

Competency Review Charges and Historical Timelines

**Submitted by Piper Laird and Laurie Keough
on behalf of the Competency Review Task Force.**

April 3rd, 2025

Development of the CRTF: Competency Review Task Force (CRTF) was formed after the November 2017 AMTA Conference and began work in January, 2018. The reason for the development of the CRTF was concern regarding declining CBMT pass rates.

Timeline of Charges from AMTA BOD to the CRTF:

2018: (Midyear report)

CHARGE 1- The goal of this task force is to review both the Professional and Advanced Competencies for consistency.

CHARGE 2 - An additional charge was added in November 2017 to review the CBMT Board Certification Domains and compare that document to the AMTA competencies.

2019: (Midyear report)

Recommendations from CRTF to the BOD:

1. The CRTF agrees that the three documents under review (Professional Competencies, The Board Certification Domains, and the Advanced Competencies) should work together as a continuum rather than 3 separate documents. Therefore, it is recommended that the headings (and sub domain and competencies within each heading) for the professional competencies, the domains, and the advanced competencies be similar across documents. The CRTF see these three documents as a continuum of knowledge to advanced knowledge:

Professional Comp. – Knowledge □ BCDs – Application □ Adv. Comp. – Advanced Knowledge

2. It is recommended that when making changes to these documents, keep in mind the intent of the documents (foundational knowledge to learn OR skill to apply OR advanced knowledge to learn) and to keep the language consistent within each of the documents with that intent in mind.

November 2019 (End of year Board Meeting):

CHARGE 3: Update and revise the competencies to reflect the growth of knowledge base of the profession.

Task force members:

Laurie Keough, Co-Chair (Mid-Atlantic) 2018-2024	Piper Laird, Co-Chair (Western) 2018-2024
Della Molloy-Daugherty (South Western) 2018-2024	Vicki Vega (South Eastern) 2018-2024
Tracy Richardson (Great Lakes) 2018-2024 **	Gary Verhagen (Mid-Atlantic) 2018-2024
Jennifer Peyton (South Eastern) 2021-2024	

Kamile Geist, initial Co-Chair/Chair (Great Lakes) 2018-2020

Ed Kahler, initial co-chair (Western) 2018-2019

Deanna Hanson-Abromeit (Mid-Western) 2018-2020

Jane Creagan, AMTA liaison 2018-2022**

**Also on Commission for Education and Clinical Training of the 21st Century Music Therapist

Additional Timeline (Meetings, Tasks, and Key Decisions:

January - June 2018

- Met 3 times via conference call (January 15, February 12, May 1), plus individual work between meetings
- Discussed charges and completed **Task #1: Comparison of CBMT Board Certification Domains (BCDs) and AMTA Competencies**. Each task force member was assigned a section of the CMBT Domains and determined which AMTA professional or advanced competency or competencies (if any) matched each domain item. The discussion of the results led to a number of questions regarding CBMT Domains and the procedures for test item selection.
- May 1st meeting was with Joy Scheck from CBMT to discuss questions the group had about the domains, test items, and how they related to the current bachelors curriculum, specifically the knowledge base to take the exam.
- Developed a plan for **Task #2: Review of Professional and Advanced Competencies**. Each task force member was assigned a certain area of the competencies documents and asked to identify 2-3 other AMTA members to create a working group for the task (see [appendix A](#)). Each work groups then answered the following questions for each competency in their assigned sections:
 - 1 – Is each item still relevant?
 - 2 – Is each item worded clearly?
 - 3 – Compare each item to the corresponding item (s) in the Advanced Competencies (if applicable)
 - a. Is each item in the correct competency?
 - b. Should any professional item go to advanced or vice versa?
 - c. Should any item be added to either document?
 - d. Should any item be removed from either document?

July - November 2018

- Had 3 intensive two-hour conference calls (July 30, September 7, September 27) to discuss the findings of each subgroup as related to Task 2. Notes were also taken concerning major topic areas to be addresses at the AMTA National Conference
- Met for two one-hour in-person meetings at the AMTA Annual Conference
- Talking Points for National Conference that arose from the CRTF’s work to this point:
 - Should the competencies continue to be two documents or combined in a developmental sequence into one document?
 - Should there be rewording and organization of professional competency categories?
 - What, if any, Advanced Competencies should be moved to Professional Competencies?
 - Should there be a better measure of competencies?
- The CRTF Chair (Kamile Geist) presented to the BOD on the results of the initial competency review. Summary of results:
 - Gaps of needed professional competence in several areas
 - Some advanced competencies belonged in the professional competencies
 - It was difficult to look for consistency between the documents because the headings were not consistent between the two documents.

- The task force also didn't see a continuum for competence from the professional competence to advanced competence.
- The headings of the professional competencies do not reflect current curricular needs of pre-professionals and advanced professionals.

January - June 2019

- Met 4 times via conference call (January 20, March 20, May 21, June 13), plus individual work between meetings
- Focus of work: completing Charge 2: Review the CBMT Board Certification Domains and compare that document to the AMTA Professional Competencies:
 - CRTF members decided that, in order to submit information related to the comparison of the BCDs to the Competencies, the work completed in 2018 needed to be revisited, re-organized and summarized with more depth.
 - It was decided to input all data into a Google form in order to compile it in a consistent format in order to effectively analyze and summarize the results.
 - Discussed findings, defined terms, and identified themes, gaps, and overlaps of the BCD and the Competencies.
 - **Came to consensus on:**
 - the differences between the documents.
 - the gaps between the documents.
 - findings and recommendations for the BOD.
- **A summary of findings and recommendations were submitted to the AMTA BOD** in the June, 2019 midyear report (see [Appendix B](#) for the complete summary and [Appendix C](#) for supporting data).
 - Summary of findings addressed the following topics:
 - 1) General differences between the Board Certification Domains and the Professional Competencies
 - 2) Related Professional and Advanced Competencies when compared to BCD's.
 - 3) Gap areas in knowledge within the professional competencies when compared to the BCDs.
 - **Recommendations** in this midyear report:
 - 1) The CRTF agrees that the three documents under review (Professional Competencies, The Board Certification Domains, and the Advanced Competencies) should work together as a continuum rather than 3 separate documents. Therefore, it is recommended that the headings (and sub domain and competencies within each heading) for the professional competencies, the domains, and the advanced competencies be similar across documents. The CRTF see these three documents as a continuum of knowledge to advanced knowledge:

Professional Comp. – Knowledge □ BCDs – Application □ Adv. Comp. – Advanced Knowledge

- 2) It is recommended that when making changes to these documents, keep in mind the intent of the documents (foundational knowledge to learn OR skill to apply OR advanced knowledge to learn) and to keep the language consistent within each of the documents with that intent in mind.

June - November 2019

- Met 2 times via conference call (July 30 and October 24), plus individual work between meetings
- Focus of work: reviewing peer professions' standards and competencies for education and training.
- Met in person at the AMTA National Conference (November)
 - **Creation and adoption of draft framework** (See [Appendix D](#))
 - Framework areas were based on the AMTA Levels of Practice Document:
 - Musical Development
 - Personal Development
 - Integrated Clinical Practice
 - Professional Development
 - Identified and proposed a Framework Readiness Continuum:
 - Readiness for Practicum
 - Readiness for Internship
 - Readiness for Entry to Practice
 - Readiness for Advanced Practice
 - November 23 - **CRTF Presentation to the Assembly of Delegates** on the work completed to date and the proposed framework.
 - **Received new charge from AMTA BOD: CHARGE 3:** Update and revise the competencies to reflect the growth of knowledge base of the profession.

January - May 2020

- Met 5 times via conference call (Jan. 5, Feb. 3, April 6, May 4, May 18), plus individual work between meetings
- Focus of work: Updating and revising competencies (Charge 3):
 - **Revised proposed Framework Readiness Continuum** to include **three points** in time:
 - Readiness for Internship
 - Readiness for Entry to Practice
 - Readiness for Advanced Practice
- Worked on the following tasks:
 - Placing current (unrevised) competencies in appropriate places within the Framework.
 - Placing suggested revised competencies in appropriate places within the Framework.
 - Placing suggested competencies in appropriate places within the Framework.
 - Looking for gaps within the Framework and crafting new competencies to fill those gaps, if needed.

June - November 2020

- Met 5 times via conference call (June 15, June 29, August 12, September 23, October 28). Three of these meetings were intensive meetings (one 4-hour and two 2-hour)
- Created subgroups (2 CRTF members per subgroup); each subgroup was assigned to work on a specific section of the framework (e.g. Music Development, Integrative Clinical Practice, Personal Development, Professional Growth) between task force meetings.
- June 24 - **Joint meeting with the Commission on Education and Clinical Training** to discuss overlaps between our work and how the work of each group may inform the work of the other.
- Began looking for two new members to replace Ed Kahler and Deanna Hanson-Abromeit (ideally individuals who could help diversify the CRTF from the Midwest and New England Regions).

January - May 2021

- **January - Membership changes:** Kamile Geist stepped down from the CRTF; Piper Laird and Laurie Keough became co-chairs. Jennifer Peyton (Southeastern Region) was appointed to the task force. Efforts to recruit members from Midwest and New England regions and to add members to further diversify the group were unsuccessful.
- Met 3 times as a group via Zoom (February 15, March 22, May 17). Subgroups met between meetings as needed. Key Focus: Development of competencies within the Competency Framework.
- **Key discussion topics:**
 1. the purpose of the document as compared and contrasted with other AMTA documents;
 2. initial work of each subgroup
 3. how to address cultural humility into the competencies;
 4. sources to review (e.g.. related to functional music skills, harm in music therapy, music therapy competencies) and a process for organizing them.
- **Key decisions:**
 - Infuse cultural humility throughout the competencies rather than a few isolated competencies rather than have one or two isolated competencies.
 - Use Bloom's Taxonomy to guide development of competencies, also focusing on skills, knowledge, and attitudes.
- February 22 - **Presented to the AMTA Assembly**
- April 26 - Attended AMTA Commission Listening Session

June - December 2021

- Met 4 times via Zoom (June 28, August 16 [4-hour retreat], October 4, November 1, December 6). Subgroups met between meetings to work on individual sections. This process continued until the end of the CRTF work in 2024.
- June 28 - Met with Tony Meadows and Lillian Eyre to discuss their article *Program Directors' Perceptions of the CBMT Exam*.
- **Key discussion topics:** "Big Questions"
 1. Intention and function of the document
 2. Titles for columns
 3. Who would be responsible for assessing competencies in each column

4. *Minimum* skills and knowledge need for entry level practice
 5. Initial discussion about the Music Development section
 6. What will go into a Preamble
- August 10 - **Joint Meeting with Commission.** We recognized a significant overlap in the discussions and work of each group and, as a result, developed a common Google folder to share resources and materials.
 - **Key decisions:**
 1. Adoption of the CRTF Grounding Statement - read aloud by CRTF members each meeting (See [Appendix E](#))
 2. Will not always need a competency in every column (ex. In a given row, may need Ready for Internship and Ready for Prof. Practice, but not Advance Practice)
 3. Musical Development section: Move away from NASM influence on music skills competencies and add more focus on functional music skills, clinical musicianship, and more diverse musical knowledge and repertoire development.
 4. June 21 - (Midyear meeting) - Action item approved by the BOD: Approved CRTF request to begin seeking input from other AMTA groups such as, but not limited to, DEI, APAC, AIAC, and the Commission. This input is to inform the work being done by the task force.

