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The development of Chatting Time Series (including Changing time is Chatting Time and Anytime is Chatting Time) – a suite of resources that support parents to interact with their babies and young children throughout the day

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Description

There are two sets of resources:

1. Changing Time is Chatting Time is designed for antenatal parents and parents of babies:

    - Video 1 Changing time is Chatting Time – how to smile, talk, laugh and sing with your baby
    - Video 2 Your Words Work Wonders – Tips for Chatting with Your Baby
    - Parent information session containing information about baby brain development, how to smile, talk, laugh and sing with your baby throughout the day and why this makes a difference to their brain
    - Parent information session in 6 bite size 3-4 minute videos
    - Parent leaflet with Changing Time songs and QR code for the videos

2. Anytime is Chatting Time is designed for parents of children from around 12 months to 3 years:

    - Video 1 Anytime is Chatting Time – how to smile, talk, laugh, sing and share stories with your child
    - Video 2 Your Words Work Wonders – Tips for Chatting with Your Child
    - Parent information session containing information about baby brain development, how to smile, talk, laugh, sing and share stories with your child throughout the day and why this makes a difference to their brain
    - Parent information session in 6 bite size 3-4 minute videos
    - Parent leaflet with Anytime song and QR code for the videos

Chatting Time resources are used in all Sure Starts in Belfast Health and Social Care Trust (BHSCT) area (and now regionally across NI) to increase parents' understanding about how their baby's brain develops and their role in this. They also give parents practical advice on how to increase interaction with their child throughout the day.

The resources mentioned can be accessed at:

https://view.pagetiger.com/chatting-time-resource-guide/v1

Context

One of Sure Start's overarching objectives is to improve language skills of children in Sure Start areas and so help end the intergenerational cycle of language deprivation. In Sure Starts in BHSCT area, around 70% of children entering the Developmental Programme for 2-3 year olds have delays in speech, language and communication. The role of the Sure Start SLT is to improve the language skills of children living in Sure Start areas by increasing the relevant knowledge and skills of those most proximal to the child i.e. parents, Sure Start staff, and members of the community. To be most effective, this capacity building needs to begin antenatally. Working with antenatal parents and parents of young babies were new areas of work to some in the newly recruited (late 2016) team of Sure Start SLTs.

The need was therefore identified for a set of resources that:

1. supported SLTs to begin work with antenatal parents and parents of babies
2. Provided user friendly tools for Sure Start SLTs and Practitioners to give consistent messages to parents (of children antenatal to 3 years) in an accessible and helpful way
3. Gave information about brain development and the importance of talking to your baby in a way that was easy to understand and easy to communicate to others
4. Packaged information in a simple accessible way
5. Supported parents to interact with their children in ways that promote emotional security and the development of language

Method

Changing Time is Chatting Time (CTCT) was first developed by the BHSCT Sure Start SLT team in 2017 to support Sure Start SLTs as they moved into a new area of work with antenatal parents and parents of babies. It provided Sure Start SLTs and other Sure Start staff with a tool that enabled giving consistent health promotion messages in a clear and concise way. CTCT increases parents' understanding of why talking to their child is so important. The resources also give them simple concrete guidance on how to do this as well as tools (songs) and modelling (videos). Early outcomes from staff and parents (see below) indicated that CTCT was supporting staff to give information to parents and supporting parents to interact differently. Therefore in 2018 the need was identified to develop a similar resource for parents of slightly older children 12-36 months. At this time, we had the opportunity to be involved in a co-design project with a group of parents from East Belfast Sure Start in partnership with Save the Children. This gave us the opportunity to:

a) Get parents' help in revising CTCT

b) Get parents' insights and guidance in developing a new resource which became Anytime is Chatting Time (ATCT)

The parents in the East Belfast Group had valuable insights into what is helpful for parents and what isn't helpful, so it was important that this group of parents had a role in the revision of CTCT and the development of ATCT. They were able to advise on what is helpful to them in their understanding of brain development and what would support them in developing 'serve and return interactions' and 'contingent talk' (Matthews et al, 2016)[1] which are identified in research as critical factors in language development.

