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Barriers, facilitators, and opportunities to accessing and providing musical care during the beginning of life: a mixed-methods survey study

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ABSTRACT

Introduction: The first 1001 days of life, from pregnancy through age two, are critical for child development and family wellbeing, yet are marked by vulnerabilities and inequities in access to care.

Theory: Creative health approaches, such as musical care, may support wellbeing while addressing these disparities. Using a mixed-methods survey approach, this article aims to understand the barriers, facilitators, and opportunities to equitably accessing/providing musical care activities during the beginning of life in the UK.

Method: Two online surveys were completed. One by 578 parents/caregivers and another by 50 providers of musical care activities. Quantitative data were analysed using descriptive statistics and regression models; qualitative data were analysed using thematic analysis.

Results: Barriers and facilitators were identified across three themes: resources and logistics (cost, proximity, timing), inclusivity and diversity (cultural fit, awareness, personal preference), and coordination and collaboration (training, organisational links). Overall, parents/caregivers expressed interest in more opportunities for participation. However, significant barriers – particularly cost and availability – limit access, especially for lower-income households. Providers highlighted the need for sustainable funding, training, and better collaboration. Facilitators included free or subsidised sessions, inclusive practices, and linking with existing services.

Discussion: Findings underscore the need for local, affordable, and culturally inclusive activities, alongside coordinated strategies to scale musical care equitably across the UK.

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Barriers and facilitators; beginning of life; health equity; musical care

Introduction

The first 1001 days of life offer a window during which foundations of children's development are laid (Health and Social Care Committee, 2019). This period from pregnancy until two years after birth offers opportunities for support but comes with significant vulnerabilities and risks for both parents and their infants[1] which are often hidden and socially patterned (Health and Social Care Committee, 2019). For example, parents' mental health and wellbeing can be affected during the beginning of life[2] with implications for their families, including increased risk of psychological challenges and delays in cognitive, motor, and language development for their children (Habib, 2012). Inequities in access to care during the beginning of life are ubiquitous in the United Kingdom (UK) (Pearce et al., 2019) and further impact on parental health, birth outcomes and infant health and development (Simoncic et al., 2022). It is therefore important to explore accessible and equitable ways of supporting families during the first 1001 days.

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There is a growing number of creative health approaches that can help support parental and infant health and wellbeing, while simultaneously addressing health and access inequities (Baskin et al., 2023; Rodríguez-Pose et al., 2023). Creative health includes different creative approaches and activities that benefit health and wellbeing, including visual and performing arts, crafts, film, literature, cooking, and gardening (National Centre for Creative Health, 2024). One such set of practices and approaches is musical care. Musical care activities – music activities that can support any aspect of people's developmental or health needs (Spiro & Sanfilippo, 2022) – can be particularly helpful in supporting parents/caregivers and their infants during the beginning of life (Sanfilippo et al., 2022). Such activities can occur in health and community settings (e.g., clinical contexts, schools, children's centres, and family hubs) and may be administered by a variety of providers (e.g., health and social care providers, third sector organisations, educational providers, private organisations, and individuals). Musical care activities encompass different types of music-based interventions, approaches, and practices including music therapy, community music, music education, and everyday uses of music (MacDonald, 2013).

There is growing evidence suggesting that musical care can support the health and well-being of infants (e.g., Costa et al., 2022), caregivers (e.g., Lin et al., 2019; Konsam et al., 2023; Ji et al., 2024), and the relationship between them (e.g., Sharman et al., 2023; Perkins, 2024). In the UK, a wide range of musical care activities is offered during the beginning of life (Spiro et al., 2025), including play and development groups that involve music, music specific groups, live concerts, as well as the certified practice of music therapy. Socio-economic inequalities in accessing music and the arts have been documented and discussed in the UK in the context of education (Dufour, 2020; Wilson et al., 2020; Henley & Barton, 2022), therapy (Mains et al., 2024), everyday access (Shaikh et al., 2021), and engagement (Fancourt & Mak, 2020).

Given the developing evidence supporting the relevance of musical care during this life stage, its relatively inexpensive nature, and the flexibility in application, from community work to targeted clinical work (Spiro et al., 2025), it is important to understand what stands in the way of, and what can facilitate, equitable access to musical care during the beginning of life in the UK. Additionally, whether certain demographic factors impact participation in and access to musical care activities.

Our overall research has two aims: (1) to understand the patterns of use of musical care during the beginning of life in the UK (reported in Spiro et al., 2025) and (2) to understand the barriers, facilitators, and opportunities to accessing and providing musical care during the beginning of life in the UK (reported here). This article explores in more depth some themes briefly reported in the first paper (Spiro et al., 2025) now interpreted with a view to specifically understand the barriers and facilitators to participating in musical care activities as well as identifying opportunities for future work.