January - May 2022

- Met 5 times via Zoom (January 3, February 7, March, April 7, May 2).
- **Key discussion topics**
 1. Continued focus on systematically revising sections of the competencies.
 2. Deep dive into **Musical Development**
 - Gathering information from Commission
 - Identified the critical music skills necessary to practice music therapy
 - Developed competencies for those skills and placed them in the Framework
 3. Developed a process to review the suggested competencies and draft of each subgroup
 4. Submitted to present at the 2022 AMTA Conference

June - December 2022

- Met 4 times (June 6, October 3, November 7, December 5th)
- Additionally, met August 16 - for a 4 hour **Virtual Retreat**
 - Worked on, reviewed, and discussed Musical Development, Professional Growth, and Literature review
- 11/1/2022 - **CRTF Presentation to Assembly of Delegates**
- **Completed work on Professional Growth**
- **Key decisions** - further defining the framework and developing a common understanding of each column - (*Figure 1*)

Ready for internship	Ready for prof practice	Advance practice
Music skills/acquisition Knowledge Early application Supported Attitudes?	Consistency Independence Therapeutic Application Musical advancement	Synthesis Innovation Deepening Research Interpret

Figure 1

January - December 2023

- Met 10 times (January 1, February 6, March 6, April 3, June 19, July 17, August 8, September 18, November 20, December 18)
- April 3 - **Complete Review of Integrative Clinical Practice**
- April 18 - **Meeting with the Commission**
 - Discuss work of each group and how the Commission's report will impact the competencies
- November 2 **AMTA Community Update**
- November 20 - **AMTA Board of Directors update**
- **Key discussion topics:**
 1. Strategic planning for wrapping up document
 2. Touch base with BOD regarding regular communication between CRTF and BOD
 3. Review of Personal Development, 2nd review of Musical Development
 4. Soft skills/professional behavior - exploration and review of resources
 5. Further discussion of key concepts/words for each column (Figure 2.)

Ready for internship	Ready for prof practice	Advance practice
Music skills/acquisition Knowledge Early application Supported Attitudes?	Consistency Independence Therapeutic Application Musical advancement Interpret Increased complexity?	Synthesis Innovation Deepening Research Expertise
(consistent skill/knowledge/with support or supervision)	(client focused/ consistent application/independence) *consider Prof. Growth and Personal Development	(synthesis, innovation, evaluation, expertise, research)

Figure 2

January - December 2024

- Met 18 times (January 15, February 19, March 18, April 15, May 20, June 3, June 17, July 1, July 15, August 5, August 19, September 16, October 7, October 21, November 4, November 18, December 2, December 16)
- October 24 - **Presentation to AMTA Board of Directors**
- **Key discussion topics:**
 1. Making final revisions to each section of the competencies framework.
 2. Meetings with President and Past President of Board of Directors - discuss potential retreat, contact updates, discussion on mechanism/s for gathering input on potential competencies.
 3. Determining and completing final steps needed to complete the charges: putting document together, creating reference list, creating definitions, review document for redundancy, edit document for clarity/conciseness, identify DEI and Safety, cross reference CBMT Domains, cross reference original professional and advanced competencies, reference past agendas to capture any missed discussion, write preamble, create a historical timeline
 4. **Reveal of the clean copy!**
 5. Review for gaps and final revisions
- **Key decisions:** Voted on using “client” - 1) operationally define the term (including all of the other possible terms that are used) and 2) clearly articulate the process and sources we used to make the decision. (See [Appendix F](#))

CHARGE 3: Update and revise the competencies to reflect the growth of knowledge base of the profession. - Completed

Appendix A: Working groups for Task 2

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Groups for Task 2

Music Foundations

- A1 Music Theory and History (Della Molloy-Daugherty, Jennifer Fiore, Christine Neugebauer)
- A2 Composition and Arranging Skills (Deanna, Deb Layman & Darlene Brooks)
- A3 Major Performance Medium Skills (Laurie, April Mounts, Bill Matney, Suzanne Sorel)
- A4 Functional Music Skills (Tracy, Alan Turry, Sharon Boyle)
- A5 Conducting Skills (Vicki, Jean Nemith, Mike Zanders)
- A6 Movement Skills (Piper, Kymla Eubanks, Olivia Houck)

Clinical Foundations

- B7 Therapeutic Applications (Tracy; Alan Turry; Sharon Boyle)
- B8 Therapeutic Principles (Tracy; Alan Turry; Sharon Boyle)
- B9 Therapeutic Relationship (Tracy; Alan Turry; Sharon Boyle)

Music Therapy

- C10 Foundations and Principles (Deanna, Deb Layman & Darlene Brooks)
- C11 Client Assessment (Deanna, Deb Layman & Darlene Brooks)
- C12 Treatment Planning (Laurie, April Mounts, Bill Matney, Suzanne Sorel)
- C13 Therapy Implementation (Della Molloy-Daugherty, Jennifer Fiore, Christine Neugebauer)
- C14 Therapy Evaluation (Vicki, Jean Nemith, Mike Zanders)
- C15 Documentation (Vicki, Jean Nemith, Mike Zanders)
- C16 Termination/Discharge Planning (Piper, Kymla Eubanks, Olivia Houck)
- C17 Professional Role/Ethics (Gary, Trish Winter, Noel Anderson)
- C18 Interprofessional Collaboration (Piper, Kymla Eubanks, Olivia Houck)
- C19 Supervision and Administration (Gary, Trish Winter, Noel Anderson)
- C20 Research Methods (Kamile, Janice Lindstrom, Melita Belgrave)

Appendix B: June, 2019 Summary of findings for Charges 1 and 2

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1) General Differences Between the Board Certification Domains (BCDs) and the Professional Competencies (PCs)

The CRTF first completed an overall thematic analysis as a comparison of the two documents. This analysis involved individual task force member's review and lengthy discussions about how they relate. The task force consulted with the CBMT Executive Director, Joy Schneck, in the spring of 2018 to discuss this as well. The thematic analysis results are the following.

Professional Competencies	Board Certification Domains
Skills to be learned	Clinical skills to be applied
Static	Dynamic
Broad	Specific
Knowledge and Concepts	Tasks
Foundational	Applicable

2) Related Professional and Advanced Competencies when compared to BCDs

Taking into account the themes that emerged when analyzing for general differences, the task force then decided to analyze each sub domain item and identify if any professional or advanced competency (ies) related to the BCD subdomain. Each task force member was assigned a section of the BCDs to analyze and then document any related professional or advanced competencies (see attached data).

The CRTF defined what we collectively meant if a BCD subdomain related (yes or no) to a professional or advanced competency (see conditions of 'yes' below).

A Board Certification sub-domain relates to an AMTA competency under one or more of the following conditions:

- 1) The words of the subdomain and competency are the same or substantially similar.*
- 2) The words of the subdomain and competency are implicitly substantially similar (e.g. range of motion could be implied in psychomotor responses).*
- 3) The subdomain is a broader idea of specifics in a competency.*
- 4) The competency is a broader idea of specifics in a subdomain item.*
- 5) The subdomain is the application of a defined skill in a competency.*

Of the 202 total BCD subdomains, the task force found that 140 BCDs met one or more of the conditions listed above for at least one professional competency and 62 of them did not. The areas that did not meet one or more of the conditions ranged across all headings in the BCDs (i.e. assessment, etc.) except for *referral* which had a corresponding professional competency for each of the four subdomain items. Although, it was found that there is not a specific *referral* section in the professional competencies.

There was a total of 72 instances of the 202 total BCD subdomains that met at least one or more of the conditions listed above for advanced competency. Of that total, 44 subdomains related to both professional and advanced competencies.

These numbers suggest that approximately 31% of the BCD subdomains do not have a corresponding foundational knowledge professional competency. In addition, approximately 37% of the subdomains do have a corresponding advanced competency as foundational knowledge.

3) Gap areas in knowledge within the professional competencies when compared to the BCDs.

While the percentages reported above indicate gaps in the professional competencies as compared to the current BCDs, the task force also found a few key areas that warrant further discussion.

Musical Domains/Competencies: The BCDs do not seem to address assessment of the musical domain. In turn, the Professional Competencies do address learning music skills but do not adequately address the knowledge needed for clinical musicianship skills, encompassing knowledge needed to assess and treat using music, nor how music could cause harm. The knowledge needed for assessing the music domain is limited in the Professional Competencies.

Theories and Approaches: The BCDs do address the need to apply a variety of theoretical approaches and models in clinical practice. The Professional Competencies do not address that entry-level practitioners should have knowledge of theories or approaches. The Advanced Competencies indicated that this knowledge is needed for advanced practice. There is a disconnect here on what is expected in current clinical practice and the knowledge needed to enter the field regarding theories and approaches.

Referral Domains/Competencies: Referral subdomain clinical application skills are listed in the BCDs and a task force member found related Professional Competencies, however there is not a referral section in the Professional Competencies.

Recommendations:

1. The CRTF agrees that the three documents under review (Professional Competencies, The Board Certification Domains, and the Advanced Competencies) should work together as a continuum rather than 3 separate documents. Therefore, it is recommended that the headings (and sub domain and competencies within each heading) for the professional competencies, the domains, and the advanced competencies be similar across documents. The CRTF see these three documents as a continuum of knowledge to advanced knowledge:

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2. It is recommended that when making changes to these documents, keep in mind the intent of the documents (foundational knowledge to learn OR skill to apply OR advanced knowledge to learn) and to keep the language consistent within each of the documents with that intent in mind.