The result of this collaboration with parents was the completion of the suite of resources outlined above – some changes were made to CTCT and ATCT was developed using insights from the parents as our guide. The parents had the opportunity to appraise the changes to CTCT and the new ATCT resource and make further changes before it was completed.

Outcomes

Aim 1 – to support SLTs to begin work with antenatal parents.

Before CTCT, Sure Start SLTs were involved in working with antenatal parents in 2 out of 9 Sure Starts.

Currently Sure Start SLTs are involved in working with antenatal parents in 9 out of 9 Sure Starts.

86% of SLTs reported increased confidence in sharing information about brain development with parents. The one SLT who did not report increased confidence had already significant experience in this area e.g. was a Solihull trainer.

Aim 2 - Provide user friendly tools for Sure Start SLTs and Practitioners to give consistent messages to parents (of children antenatal to 3 years) in an accessible and helpful way.

Aim 3 - Give information about brain development and the importance of talking to your baby in a way that was easy to understand and easy to communicate to others.

Aim 4 - Package information in a simple accessible way.

These aims were not evaluated separately. Rather, the outcomes can be inferred because:

- CTCT is now used in all 38 Sure Start across Northern Ireland
- Use of ATCT is currently being introduced across all 38 Sure Starts in Northern Ireland
- Following the introduction of CTCT, Practitioners (SLTs and other Sure Start Practitioners) reported giving information about brain development and early interaction more frequently
- Parent outcomes for CTCT and ATCT (below) report behaviour change

Aim 5 – Support parents to interact with their children in ways that promote emotional security and the development of language.

Parent outcomes are being gathered in 3 ways (as per Royal College of Speech and Language Therapists (RCSLT) Framework: Measuring Outcomes outside individualised care June 2021)[2].

a) Quantity of information shared
b) Parent report of behaviour change as captured by parent questionnaire
c) Individual examples of change as captured by staff observations and parent stories

Quantitative data is difficult to obtain due to the nature of the service area and the subjectivity but our qualitative data from our parent feedback shows behaviour change in those parents who responded to questionnaires (see b) below):

a) Quantity of information shared:
    - CTCT video views – 2712
    - Your words work wonders (baby) video views – 736
    - ATCT video views – 2542

- Your words work wonders (toddler) – 668
- CTCT information embedded into work of all 38 Sure Starts
- Bite size videos shared via YouTube or WhatsApp in all Belfast Sure Starts (CTCT with antenatal parents and parents of babies; ATCT with parents of children in Developmental Programme for 2-3 Year Olds ie approx. 300 parents per year)
- Chatting time Staff Resource Guide on Page Tiger – 421 visits spread consistently since it was first published indicating that it is still being used

b) Parent report of behaviour change (from questionnaire responses 'what would you tell another parent?'):
CTCT – ***"understanding the upper brain and lower brain. So concentrating on keeping the baby calm. talking also in sing song way which definitely catches his attention more now".***
"calmer babies engage more. lots of communication can be done by singing and talking to them in a sing song way. they will pay more attention and start engaging with coos and this will help further in developing their speech"
"Singing and talking more to my baby and she smiles and makes noises back"
ATCT – what would you tell another parent?
"How something quite simple like singing while driving, can help engage your child"
"That its surprising how much I told my child what he liked and (when I follow his lead) ***he actually has his own point of view and his own likes"***
"Give them one on one time and properly listen and have conversations about them and their interests and it will pay off 10 fold"

c) Examples of change reported by others: CTCT
Midwife fed back that some parents have talked about how the changing time songs 'really work'- they help 'calm down' the baby and make changing time more enjoyable.
Family Support Worker reports 'I have noted a change in parents with whom I have completed CTCT with the feedback being they are all singing to their babies now and some reading to their babies. It started conversations with parents where they said 'I didn't know you could read to a small baby 'which lead to a book talk and information on books etc. Mums reported that they have put the songs on the wall beside the nappy changer to aid them.'
Family Support Worker reports 'At Infant Massage, one Mum said that she has been singing the "Change your nappy, here we go" song to her wriggly six month old when changing him. He loves it and said it also really calms her down and it is less of a battle for both of them! At the end of the session we all sang it as we dressed our babies and nearly everyone joined in (without the handout), so they must be singing it at home'.

