contributes new understandings about music therapy service implementation. In our experience, music therapists tend to view service development from their own perspectives and experience. Music therapists in our study interpreted interprofessional tensions “personally” and viewed it as their sole responsibility to develop their music therapy service alone. A change management perspective highlights the important role of others in organisational change and emphasises the
impact of change on other workers’ values, practices, roles and identities. From a change management perspective, music therapists should expect some resistance to the introduction of a new service, and consider ways in which they can work with others to establish music therapy successfully.

If resistance is to be an expected part of music therapy service development, it may be important for new music therapists to gain professional and emotional support. Some of the music therapists in my study found healthcare management to be supportive, while others regarded professional supervision as essential for their work as sole music therapy practitioners. Those who had published or presented their work reported that they had gained greater confidence through sharing their work with professional colleagues. One music therapist reported that the support of an experienced service developer had enabled her to manage strong emotional responses and to “gain perspective”. While a need for professional supervision has been identified by previous music therapy authors (Forinash, 2001; Jackson, 2008), the introduction of a new service may be a particularly intense period when supervision is essential. There may be a special role for supervision in supporting music therapists to cope with service development demands and disappointments and in helping music therapists to manage their own and others’ emotional responses to development work.

Understanding music therapy service development from a change management perspective led us to consider ways in which other workers can help to facilitate the establishment of music therapy services. In our narrative and ethnographic research, other workers showed greater acceptance of the introduction of music therapy when they had observed music therapy sessions and saw the benefits of music therapy services for patients, family members, or for themselves. We would therefore encourage other healthcare workers to take an active interest in the work of the new music therapist and to take up opportunities to observe the music therapist’s work.

It was apparent that music therapists were often unsure of what was required to gain management support for their services. Healthcare managers may be able to assist music therapists by explaining their priorities and sharing their management culture and ethos. Music therapists may also benefit from the appointment of a service development steering group, including representatives from management, finance, and human resources. Managers have important roles to play in identifying local champions and providing employees with protected time to contribute to steering groups (Kirchner et al., 2012).

Current processual approaches highlight the political aspects of organisational change (Dawson, 2003). It occurs to us that there has been little previous reflection in music therapy about who holds the power in relation to the implementation of music therapy services. In our experience, music therapists face enough challenges in developing new work, before it is possible to identify locations of power within their organisations. We wonder whether the formation of strategic alliances in music therapy has been the result of such elements as luck, or connections that are not established by design. Viewing music therapy service development from a change management perspective may provoke further interest in our profession about who holds power in relation to the development and support of new positions, and how this power can best be accessed and utilised.

**Conclusions and recommendations**

A change management perspective offers new and promising ways of understanding music therapy service development, a context in which a new, emerging profession is introduced to a team of more established, historically powerful ones. Organisational change theories and models depict change as a challenging process, which requires shifts in workers’ practices and identities, and takes considerable time and effort. When viewed from this perspective, music therapists’ experiences of resistance and struggle could be regarded as similar to accounts of change initiatives in other arenas. This new interpretation leads us to make the following recommendations for music therapists, healthcare managers, and interprofessional team members.

Organisational change models may not provide simple recipes for introducing music therapy services successfully. However, current change management perspectives point to the importance of
considering cultural and contextual aspects when introducing change. We suggest that music therapists may wish to consider aspects such as the organisational culture, the team’s history of change acceptance, and the locations of power within their healthcare organisations when developing new services. Music therapists may be more likely to succeed in establishing a service if they consult and collaborate with other workers and recognise the impact of music therapy service implementation on others’ practices, roles, and responsibilities. Further training around change management processes may assist music therapists to develop the knowledge and skills to engage key people within their organisations.

Other healthcare workers and managers can play important roles in the establishment of music therapy services. Possibilities for colleagues’ contribution to music therapy service development include attending and observing music therapy sessions, inviting the music therapist to participate in conjoint therapy sessions, including the music therapist in team meetings and decisions, and sharing practice knowledge about the local culture. Health care managers may wish to consider the implementation of a steering group to help guide the introduction of a music therapy service.

A change management perspective further emphasises the challenging nature of music therapy service development. However, we would like to point out that although music therapists in our study described development work as challenging, they also appeared extremely passionate and persistent about their work. Music therapists in our research sustained firm beliefs about the value of music therapy and gained a strong sense of reward through working with patients and families. Seeing patients benefit from sessions appeared to be a powerful motivating force for music therapists who were struggling to develop their positions. Despite the challenges of service development, music therapists indicated that they were making important contributions to patients’ health and to the work of healthcare teams.

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