Materials and methods

Design and setting of the study

The aim of this article is to understand the barriers, facilitators, and opportunities to equitably providing and accessing musical care activities during the beginning of life in the UK. This study included two phases: Preparatory consultation with key stakeholders using focus groups and feedback forums (Phase 1, detailed in Appendix 1) and preparing for two cross-sectional online surveys – one for families/parents and one for musical care providers (Phase 2). Ethical approval was given by the cross-institutional Conservatoires UK Research Ethics Committee on 18 February 2022, ID CUK/SF/2021–22/8. This ethics committee oversees submissions from conservatoires in the UK such as The Royal College of Music, Guildhall School of Music and Drama, Royal Northern College of Music, Royal Central School of Speech and Drama, Royal Conservatoire of Scotland, and Royal Birmingham Conservatoire. All participants gave informed written consent before taking part in the study and this study was conducted in accordance with the principles stated in the Declaration of Helsinki. The Consensus-Based Checklist for Reporting of Survey Studies (Sharma et al., 2021) was used in preparing this paper (Appendix 2).

Characteristics of respondents

In total, 578 respondents living in the UK completed the parent/caregiver survey. Respondents were geographically spread around the UK with 82% reporting being White, broadly reflecting the general

population (as represented in the 2021 Census (Office for National Statistic (ONS), 2023). Most respondents (81%) identified as women and 32% reported having a household income of £20,000–£39,000. (See Appendix 3 for full demographic information).

In total, 50 respondents completed the provider survey. Most were living in England (92%), 96% identified as women, 84% as White, and the mean age was 42.2 ($SD = 9.09$). Over half (56%) had been working in musical care for five years or more (with 36% doing so for 10 or more years). Most respondents (68%) had not had training in delivering musical care activities in the perinatal period or in early years and for almost half (46%) delivering musical care work was not their primary source of income. The practitioners had a variety of training and experience (e.g., music therapist, play therapist, child development experts, parents, and community musicians).

Materials

Both surveys, created in Qualtrics, included open and closed questions. To prepare the surveys a preparatory consultation was undertaken with key stakeholders (service users, experts in public health policy, experts in health care implementation, and musical care providers) using focus groups and feedback forums (Phase 1, detailed in Appendix 1). The aims were to ensure that the surveys address the key open questions about how parents/caregivers and providers experience musical care activities and what the barriers and opportunities might be. We asked stakeholders specific questions about (1) terminology, phrasing, and answer options, (2) the scope of musical care activities that should be included, and (3) plans for survey dissemination. Their suggestions were then included in the final survey. The surveys were then piloted by all research team members who include musical care practitioners and parents, including those with experience of mental health issues.

The parent/caregiver survey targeted parents/caregivers who were expecting a baby or had had a baby during the last five years. The provider survey targeted providers who over the last five years had run or were currently running musical care activities for families who are or had been expecting a baby or had babies up to two years of age. The five-year period was in recognition of the changes in in-person musical care activity provision during the COVID-19 pandemic. For the full surveys see Appendix 4. For more detail on the survey structure and development see Spiro et al. (2025).

Procedure

The parent/caregiver survey was open 21 June to 18 July 2022. The provider survey was open 8 June to 27 July 2022. Recruitment for the parent/caregiver survey was conducted through (1) social media through purposive sampling informed by our professional networks and (2) Prolific, an online platform that distributes surveys and pays respondents. We aimed to recruit respondents from a range of ethnic backgrounds and from regions around the UK broadly in line with the proportions of ethnicity and region as represented in the 2021 census. The survey was designed to take 20 minutes. Respondents through Prolific were paid £8 per hour.

Using purposive sampling, recruitment for the providers survey was through (1) the professional networks of the team, particularly that of ET through her app Happity,[3] (2) emailing organisations who work in the areas of early years or musical care or (3) through an open call on social media. All respondents recruited through social media could enter a draw for a £20 Amazon gift voucher.

Survey analysis

Analysis of all open questions used Dedoose.[4] Starting with the parent/caregiver survey, two authors (CS and MR) independently carried out an initial inductive process of coding and analysis using thematic analysis (Terry & Braun, 2017), through either descriptive or reflexive interpretation (Braun et al., 2021). The briefer responses were grouped into descriptive codes, but more detailed codes and subthemes were developed for the more expansive responses. The provider survey was analysed using the coding framework of the parent/caregiver survey where relevant. An initial inductive process of coding and analysis using thematic analysis was carried out for responses on new areas. At equal points during the

analysis, CS and MR met to discuss and cross-check themes and interpretations, discuss any disagreements and referred to NS and KRS if needed.