Key learning points

- Parents are most likely to do something if it makes it easier to get through the day (insight given by East Belfast parents in co-design group). Singing songs makes nappy changing easier and so parents do it. There are also some parent reports of transferring this behavior to other stressful situations.
- Giving the information in a conversational way (using the illustrations from the parent session folder) rather than 'giving a talk' engages parents better. Information is best received when delivered by someone the parents have a trusted relationship with.

- Parents are very interested in brain development and how they can influence this in a positive way (see an example above about a parent comment re upper brain and lower brain) but they want tools to help them do this. This has resulted in further co-productions and the development of the Sure Start Chat with Me books.
- Bite size videos were introduced during lockdown and were positively received by parents who reported doing things differently as a result (see ATCT behavior change comments above). Staff found it easier to open up discussions with parents when the parents had already watched the Bite Sized videos.
- As a result of this feedback from staff and parents, Chatting Time training for staff was developed by the Sure Start SLTs and a working group of Family Support Workers. Chatting Time training is developed to help Sure Start staff explore how to embed the key messages from Chatting time into all areas of work with parents rather than just delivering a parent information session. Example of Family Support Worker feedback
  "We are thinking about parent/child relationships, more specifically the connection using ATCT language. We are developing processes within our planning to help embed this language into our programme as a way of using a shared language to discuss attachment and bonding"

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The added value of art therapy practice within maternity and perinatal parent-infant mental health

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Practice description

Art therapy within maternity and perinatal parent-infant mental health (PPIMH) is a developing area of practice in the UK (Hogan et. al, 2017). This therapy uses artmaking to explore emotional difficulties such as anxiety in pregnancy or postnatal depression. It focuses on improving relationships between parents and their babies up to twenty-four months. A systemic and psychologically dynamic approach ensures a broad therapeutic space for exploring family environments and the deeper transgenerational relationships between parents and their baby's developing personality (Jones, 2019). This model reflects the philosophy of the department where this study was conducted.

Arts in PPIMH features in government reports, such as the Creative Health Inquiry Report (2017) and Arts in Health Evidence-based Interventions (WHO, 2019). The vitality featured in art therapy complements the cultural, socio-economic, and neurological diversity of this demographic. The physical and mental changes that come with pregnancy invite a holistic approach including the arts, mindfulness, and yoga. All have been found to have good economic outcomes for perinatal mental health (Bauer et. al., 2016). The kinesthetic qualities of artmaking (see Elbrecht, 2013) can help subdue emotional and psychological distress resulting from deeply traumatic perinatal experiences. Its sensory methodology helps to regulate attachment transmissions by providing a bi-directional space that encourages bonding and reflective function (Bruce, 2020).

Pandemic context

One in five mothers experience a spectrum of anxiety and depression during the perinatal period (Creative Health Inquiry Report, 2017). A post-pandemic report suggests this figure is now higher (Babiesinlockdown, 2021). The pandemic has also impacted fathers/partners. Women from disadvantaged socio-economic backgrounds are three times more likely to suffer perinatal illness than others in the UK. Black minorities and Asian populations have been most severely affected by the pandemic (Papworth et al., 2021). In 2017, perinatal depression was estimated to represent a long-term cost to UK society of £8.1 billion per annum (Creative Health Inquiry Report, 2017). There has since been an increase in the availability of perinatal services across some parts of the UK, but isolating effects of lockdowns have been particularly stressful for vulnerable women with babies (Papworth et al., 2021). Stigma is a significant barrier to seeking help. It is therefore likely that many perinatal illnesses remain untreated (Broadhurst et al., 2017). Some women are afraid to accept help fearing their baby may be removed from their care or they will be judged as not *good enough* parents (Papworth et al., 2021). Jones aptly uses the phrase '*illness of trust*' (Jones, 2021).

