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# Conducting Clinical Studies in Community Health Settings: Challenges and Opportunities for Music Therapists

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# *Conducting Clinical Studies in Community Health Settings: Challenges and Opportunities for Music Therapists*

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ABSTRACT: In this article, music therapy researchers and clinicians share lessons learned through engaging in collaborative research with healthcare providers in community settings. Practical aspects of conducting research in community health settings are discussed, including consulting on-site music therapists, healthcare providers, and administrators in the earliest stages of research planning; integration of research team members with community healthcare providers; and strategies for successful study implementation. We present our experiences of challenges surrounding the aspects of study implementation, such as recruitment, obtaining consent, and collecting outcome data, as well as opportunities that have resulted from our work, such as increased visibility for music therapy services, collaboration on protocol refinement, and continuing music therapy services beyond the study. Throughout the article, we refer to two research studies that illustrate the collaborative process as well as offer practical examples of challenges and problem-solving.

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In 2015, the American Music Therapy Association (AMTA) published *Improving Access and Quality: Music Therapy Research 2025* (MTR 2025; American Music Therapy Association, 2015), a 10-year strategic research plan. In addition to recommendations related to specific populations, policy, music therapy recognition, access, and funding, several recommendations pertained to the urgent need to increase research capacity (e.g., having more music therapists involved with conducting research). One of these recommendations was "to increase meaningful engagement of clinicians in research" (American Music Therapy Association, 2015). In their white papers included in the MTR 2025 proceedings, Bradt (2015) and Whitehead-Pleaux (2015) argued for the need to include clinicians in music therapy research teams and to ensure that the clinician plays a vital role in all stages of the research process, not just intervention implementation. Engagement of music therapy clinicians in research can happen in various ways, often involving a collaboration between academic researchers and clinicians in community settings. For example, an academic researcher may approach a clinician to explore the possibility of collaborating on a research study at the clinician's site. Alternately, a clinician may approach an academic researcher to inform them that they would be interested in a collaborative research project related to a specific health problem. We have been involved in several projects in which academics, music therapy clinicians, and healthcare providers in community health settings came together to develop and conduct innovative research studies.

In this article, we present our experiences of engaging in a collaborative process throughout the different research stages, namely (1) conceptualization of the study, (2) building collaborative relationships with community health settings, (3) recruitment and enrollment, and (4) data collection. We also reflect on the opportunities and challenges encountered along the way. We hope that this information will be helpful to music therapy researchers and clinicians as they embark on collaborative research journeys.

Throughout this article, we refer to two research studies that illustrate the collaborative process as well as offer practical examples of challenges and problem-solving. A brief overview of these research studies is presented in Table 1. The first study,

Table 1
*Overview of Study Elements*

| Study Title | Vocal Music Therapy for Chronic Pain Study (Low et al., 2019) | Resilience Songwriting Program Study (Myers-Coffman et al., 2019) |
|---|---|---|
| Study aims | Investigate the feasibility and provide treatment effect estimates of a 12-week group music therapy program for chronic pain management. | Examine the feasibility and experience of an 8-session group songwriting program with adolescents grieving the death of a loved one and explore its impact on grief, emotional expression, self-esteem, meaning-making, and coping. |
| Study design | Mixed methods intervention study in which qualitative data were embedded within a randomized controlled trial (Creswell & Plano Clark, 2018). | Single group, pre/posttest convergent mixed methods design in which quantitative and qualitative data were collected in a parallel fashion (Creswell & Plano Clark, 2018). |
| Sample size | *N* = 43 | *N* = 10 |
| Setting | The Stephen and Sandra Sheller 11th Street Family Health Services, located in Philadelphia, PA. The center serves a neighborhood of 20,000 low-income residents in a major city (90% African-American). The center operates on an integrative health care model and offers primary care, behavioral health, dental services, creative arts therapies, and health education and wellness services. | 3 locations: (1) A community behavioral health center in Philadelphia, PA; (2) An after-school bereavement support program at a pediatric hospital in Indianapolis, IN; and (3) A middle school in Gainesville, GA. |
| Intervention description | Twelve weekly 90-minute sessions that include active engagement in creative music-making experiences, integrated with psychoeducation about the interaction between music and the multidimensional nature of pain perception and pain management. | Eight, 90-minute sessions (60-minute sessions at school location) that engage adolescents in original songwriting that emphasizes agency, collaboration, and creative flexibility and integrates cognitive-behavioral strategies such as psychoeducation and cognitive reframing. |
| Intervention delivery | Delivered by board-certified music therapist employed at the community health center. | Delivered by board-certified music therapist employed at each site. |
| Control condition | Wait-list control. | No control condition. |
| Recruitment | Posting of study flyers; study coordinator was present on site several days per week to actively recruit; meetings with clinical staff to inform about study and receive suggestions for recruitment strategies. | Posting of study flyers; referrals from therapists, school counselors, and local organizations working with grieving youth; snowball sampling. |
| Obtaining informed consent/assent | Study coordinator and research assistants. | Research assistant at pediatric hospital support program; music therapy clinician at middle school and behavioral health clinic. |
| Data collection | Study coordinator and research assistants were responsible for all data collection. | Research assistant at pediatric hospital support program; music therapy clinician at middle school and behavioral health clinic. |