For example, CS and MR encountered differing initial interpretations when coding references to 'enjoyment and play' and 'infant development', as parents sometimes described these concepts together. The coders then agreed to keep the codes distinct to better capture nuanced differences in how parents spoke about play as a component of development. Other codes included 'venue hire' under the sub-theme 'cost' and 'childcare' under the sub-theme 'Not inclusive or accessible to sibling'. The analyses of both data sets were then brought together by NS and KRS and the themes further refined which led to the themes presented in this paper. In the presentation of our themes, we integrated the qualitative data with findings from related closed questions.

Responses to numeric and closed questions were summarised using descriptive statistics in Excel. Statistical analyses were performed by ACH using Python 3.13. Analyses proceeded using a hypothesis-driven modelling approach, examining demographic data as predictors for likelihood of participating in musical care activities and reasons for not participating. There was no missing data among any of the variables analysed, and it was not deemed necessary to adjust the data to account for the representativeness of the sample. Demographic predictors (income, ethnicity, region, and gender) were collapsed into broader categories (above/below median income; White/non-White; non-female/female, four region groups) to reduce sparsity. Participation was measured as the count of unique activities reported ($M = 2.7$). Preliminary diagnostics indicated non-normality and overdispersion (Shapiro–Wilk, $p < .001$; Levene's test, $p = .03$); therefore, participation scores were modelled using negative binomial regression, with model fit assessed via AIC, BIC, pseudo-R^2, and coefficient significance. For barriers to participating in activities (13 possible closed options (See Table 2)), a one-vs-rest multinomial logistic regression was conducted on each possible answer to estimate the odds of all demographic groups endorsing any given reason (see Appendix 5).

Positionality of the research team

The research team included members from different disciplines and with a range of lived experience. Experience of the team included research and teaching in music and health, psychology, health sciences, and music therapy practice. It also included a founder of a platform for parents to identify parent and infant activities. The majority of the team work in fields connected with music, live and work in large cities, are white, British, and identify as female. The team also included parents, including those with lived experience of mental health challenges. All of these factors could impact how we designed our survey and interpreted our results. For example, many of us have seen and experienced the reduction of arts funding which may have lead to a negative bias of the situation.

Results

Most of the respondents reported participating in musical care activities ($n = 475$, 83%) with play and development groups that involve some music the most commonly attended activities (see Spiro et al., 2025 for detail on patterns of using musical care activities in the UK). Whether or not they had participated, most respondents would have liked to participate or participate more ($n = 369$, 64%). Overall, a negative binomial regression found that demographic characteristics did not significantly correlate with participation (Pseudo-$R^2 = .016$) (see Appendix 5).

Barriers and facilitators to accessing and providing musical care activities

Thematic analysis identified three broad themes that encompass the barriers and facilitators to accessing and providing musical care activities described by parents/caregivers and providers: (1) Resources and logistics, (2) Inclusivity and diversity, and (3) Coordination and collaboration (Table 1) (Example quotes provided in Appendix 6).

Alongside the thematic analysis results, we report findings based on two rating questions from the surveys (Tables 2 and 3).

Table 1. Barriers and facilitators to access to and provision of musical care activities in the UK.

Themes	Barriers and facilitators
1. Resources and logistics	a. Cost Barrier • Expensive Facilitators • Free or subsidised b. Proximity and availability Barriers • Geographic proximity • Grass is greener • Oversubscription c. Time Barriers • Inconvenient and inflexible timing • Lack of time
2. Inclusivity and diversity	a. Cultural and social fit Barriers • Feeling like an outsider • Anxiety • Not inclusive or accessible to siblings, fathers and other caregivers • Lack of diversity of who can attend and content. Facilitators • Inclusivity and demographic diversity in the sessions • Supportive and diverse leadership • Social connections b. Awareness Barriers • Dependent on social networks • Lack of knowledge and time to advertise • Lack of diversity in advertising materials Facilitators • Linking with existing services • Advice from friends c. Personal Preference Barriers • Lack of interest in musical activity • Feeling can do music at home
3. Coordination and collaboration	a. Training and education • Barrier • Accessibility of training opportunities b. Collaboration across organisations Barrier • Difficulties in communication and collaboration across and within organisations. Facilitators • Support from other organisations and health professionals