Study context

A six-month art therapy service review was completed within the author's PPIMH department in 2017. The aim was to help commissioners and professionals understand the benefits of art therapy in this field. Service user feedback was analysed. The findings were later published (Bruce & Hackett, 2020). It is summarised here with a focus on wider determinates and health improvements from including art therapy within perinatal mental health services.

Referrals to the department came from professionals working within the field. The annual referral rate was 1100 at the time of the review. Art therapy was a one-day-per-week service. Referrals were discussed at weekly multi-disciplinary team meetings. Twelve referrals were accepted for art therapy during the review period. Nine led to face-to-face assessments. Presentations included symptoms of anxiety, perinatal depression, posttraumatic stress disorder and self-harming behaviours. Parent-infant bonding issues were predominant. Some women were pregnant, others had babies up to ten months old. Five were from ethnic minorities, four were white British. English was a second language for four women. One used an interpreter. Three families received social care. Five were from low-income, temporary, or overcrowded households. Therapeutic support was offered to fathers. One requested it. Partners were encouraged to attend a father's group run by the department. Five women received psychiatric services. Seven attended community groups with their babies whilst pursuing art therapy.

Method

Interventions for the nine women and babies took place in the department's creative therapy room. This was made to feel bright and cheerful. The windows looked out onto green shrubbery. The service also arranged home appointments. Parent-infants were offered weekly ninety-minute sessions. Forty-eight of sixty-eight sessions were attended. This was above average for the department at the time of the review. Intervention length ranged from six-weeks to beyond twelve months. Sessions began with yoga or mindfulness exercises followed by time for artmaking. Art materials were available and could be used freely within the space. The floor was the most common place for activity. This invited mother-baby interaction when a baby was present.

The process of artmaking sometimes aroused memories that reminded women of their own adverse experiences of being parented. This could be a concern, but often generated opportunities for the therapist to help the parent unpack what was recalled, encouraging inter-relational repair and positive moments of mother-baby connection. Session-by-session risk management was paramount in treatment planning. Mothers' own words were used to describe desired intervention outcomes. Six-weekly reviews helped parents recognise how well they were progressing. This promoted resilience in parenting ability. Interventions were delivered by a fully qualified art therapist with post-graduate qualifications in infant mental health.

Service-user experiences

Two questionnaires were designed to facilitate the service review. These were self-reporting and used to gather views and experiences of the nine women. The British Association of Art Therapists' research officer was consulted in developing the questionnaires. PPIMHS Strategic & Clinical Lead guided the sensitive quality of the questions for this population. The first included twelve closed questions asking about general experiences of the art therapy service. Answer choices included *very* *true*, *partly true,* or *not true*. The second included ten questions about the women's therapeutic experiences. This aimed to capture moods and feelings recalled from the intervention. A selection of twenty *feeling* words such as *afraid, worried, anxious, relaxed, comfortable,* and *calm* appeared on the sheet. Women could circle words that most accurately matched their feelings before and after the intervention. Room was left for additional comments on each sheet. Eight of nine mothers returned completed questionnaires.

Table 1 highlights the proportion of women who measured *very true* in relation to aspects of their general experience (questionnaire 1). Table 2 highlights the proportion who measured *very true* in relation to aspects of their therapeutic experience. Table 3 highlights the women's most circled *feeling words* in relation to *their* therapeutic experience (questionnaire 2).

No. of mothers	Statements in relation to mothers' general experience of the art therapy service
7/8	I feel that the person who saw me / me and my baby listened to me
7/8	It was easy to talk to the person who saw me / me and my baby
5/8	I have been given enough explanation about how art psychotherapy can help
7/8	The creative art therapy room is comfortable
7/8	The art materials were appropriate
2/8	It is quite easy to get to the place where the appointments are held

Table 1.