Vocal Music Therapy (VMT) for Chronic Pain (Low, Lacson, Zhang, Kesslick, & Bradt, 2019), was a feasibility study aimed at examining the impact of a 12-week VMT program on core outcomes in chronic pain. This study was conducted in a community healthcare setting that serves low-income residents in a major city (Low et al., 2019). The second study, the Resilience Songwriting Program for adolescent bereavement, was an exploratory study that looked at the impact of an 8-session songwriting program on grief and resilience outcomes (Myers-Coffman, Baker, Daly, Palisano, & Bradt, 2019). This study was conducted in two community behavioral health settings and one middle school (Myers-Coffman et al., 2019). As we refer to several roles of research team members throughout this article, Table 2 includes a description of roles and responsibilities, including those of principal investigator, study coordinator, research assistant, and music therapy clinician.

### Study Conceptualization

Quantitative and qualitative research studies come with unique challenges related to research rigor and study feasibility. The VMT for Chronic Pain and Resilience Songwriting studies both utilized a mixed methods design (inclusive of both qualitative and quantitative methods). In this article, we exclusively address considerations specific to experimental research. Conducting studies in a community setting poses challenges that may not be present when conducting studies in a laboratory setting. When conceptualizing experimental

Table 2
*Roles of Study Personnel*

| Role | Definition |
|---|---|
| Principal investigator | The principal investigator is the lead researcher of a study. The principal investigator oversees all aspects of the study and assumes responsibility for the scientific integrity of the project. In the studies discussed in this article, each principal investigator was also a board-certified music therapist. |
| Study coordinator | Individual responsible for coordination of day-to-day study activities including recruitment and enrollment, overseeing data collection, scheduling, and communication with participants regarding study-related activities. The study coordinator also assists with supervision of research assistants. |
| Research assistant | Individual responsible for aspects of research study implementation as assigned (e.g., screening, obtaining informed consent, data collection, data entry). |
| Music therapy clinician | Music therapist who implements the music therapy intervention in a research study. In the studies presented in this article, the music therapy clinicians were board-certified music therapists employed by the community health settings at which the research studies took place. |

research studies in community health settings, research teams need to consider issues such as available sampling pool, acceptability of control conditions, and confounding variables (e.g., treatment contamination) that may be present in small healthcare clinics.

### Sample Size

Sample size in quantitative research studies is determined by the type of study and whether or not the intent is to conduct a powered study. The purpose of exploratory, feasibility, and pilot studies is not to run inferential statistics to test treatment efficacy and, therefore, the sample sizes of these types of studies are relatively small and often influenced by the availability of funding as well as the researcher's timeframe (e.g., needing to recruit 20–50 participants) (LaGasse, 2013). The purpose of efficacy studies, in contrast, is to examine treatment efficacy through inferential statistics that are sufficiently powered. In this case, sample sizes are determined using statistical power computations (Wittes, 2002). The implementation of efficacy trials typically requires a significant amount of funding due to large sample sizes.

It is important to establish the targeted sample size during the early phases of study conceptualization so that initial conversations with potential community health setting collaborators include discussions related to the available participant pool (i.e., given the eligibility criteria for the study, the number of participants served annually by the site who would meet the study's criteria). An accurate estimate of the potential sample pool is an essential step in planning for study implementation. If the potential participant pool is low, the researcher may need to involve multiple study sites. This was the case for the Resilience Songwriting study (Table 1). While the principal investigator (K. Myers-Coffman) had access to use the behavioral health clinic at her university to conduct the study, there had never before been bereavement programming there. Because it took three months to recruit four participants, it was determined that this site alone would not offer a sufficient number of participants to complete the study.