Table 2. Barriers experienced by respondents who had wanted to attend any or attend more activities ($N = 369$).

	n	%
I didn't have the money	156	42
There weren't any activities available	118	32
I didn't have time	85	23
I later found out about activities that I could have gone to	73	20
I had issues around childcare (e.g., an older child to care for)	67	18
I didn't feel they were open to me	64	17
I didn't have a way of getting to activities	63	17
I didn't have confidence in my musical abilities	47	13
I didn't have access to musical equipment	23	6
I didn't have confidence using digital equipment (e.g., laptop for joining activities online)	10	3
There was a language barrier	2	1

1. Resources and logistics

This theme describes practical aspects influencing access and provision of musical care activities. Three sub-themes were identified: Cost, Proximity and availability, and Time. Respondents discussed barriers across all three sub-themes and only provided examples of facilitators related to cost.

Table 3. Respondents' ranking of factors' importance in their decision to participate ($N = 578$).

	Mean	Standard deviation
Inclusivity and feeling welcome	1.36	0.69
Location (e.g., distance from home)	1.5	0.71
Value for money	1.69	0.87
Delivery method (e.g., virtual, in person)	1.7	0.89
Pram access	2.19	1.05
Group size	2.3	0.94
Recommendation from others	2.35	0.91
Training/credentials of group leader	2.41	0.96
Group make-up (father's only group, mum's other group, etc.)	3.15	1.21
Own confidence in musical abilities	3.15	1.09

*Respondents rated on a likert scale (1 = very important, 5 = not important).

a. Cost

The most common barrier selected was 'did not have the money' ($n = 156$, 42%, Table 2). 'Value for money' was rated the third highest in importance for going to an activity ($M = 1.69$, $SD = 0.87$, Table 3). Furthermore, respondents with below-median income were more likely to report cost as a barrier (OR = 1.45, 95% CI [1.00, 2.11], $p = .048$).

In the open questions, parents/caregivers commented that musical care activities were expensive, and sometimes more so than other activities. Parents/caregivers also discussed expense in the context of choosing essential versus luxury pursuits; 'I found the more arts/music-based groups and activities seemed to be regarded as less "essential," a luxury or even more middle-class and were therefore priced to make it difficult for those on lower incomes to afford' (Parent/caregiver). Some parents/caregivers compared the high cost to the free option of singing at home. Providers showed their awareness of the limitations of who they can reach because of the cost they charge. Providers explained the limitations of their own financial pressures including venue hire and time. Respondents highlighted the benefits of free or subsided opportunities in facilitating participation and practitioners connected lower funding to reduced quality of provision.

b. Proximity and availability

Geographic proximity was rated as an important factor in attending activities ($M = 1.5$, $SD = 0.71$, Table 3). 32% reported that 'there weren't any activities available' ($n = 118$) and 17% reported that they 'didn't have a way of getting to activities' ($n = 63$, Table 2). Availability was a statistically significant barrier ($\chi^2(6) = 17.33$, $p = .008$, pseudo-$R^2 = .03$) for parents/caregivers, at the aggregate level, with those below-median income being less likely to report availability as a barrier (OR = 0.50, 95% CI [0.33, 0.75], $p = .001$).

Some parents compared their situation negatively to that in other geographic and socio-economic regions feeling that the 'grass was greener' elsewhere. They had (sometimes opposite) interpretations about the reason for the lack of availability, ranging from lack of funding in particular regions, to comparisons between rural and larger urban centres, to lack of resources attributed to either regional affluence or regional lack of money. For example, one parent/caregiver explained 'More affluent areas in the UK have lots of access to these activities whereas poorer areas don't' while another asked for 'More availability of it throughout all areas not just surestart/economically deprived areas'. Some parents/caregivers commented that even when classes were nearby, they were oversubscribed.

c. Time

Time was mentioned in two contexts: inconvenient and inflexible timing, and personal lack of time to attend. Several parents/caregivers commented on a mismatch between when classes are available and when parents/caregivers were available to attend. Others described how long-term commitment required for participation, and booking requirements that assume weekly availability, were barriers. Almost a quarter of respondents reported that they did not have time to participate in these activities ($n = 85$, 23%, Table 2).

Overall, time was a significant barrier ($\chi^2(6) = 16.86$, $p = .010$, pseudo-$R^2 = .03$), with respondents identifying as female being less likely than males to report time as a barrier (OR = 0.35, 95% CI [0.20, 0.61], $p < .001$).