Appendix C: June, 2019: Supporting data for summary of findings

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CBMT Domain	CBMT Subdomain	Subdomain relates to a professional competency ?	Professional competency (ies) that relate(s) to the subdomain.	Subdomain relates to an advanced competency?	Advanced competency(ies) that relate(s) to the subdomain?	Comments from task force regarding the relationships between BCD and Competencies.
I.A. Referral	I.A.1. Utilize or develop appropriate referral protocol for population.	Yes	B.7.1. Demonstrate basic knowledge of the potential, limitations, and problems of populations specified in the Standards of Clinical Practice.	No		AMTA Competency B.7.1 is the only competency that addresses any aspect of the CBMT Referral domain. All other domains are not present in professional or advanced competencies. Competency is general in nature and combines aspects of subdomain. Referral is broken down into specific component of referral process (e.g. use or develop)
I.A. Referral	I.A.2. Evaluate the appropriateness of a referral for music	Yes	B.7.1. Demonstrate basic knowledge of the potential, limitations, and problems of populations specified in the Standards of Clinical Practice.	No		Competency is general in nature and combines aspects of subdomain. Referral is broken down into specific component of referral process (e.g. evaluation of the appropriateness for the referral to music therapy)
I.A. Referral	I.A.3. Prioritize referrals according to immediate client needs	Yes	B.7.1. Demonstrate basic knowledge of the potential, limitations, and problems of populations specified in the Standards of Clinical Practice.	No		Competency is general in nature and combines aspects of subdomain. Referral is broken down into specific component of referral process (e.g. prioritization of referrals)
I.A. Referral	I.A.4. Educate staff, treatment team, or other professionals regarding appropriate referral criteria for music therapy based on population needs	Yes	B.7.1. Demonstrate basic knowledge of the potential, limitations, and problems of populations specified in the Standards of Clinical Practice.	No		Competency is general in nature and combines aspects of subdomain. Referral is broken down into specific component of referral process (e.g. education on appropriate referral criteria)

I.B. Assessment	I.B.1. Observe client in music and/or non-music settings.	Yes	C.10.2. Principles and methods of music therapy assessment, treatment, evaluation, and termination for the populations specified in the Standards of Clinical Practice.	Yes	B.4.1. Apply comprehensive knowledge of current methods of music therapy assessment, treatment, and evaluation.	General professional and advanced competency on Assessment observation in music and non-music contexts
I.B. Assessment	I.B.2. Obtain client information	Yes	C.10.2. Principles and methods of music therapy assessment, treatment, evaluation, and termination for the populations specified in the Standards of Clinical Practice.	Yes	B.4.1. Apply comprehensive knowledge of current methods of music therapy assessment, treatment, and evaluation.	general to assessment competencies; BCD is more specific and broken down
I.B. Assessment	I.B.3.b. communicative	No		No		communicative is not present in the competencies
I.B. Assessment	I.B.3.c. emotional	Yes	C.10.3. The psychological aspects of musical behavior and experience including, but not limited to, perception, cognition, affective response, learning, development, preference, and creativity.	No		general reference to emotional as psychological aspects of assessment in competences; BCD is a specific job task
I.B. Assessment	I.B.3.d. musical	No		No		Ironically, competencies reference to client functioning, strengths and needs are not addressed in professional or advanced competencies; itemized in BCD as a task to address
I.B. Assessment	I.B.3.e. physiological	Yes	C.10.4. The physiological aspects of the musical experience including, but not limited to, central nervous system, peripheral nervous system, and psychomotor responses.	No		similar in both contexts

I.B. Assessment	I.B.3.f. psychosocial	Yes	B.7.3. Demonstrate basic knowledge of typical and atypical human systems and development (e.g., anatomical, physiological, psychological, social.); C.10.3. The psychological aspects of musical behavior and experience including, but not limited to, perception, cognition, affective response, learning, development, preference, and creativity.	No		general aspects in competencies; BCD specific are to be assessed
I.B. Assessment	I.B.3.g. sensorimotor	Yes	C.10.4. The physiological aspects of the musical experience including, but not limited to, central nervous system, peripheral nervous system, and psychomotor responses.	No		
I.B. Assessment	I.B.3.h Identify client functioning level, strengths, and areas of need within the following domains: spiritual	No		No		

I.B. Assessment	I.B.4.a Identify client's: a) active symptoms, b) behaviors, g) manifestation of affective state, i) preferences	Yes	C.11.1. Select and implement effective culturally-based methods for assessing the client's strengths, needs, musical preferences, level of musical functioning, and development, B.7.2. Demonstrate basic knowledge of the causes, symptoms of, and basic terminology used in medical, mental health, and educational classifications.; C.11.3. Identify the client's functional and dysfunctional behaviors; C.10.3. The psychological aspects of musical behavior and experience including, but not limited to, perception, cognition, affective response, learning, development, preference, and creativity.	No		
I.B. Assessment	I.B.4.b Identify client's: c) clinical history, d) cultural and spiritual background, when indicated, e) family dynamics and support systems, f) learning styles, h) music background and skills, j) social and interpersonal relationships, k) stressors related to present status, l) resources	No		No		

I.B. Assessment	I.B.5. Document intake and assessment information.	Yes	C.11.2. Observe and record accurately the client's response to assessment; C.11.5. Communicate assessment finding and recommendations in written and verbal forms.	Yes	A.7.1. Reproduce, notate, and transcribe musical responses of clients.	
I.B. Assessment	I.B.6. Understand the possible effects of medical and psychotropic drugs.	Yes	C.11.2. Observe and record accurately the client's response to assessment; C.11.5. Communicate assessment finding and recommendations in written and verbal forms.	No		
I.B. Assessment	I.B.7. Select musical assessment tools and procedures.	Yes	C.11.1. Select and implement effective culturally-based methods for assessing the client's strengths, needs, musical preferences, level of musical functioning, and development.	Yes	A. Musical & Artistic Development	
I.B. Assessment	I.B.8. Select non-musical assessment tools and procedures.	Yes	C.11.1. Select and implement effective culturally-based methods for assessing the client's strengths, needs, musical preferences, level of musical functioning, and development.	No		
I.B. Assessment	I.B.9. Adapt existing assessment tools and procedures.	Yes	C.11.1. Select and implement effective culturally-based methods for assessing the client's strengths, needs, musical preferences, level of musical functioning, and development.	Yes	B.4.6. Design or adapt assessment and evaluation procedures for various client populations.	

I.B. Assessment	I.B.10. Develop assessment tools and procedures.	Yes	C.10.3. The psychological aspects of musical behavior and experience including, but not limited to, perception, cognition, affective response, learning, development, preference, and creativity.; C.11.1. Select and implement effective culturally-based methods for assessing the client's strengths, needs, musical preferences, level of musical functioning, and development.	Yes	B.4.6. Design or adapt assessment and evaluation procedures for various client populations.	general area of assessment; BCD is related to a specific task.
I.B. Assessment	I.B.11. Create an assessment environment or space conducive to the assessment protocol and/or client's needs.	No		No		
I.B. Assessment	I.B.12. Engage client in musical and non-musical experiences to obtain assessment data.	No		No		
I.B. Assessment	I.B.13. Identify client responses	Yes	C.11.4. Identify the client's therapeutic needs through an analysis and interpretation of assessment data.	Yes	B.4.13. Respond to the dynamics of musical and interpersonal relationships that emerge at different stages in the therapy process.	indirectly related. BCD itemizes client response to types of musical experiences, non-musical experiences, styles of music and elements of music. Neither professional or advanced competencies are this specific.
I.C. Interpret Assessment Information and Communicate Results	I.C.1. Evaluate reliability and presence of bias in information from available resources	Yes	C.11.1. Select and implement effective culturally-based methods for assessing the client's strengths, needs, musical preferences, level of musical functioning, and development.	Yes	B.4.1. Apply comprehensive knowledge of current music therapy assessment, treatment, and evaluation.	Important discrepancy between the BCD and the professional competencies here, related to understanding reliability, bias, research, and evidence-based practice. As I look more closely, that seems to be a gap in general in the Prof. Comp.

I.C. Interpret Assessment Information and Communicate Results	I.C.2. Identify factors which may impact accuracy of information gathered during assessment (e.g., precipitating events, medications, health considerations).	Yes	C.11.2. Observe and record accurately the client's response to assessment.	Yes	B.4.1. Apply comprehensive knowledge of current music therapy assessment, treatment, and evaluation.	BCD is about identifying outside factors that impacts accuracy of info gathered in assessment; Professional Competency is about observing and recording in actual assessment. Advanced competency is broad - applying comprehensive knowledge of assessment - the BCD is embedded within it.
I.C. Interpret Assessment Information and Communicate Results	I.C.3. Draw conclusions and make recommendations based on analysis and synthesis of assessment findings.	Yes	C.11.4. Identify the client's therapeutic needs through an analysis and interpretation of assessment data.	Yes	B.4.7. Utilize advanced music therapy methods within one or more theoretical frameworks to assess and evaluate clients' strengths, needs and progress.; A.7.6. Use different methods of musical analysis for client assessment and evaluation.	Both advanced competencies are directly related - one adds "utilize advanced methods..." language and the other specifically addresses use of different methods of musical analysis. But otherwise language at both levels of very consistent.
I.C. Interpret Assessment Information and Communicate Results	I.C.4. Acknowledge therapist's bias and limitations in interpreting assessment information (e.g., cultural differences, clinical orientation).	Yes	C.17.8. Demonstrate critical self-awareness of strengths and weaknesses. C.17.9. Demonstrate knowledge of and respect for diverse cultural backgrounds.	Yes	B.8.5. Recognize limitations in competence and seek consultation.; B.8.7. Implement music therapy approaches based on knowledge of and sensitivity to the roles and meanings of musics in diverse cultures. B.8.8. Work with culturally diverse populations, applying knowledge of how culture influences issues regarding identity formation, concepts of health and pathology, and understanding of the role of therapy.	All related competencies (professional and advanced) address therapist's competence r/t self-awareness, cultural sensitivity, and cultural competence, but not directly related to assessment.
I.C. Interpret Assessment Information and Communicate Results	I.C.5. Communicate assessment findings and recommendations in oral, written, or other forms (e.g., video, audio).	Yes	C.11.5. Communicate assessment finding and recommendations in written and verbal forms.	Yes	B.4.14. Fulfill the clinical roles and responsibilities of a music therapist within a total treatment milieu and in private practice.	Wording for professional competencies is very similar to BCD. Advanced competencies are much broader than both of the others (r/t fulfilling clinical roles and responsibilities of a music therapist).
I.D. Treatment Planning	I.D.1. Involve client in the treatment planning process when appropriate.	Yes	C.20.4. Integrate the best available research, music therapists' expertise, and the needs, values, and preferences of the individual(s) served.	Yes	B.4.1. Apply comprehensive knowledge of current methods of music therapy assessment, treatment, and evaluation.	The wording of the professional competency is MUCH more specific than the BCD (in my opinion, the PC is better). Correlation between BCD and AC is very indirect. This task would assumed under this AC.