### Site Approval

Once the music therapy clinician and academic researcher agree on a preliminary plan for the research study and the size of the available sampling pool has been determined to be adequate, approval from the community setting is sought. Approval in the earliest planning stages of the study allows for site providers and administrators to offer input regarding the intervention (e.g., length and frequency), study design, and strategies for recruitment and study implementation. The music therapy clinician plays an important role in liaising between site personnel and the academic researcher in these initial stages. It is important to have these types of planning meetings before seeking approval from the academic institution's Institutional Review Board (IRB), as significant changes to the study design, eligibility criteria, intervention protocol, and study implementation procedures may result from the site's input.

### Intervention Choice

When music therapy clinicians and academic researchers explore potential collaborations in the context of community health services, it is important to consider whether the intervention and study design elements align with the clinician's therapeutic orientation as well as the site's day-to-day healthcare practice. Early discussions can help researchers determine whether clinicians have the necessary skills to implement the intervention protocol as designed; this will be discussed in further detail below.

### Control Conditions

The use of controlled studies, whether randomized or not, that include a no-treatment control or treatment-as-usual (TAU) may not be appropriate or desirable for some community settings. The setting may not agree to have a potentially valuable treatment withheld from patients allocated to the control condition. In addition, the use of TAU conditions may lead to high attrition as participants allocated to the control treatment arm may be disappointed to not receive the music therapy intervention and may drop out of the study. Furthermore, healthcare providers may be less eager to refer their patients to a randomized controlled trial (RCT) that has a no-treatment or TAU control condition (Bradt, 2012; Kinser & Robins, 2013).

An alternative is to use a comparison treatment (e.g., songwriting vs. music listening; music therapy group intervention

vs. a verbal support group) (Bradt, 2012) or low-dose treatment condition (e.g., listening to audiobooks) (Robb et al., 2008). However, when conducting studies in a small community health center, this may still prove problematic. Participants assigned to different treatment arms are likely to know each other, mention their experiences to others in the waiting room, or talk about their music therapy experiences while attending other treatments at the clinic. When control participants hear about participants' experiences in the music therapy sessions, they may still feel resentful for not having been assigned to that group.

To address these issues, we opted to use a wait-list control group in the VMT for Chronic Pain study. Participants randomized to the wait-list control arm continued to receive regular treatment at the center for the first 12 weeks. During this time, participants randomized to the music therapy treatment arm received weekly music therapy sessions. Measurements were obtained from both treatment arms during this 12-week period. Once participants in the control study arm had completed the 12-week waiting period, they received the 12-week music therapy treatment. Having participants wait for 12 weeks before they receive the intervention may still lead to some attrition but attrition in waitlist control group studies is typically less than in a TAU control scenario (Bradt, 2012).

### Treatment Contamination

Another issue to consider is the "contamination" of the treatment groups in small community settings. Treatment contamination refers to the issue of participants in the control group learning about some treatment aspects or techniques of the intervention group and beginning to adopt those to improve their health (Pence et al., 2015; Torgerson, 2001). Even though participants in the VMT for Chronic Pain study were asked not to talk to other patients at the center about their experiences in the music therapy group, it is difficult to know whether participants adhere to such requests. The risk of treatment contamination can be minimized by educating study participants about what they can do to help uphold scientific rigor of the study. Once participants understand why it is important that they do not speak to other patients about the study, they may be more likely to comply with this request.

### Confounding Variables

The availability of other treatments at the site is an important confounding variable to consider when designing a study for a community setting. It is often not possible to prohibit study participants from participating in other treatments for ethical reasons. However, it is possible to seek IRB permission to ask participants not to add any new treatments to their care plan for the duration of the study. Such a request needs to be detailed in the informed consent form. Alternatively, the use of other treatments at the center can be tracked and subsequently used as a covariate in statistical analyses. In the VMT for Chronic Pain study (Low et al., 2019), it was not possible to keep study participants from engaging with other services available because the center uses an integrated health model. Therefore, we tracked the use of other healthcare services by examining participants' visits documented in their medical records.