2. Inclusivity and diversity

Inclusivity and feeling welcome was rated as most important in the decision to attend a musical care activity ($M = 1.36$, $SD = 0.69$, Table 3). Three sub-themes included cultural and social fit, awareness of activities, and personal preference. Respondents discussed barriers and facilitators for all themes except personal preference.

a. Cultural and social fit

Issues of cultural and social fit were discussed by parents/caregivers and providers. Almost a fifth of parents/caregivers reported that they did not feel musical care activities were open to them ($n = 64$, 17%, Table 2). Barriers included the presence of cliques and feeling judged by others leading to feelings of being an outsider, feelings of anxiety, lack of inclusive and accessible spaces and activities for siblings, fathers and other caregivers, and lack of diversity of who can attend and content.

Parents/caregivers reported feeling like outsiders to established groups, feeling judged, feeling socially or culturally excluded, or that they did not attend because of social anxiety. One parent/caregiver, when discussing a playgroup that involved music for infants, reported feeling '[u]ncomfortable and lonely as the group of people were already established with each other and didn't make any effort or allow me to socialise with them'. Another explained: 'The [sensory music] group I attended were always in wealthy middle-upper class areas which I often felt like I didn't fit into'. Other parents/caregivers mentioned the risks of going and hearing conversations that were difficult because of differences in experiences of birth and parenthood.

Almost a fifth of parents/caregivers identified issues around childcare (e.g., an older child to care for) ($n = 67$, 18%, Table 2) as barriers to attending. Parents/caregivers commented on the lack of access for families with multiple children or even exclusion of certain caregivers (particularly fathers). Lack of accessible space was also seen as a barrier (e.g., pram access was ranked as somewhat important for accessing musical care activities, $M = 2.19$, $SD = 1.05$, Table 3). Lack of diversity in who could attend (e.g., children with disabilities and different ethnicities) and lack of musical diversity (e.g., in genre, culture, or language) were also discussed as barriers.

Conversely, many respondents commented on openness to older children and demographic diversity as facilitators. Parents/carers noted the role of the leader in facilitating a positive and inclusive experience: '[t]he lady who ran [the sensory music group] completely understood my anxiety and put measures in place to support me'. They also commented on the feelings of social connection that facilitated their participation: 'it was a group [music] session which involved like-minded parents. A very friendly and welcoming atmosphere'.

b. Awareness

Lack of awareness of activities was reported as a barrier to participation. A fifth of parent/caregivers 'later found out about activities that [they] could have gone to' ($n = 73$, 20%, Table 2). Barriers discussed included advertising being dependent on specific social networks and knowledge, lack of providers' knowledge about how to advertise, and lack of diverse representation in advertising materials.

Respondents discussed how knowledge from social networks (who they know and what they know) was one of the main ways they became aware of musical care activities. Lack of access to this local and specific knowledge acted as a barrier to access as well as impacting the diversity of the participants. Providers discussed barriers they experienced related to having the knowledge and time to properly advertise their activities. Parents/caregivers also commented on the lack of diversity in the advertising they see for these activities. For example, one commented on the need to '[Market] sessions in a more inclusive way – I'm mixed race/heritage and struggled to find any activities that embraced our multicultural community/our family heritage'.

Providers discussed how linking with existing services helped raise awareness. For example, one provider discussed how they worked with health visitors to increase awareness of their activity, while another discussed how they increased 'awareness within the local community' by having the 'event shared by [the] local child and family wellbeing unit's social media'.

c. Personal preference

Parents/caregivers commented on the balance between their personal preferences and the perceived usefulness for their children. They also made comparisons between community and at-home activities, highlighting preference for one over the other. For some, musical care activities were not of interest at all. For others, musical care activities were seen as not needed, or at least not helpful at different times in their child's development: 'I felt that pre-birth there wasn't much that a class or formal music class etc would provide for my son'. Some parents/caregivers described a tension between wanting to do something for their child but not enjoying the activities themselves: 'I don't care for them, I participated for my kids' sake and stomached what I could'. For several parents/caregivers, music making at home was seen as preferable because they saw community music making activities as unnecessary, less fun, or not as accessible.

3. Coordination and collaboration

Coordination and collaboration included two sub-themes: training and education and cooperation across organisations. Concerns in this area were primarily expressed by providers rather than parents/caregivers. Barriers included lack of training and education opportunities, while facilitators included successful examples of cooperation across organisations.

a. Training and education

Parents/caregivers ranked training/credentials of the group leader as less important in their decision to participate compared to other factors ($M = 2.41$, $SD = 0.96$, Table 3). Practitioners had a range of training and experience including music-specific (e.g., music education, music therapy), child development (e.g., early years/child development and Makaton/sign language), and therapies beyond music therapy (e.g., play therapy). Some saw their own experience as parents as sufficient preparation for this work: 'I'm a mum to a 2 and 3 year old! What more experience could I need!'.