I.D. Treatment Planning	I.D.2.a)Consult the following in the treatment planning process: clinical and research literature and other resources	Yes	C.20.1. Interpret information in the professional research literature.; C.20.4. Integrate the best available research, music therapists' expertise, and the needs, values, and preferences of the individual(s) served.	Yes	B.4.1. Apply comprehensive knowledge of current methods of music therapy assessment, treatment, and evaluation. B.4.2. Utilize comprehensive knowledge of human growth and development, musical development, diagnostic classifications, etiology, symptomology, and prognosis in formulating treatment plans.	Correlation in PC is very close, but wording in PC is much more specific than in BCD. Correlation is between BCD and AC is indirect because the BCD is embedded/assumed within the broader ACs.
I.D. Treatment Planning	I.D.2.b)Consult the following in the treatment planning process: client's family, caregivers, or personal network, when appropriate	No		No		Na
I.D. Treatment Planning	I.D.2.c) Consult the following in the treatment planning process: other professionals, when appropriate.	Yes	C.18.4. Collaborate with team members in designing and implementing interdisciplinary treatment programs.	No		Relationship between the BCD and PC is very strong; wording is very similar. Can't find any wording specific to consulting with treatment team in AC other than vague "within total treatment milieu" wording in I.B.4.14
I.D. Treatment Planning	I.D.3. Coordinate treatment with other professionals.	Yes	C.12.10. Coordinate treatment plan with other professionals.	Yes	B.4.15. Apply advanced skills in co-facilitating treatment with professionals from other disciplines.	Relationship between BCD and PC is very strong; wording is very similar. BCD can be assumed within the noted AC, which is broader.
I.D. Treatment Planning	I.D.4. Evaluate the role of music therapy within the overall therapeutic program.	Yes	C.18.3. Define the role of music therapy in the client's total treatment program.	Yes	B.4.12. Relate clinical phenomena in music therapy to the broader treatment context.	Wording of BCD and PC is identical EXCEPT BCD use the word "evaluate" and PC use the word "DEFINE - significant difference. This BCD can be assumed within the broader related AC.
I.D. Treatment Planning	I.D.5. Consider the length of treatment when establishing client goals and objectives.	Yes	C.12.4. Provide preliminary estimates of frequency and duration of treatment.	Yes	B.4.8. Design treatment programs for emerging client populations.; B.4.14. Fulfill the clinical roles and responsibilities of a music therapist within a total treatment milieu and in private practice.	Connection is tenuous - BCD is r/t considering length of Tx when establishing goals and obj; PC is r/t providing estimates of frequency and duration of Tx. Yet, this was the only correlation of on this topic between the two documents. BCD can be assumed within the broader AC.

I.D. Treatment Planning	I.D.6.a)-e) Establish client goals and objectives that are: achievable, measurable, realistic, specific, time-bound	Yes	C.12.2. Formulate goals and objectives for individual and group therapy based upon assessment findings.	Yes	B.4.8. Design treatment programs for emerging client populations.; B.4.14. Fulfill the clinical roles and responsibilities of a music therapist within a total treatment milieu and in private practice.	BCD and PC are very similar, but wording of BCD is much more specific and concrete. BCD can be assumed within the broader ACs.
I.D. Treatment Planning	I.D.7. Use a data collection system for measuring clinical outcomes to reflect criteria in objective.	Yes	C.15.2. Document clinical data. ; C.15.6. Develop and use data-gathering techniques during all phases of the clinical process including assessment, treatment, evaluation, and termination.	Yes	B.4.14. Fulfill the clinical roles and responsibilities of a music therapist within a total treatment milieu and in private practice.	BCD and two PCs are all saying similar things, but differently and with different levels of specificity. BCD can be assumed within broader AC.
I.D. Treatment Planning	I.D.8. Create environment or space conducive to client engagement.	Yes	C.12.7. Create a physical environment (e.g., arrangement of space, furniture, equipment, and instruments that is conducive to therapy).	Yes	B.4.5 Utilize the dynamics and processes of various theoretical models in individual, dyadic, family and group music therapy.	Relationship between BCD and PC very strong - wording is very similar. BCD can be assumed within broader AC.
I.D. Treatment Planning	I.D.9. Consider client's age, culture, language, music background, and preference when designing music therapy experiences.	Yes	C.17.9. Demonstrate knowledge of and respect for diverse cultural backgrounds.; 17.10 Treat all persons with dignity and respect, regardless of differences in race, ethnicity, language, religion, marital status, gender, gender identity or expression, sexual orientation, age, ability, socioeconomic status, or political affiliation. C.17.11 Demonstrate skill in working with culturally diverse populations.	Yes	B.8.7. Implement music therapy approaches based on knowledge of and sensitivity to the roles and meanings of musics in diverse cultures. B.8.8. Work with culturally diverse populations, applying knowledge of how culture influences issues regarding identity formation, concepts of health and pathology, and understanding of the role of therapy.	PC are indirect because they are only related to therapist's overall cultural competence and sensitivity, but not as related to Tx planning. AC are more closely aligned with BCD; language focused more in depth and includes implementation.

I.D. Treatment Planning	I.D.10. Design music therapy experiences that address client goals and objectives based on available research; clinical expertise; and the needs, values, and preference of the clients.	Yes	C.12.1. Select or create music therapy experiences that meet the client's objectives. C.20.4. Integrate the best available research, music therapists' expertise, and the needs, values, and preferences of the individual(s) served.	Yes	B.4.1. Apply comprehensive knowledge of current methods of music therapy assessment, treatment, and evaluation. B.4.2. Utilize comprehensive knowledge of human growth and development, musical development, diagnostic classifications, etiology, symptomology, and prognosis in formulating treatment plans.; B.4.8. Design treatment programs for emerging client populations.	Wording of BCD almost merges wording of the two PCs. BCD can be assumed within these broader ACs.
I.D. Treatment Planning	I.D.11. Use appropriate musical instruments and equipment consistent with treatment needs.	Yes	C.12.5. Select and adapt music, musical instruments, and equipment consistent with the strengths and needs of the client.	Yes	B.4.1. Apply comprehensive knowledge of current methods of music therapy assessment, treatment, and evaluation.; B.4.9. Employ one or more models of music therapy requiring advanced training.	BCD and PC are very closely related - wording is very close. BCD can be assumed within these broader ACs.
I.D. Treatment Planning	I.D.12. Use non-music materials consistent with music therapy goals and clients' learning styles (e.g., adaptive devices, visual aids)	No		No		NA
I.D. Treatment Planning	I.D.13. Plan sessions of appropriate duration and frequency.	Yes	C.12.4. Provide preliminary estimates of frequency and duration of treatment.	Yes	B.4.1. Apply comprehensive knowledge of current methods of music therapy assessment, treatment, and evaluation.; B.4.14. Fulfill the clinical roles and responsibilities of a music therapist within a total treatment milieu and in private practice.	P.C. item C.12.4.r/t preliminary estimates of frequency and duration of Tx. But significant difference. This BCD can be assumed within these broader ACs.
I.D. Treatment Planning	I.D.14. Determine group and/or individual placement based on assessment findings.	Yes	C.12.9. Determine the client's appropriate music therapy group and/or individual placement.	Yes	B.4.1. Apply comprehensive knowledge of current methods of music therapy assessment, treatment, and evaluation.; B.4.14. Fulfill the clinical roles and responsibilities of a music therapist within a total treatment milieu and in private practice.	BCD and PC are a very close match. BCD can be assumed within broader ACs.

I.D. Treatment Planning	I.D.15. Structure and organize music therapy experiences within each session to create therapeutic contour (e.g., transitions, pacing, sequencing, energy level, intensity).	Yes	C.13.8. Sequence and pace music experiences within a session according to the client's needs and situational factors.	Yes	B.4.1. Apply comprehensive knowledge of current methods of music therapy assessment, treatment, and evaluation.; B.4.14. Fulfill the clinical roles and responsibilities of a music therapist within a total treatment milieu and in private practice.	BCD and PC a very close match, but with different wording. BCD can be assumed within broader ACs.
I.D. Treatment Planning	I.D.16. Design programs to reinforce goals and objectives for implementation outside the music therapy setting.	No		Yes	B.4.14. Fulfill the clinical roles and responsibilities of a music therapist within a total treatment milieu and in private practice.	BCD could be assumed under broader AC.
I.D. Treatment Planning	I.D.17. Document treatment plan.	Yes	C.15.5. Document and revise the treatment plan and document changes to the treatment plan.	Yes	B.4.14. Fulfill the clinical roles and responsibilities of a music therapist within a total treatment milieu and in private practice.	BCD and PC a direct match, but PC is more specific. BCD can be assumed within the broader AC.
II.A. Implementation	II.A.1.a. Develop a therapeutic relationship by building trust and rapport.	Yes	B.8.1. Demonstrate basic knowledge of the dynamics and processes of a therapist-client relationship. B.8.2. Demonstrate basic knowledge of the dynamics and processes of therapy groups.	No		Very loosely connected. BCD refers specifically to development of a therapeutic relationship; PC refers to demonstrating basic knowledge of what a therapeutic relationship is. Not the same.
II.A. Implementation	II.A.1.b. Develop a therapeutic relationship by being fully present and authentic	Yes	B.9.3. Use oneself effectively in the therapist role in both individual and group therapy, e.g., appropriate self-disclosure, authenticity, empathy, etc. toward affecting desired therapeutic outcomes.	No		Both BCD and PC are stated in the active tense of the therapeutic relationship.
II.A. Implementation	II.A.1.c. Develop a therapeutic relationship by establishing boundaries and communicating expectations.	Yes	C.13.4. Provide models for and communicate expectations of behavior to clients.	No		They are directly related, but the quality could be better. BCD talks about boundaries and PC does not.