## Building Collaborative Relationships with Community Health Providers

### The Importance of Staff Investment

Obtaining approval from a community healthcare setting to conduct a study at their site is an important first step. However, approval by administrators does not necessarily mean that providers and staff at the site will be committed to study implementation. Despite initial excitement about the study, clinical needs can easily take precedence over study-related activities. Limiting the principal investigator's presence at the site to sporadic visits (e.g., for protocol training, checking in on recruitment efforts, obtaining consents, and collecting data) may lead to study failure. Therefore, the inclusion of one or more site personnel on the research team is highly recommended.

In the VMT for Chronic Pain study (Low et al., 2019) and the Resilience Songwriting study (Myers-Coffman et al., 2019), the music therapists were board-certified clinicians working as full- or part-time employees at the respective study sites. It was important to identify music therapy clinicians who would be able to implement the research protocols as written. For example, in the Resilience Songwriting study, one factor in selecting study sites was whether the music therapist employed by the site had strong songwriting skills, felt comfortable implementing cognitive-behavioral strategies, and could honor the strength-based lens guiding the protocol (Myers-Coffman et al., 2019). In the VMT for Chronic Pain study, it was essential for the principal investigator to review the psychoeducational components related to pain management with the music therapy clinician (Low et al., 2019). In each study, the principal investigators made time to provide weekly supervision and support to the music therapy clinicians as they implemented the research protocol. Feedback from the music therapy clinicians regarding protocol implementation was used to help refine the study protocols for future studies.

It is important that the clinician be viewed as an integral member of the research team, rather than solely as the music therapist who implements the intervention protocol. The music therapy clinician is an essential resource for adapting the study protocol to site-specific contexts, liaising with site personnel, and conveying to potential participants trust in the research project and team. The latter is especially important when conducting research in community settings that serve minority individuals due to historically well-founded mistrust of scientists and university researchers (Henry, Tolan, Gorman-Smith, & Schoeny, 2017; Scharff et al., 2010).

Besides the music therapy clinician, it may benefit the research team to include a site administrator or healthcare provider on the team. This person may function as an advocate for the study in day-to-day clinical contexts by helping the research team navigate logistical issues, such as securing rooms for consent and data collection, streamlining referral processes, and obtaining access to site-specific electronic records (given that IRB approval is granted for access to such records).

### Establishing Presence at the Research Site

Integration of research team members with on-site health providers through regular on-site presence is essential for successful study implementation as it helps to foster

collaborative working relationships. This communicates that the researcher(s) will be available to provide information, answer questions, meet with potential study participants, and address any unanticipated needs that may arise as the study unfolds. Studies conducted by J. Bradt's research group typically have a research team member on-site 2–3 days per week. This may not be a feasible scenario in all cases, especially if no external funding is available to pay for research assistants. However, music therapy undergraduate and graduate students are often eager to obtain research experience. With adequate training and supervision, they can perform these essential functions. These experiences could be integrated into research coursework. Additionally, we have learned that the academic researcher may find it worthwhile to reach out to Departments of Psychology, Education, or Schools of Medicine, as many students and residents are looking for volunteer research opportunities.

In the VMT for Chronic Pain study, the principal investigator (J. Bradt) assigned the study coordinator (C. Lacson) to be at the research site for 2–3 days a week. The study coordinator's on-site presence began several weeks prior to the study start date. She attended in-service meetings, healthcare team meetings, and morning huddles (i.e., an informal interdisciplinary meeting including care providers and administrative staff) in primary care to inform all providers about the upcoming study and to allow for the site personnel to become familiar with her presence and purpose at the site. She interacted with providers and staff as much as possible so that people were regularly reminded of the study and had opportunities to ask questions.

### Minimizing Study Burden on Clinical Staff

Keeping the study burden to a minimum for clinical staff is an important factor for successful implementation of research studies in community settings. On-site presence of a research team member plays an important role in this. In the VMT for Chronic Pain study, the study coordinator (C. Lacson) regularly offered to assist the music therapy clinician (A. Kesslick) in preparing materials for session implementation. By taking responsibility for tasks such as making copies of song lyrics and handouts, editing audio recordings made during study sessions, creating CD track lists and sleeves, and burning CDs of music made during the sessions for participant use at home, the study coordinator reduced study burden by minimizing the time required for the music therapist to prepare for study sessions.

## Study Recruitment and Enrollment

Issues with recruitment are one of the most common reasons for study failure. The inability to recruit and retain the required number of participants poses serious threats to both the internal and external validity of a research study (Fletcher, Gheorghe, Moore, Wilson, & Damery, 2012; Gul & Ali, 2010).