Providers connected the lack of training opportunities to too few professionals able to do this work, impacting access. Providers also talked about the lack of training opportunities due to cost or proximity. Even when cost is not a barrier, providers still found it difficult to access training: 'I would like to attend Kodály courses in person but there are none that I know of in my area'.

b. Collaborating across organisations

Providers commented on the difficulties and success they had experienced in collaborating with other organisations (e.g., charities, universities, local authorities, and funders including NHS, funding bodies, and charities) and health professionals. Successful collaborations led to support with recruitment, funding, training, and space.

Suggestions to increase equitable access

Respondents gave suggestions to help ensure better and more equitable access to musical care activities in the UK (Table 4).

These included offering free or subsidised spaces, free venue hire for providers, and ensuring classes are offered outside of working hours. Respondents also recommended increasing the number of jobs for providers who work across different contexts and groups. Many suggested increasing the inclusivity and diversity of musical care activities through diversifying the musical content, languages, and background

Table 4. Suggestions to increase equitable access to musical care activities in the UK.

Themes	Suggestions to increase equitable access
1. Resources and logistics	a. Cost • Different funding models to support free/subsidised spots • Support with venue hire costs b. Proximity and availability • Increase in posts for musical care practitioners c. Time • Have classes outside of working hours
2. Inclusivity and diversity	a. Cultural and social fit • Include songs from different cultures/languages/faiths • Have multicultural/diverse leaders • More sessions for fathers and other caregivers • Session that include people with a range of musical ability • More sessions for children and adults with disabilities and health needs b. Awareness • More effective/inclusive marketing
3. Coordination and collaboration	a. Training and education • More training and support • More knowledge exchange b. Collaboration across organisations • More support from public sector organisations • Directory/Network

of group leaders. Respondents further suggested that activities and spaces should be welcoming, diverse, and accessible to people from different countries and faiths, with a range of musical abilities, a range of disabilities and mental health needs, and to siblings and other caregivers. Providers suggested more training and support with specific types of training, education, and knowledge exchange, such as support with inclusive marketing. Respondents suggested better cooperation with public sector organisations, which could help addressing barriers around funding and space availability. The potential for collaboration through a network or association, or the availability of a directory of services, was also highlighted.

Discussion

Our results show that parents/caregivers would like to participate in more musical care activities and that providers are working towards improving accessibility to, and diversity and inclusion in, their activities. However, significant barriers exist. Although providers and parents/caregivers described facilitators to support better inclusivity and diversity, respondents expressed the need for local, affordable musical care activities that take place at suitable times, where they feel welcome and represented. Providers of musical care activities further highlighted the need for new and more sustainable funding models, training opportunities, and better coordination and collaboration with other organisations (e.g., charities, universities, local authorities, and funders including NHS, funding bodies, and charities) and health professionals. Their suggestions lead to potential opportunities for a more collaborative, coordinated, and integrated approach to address the identified barriers and better utilise the identified facilitators, to support equitable access to musical care during the beginning of life in the UK.

From barriers to opportunities

The findings not only identify barriers and facilitators to accessing musical care during the beginning of life in the UK, but also point to suggestions for overcoming these barriers. Figure 1 brings together the barriers, facilitators, and suggestions discussed within our survey.

Resources and logistics

Cost was highlighted as one of the most important barriers or facilitators, with lower income parents/caregivers being more likely to experience this as a barrier. Availability was a statistically significant barrier overall. However, respondents with below-median income were less likely to report availability as a barrier. This may indicate that those with lower incomes are aware of activities, but participation is

Theme	Barriers & facilitators	Suggestions
1. Resources and logistics	**Cost**	
	Barrier: Expensive *Facilitators:* Free or subsidised	• Different funding models to support free/subsidised spots • Support with venue hire costs
	Proximity and availability	
	Barriers: Geographic proximity; Grass is greener; Oversubscription	• Increase in posts for musical care practitioners
	Time	
	Barriers: Inconvenient and inflexible timing; Lack of time	• Have classes outside of working hours
2. Inclusivity and diversity	**Cultural and social fit**	
	Barriers: Feeling like an outsider; Anxiety; Not inclusive or accessible to siblings, fathers and other caregivers; Lack of diversity of who can attend and content *Facilitators:* Inclusivity and demographic diversity in the sessions; Supportive and diverse leadership; Social connections	• Include songs from different cultures/languages/faiths • Have multicultural/diverse leaders • More sessions for fathers and other caregivers • Sessions that include people with a range of musical ability • More sessions for children and adults with disabilities and health needs
	Awareness	
	Barriers: Dependent on social networks; Lack of knowledge and time to advertise; Lack of diversity in advertising materials *Facilitators:* Linking with existing services; Advice from friends	• More effective/inclusive marketing
	Personal preference	
	Barriers: Lack of interest in musical activity; Feeling can do music at home	
3. Coordination and collaboration	**Training and education**	
	Barriers: Accessibility of training opportunities	• More training and support • More knowledge exchange
	Collaboration across organisations	
	Barrier: Difficulties in communication and collaboration across and within organisations *Facilitators:* Support from other organisations and health professionals	• More support from public sector organisations • Directory/Network