II.A. Implementation	II.A.1.d. Develop a therapeutic relationship by providing ongoing acknowledgement and reflection.	Yes	C.13.1. Recognize, interpret, and respond appropriately to significant events in music therapy sessions as they occur.; C.13.6. Provide feedback on, reflect, rephrase, and translate the client's communications.	No		implicitly connected
II.A. Implementation	II.A.1.e. Develop a therapeutic relationship by providing a safe and contained environment	Yes	C.12.7. Create a physical environment (e.g., arrangement of space, furniture, equipment, and instruments that is conducive to therapy).	No		similar wording
II.A. Implementation	II.A.1.f. Develop a therapeutic relationship by recognizing and managing aspects of one's own feelings and behaviors that affect the therapeutic process	Yes	B.9.1. Recognize the impact of one's own feelings, attitudes, and actions on the client and the therapy process.	No		similar wording
II.A. Implementation	II.A.1.g. Develop a therapeutic relationship by recognizing and working with transference and countertransference dynamics	No		Yes	B.4.13. Respond to the dynamics of musical and interpersonal relationships that emerge at different stages in the therapy process.	implicitly connected
II.A. Implementation	II.A.1.h. Develop a therapeutic relationship by understanding group dynamics and process	Yes	B.8.2 Demonstrate basic knowledge of the dynamics and processes of therapy groups.	No		similar wording
II.A. Implementation	II.A.2.a. Provide music therapy experiences to address client's ability to empathize	No		Yes	B.4.2. Utilize comprehensive knowledge of human growth and development, musical development, diagnostic classifications, etiology, symptomology, and prognosis in formulating treatment plans.	BCD is specific to a client skill; AC is very broad and vague compared to BCD

II.A. Implementation	II.A.2.aa. Provide MT experiences to address a client's musical and other creative responses.	Yes	C.10.3. The psychological aspects of musical behavior and experience including, but not limited to, perception, cognition, affective response, learning, development, preference, and creativity.	No		BCD is specific to "providing MT experiences" and to music/creative responses; PC is broad: "apply basic knowledge" and lists much more than creative responses. Weak relationship.
II.A. Implementation	II.A.2.ab. Provide MT experiences that address a client's neurological and cognitive function.	Yes	C.10.4. The physiological aspects of the musical experience including, but not limited to, central nervous system, peripheral nervous system, and psychomotor responses.	No		BCD is specific and is about providing specific MT intervention; PC is about applying basic knowledge and is broader than the BCD.
II.A. Implementation	II.A.2.ac. Provide MT experiences to address client's nonverbal expression.	Yes	C.10.3. The psychological aspects of musical behavior and experience including, but not limited to, perception, cognition, affective response, learning, development, preference, and creativity.	No		Very negligible connection between BCD and PC. "Nonverbal expression" could be implied but it's a stretch.
II.A. Implementation	II.A.2.ad. Provide MT experiences to address client's on-task behavior.	Yes	C.13.3. Provide verbal and nonverbal directions and cues necessary for successful client participation.; C.13.4. Provide models for and communicate expectations of behavior to clients.	No		BCD is related to the PCs listed, but the quality could be better; one of the PCs could be more specific about on-task behavior.
II.A. Implementation	II.A.2.ae. Provide MT experiences to address client's oral motor control.	No		No		
II.A. Implementation	II.A.2.af. Provide MT experiences to address client's pain.	No		No		

II.A. Implementation	II.A.2.ag. Provide MT experiences to address client's participation/engagement.	Yes	C.13.3. Provide verbal and nonverbal directions and cues necessary for successful client participation.	No		They are directly related; however, BCD is more specific with "engagement" which I feel is more than just participation.
II.A. Implementation	II.A.2.ah. Provide MT experiences to address client's physiological symptoms.	Yes	C.10.4. The physiological aspects of the musical experience including, but not limited to, central nervous system, peripheral nervous system, and psychomotor responses.	No		BCD = active use of MT intervention, and specific to physiological responses; PC is "apply basic knowledge of..." and is broad
II.A. Implementation	II.A.2.ai. Provide MT experiences to address client's pragmatics of speech.	No		Yes	B.4.2 .Utilize comprehensive knowledge of human growth and development, musical development, diagnostic classifications, etiology, symptomology, and prognosis in formulating treatment plans.	Pragmatics of speech is specific. Indirectly related to the AC regarding the utilization of comprehensive knowledge, and likely occurs with advanced practice.
II.A. Implementation	II.A.2.aj. Provide MT experiences to address client's preparedness for stressful situations.	No		Yes	B.4.2 .Utilize comprehensive knowledge of human growth and development, musical development, diagnostic classifications, etiology, symptomology, and prognosis in formulating treatment plans.	Loosely related. The BCD would likely occur with advanced experience and in advanced practice.
II.A. Implementation	II.A.2.ak. Provide MT experiences to address client's quality of life.	No		Yes	B.4.12. Relate clinical phenomena in music therapy to the broader treatment context.	AC is actually vague while BCD is specific to a provision in MT. Relate clinical phenomena in what context? For the client? These are related but quality could be improved in the writing of the AC.
II.A. Implementation	II.A.2.al. Provide MT experiences to address client's range of motion.	Yes	C.10.4. The physiological aspects of the musical experience including, but not limited to, central nervous system, peripheral nervous system, and psychomotor responses.	Yes	B.4.7. Utilize advanced music therapy methods within one or more theoretical frameworks to assess and evaluate clients' strengths, needs and progress.	BCD and PC: negligible relationship but could possibly be implied. Actually, the BCD likely occurs in advanced practice. ROM could fall under the model of NMT so the AC is a better fit than the PC.

II.A. Implementation	II.A.2.am. Provide MT experiences to address client's reality orientation.	Yes	C.10.3. The psychological aspects of musical behavior and experience including, but not limited to, perception, cognition, affective response, learning, development, preference, and creativity.	No		Weak but implied relationship between BCD and PC.
II.A. Implementation	II.A.2.an. Provide MT experiences to address client's responsibility for self.	Yes	C.13.4. Provide models for and communicate expectations of behavior to clients.	No		Weak but implied relationship between BCD and PC.
II.A. Implementation	II.A.2.ao. Provide MT experiences to address client's self-awareness and insight.	No		Yes	B.4.10. Utilize advanced verbal and nonverbal interpersonal skills within a music therapy context.	The BCD does not relate to any PC, but could be related to the AC in advanced practice. Implied relationship.
II.A. Implementation	II.A.2.ap. Provide MT experiences to address client's self-esteem.	Yes	C.10.5. Philosophical, psychological, physiological, and sociological basis of music as therapy.	No		The BCD is implied in the PC and the relationship is weak. Targeting self-esteem (the BCD) would be basic knowledge of the psychological basis of music in therapy (the PC).
II.A. Implementation	II.A.2.aq. Provide MT experiences to address client's sense of self with others.	Yes	C.13.11. Promote a sense of group cohesiveness and/or a feeling of group membership.	No		implicitly connected
II.A. Implementation	II.A.2.ar. Provide MT experiences to address client's sensorimotor skills.	Yes	C.10.3. The psychological aspects of musical behavior and experience including, but not limited to, perception, cognition, affective response, learning, development, preference, and creativity.	No		implicitly connected

II.A. Implementation	II.A.2.as. Provide MT experiences to address client's sensory integration.	Yes	C.10.3. The psychological aspects of musical behavior and experience including, but not limited to, perception, cognition, affective response, learning, development, preference, and creativity.; C.10.4. The physiological aspects of the musical experience including, but not limited to, central nervous system, peripheral nervous system, and psychomotor responses.	No		
II.A. Implementation	II.A.2.at. Provide MT experiences to address client's sensory orientation	Yes	C.10.4. The physiological aspects of the musical experience including, but not limited to, central nervous system, peripheral nervous system, and psychomotor responses.	No		implicitly connected
II.A. Implementation	II.A.2.au. Provide MT services to address client's auditory perception.	Yes	C.10.3. The psychological aspects of musical behavior and experience including, but not limited to, perception, cognition, affective response, learning, development, preference, and creativity.	No		implicitly connected
II.A. Implementation	II.A.2.av. Provide MT services to address client's social skills and interactions.	Yes	C.10.3. The psychological aspects of musical behavior and experience including, but not limited to, perception, cognition, affective response, learning, development, preference, and creativity.	No		implicitly connected

II.A. Implementation	II.A.2.aw. Provide MT experiences to address client's spirituality.	No		Yes	B.4.12. Relate clinical phenomena in music therapy to the broader treatment context.	implicitly connected
II.A. Implementation	II.A.2.ax. Provide MT experiences to address a client's spontaneous communication/interactions.	Yes	C.10.3. The psychological aspects of musical behavior and experience including, but not limited to, perception, cognition, affective response, learning, development, preference, and creativity.	No		implicitly connected
II.A. Implementation	II.A.2.ay. Provide MT experiences to address client's strength and endurance	Yes	C.10.4. The physiological aspects of the musical experience including, but not limited to, central nervous system, peripheral nervous system, and psychomotor responses.	No		implicitly connected
II.A. Implementation	II.A.2.az. Provide MT experiences to address a client's support systems.	No		Yes	B.4.12. Relate clinical phenomena in music therapy to the broader treatment context.	implicitly connected
II.A. Implementation	II.A.2.b. Provide MT experiences to address client's ability to use music independently for self-care	No		Yes	B.4.12. Relate clinical phenomena in music therapy to the broader treatment context.	implicitly connected
II.A. Implementation	II.A.2.ba. Provide MT experiences to address client's verbal and nonverbal communication.	Yes	C.13.6. Provide feedback on, reflect, rephrase, and translate the client's communications.; C.13.7. Assist the client in communicating more effectively.	No		similar wording
II.A. Implementation	II.A.2.bb. Provide MT services to address client's verbal and/or vocal responses.	Yes	C.10.4. The physiological aspects of the musical experience including, but not limited to, central nervous system, peripheral nervous system, and psychomotor responses.	No		implicitly connected

II.A. Implementation	II.A.2.bc. Provide MT experiences to address a client's vocal production.	Yes	C.10.4. The physiological aspects of the musical experience including, but not limited to, central nervous system, peripheral nervous system, and psychomotor responses.	Yes	B.4.7. Utilize advanced music therapy methods within one or more theoretical frameworks to assess and evaluate clients' strengths, needs and progress.	implicitly connected
II.A. Implementation	II.A.2.bd. Provide MT experiences to address client's wellness.	No		Yes	B.4.12. Relate clinical phenomena in music therapy to the broader treatment context.	implicitly connected
II.A. Implementation	II.A.2.c. Provide MT experiences to address client's abuse and trauma	No		Yes	B.4.8. Design treatment programs for emerging client populations.	implicitly connected
II.A. Implementation	II.A.2.d. Provide MT experiences to address client's ADL's	Yes	C.10.4. The physiological aspects of the musical experience including, but not limited to, central nervous system, peripheral nervous system, and psychomotor responses.	No		implicitly connected
II.A. Implementation	II.A.2.e. Provide MT experiences to address client's adjustment to life changes or temporary or permanent changes in ability	No		Yes	B.4.12. Relate clinical phenomena in music therapy to the broader treatment context.	implicitly connected
II.A. Implementation	II.A.2.f. Provide MT experiences to address client's aesthetic sensitivity.	No		Yes	B.4.2. Utilize comprehensive knowledge of human growth and development, musical development, diagnostic classifications, etiology, symptomology, and prognosis in formulating treatment plans.	BCD is specific to aesthetic responses of the client; AC is very broad
II.A. Implementation	II.A.2.g. Provide MT experiences to address client's affect, emotions, and moods	Yes	C.10.3. The psychological aspects of musical behavior and experience including, but not limited to, perception, cognition, affective response, learning, development, preference, and creativity.	No		BCD specifies affect, emotions, moods; PC specifies affect but much broader