### Passive Versus Active Recruitment Strategies

Passive recruitment strategies rely on potential study participants taking the initiative to contact the research team using a phone number or email provided on advertising materials about the study. Relying solely on passive recruitment strategies such as posting study flyers and handing flyers to potential referral sources has been found to be insufficient for study recruitment (Raynor et al., 2009). Active recruitment strategies utilize existing resources to engage potential participants and use direct contact with potential participants and/or referral sources (Davis et al., 2018).

Communicating respect and appreciation for the clinical and site providers' willingness to add study recruitment to their workloads builds goodwill between researchers and clinicians, increases commitment to the study, and improves the likelihood of successful study completion. Lack of referrals typically does not indicate lack of support for the study. Instead, we have learned that active reminders in the form of physical on-site presence by research team members are essential to sustaining a continuous flow of referrals.

The VMT for Chronic Pain study employed a mix of active and passive recruitment strategies to stimulate interest in the study at The Stephen and Sandra Sheller 11th Street Family Health Services. First, an attractive, colorful study flyer was posted across the center and distributed to all providers. Second, the study coordinator (C. Lacson) dedicated one day a week to working at an unoccupied desk within the primary care team's shared workspace and made sure to attend the weekly huddle. Her regular attendance at this meeting seemed to stimulate referrals from care providers once she demonstrated that she would follow up immediately and in-person with every patient who was referred during a routine healthcare appointment. She was also able to promptly answer questions that arose about the eligibility criteria for the study. With IRB approval, we obtained access to the electronic medical records so that the study coordinator could communicate directly with providers using the same interface in which all patient-related communications took place. This had the added benefit of allowing the study coordinator a direct means of updating providers on whether the patients they referred ultimately enrolled and alerting providers when their patient self-referred to the study. Third, the Director of Creative Arts Therapies spoke about the study at the staff meetings for providers in different departments. Various in-house communications available (e.g., email blasts, staff newsletters) were used to give details to community healthcare providers about the study. Fourth, the study coordinator attended the Community Advisory Council meeting to speak with Community Ambassadors (e.g., longstanding members who receive or had received services at The Stephen and Sandra Sheller 11th Street Family Health Services) about the study, giving a brief description of how music therapy might be helpful for chronic pain management and staying after the meeting to connect informally with community members. Finally, after a study presentation to the dental team, the dental care staff suggested including a short screening form for the music therapy study in their standard intake packet. The study coordinator followed up weekly to collect completed forms and to coordinate patient contact with follow-up dental appointments.

In the Resilience Songwriting study, passive recruitment through flyers was primarily used for the behavioral health center and the pediatric hospital bereavement support program. This yielded low recruitment levels and it became clear to the principal investigator (K. Myers-Coffman) that more active strategies were needed. These included working with local organizations who might have youth they could directly refer to the study, giving on-site presentations to speak

directly to youth and their caregivers, and asking for contact information of other organizations that might be good referral sources. It was critical to rely on local networking at each site to assist with these active recruitment strategies rather than relying solely on flyers and brochures. Active recruitment was the only strategy used for the middle school setting in that the school counselor gave the clinician direct referrals. At this site, six referrals were generated within the first week. The other two locations took months to furnish the same number of referrals.

### Obtaining Consent from Participants

Whenever possible, the on-site music therapist should not be involved with obtaining consent to avoid placing undue pressure on potential study participants (Dileo, 2001). Participants may be hesitant to state that they are not interested in participating in the research study if they have had therapeutic encounters with the music therapist. However, we realize that in the case of unfunded studies, the music therapist may need to assist with recruitment and consent. In addition, student research often relies on the researcher being the study clinician due to time and funding constraints.

In the Resilience Songwriting study, the principal investigator (K. Myers-Coffman) was the music therapy clinician at one of the sites as this was her dissertation research. She felt it was challenging to present the information in the informed consent in a neutral way so as to not risk participants feeling coerced into study enrollment. At the same time, presenting the study information accurately but with some level of enthusiasm for the participant's interest in the study is important. This issue was discussed frequently during supervision meetings with the principal investigator's advisor (J. Bradt).

Several strategies can be implemented to avoid introducing bias and undue pressure by the music therapy clinician. First, if possible, a dedicated research team member other than the music therapy clinician should obtain the participant's consent or assent. If this is not possible, consent sessions should be audio recorded so that another team member can conduct a quality assessment by listening to the recordings. An alternative is to have a second person at the site witness the consent session to assure that no pressure to enroll was placed on the participant and that all relevant information was provided.