Figure 1. Themes, barriers, facilitators, and suggestions for improving equitable access to musical care during the beginning of life.
*Anthropic's Claude Sonnet 4.6 was used in the generation of this figure.

limited because of cost. Cost and lack of availability are well-documented barriers to accessing the arts (Moore, 1998; Fancourt & Mak, 2020) and parenting support generally (Koerting et al., 2013; Action for Children, 2022).

Many musical care activities in the UK rely on commissioning by healthcare providers, local authorities, charities, and private organisations. There are two models of commissioning; one that is commodified (a buying and selling model) and the other more collaborative (Sheaff et al., 2024). The new integrated care systems move towards this collaborative model where regional partnerships of health and care organisations, including the NHS, local councils, and the voluntary sector, work together to plan, fund, and deliver services. However, barriers include challenges for voluntary sector organisations in attracting funding and interest from social prescribing commissioners, heterogeneity in the evaluation methods, and difficulties in professional roles with high staff turnover (Thomson & Chatterjee, 2023). This funding and political context make for a competitive landscape, with short-term financial support, which contribute to our identified barriers of cost and availability.

This project identified strategies used to reduce cost barriers by those providing musical care activities. These included offering free or subsidised places, innovative payment models (e.g., pay what you can), and working with funders or other organisations to support costs (e.g., offering free venues). System-level and local opportunities can be seen in suggestions and experiences including collaborative commissioning models and how providers make charging decisions.

Cultural and social fit

Identified barriers and facilitators around cultural and social fit of musical care activities included considerations around ethnicity, cultural background, language, familial role, family size, special educational needs, and musical content and experience. Parents/caregivers and providers discussed how these considerations were critical in how these activities are advertised (Koerting et al., 2013), how they are structured, where they are held, and who they are provided by. This relates to recent attention to diversity in training and delivery of musical care activities (Lindo, 2023). The complexity in considerations of inclusion speaks to the importance of taking an intersectional approach (Crenshaw, 1991; Rojas-García et al., 2022) to this work: understanding how people's intersecting characteristics play a role in their access, and experience of, musical care activities.

Preference also played a role in parents'/caregivers' decision-making. Some respondents felt they were not interested in the activities; others felt they could make music with their babies at home; others did not like certain aspects of the musical care activity. Other respondents only attended these activities because their child liked them not because they enjoyed them. This highlights the importance of preference in understanding the potential benefits and experiences of engaging with musical care activities (e.g., Sanfilippo et al., 2020). Participatory methods in the development and implementation of musical care activities presents opportunities to better account for people's complex experiences and preferences, leading to musical care activities to address their specific needs (Anstee et al., 2026).

Collaboration and coordination

The findings of this work, alongside other initiatives (e.g., those described in the Creative Health Review (The National Centre for Creative Health & All-Party Parliamentary Group on Arts, Health and Wellbeing, 2023), present opportunities around collaboration and coordination across sectors, which in turn can provide opportunities for logistics and resourcing, diversity and inclusivity, and training and collaboration.

There are examples of established collaborations between the health and community voluntary sector organisations in the UK. For example, social prescribing, where people are connected to activities, groups and services in their community usually provided by community voluntary sector organisations, has been found to positively impact people's health and wellbeing and reduce costs (National Academy for Social Prescribing, 2024). Additionally, social prescribing has been shown to support wellbeing across different sociodemographic populations (Bu et al., 2026), however there are inequalities in referral with only 38% of referrals resulting in interventions being accessed (Bu et al., 2025). Arts-based activities like musical care activities are a recognised component of social prescribing activities offered. However, reaching successful collaboration between the health service and community organisations will necessitate the ability to have trust and a shared understanding, navigate differences in professional boundaries, have time and resources to support this collaboration, and appropriately address the overall power imbalance and avoid exploitation of voluntary sector organisations (Southby & Gamsu, 2018; Croft & Currie, 2020; Alderwick et al., 2021).