II.A. Implementation	II.A.2.h. Provide MT experiences to address client's agitation.	No		Yes	B.4.10. Utilize advanced verbal and nonverbal interpersonal skills within a music therapy context.	A negligible relationship between BCD and AC
II.A. Implementation	II.A.2.i. Provide MT experiences to address a client's aggression.	Yes	C.13.1. Recognize, interpret, and respond appropriately to significant events in music therapy sessions as they occur.	Yes	B.4.10. Utilize advanced verbal and nonverbal interpersonal skills within a music therapy context.	implicitly connected
II.A. Implementation	II.A.2.j. Provide MT experiences to address a client's anticipatory grief.	No		no		
II.A. Implementation	II.A.2.k. Provide MT experiences to address a client's attention.	Yes	C.10.4. The physiological aspects of the musical experience including, but not limited to, central nervous system, peripheral nervous system, and psychomotor responses.	No		negligible relationship between BCD and PC
II.A. Implementation	II.A.2.l. Provide MT experiences to address a client's auditory perception.	Yes	C.10.4. The physiological aspects of the musical experience including, but not limited to, central nervous system, peripheral nervous system, and psychomotor responses.	No		Weak relationship between BCD and PC
II.A. Implementation	II.A.2.m. Provide MT experiences to address a client's autonomy.	Yes	C.13.11. Promote a sense of group cohesiveness and/or a feeling of group membership.	No		BCD "autonomy" implies more than just in a group; PC refers to group aspects only.
II.A. Implementation	II.A.2.n. Provide MT experiences to address a client's bereavement.	No		No		
II.A. Implementation	II.A.2.o. Provide MT experiences to address a client's coping skills.	No		Yes	B.4.12. Relate clinical phenomena in music therapy to the broader treatment context.	BCD "coping skills" is specific; AC is broader and could be implied

II.A. Implementation	II.A.2.p. Provide MT experiences to address a client's development of speech.	Yes	C.10.3. The psychological aspects of musical behavior and experience including, but not limited to, perception, cognition, affective response, learning, development, preference, and creativity.; C.13.7. Assist the client in communicating more effectively.	No		loose connections
II.A. Implementation	II.A.2.q. Provide MT experiences to address a client's executive functions.	No		Yes	B.4.1. Apply comprehensive knowledge of current methods of music therapy assessment, treatment, and evaluation.	these specific domains could be implied in advanced practice competencies such as this one. EF could be part of advanced practice as in NMT.
II.A. Implementation	II.A.2.r. Provide MT experiences to address a client's functional independence.	No		Yes	B.4.1. Apply comprehensive knowledge of current methods of music therapy assessment, treatment, and evaluation.	these specific domains could be implied in advanced practice competencies such as this one. EF could be part of advanced practice as in NMT.
II.A. Implementation	II.A.2.s. Provide MT experiences to address a client's generalization of skills to other settings.	No		Yes	B.4.12. Relate clinical phenomena in music therapy to the broader treatment context.	similar wording
II.A. Implementation	II.A.2.t. Provide MT experiences to address a client's grief and loss.	No		Yes	B.4.1. Apply comprehensive knowledge of current methods of music therapy assessment, treatment, and evaluation.	implicitly connected
II.A. Implementation	II.A.2.u. Provide MT experiences to address a client's group cohesion and/or feeling of group membership.	Yes	C.13.11. Promote a sense of group cohesiveness and/or a feeling of group membership.	No		similar wording
II.A. Implementation	II.A.2.v. Provide MT experiences to address a client's impulse control.	Yes	C.10.4. The physiological aspects of the musical experience including, but not limited to, central nervous system, peripheral nervous system, and psychomotor responses.	No		implicitly connected

II.A. Implementation	II.A.2.w. Provide MT experiences to address a client's interactive response.	Yes	C.10.3. The psychological aspects of musical behavior and experience including, but not limited to, perception, cognition, affective response, learning, development, preference, and creativity.	No		implicitly connected
II.A. Implementation	II.A.2.x. Provide MT experiences to address a client's initiation.	Yes	C.10.3. The psychological aspects of musical behavior and experience including, but not limited to, perception, cognition, affective response, learning, development, preference, and creativity.	No		implicitly connected
II.A. Implementation	II.A.2.y. Provide MT experiences to address a client's memory.	Yes	C.10.3. The psychological aspects of musical behavior and experience including, but not limited to, perception, cognition, affective response, learning, development, preference, and creativity.	No		implicitly connected
II.A. Implementation	II.A.2.z. Provide MT experiences that address a client's motor skills.	Yes	C.10.4. The physiological aspects of the musical experience including, but not limited to, central nervous system, peripheral nervous system, and psychomotor responses.	No		Both BCD and PC = motor skills/psychomotor skills; PC is broader but the two are directly related.

II.A. Implementation	II.A.3. Recognize how the following theoretical orientations inform music therapy practice: a) behavioral. b) cognitive. c) holistic. d) humanistic/existential. e) neuroscience. f) psychodynamic.	No		Yes	I.B.4.4. Understand the dynamics and processes of therapy form a variety of theoretical perspectives. I.B.4.7. Utilize advanced music therapy methods within one or more theoretical frameworks to assess and evaluate client's strengths, needs, and progress. I.A.1.5. Use current theoretical, clinical and research literature from music therapy and related fields to identify emerging models and to predict/propose future models and trends for music therapy.	BCD says recognize and the advanced competencies are about application, differentiation, synthesis, identification, and use
II.A. Implementation	II.A.4. Recognize how the following music therapy treatment approaches and models inform clinical practice: a) behavioral. b) culture centered. c) community music therapy. d) developmental. e) humanistic. f) improvisational. g) medical, h) neurological, i) psychodynamic.	Yes	B.8.3. Demonstrate basic knowledge of accepted methods of major therapeutic approaches. C.10.1. Existing music therapy methods, techniques, materials, and equipment with their appropriate applications.	Yes	I.A.1.5. Use current theoretical, clinical and research literature from music therapy and related fields to identify emerging models and to predict/propose future models and trends for music therapy.	BCD is specific in the treatment approaches; the competencies are general
II.A. Implementation	II.A.5.a. To achieve therapeutic goals: a) apply the elements of music (e.g., tempo, pitch, timbre, melody, harmony, rhythm, meter, dynamics).	No		No		
II.A. Implementation	II.A.5.b. apply receptive music methods.	No		Yes	II.A.7.5. Design and utilize a broad range of receptive music experiences for therapeutic purposes.	BCD is applying and AC is design and utilize
II.A. Implementation	II.A.5.c. apply standard and alternate guitar tunings.	Yes	A.4.1.7. Tune stringed instruments using standard and other tunings.	No		BCD refers to the application of PC refers to functional ability to do

II.A. Implementation	II.A.5.d. apply a variety of scales, modes, and harmonic progressions.	No		Yes	II.A.7.9. Apply advanced musical skills in the clinical use of at least two of the following: keyboard, voice, guitar and/or percussion.	BCD is specific advanced skills and the AC are a broader term of advanced musical skills
II.A. Implementation	II.A.5.e. arrange, transpose, or adapt music.	Yes	A.1.5. Transpose simple compositions. A.2.2. Adapt, arrange, transpose, and simplify music compositions for small vocal and nonsymphonic instrumental ensembles. A.4.1.6. Harmonize and transpose simple compositions in several keys.	Yes	II.A.7.7. Harmonize and transpose simple compositions in several keys.	BCD are specific to use of arrange, transpose and adapt to meet a therapeutic goal, PC are listed as the ability to do them
II.A. Implementation	II.A.5.f. compose vocal and instrumental music.	Yes	A.2.1. Compose songs with simple accompaniment.	Yes	II.A.7.2. Design and employ a broad range of compositional experiences in order to address therapeutic needs.	BCD are to achieve therapeutic goal, PC can be done, AC is application of to address therapeutic need
II.A. Implementation	II.A.5.g. empathize with client's music experience.	Yes	B.9.3. Use oneself effectively in the therapist role in both individual and group therapy, e.g., appropriate self-disclosure, authenticity, empathy, etc. toward affecting desired therapeutic outcomes.	Yes	I.B.4.13. Respond to the dynamics of musical and interpersonal relationships that emerge at different stages in the therapy process.	
II.A. Implementation	II.A.5.h. employ active listening.	Yes	C.13.6. Provide feedback on, reflect, rephrase, and translate the client's communications.	No		
II.A. Implementation	II.A.5.i. employ functional skills with: 1.) voice. 2.) keyboard. 3.) guitar. 4.) percussion instruments.	Yes	A.4.1.1. Lead and accompany proficiently on instruments including, but not limited to, voice, piano, guitar, and percussion. A.4.1.8. Utilize basic percussion techniques on several standard and ethnic instruments.	Yes	II.A.7.9. Apply advanced musical skills in the clinical use of at least two of the following: keyboard, voice, guitar and/or percussion.	BCD employ functional skills, PC is demonstrating basic foundation, AC is applying advanced musical skills in clinical use

II.A. Implementation	II.A.5.j. employ music relaxation and/or stress reduction techniques.	No		No		
II.A. Implementation	II.A.5.k. exercise leadership and/or group management skills.	Yes	B.8.2. Demonstrate basic knowledge of the dynamics and processes of therapy groups. B.9.3. Use oneself effectively in the therapist role in both individual and group therapy, e.g., appropriate self-disclosure, authenticity, empathy, etc. toward affecting desired therapeutic outcomes. B.9.4. Utilize the dynamics and processes of groups to achieve therapeutic goals.	Yes	II.B.8.6. Apply the principles of effective leadership.	
II.A. Implementation	II.A.5.l. facilitate community building activities.	Yes	C.13.11. Promote a sense of group cohesiveness and/or a feeling of group membership.	No		
II.A. Implementation	II.A.5.m. facilitate transfer of therapeutic progress into everyday life.	No		Yes	I.B.4.12. Relate clinical phenomena in music therapy to the broader treatment context.	
II.A. Implementation	II.A.5.n. identify and respond to significant events.	Yes	C.13.1. Recognize, interpret, and respond appropriately to significant events in music therapy sessions as they occur.	No		BCD and PC are in alignment
II.A. Implementation	II.A.5.o. improvise instrumental and vocally.	Yes	A.4.3. Improvise on pitched and unpitched instruments, and vocally in a variety of settings including individual, dyad, small or large group.	Yes	II.A.7.4. Improvise in a variety of musical styles.	BCD and PC are in alignment, AC is to improvise over a variety of styles of music

II.A. Implementation	II.A.5.p. integrate current technology into music therapy practice according to client need.	Yes	C.10.6. Use of current technologies in music therapy assessment, treatment, evaluation, and termination.	Yes	B.8.9. Identify new applications of technology or develop new technologies for use in music therapy practice.	BCD integrate technology according to need, PC broader apply basic knowledge in assessment, treatment, evaluation and termination, AC goes a step further in identifying new applications or develop new
II.A. Implementation	II.A.5.q. integrate movement with music.	Yes	A.6.1. Direct structured and improvisatory movement experiences.	No		BCD integrate movement to reach therapeutic goal, PC direct structured movement
II.A. Implementation	II.A.5.r. observe client responses.	Yes	C.11.2. Observe and record accurately the client's responses to assessment. C.13.1. Recognize, interpret, and respond appropriately to significant events in music therapy sessions as they occur. C.13.13. Recognize and respond appropriately to effects of the client's medications. C.14.3. Recognize significant changes and patterns in the client's response to therapy. C.14.4. Recognize and respond appropriately to situations in which there are clear and present dangers to the client and/or others.	No		BCD is to achieve therapeutic goal, PC are for documentation and recognition of significant changes or patterns
II.A. Implementation	II.A.5.s. provide visual, auditory, or tactile cues.	Yes	C.13.3. Provide verbal and nonverbal directions and cues necessary for successful client participation.	No		BCD is specific, PC is broader cues for successful client participation