No. of mothers	Statements in relation to mothers' therapeutic experience
4/8	Art therapy provides or provided me with an alternative way of communicating.
4/8	During art therapy I felt my mood change for the better following session 1.
3/8	During art therapy I felt my mood change for the better following session 3.
5/8	During art therapy I felt my mood change for the better following session 6.
4/8	The review(s) during the art therapy intervention was/were useful.
6/8	Art therapy is helping or has helped me to understand myself and my problem(s) better.
3/8	Art therapy is helping or has helped me to understand my baby's needs and improve my relationship with my baby.
7/8	The room/environment is helping or has helped me to feel comfortable about sharing my thoughts and feelings.
6/8	The art materials are helping or have helped me to express how I feel.

Table 2.

No. of mothers	Most circled feeling *words from questionnaire 2*
6/8	Before: *worried, anxious, and afraid*
5/6	After: *stable, relaxed, comfortable, and calm*

Table 3.

The results demonstrated that women felt their views and anxieties were considered. Six of eight thought art therapy helped them grasp an understanding of their problems. This ratio suggests that art therapy may offer a generous section of the public a more relaxed way of speaking about their troubles. Half of the women said they appreciated being offered an *alternate way of communicating*. This suggests that art therapy may offer marginalised sectors of the population diverse and inclusive ways to feel valued and understood, particularly if English is not their first language. Feeling understood increases resilience and confidence. This has potential to impact on other aspects of women's lives, for instance in developing creative abilities or pursuing new ways of developing careers balanced with parenting. Half the women experienced positive mood changes following initial sessions. Mood changes may have been influenced by prescribed medication. Three women claimed that art therapy helped them understand their baby's needs. Whilst women didn't always perceive bonding and attachment as a central issue, some said that they did not want to parent their babies in the way that they had been parented. Their drawings reflected this and helped them to see things from their baby's perspective. This can also substantiated by the women's written feedback. Empathy and compassion for others is impactful for society. It can positively affect the health and well-being of future generations. Attendance at parent-infant groups and/or other treatments received concurrent to art therapy could have prejudiced these views. Circumstantial and broader environmental factors may also have influenced change. Samples of women's feedback included:

"drawing gives me memories to put right [in the mother's mind] *and help*[ed]*…me and my baby…it helps me think about my baby's feelings"*

"making things relaxes my anxiety"

"It [art therapy] *jogged me back into thinking 'I can cope without a service'."*

"I looked forward to…art therapy."

These examples suggest women found the art therapy space relaxing. A place where feelings could be held, and anxiety reduced, promoting trust, positivity, and resilience. Women said they felt inspired to find alternative ways to combat anxiety, such as joining craft groups, or spending more time walking in nature. These healthy life-style choices helped one woman become less reliant on services, thus providing an example of reducing wider socio-economic costs.

One woman attended weekly art therapy sessions with her baby over a six-month period. She willingly granted permission to publish her personal story, keen for others to benefit from this approach. Vignette one describes the woman's perception of her background and how this influenced her current mood relating to her baby. The second summarises positive changes gained from the therapy. The final vignette features her responses to a third questionnaire developed to guide an interview approximately six months after the intervention. Vignettes capture her views and experiences of art therapy and the effect this had on her relationship with him. A pseudonym is used here.

Vignette one

In the first months of art therapy, Sandra used drawings to describe how her parents suffered from addiction to alcohol. She was often shut in a bedroom for hours at a time and spoken to in a humiliating and derogatory way. She said, this made her childhood feel frightening and confusing. She described suffering from depression. As a teenager she attempted suicide. Sandra accepted this art therapy intervention shortly after the birth of her fifth baby. She also admitted to suffering depression during previous pregnancies.

The therapist noticed that Sandra hardly looked at her baby during session one. Baby lay quiet and still whilst Sandra spoke of feeling "*lost, isolated and worse than ever before*". She said how hard it was to feel positive about her baby. Sandra used clay to create the image of a baby (Figure 1).

Figure 1.