Limitations and future work

The large survey method allows for breadth of understanding but may miss depth of people's experiences or system level barriers within specific contexts or regions. Additionally, the survey was hosted online and in English which limits the representation of our sample. Despite a large and diverse dataset, our sample is also limited in providers' experiences and underrepresents minority voices because of the sampling approach. Future research could extend this work to include more practitioners, with particular attention to (1) practitioners who work across the spectrum of organisations and settings where this work is taking place (e.g., large organisations to independent practitioners; NHS, charity, educational, or private setting) and (2) a broader geographic and ethnic range. Future research should also focus on minority groups and on individuals referred to musical care for specific health reasons, including a focus on those referred to more specialist activities like music therapy.

Further work is also urgently needed across the themes identified. For example, in terms of resources and logistics, context-specific research is needed to understand which forms of funding and systems level processes are most successfully increasing access to musical care activities. In terms of cultural and social fit, research is needed to identify communities who are experiencing exclusion from appropriate musical care activities and co-develop suitable and accessible work. In terms of collaboration and coordination, beyond the continued exploration of collaboration models, there are still fundamental questions about the practitioners in this wider field and the kind of training is needed – both for practitioners and other professionals they work with. Finally, this survey approach could be used to understand barriers, facilitators, and opportunities in access to musical care across different life stages.

Policy implications

As we identify the way forward for musical care during the beginning of life in the UK, much can be learned from existing collaborative models in the UK and their successes and challenges. To better understand opportunities in this creative health landscape, and following the data collection reported here, a policy panel was held to co-develop policy recommendations to equitably scale musical care activities during the beginning of life in England and Wales. Scaling typically focuses on the infrastructure needed to reach a broader proportion of a population (Côté-Boileau et al., 2019). Patterns of inequities have been observed within the process of scaling, as encapsulated in the 'inverse equity hypothesis' (Victora et al., 2018), where new health interventions are often initially adopted in privileged socio-economic contexts, thus increasing inequalities. The policy recommendations included ensuring long-term funding, creating a collaborative environment for place-based approaches and community spaces, including and recognising musical care in quality standards and guidance, and empowering the musical care workforce with the skills they need for high quality and safe practice (Find the full policy recommendations document here: https://tinyurl.com/2su9te3c).

Conclusion

This study identified barriers and facilitators to parents'/caregivers' access to musical care activities during the beginning of life in the UK. Parents/caregivers and providers' suggestions lead to potential opportunities for a more collaborative, coordinated, and integrated approach to address the identified barriers around resources, inclusivity, diversity, and training, and better utilise the identified facilitators, to support equitably scaling musical care during the beginning of life across the UK.

CRediT roles

KRS: Conceptualisation, data curation, formal analysis, investigation, methodology, supervision, writing – original draft, writing – review & editing

NS: Conceptualisation, data curation, formal analysis, funding acquisition, investigation, methodology, project administration, supervision, writing – original draft, writing – review & editing

CS: Data curation, formal analysis, writing – review & editing

MR: Data curation, formal analysis, writing – review & editing

ACH: Data curation, formal analysis, writing – review & editing

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EC: Methodology, investigation, writing – review & editing
RP: Methodology, investigation, writing – review & editing
ET: Methodology, investigation, writing – review & editing

Notes

1. We use 'infant' to include babies from birth until two years of age.
2. We use 'beginning of life' to encompass the period of pregnancy until the infants are two years old, a period that aligns with the first 1001 days. This term emphasises the importance of the familial/caregiving unit.
3. Happity is the largest online platform in the UK for parents to find online and in-person classes for pregnancy and for babies and toddlers.
4. Dedoose is an app that helps with analysis qualitative and mixed methods data. In this study we used to highlight and tag the text responses with codes and then summarise the codes and themes.

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Disclosure statement

The authors report there are no competing interests to declare.

AI declaration

In the preparation of this manuscript, Anthropic's Claude Sonnet 4.6 was used to support the generation of Figure 1. Using the tables produced by the research team, we asked Claude to suggest different ways we might present the table as a figure to help readability. Through further prompts in Claude and then through final editing by the research team, the final image was produced. We have checked and have the right to publish these images as per Anthropic's terms and conditions. We as authors take full responsibility for the integrity of the whole content and confirm the originality and accuracy of the content.

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Data availability statement

The data files for this project are available on RCM Online (https://doi.org/10.24379/RCM.00002606) with some data redacted to protect respondents' anonymity.

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