## Data Collection

As with obtaining consent, the on-site music therapy clinician should not be involved with data collection whenever possible to avoid outcome assessment bias. When the music therapy clinician administers the outcome measures, participants may want to answer in ways that seem desirable to the music therapist. Therefore, having dedicated outcome assessment study personnel is preferred. In case of lack of funding for study personnel, finding someone neutral to help with data collection can help minimize such biases. Providers, administrators at the site, or fellow students or colleagues may be willing to volunteer time to gain research experience. However, relying on the goodwill of volunteers can pose a challenge as other professional obligations may need to take priority on the day of data collection. Moreover, participants may cancel an outcome assessment appointment. Rescheduling outcome assessments within the allotted timeframe of the study protocol may prove challenging when relying on the limited availability of volunteer outcome assessors.

## Challenges and Opportunities

### Population-Specific Challenges

Each population presents unique challenges for recruitment and enrollment. Participation in RCTs can be burdensome, particularly for underserved populations or people with chronic health conditions who may already be managing complex life circumstances and healthcare needs (Pyatak et al., 2013). Indeed, a potential mismatch between academic researchers' expectations and community members' everyday life realities has been discussed in the literature as being a factor contributing to trial failure (Pyatak et al., 2013). Researchers with higher levels of education and advantageous socioeconomic circumstances may not be familiar with the lifestyles, struggles, and motivations of study participants from disadvantaged populations. For example, participants who recurrently miss study appointments and sessions may be perceived as noncompliant, whereas the participants may just not have the financial or logistical means to attend the appointment or may feel that the intervention is not helpful in addressing their needs. Music therapists who work with the population under investigation can offer valuable input regarding the specific needs and challenges faced by potential participants.

We experienced this in the VMT for Chronic Pain study (Low et al., 2019). In addition to the unpredictability of chronic pain, participants faced many challenges due to difficult socioeconomic circumstances. Once a potential participant screened eligible, the study coordinator (C. Lacson) scheduled them to come in for a meeting to discuss and obtain informed consent. Many people did not show up for the consent meeting, despite reminder calls placed the day before and the morning of the appointment. Reasons for this varied. Often, no-shows were due to transportation challenges: (a) they were relying on transportation that never arrived to travel to the clinic, (b) they stated the weather was too severe to allow for travel to the clinic without experiencing increased pain or discomfort from having to stand outside to wait for the bus; or (c) their pain on a given day was too severe to travel on multiple buses to get to the center. Other reasons included participants being unexpectedly asked to provide childcare; not receiving the reminder call or voicemail due to running out of minutes on a cell phone plan; and simply forgetting about the appointment. The participants at The Stephen and Sandra Sheller 11th Street Family Health Services faced multiple barriers to attending VMT for Chronic Pain study sessions and other health-related appointments at the clinic, despite intention and an earnest desire to follow through. The eventual recruitment of some of these participants to the study was only possible with the collaboration of their most frequently seen providers.

### Site-Specific Challenges

Finding a balance between an ideal and feasible treatment length is a dilemma often encountered when conducting research in community healthcare centers. Moreover, lengthy treatment protocols, even if found to be effective, may

eventually lead to problems with enrollment because patients may not want to commit to a lengthy treatment or because the treatment is deemed too expensive by administrators.

Intervention duration needed to be adapted for the sites that participated in the Resilience Songwriting study. The pediatric hospital bereavement support center typically ran closed group sessions in seasonal formats, so the Resilience Songwriting study's 8-week closed group sessions fit well within the normal programming schedule. However, starting dates of new groups had to align with the starting dates of their seasonal program schedule. Fixed program starting dates can present recruitment challenges for group interventions, as an a priori set target sample size needs to be enrolled and consented by the program start date. The middle school setting usually ran 6-week, closed group programming during class periods; this closely aligned with the study's original design. However, class periods were 60 min long. Therefore, the principal investigator (K. Myers-Coffman) and music therapy clinician at that site worked together to refine the intervention protocol from 90 to 60 min and examined the feasibility of this modification.