Pushing her efforts aside, she said she felt *"useless".* In a different session she scratched an image of herself hidden in a box. The box lay beneath her "*overpowering*" father whose face she *"couldn't think about"*. Sandra appeared unaware of how these memories affected her feelings and prevented her from encouraging her baby to thrive. The therapy enabled her to discuss how she may have unknowingly wanted her baby to feel robbed of affection, like she had felt robbed.

Vignette two

During month three, Sandra began making connections between her images and her childhood suffering. She grew more trusting of the art therapy process. Her confidence increased. She began using whole arm movements to draw across an expanse of paper on the therapy room wall. Sandra created a cohesive visual story of the *"rubbish"* she said was "*suffocating her mind*". She exercised her imagination, creating space to think of how her baby could be stimulated. Their relationship became increasingly animated. She began prioritising his needs. He gradually reached for toys, like Sandra reached to draw with her hands.

Vignette three

During the subsequent interview, Sandra said *“having someone listen and witness my story in a non-judgmental way helped me learn to trust”*. She reflected on images made during the intervention and described how her self-understanding had helped her feel more able to meet her baby’s emotional needs. She said this shift came through her hands [kinaesthetic] and through the space available to *“sick out her feelings in art therapy”.* She spoke of the *“joy”* she now sought internally and the hope she held for her baby’s future.

Outcomes and learning

Research into perinatal parent-infant art therapy is limited (Bruce & Hackett 2020, Hogan et al, 2016). However, this study offers an example of how the cost of perinatal depression to UK society could be reduced. Bauer et al. suggest that increased access to treatment for common maternal mental health problems could provide a net benefit of half a billion pounds (2022). Further studies are needed to examine the reliability and validity of art therapy within this field. Nevertheless, these findings reveal the importance of considering the mental health and well-being of parents and their immediate environment in developing their baby’s personality. This innovative approach forms a creative space for parents and babies to thrive together while considering inter-relational repair. This inclusive and diverse approach may also positively contribute to intergenerational health improvements in individuals, communities, and wider society.

As part of the NHS Long Term Plan for perinatal services, the Trust where the review was conducted successfully bid to develop a community maternal mental health service to reach women suffering from posttraumatic stress disorders and perinatal traumas such as sub-fertility, miscarriage, still birth, traumatic birth and loss of a baby through removal by social care (https://www.england.nhs.uk/2021/04/dedicated-mh-services/). Art therapy is being integrated into its forward-looking strategy. This is also reflected in the development of other community teams across England.

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Provision of Therapeutic Boxing for Psychiatric Intensive Care Unit

Description

The aim of the project was to increase access to physical activity on a 10-bed Psychiatric Intensive Care Unit (Willows). The Live Team at Highbury Hospital, worked in partnership with a Nottingham City Council project, Get Out Get Active, and local boxing initiative Evolve CIC, to provide a continuous intensive boxing course directly onto the Willows Unit.

Inpatients on the Willows Unit were offered two sessions a week of non-contact boxing skills, through a professional boxing instructor from Evolve CIC, and encouraged to continue participation at the instructor's club with increased support post discharge.

Context

Evidence shows that people with Severe Mental Illness die up to twenty years younger than the average population (NICE 2018; De Hert et al., 2011; Stubbs B et al., 2015). Physical activity could have a vital role in addressing the health inequalities experienced by people living with severe mental illness, in addressing premature mortality, in preventing the onset of comorbidities, and in improving the overall health and wellbeing of this population. (Ashdown-Franks et al., 2018).

The Live Team were initially awarded Sport England year-long project funding in September 2018, to address inpatients requests for increased levels of physical activity across multiple hospital sites within Nottinghamshire.

The boxing sessions were tailored and adapted to the meet the needs of the Willows Unit inpatients, as the Unit provides specialist support to high-risk patients from a diverse population. Our objectives for the boxing sessions were to embed physical activity on the Willows Unit; engage the whole ward team; inspire and support inpatients to continue to access boxing beyond admission; improve levels of engagement and improve mood.

As boxing sessions developed, staff observed and tried to capture the positive impact on the ward environment and identify any correlation with a decrease in violence and aggression incidents.