II.A. Implementation	II.A.5.t. provide verbal and nonverbal guidance.	Yes	C.13.3. Provide verbal and nonverbal directions and cues necessary for successful client participation. C.13.5. Utilize therapeutic verbal skills in music therapy sessions. C.13.6. Provide feedback on, reflect, rephrase, and translate the client's communications. C.13.7. Assist the client in communicating more effectively.	Yes	B.4.10. Utilize advanced verbal and nonverbal interpersonal skills within a music therapy context.	BCD is general, PC are more specific, and AC are advanced skills
II.A. Implementation	II.A.5.u. provide guidance to caregivers and staff to sustain and support the client's therapeutic progress.	Yes	C.18.4. Collaborate with team members in designing and implementing interdisciplinary treatment programs.	No		BCD is specific to providing guidance, PC is collaboration with the treatment team
II.A. Implementation	II.A.5.v. mediate problems among clients within the session.	Yes	C.13.11. Promote a sense of group cohesiveness and/or a feeling of group membership.	Yes	B.4.13. Respond to the dynamics of musical and interpersonal relationships that emerge at different stages in the therapy process.	
II.A. Implementation	II.A.5.w. select adaptive materials and equipment.	Yes	C.12.5. Select and adapt music, musical instruments, and equipment consistent with the strengths and needs of the client.	No		
II.A. Implementation	II.A.5.x. share musical experience and expression with clients.	Yes	C.13.9. Conduct or facilitate group and individual music therapy.	No		
II.A. Implementation	II.A.5.y. sight-read.	Yes	A.1.3. Sight-sing melodies of both diatonic and chromatic makeup. A.1.5. Transpose simple compositions.	No		BCD is application to achieve therapeutic goal, PC is functional skill able to perform
II.A. Implementation	II.A.5.z. use creativity and flexibility in meeting client's changing needs	Yes	C.14.5. Modify treatment approaches based on the client's response to therapy.	No		

II.A. Implementation	II.A.5.aa. use music to communicate with client.	Yes	C.13.3. Provide verbal and nonverbal directions and cues necessary for successful client participation. C.13.7. Assist the client in communicating more effectively.	No		
II.A. Implementation	II.A.5.ab. use song and lyric analysis.	No		No		
II.A. Implementation	II.A.5.ac. utilize a varied music repertoire (e.g., blues, classical, folk, jazz, pop) from a variety of cultures and subcultures. jazz, pop) from a variety of cultures and subcultures.	Yes	A.4.3. Improvise on pitched and unpitched instruments, and vocally in a variety of settings including individual, dyad, small or large group. C.13.12. Develop and maintain a repertoire of music for age, culture, and stylistic differences.	Yes	II.A.7.8. Utilize extensive and varied repertoire of popular, folk, and traditional songs.	BCD utilize to meet goals and more depth , PC develop and maintain repertoire, AC utilize extensive and varied
II.B. Safety	II.B.1. Recognize and respond to situations in which there are clear and present dangers to a client and/or others.	Yes	C.14.4. Recognize and respond appropriately to situations in which there are clear and present dangers to the client and/or others.	No		same
II.B. Safety	II.B.2. Recognize the potential harm of music experiences and use them with care.	No		No		
II.B. Safety	II.B.3. Recognize the potential harm of verbal and physical interventions during music experiences and use them with care.	No		No		
II.B. Safety	II.B.4. Observe infection control protocols (e.g., universal precautions, disinfecting instruments).	No		No		

II.B. Safety	II.B.5. Recognize the client populations and health conditions for which music experiences are contraindicated and adapt treatment as indicated.	No		Yes	I.B.4.3. Understand the contraindications of music therapy for client populations served. I.B.4.18. Recognize and apply comprehensive knowledge of contra-indications for music therapy interventions and seek consultation as indicated.	
II.B. Safety	II.B.6. Comply with safety protocols with regard to transport and physical support of clients.	No		No		
II.B. Safety	II.B.7. Inspect materials and instruments on a regular basis.	Yes	C.19.2. Manage and maintain music therapy equipment and supplies.	No		
II.C. Termination and Closure	II.C.1. Assess potential benefits and detriments of termination.	Yes	C.16.1. Assess potential benefits/detriments of termination of music therapy.	No		
II.C. Termination and Closure	II.C.2. Determine exit criteria.	Yes	C.16.2. Develop and implement a music therapy termination plan.	No		
II.C. Termination and Closure	II.C.3. Inform and prepare client.	Yes	C.16.4. Inform and prepare the client for approaching termination from music therapy.	No		
II.C. Termination and Closure	II.C.4. Coordinate termination with a client's overall treatment.	Yes	C.16.3. Integrate music therapy termination plan with plans for the client's discharge from the facility.	No		
II.C. Termination and Closure	II.C.5. Provide a client with transitional support and recommendations.	No		No		
II.C. Termination and Closure	II.C.6. Help client work through feelings about termination.	No		No		
II.C. Termination and Closure	II.C.7. Address client needs during staffing changes (e.g., therapist leaves job, job transfer, leave of absence).	No		No		

III.A. Documentation	III.A.1. Develop and use data-gathering techniques and forms.	Yes	C.15.6. Develop and use data-gathering techniques during all phases of the clinical process including assessment, treatment, evaluation, and termination.	No		15.2 states "Document clinical data." It does not state anything about developing the techniques and forms.
III.A. Documentation	III.A.2. Record client responses, progress, and outcomes	Yes	15.3 Write professional reports describing the client throughout all phases of the music therapy process in an accurate, concise, and objective manner	No		The AMTA 15.3 competency is written in a more general manner but I felt, "all phases of the music therapy process," encompasses the CBMT III.A.2. for "record client responses, progress, and outcomes."
III.A. Documentation	III.A.3. Employ language appropriate to population and facility	No		No		There is no language in the AMTA competencies under Documentation that address the appropriate language pursuant to clinical population and facility.
III.A. Documentation	III.A.4. Document music therapy termination and follow-up plans.	Yes	15.6 Develop and use data-gathering techniques during all phases of the clinical process including assessment, treatment, evaluation, and termination.	No		15.6 Generally mentions termination in data-gathering techniques.
III.A. Documentation	III.A.5. Provide periodic treatment summaries.	Yes	15.3. Write professional reports describing the client throughout all phases of the music therapy process in an accurate, concise, and objective manner.	No		My sub-committee suggested that we add subject manner to this competency.
III.A. Documentation	III.A.6. Adhere to internal and external legal, regulatory, and reimbursement requirements.	Yes	15.1. Produce documentation that accurately reflects client outcomes and meet the requirements of internal and external legal, regulatory, and reimbursement bodies.	No		There is a direct, almost word for word, correlation between the verbiage in the CBMT Domain and the AMTA Competency.

III.A. Document ation	III.A.7. Provide written documentation that demonstrates evidence-based outcomes related to addressed goals/interventions.	Yes	15.3. Write professional reports describing the client throughout all phases of the music therapy process in an accurate, concise, and objective manner	No		I feel that the intent of both the CBMT sub-domain and AMTA Competency is the same. However, the CBMT sub-domain is more specific in that it addresses "evidence-based outcomes" and "goals/interventions."
III.B. Evaluation	III.B.1. Identify information that is relevant to client's treatment process.	No		No		I really felt that we are comparing apples and oranges here and that there was no comparison.
III.B. Evaluation	III.B.2. Differentiate between empirical information and therapist's interpretation.	No		No		I could not find any AMTA Competency that addresses "empirical information and therapist's interpretation." What seems to be missing overall from the AMTA Competencies is the therapist's role in this process.
III.B. Evaluation	III.B.3. Acknowledge therapist's bias and limitations in interpreting information.	No		No		No AMTA Competency comparison found.
III.B. Evaluation	III.B.4. Review treatment plan regularly.	Yes	14.6 Review and revise treatment plan as needed	No		There is a direct relationship between the CBMT sub-domain and the AMTA Competency
III.B. Evaluation	III.B.5. Modify treatment plan regularly.	Yes	14.5 Modify treatment approaches based on the client's response to therapy.	No		There is a direct relationship between this CBMT sub-domain and the AMTA Competency.
III.B. Evaluation	III.B.6. Respond to sign of distress and limits of client tolerance to treatment.	Yes	14.3. recognize significant changes and patterns in the client's response to therapy.	No		There is a direct relationship between the CBMT sub-domain and the AMTA Competencies.
III.B. Evaluation	III.B.7. Analyze all available data to determine effectiveness of therapy.	Yes	14.6 Review and revise treatment plan as needed	No		
III.B. Evaluation	III.B.8. Consult with music therapy and non-music therapy professionals.	No		No		There is no AMTA Competency that relates to consulting para-professionals.
III.B. Evaluation	III.B.9 Communicate with client and/or client's family, caregivers, treatment team, and personal network as appropriate.	No		No		There is no AMTA Competency under Evaluation that addresses "client's family, caregivers, treatment team, and personal network."

III.B. Evaluation	III.B.10 Make recommendations and referrals as indicated.	No		No		There is no AMTA Competency that addresses making "recommendations and referrals."
III.B. Evaluation	III.B.11 Compare the client and therapist subjective experience/response to the elements, forms, and structures of music	No		No		There is nothing that even remotely in the AMTA Competencies that addresses the client's or therapist's subjective experience etc. to music
IV.A. Professional Development	IV.A.1. Assess areas for professional growth and set goals.	Yes	C.17.8. Demonstrate critical self-awareness of strengths and weaknesses.	No		Goal setting for professional development is included in the CBMT domain, but not in the Professional Competencies.
IV.A. Professional Development	IV.A.2. Review current research and literature in music therapy and related disciplines.	Yes	C.20.1. Interpret information in the professional research literature.	Yes	I.A.1.5. Use current theoretical, clinical and research literature from music therapy and related fields to identify emerging models and to predict/propose future models and trends for music therapy.	
IV.A. Professional Development	IV.A.3. Participate in continuing education.	Yes	C.17.3. Demonstrate dependability: follow through with all tasks regarding education and professional training.	No		
IV.A. Professional Development	IV.A.4. Engage in collaborative work with colleagues.	Yes	C.18.4 Collaborate with team members in designing and implementing interdisciplinary treatment programs.	No		
IV.A. Professional Development	IV.A.5. Seek out and utilize supervision and/or consultation.	Yes	C.19.1. Participate in and benefit from multiple forms of supervision (e.g., peer, clinical).	No		
IV.A. Professional Development	IV.A.6. Expand music skills.	Yes	C.13.12. Develop and maintain a repertoire of music for age, culture, and stylistic differences.	No		AMTA competency states "Develop and maintain a repertoire of music..." It does not focus on expanding musical skills.
IV.A. Professional Development	IV.A.7. Develop and enhance technology skills.	Yes	C.10.6. Use of current technologies in music therapy assessment, treatment, evaluation, and termination.	No		CBMT states "Develop and enhance..." AMTA competencies state "Use technology," but does not suggest enhancing skills.