### Increased Visibility of Music Therapy Services

Conducting clinical research in community health settings is not without challenges. Yet collaborative research in these settings may result in opportunities for improving care and increasing access to music therapy services. Research studies at community sites create many encounters in which the research team and the music therapy clinicians can educate staff and clients about the nature and goals of music therapy within the study, thereby increasing visibility of the music therapy program. In the VMT for Chronic Pain study, recruitment efforts often resulted in a conversation about music therapy in general and music therapy (and other creative arts therapies) services available at the site. On some occasions, the study coordinator (C. Lacson) concluded a study-related conversation without successfully recruiting a potential participant but provided a referral to another creative arts therapy clinician for treatment of an issue unrelated to pain or treatment of a participant's relative. Because the study coordinator was knowledgeable about the other services available at the center, she often provided potential participants with contact information for these services, even if they were not interested in participating in the music therapy study.

### Collaboration on Protocol Refinement

As stated above, it is important to foster collaborations that go beyond using the music therapy clinician only for intervention implementation and move toward partnership between the researcher and the clinician from the onset of the project. Because the Resilience Songwriting study used a new intervention protocol, the principal investigator (K. Myers-Coffman) entered the study with a desire to gather input on the protocol from the clinicians as they implemented it. Gathering this feedback provided valuable insight into the clinical realities of study implementation for each location and allowed for the clinicians to collaboratively refine the intervention protocol with the principal investigator for future studies. From the music therapy clinician's perspective (C. Krater), this consistent communication was important in order to recall the essential elements of the protocol, such as the guiding theoretical framework and different techniques the principal investigator encouraged the clinicians to use during implementation. Additionally, these discussions helped to identify where there was room for clinical tailoring in the moment and which elements of the protocol needed to be implemented as written. Consistent communication from the researcher promoted a feeling of partnership, supporting the clinician's sense of autonomy and improving confidence in the implementation.

Similarly, for the VMT for Chronic Pain study, clinician input on the music therapy protocol was sought prior to study onset as well as throughout the duration of the study. Each time a group had completed the 12-week protocol, the music therapy clinician (A. Kesslick) and the principal investigator (J. Bradt) met to discuss clinician session notes and jointly refine the protocol.

### Continuing Music Therapy Services After the Study

Finally, when research study findings indicate significant treatment benefits, such findings can be used to negotiate for increased funding for music therapy services at the site or to pursue external program funding to help expand the music therapy programming. This happened after the initial music therapy study (on which the VMT for Chronic Pain study was based) was conducted at The Stephen and Sandra Sheller 11th Street Family Health Services (Bradt, Norris, Shim, Gracely, & Gerrity, 2016). Following the completion of this study, participants continued to share their positive experiences with other providers and administrators at the center. In addition, many of them explicitly asked for music therapy services to be added to the array of programming at the center. The positive feedback from study participants in addition to the promising results of the study eventually resulted in the hire of a full-time music therapist (A. Kesslick).

In the Resilience Songwriting study, the behavioral health clinic was able to provide a music therapy service that previously had not been offered. Similarly, because the pediatric hospital bereavement support program primarily worked with youth 5–10 years of age, they were able to expand their programming and provide services specifically for adolescents. This collaboration provided the music therapy clinician (C. Krater) access to a researcher who was passionate and knowledgeable about the population and also had time, resources, and knowledge to devote to designing an evidence-based practice protocol. The networking with other organizations that took place during the Resilience Songwriting study may result in continued interest in future collaborations, due to the positive feedback given by adolescents referred by those organizations.

## Summary and Conclusions

We have offered the above lessons learned by our group as guidance for music therapy researchers and clinicians embarking upon research collaborations of their own. We believe that this is a timely response to the recommendations of MTR 2025, which urgently calls for more clinician-driven research (Bradt, 2015; Whitehead-Pleaux, 2015). In summary, a successful collaboration depends on building

partnerships in which the academic researcher, music therapy clinician, and study site administrators are equally involved in decision-making related to the study. Music therapy researchers should acknowledge the practical wisdom of site personnel in all aspects of study implementation. We have found the greatest success by consulting with music therapy clinicians and community health center personnel in the early stages of study planning. During study introduction and implementation, it is important for the research team to convey ongoing appreciation for the clinician's and the community health center's willingness to add the study to an already overflowing workload. Establishing supportive relationships from the outset will benefit all aspects of the study, from advertising to potential participants to study enrollment and smooth implementation of the study protocol. These collaborative partnerships may result in increased access to music therapy services, interest in sustaining music therapy at the site beyond the life of the study, and knowledge that will help support negotiations for increases to music therapy programming or funding.

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