Method

Through a partnership with Nottingham City Council's Get Out Get Active inclusive sports project and Evolve CIC, a Nottingham estate-based boxing club, collectively we aimed not only to engage inpatient services but to maximise the benefit and connect the Willows inpatients to the wider non statutory community sport resources, and demonstrate investment and relevance in valuing our services users by providing best quality to ensure engagement.

The boxing instructor offered an outside perspective and created a different dynamic in the Willows Unit. Boxing skills and breathing exercises were included in the sessions that were offered twice a week. The instructor's approach and personality fostered good team cohesion and had a positive impact on the ward atmosphere each time they arrived, their approach appeared to normalise discharge and created opportunities for inpatients and staff to think about engaging in community boxing or general physical activities post-discharge.

Internally a whole team approach was essential to support the success of this project, inclusive of the Live Team, Willows ward management to healthcare assistants and therapy staff, all who worked collaboratively and collectively, ensuring suitable engagement and safety was maintained.

Outcomes

The impact of the boxing sessions was captured via multiple qualitive outcome measures including an electronic feedback form that sat within an inpatient's electronic note, staff interviews, individual case studies and the Incident Reporting System.

Willows ward staff reported that they observed positive changes in inpatient behaviour and were surprised at the levels of engagement from specific inpatients who had declined offers of other onward activities or social interactions with staff.

Inpatients who engaged in a boxing session were supported by staff to complete a feedback form that focused on the individual's mood pre- and post-boxing session. Results from this after every session showed an uplift in mood for all inpatients, which therefore created a positive impact overall on the ward after the session had taken place.

There were several requests from inpatients to access Evolve CIC's boxing club within the community, post-discharge from the Willows Unit. Details of the boxing club were passed on to inpatients upon this request, as well as Evolve CIC setting up a dedicated session at the club specifically for Willows service users to attend, having one service users attend the club independently amongst the public, beyond his discharge from inpatient services.

Reporting level of incidents: days of session / days not / for engaged/participants / reduced violence and aggression through relieving stressors – why and rationale? Nature of the ward, boxing negative?

Learning points

Collecting data and measuring impact poses an on-going problem and having additional training on this may have been beneficial to all staff involved. All staff and external providers agreed it was hugely successful and identified numerous benefits but this was mainly via discussion and observation with all involved. It is difficult to represent that with evidence particularly in relation to cost effective/value for money and longer-term benefits in health and prevention especially in terms of securing or ensuring this is funded.

The perception of boxing initially created its own barriers with ward staff, with serious concerns about increased risk of violence and aggression, but these were easily challenged when sessions were witnessed in action, and we learnt to anticipate this and reassure staff teams when rolling out sessions on other wards. Additionally, we found that when staff participated in the sessions alongside the inpatients, it changed the dynamic of staff and inpatients' therapeutic relationships.

On-going plans are to continue to roll out across wards, including a dementia ward. The next steps are to seek funding to enable access to more boxing sessions on multiple inpatient wards and for further funding to be sustained via the wards. We hope to further develop links to community boxing resources and support transition to community access for inpatients.

The COVID-19 pandemic did put the project on hold, but the Live Team remain committed to continuing the developments of provision of boxing sessions when safe to do so.

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AHPs Public Health

RSPH
ROYAL SOCIETY FOR PUBLIC HEALTH
VISION, VOICE AND PRACTICE

Preceptorship Public Health Initiative: New Graduates

As Orthoptists, Public Health conversations form part of our everyday interactions with patients. We should aim for this to be embedded naturally, rather than this being an ‘add on’ in our conversations. We should identify opportunities to have Healthy Conversations within clinics, more so now than ever, owing to the impacts of Coronavirus!

What conversations might we have with patients?

Some conversations are ‘easier’ to have with patients than others – i.e. a patient with Thyroid Eye Disease and discussing the benefits of stopping smoking, due to the evidence linked with our Orthoptic Knowledge. In these scenarios, we may feel more comfortable having this conversation. However, Public Health covers a large spectrum of issues…

- Mental Health
- Smoking
- Diabetes
- Weight Loss
- High Blood Pressure
- Alcoholism
- Substance Misuse
- Falls
- Dementia
- Vaccination
- Oral Hygiene

What Is Public Health?