IV.B. Professional Responsibilities	IV.B.1. Document all treatment related communications.	Yes	C.15.1. Produce documentation that accurately reflects client outcomes and meet the requirements of internal and external legal, regulatory, and reimbursement bodies. C.15.2. Document clinical data. C.15.3. Write professional reports describing the client throughout all phases of the music therapy process in an accurate, concise, and objective manner. C.15.4 Effectively communicate orally and in writing with the client and client's team members. C.15.5. Document and revise the treatment plan and document changes to the treatment plan.	No		AMTA competencies are more specific and thorough.
IV.B. Professional Responsibilities	IV.B.2. Document all non-treatment related communications.	No		No		Non-treatment related communication is not addressed in the AMTA competencies.
IV.B. Professional Responsibilities	IV.B.20. Serve as a representative, spokesperson, ambassador, or advocate for the profession of music therapy.	Yes	C.18.2. Communicate to other departments and staff the rationale for music therapy services and the role of the music therapist.	No		
IV.B. Professional Responsibilities	IV.B.3. Maintain and expand music repertoire.	Yes	C.13.12. Develop and maintain a repertoire of music for age, culture, and stylistic differences.	No		The AMTA competency says "Develop and maintain." CBMT says "Expand..."

IV.B. Professional Responsibilities	IV.B.4. Interact with the client in an authentic, ethical, and culturally competent manner that respects privacy, dignity, and human rights.	Yes	C.17.1. Interpret and adhere to the AMTA Code of Ethics.	No		
IV.B. Professional Responsibilities	IV.B.5. Respond to public inquiries about music therapy.	No		No		The AMTA competencies do not address responding to public inquiries about music therapy.
IV.B. Professional Responsibilities	IV.B.6. Conduct information sharing sessions, such as in-service workshops, for professionals and/or the community.	No		No		AMTA competencies do not address conducting information sharing sessions.
IV.B. Professional Responsibilities	IV.B.7. Communicate with colleagues regarding professional issues.	Yes	C.18.2. Communicate to other departments and staff the rationale for music therapy services and the role of the music therapist.	No		
IV.B. Professional Responsibilities	IV.B.8. Maintain professional and effective working relationships with colleagues and community members.	Yes	C.17.4. Accept criticism/feedback with willingness and follow through in a productive manner. C.17.5. Resolve conflicts in a positive and constructive manner. C.17.7. Express thoughts and personal feelings in a consistently constructive manner.	No		The AMTA competencies are more specific.
IV.B. Professional Responsibilities	IV.B.9. Work within a facility's organizational structure, policies, standards, and procedures.	No		Yes	I.B.3.2. Adhere to accreditation requirements for clinical agencies, particularly with regard to music therapy.	CBMT is focused on the clinician. The AMTA Advanced Competencies are focused on the University Professor.
IV.B. Professional Responsibilities	IV.B.10. Maintain client confidentiality as required by law (e.g., HIPAA, IDEA).	Yes	C.17.12. Adhere to the Standards of Clinical Practice.	Yes	I.B.3.1. Adhere to laws and occupational regulations governing the provision of education and health services, particularly with regard to music therapy.	The AMTA Advanced Competency is more general.

IV.B. Professional Responsibilities	IV.B.11. Supervise staff, volunteers, practicum students, or interns.	No		Yes	I.B.2.1. Establish and maintain effective supervisory relationships with supervisees. 2.2 Promote the professional growth, self-awareness, and musical development of the supervisee. 2.3 Apply research findings and theories of supervision to music therapy supervision. 2.4 Design and implement methods of observing and evaluating supervisees that have positive effects on music therapy students and professionals at various levels of advancement and at different stages in the supervisory process. 2.5 Analyze the supervisee's music therapy sessions in terms of both the effects of musical, verbal, and nonverbal interventions and the musical and interpersonal dynamics and processes of the client(s)-therapist relationship. 2.6 Use music to facilitate the supervisory process. 2.7 Apply knowledge of norms and practices of diverse cultures to the supervisory process as indicated. 2.8 Evaluate the effectiveness of various approaches and techniques of supervision. 2.9 Evaluate the effects of one's own personality, supervisory style, and limitations on the supervisee and the supervisory process and seek consultation as indicated.	The AMTA Advanced Competencies are more specific about supervision types and needs.
IV.B. Professional Responsibilities	IV.B.12. Adhere to the CBMT Code of Professional Practice.	Yes	C.17.1. Interpret and adhere to the AMTA Code of Ethics. C.17.2. Adhere to the Standards of Clinical Practice.	No		
IV.B. Professional Responsibilities	IV.B.13. Fulfill legal responsibilities associated with professional role (e.g., mandated	No		Yes	I.B.3.1. Adhere to laws and occupational regulations governing the provision of education and health services, particularly with regard to music therapy.	CBMT specifically lists legal responsibilities. AMTA competencies do not.

	reporting, release of information).					
IV.B. Professional Responsibilities	IV.B.14. Practice within scope of education, training, and abilities.	No		No		
IV.B. Professional Responsibilities	IV.B.15. Maintain equipment and supplies.	Yes	C.19.2. Manage and maintain music therapy equipment and supplies.	No		
IV.B. Professional Responsibilities	IV.B.16. Engage in business management tasks (e.g., marketing, payroll, contracts, taxes, insurance).	Yes	C.19.3. Perform administrative duties usually required of clinicians (e.g., scheduling therapy, programmatic budgeting, maintaining record files).	No		AMTA is more general, stating "Perform administrative duties..."
IV.B. Professional Responsibilities	IV.B.17. Prepare and maintain a music therapy program budget.	Yes	C.19.3. Perform administrative duties usually required of clinicians (e.g., scheduling therapy, programmatic budgeting, maintaining record files).	No		AMTA is more general, stating "Perform administrative duties..."
IV.B. Professional Responsibilities	IV.B.18. Prepare accountability documentation for facility administration and/or local, state, and federal agencies.	Yes	C.15.1. Produce documentation that accurately reflects client outcomes and meet the requirements of internal and external legal, regulatory, and reimbursement bodies.	No		
IV.B. Professional Responsibilities	IV.B.19. Maintain assigned caseload files (e.g., electronic, digital, audio, video, hard copies) in an orderly manner.	Yes	C.19.3. Perform administrative duties usually required of clinicians (e.g., scheduling therapy, programmatic budgeting, maintaining record files).	No		AMTA is more general, stating "Perform administrative duties..."

Appendix D: November 2019 Proposed Competency Framework

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Sections:

I: Musical Development

II: Integrative Clinical Practice

III. Personal Development

IV. Professional Growth

READINESS FOR PRACTICUM	READINESS FOR INTERNSHIP	READINESS FOR ENTRY TO PRACTICE	READINESS FOR ADVANCED PRACTICE
1a. Appropriate competency	1b. Appropriate competency	1c. Appropriate competency	1d. Appropriate competency
2a. Appropriate competency	2b. Appropriate competency	2c. Appropriate competency	2d. Appropriate competency
3a. Appropriate competency	3b. Appropriate competency	3c. Appropriate competency	3d. Appropriate competency
4a. Appropriate competency	4b. Appropriate competency	4c. Appropriate competency	4d. Appropriate competency
5a. Appropriate competency	5b. Appropriate competency	5c. Appropriate competency	5d. Appropriate competency

Appendix E: Competency Review Task Force Grounding Statement

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We, the members of the Competency Review Task Force, enter this space with diverse experiences and perspectives.

We are

music therapy clinicians, educators, internship directors, and researchers who are passionate about the future of music therapy and the development of competencies to guide our profession.

Our intention

is to create a space where individuals feel their safety and security are paramount.

Our purpose

is to engage in necessary dialogue that promotes awareness, strength, and collaboration needed to guide our work.

We commit

to do the work to create sustainable change.

We accept our individual and collective limitations, while continuing to strive towards these ideals.

We will:

- prioritize people over agendas
- focus on the bigger picture over individual lens
- actively listen to each other with compassion
- assume good intentions
- leave room for others to share thoughts and opinions
- speak honestly when we feel called to do so without fear of retaliation
- acknowledge that people process differently and give permission for people to respond when they feel ready
- ask questions
- provide thoughtful and gentle feedback* to each other
- call a time-out when needed

Adapted from the IPPA Workgroup authored by Kristen O'Grady and the MAR
Adopted 12/6/21

*Constructive feedback:

"Did you consider ____?"

"Tell me how you decided to include x and not y?"

"I'm wondering about..."

"Help me understand..."

"I'm curious about..."

Appendix F: “Client” language decision

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“Client” vs. “Those served” language discussion:

Terms considered/discussion:

- Client, patient, those served, service users, consumers, individuals, resident, patient
- Agreement that it isn’t realistic to list them all
- Need to identify and discuss the term used in the Preamble

Resources (and language used in other resources):

- McFerran (2021). [Reconsidering the dominant narrative of the music therapy profession for the future](#)
- Rizkallah (2024). [In defence of working with “patients” in music therapy.](#)
- [ASHA](#) - “individual other recipients of services”
- [American Occupational Therapy Association](#) - “client” and “consumer”
- [American Physical Therapy Association](#): patients
- [NASW](#): “clients”
- [American Art Therapy Association](#): “clients”
- [CBMT](#): “client”
- [NCTRC](#): “client”
- APA - [Inclusive Language Guide \(apa.org\)](#) - “client”
- AMTA Commission report - “client”

“Client”	“Those served”	“Patients”	“Other” (Individuals; Consumer)
<p>PROS: Many DEI authors are using this term in their writing</p> <p>Commission also used client in their writing</p> <p>Language used in Code of Ethics</p> <p>CONS:</p> <p>Latin roots: “protecting of others”, but also “hear and obey”</p> <p>Infers that the individual sought out services, but that is not always the case</p>	<p>PROS: Avoid language specific to one setting</p> <p>CONS: “Serve” language has roots in slavery</p>	<p>PROS: Acknowledges inherent power differential</p> <p>CONS: Medical model</p>	<p>PROS: Does not label</p> <p>CONS: “Consumer” feels transactional</p> <p>“Individual” is very broad</p>