- Allowing patients to *think* about their current Health and Lifestyle
- Being Encouraging and Supporting
- Signposting

What Public Health is NOT

- Pressuring Patients to Change
- Counselling
- Knowing all the Answers
- Lengthy Conversations
- Reciting lots of statistics to patients

How To! Cue, Conversation, Conclusion

Cue – A hook which enables the patient to raise a subject with the health professional or vice versa.

- Example: A patient presents with an accommodative spasm and appears stressed.
- Example: There is a strong smell of alcohol on the patient’s breath as they speak to you.

TASK: Can you think of any more Cues which may present themselves in clinic?

………………………………………… ………………………………………… …………………………………………

Conversation – The brief intervention – Give the opportunity to ‘explore’ the change and think about the positive impact it can have. You can ‘Pop in a Positive’! Patients may have a negative view if they have tried to make this change before and not been successful.

- “It’s great that you’re thinking about taking that first step to making a change.”

- “It sounds like you have been successful before, even if it only has been for a few days.”
- “There are some great online resources that can help you learn about managing stress.”

TASK: What positive phrases can you think of to form part of the conversation?

……………………………………. ……………………………………… ………………………………………

Open Discovery Questions are a useful way to encourage patients to actively think about a change in their life and explore how they may begin this change.

- What support do you need?
- How would you like to approach this change?
- If this is something you would like to change, would you like to tell me about it?

TASK: Can you think of any more Open Discovery Questions which could be used?

……………………………………..………. ……………..……………………………. …………..………………………………..

Conclusion – Signpost to follow up/specialist support services. Knowing what is available in the local area is important to determine a patient’s outcome. Keep it brief, up to date and relevant!

TASK: Which services are available to signpost patients to? Research your <u>local</u> support.

………
………
………
………
………

<u>Real Examples</u>

① A patient with acquired downbeat nystagmus presented to the Orthoptic Clinic.

Cue: She expressed that she had found the Coronavirus Lockdown period particularly challenging.

Conversation: “What sort of support did you have in place prior to the Coronavirus lockdown and in what ways did you find these helpful?”

“Occupational Therapists were helping me to fill in forms for work-related adjustments which started to make me feel more comfortable and positive about going to work, but this had stopped due to the lockdown. I had been attending a support group for people with Brain Injuries to talk about similar problems.”

“It’s brilliant that you found this support so useful before lockdown, let’s see if we can restart these avenues of support now.”

Conclusion: A letter to the GP detailing the diagnosis and management of her condition with an additional line of the patient’s request to access additional local support. The Occupational Therapy Team were also copied into this letter, at the patient’s request. The patient felt as if she had made progress by coming to the Orthoptic appointment and was very grateful that support could resume.

② A patient has an acquired 6th Nerve Palsy and uncontrolled blood pressure.

Cue: Using the time we cut and fit prisms onto glasses, we could use this an opportunity to ask if a patient has any questions.

Conversation: "So, how common is double vision?"
Discuss reasons behind the patient's double vision or give them the opportunity to think about their overall blood pressure control. "It's a really positive step that you're thinking about controlling your blood pressure. If you are looking to resolve/improve the double vision, would you like to tell me about how I can help?"

Conclusion: The patient felt they would benefit from visiting their GP to access a home Blood Pressure Monitor. This was documented in the notes and at the follow up visit, the double vision had completely resolved. The patient felt much better in themselves, with much improved BP control.

Record Interactions - Have a Go!

TASK: Identify opportunities within Clinic and 'Have a Go'. You should document in the notes when a Healthy Conversation has taken place so the next Orthoptist may discuss outcomes with the patient at the next visit. They may discuss if any positive changes have been made to a patient's lifestyle and if further support and signposting is required.

	Date	**Cue**	**Conversation**	**Conclusion**
1.				
2.				
3.				

The more we attempt to have these conversations, this improves our confidence as clinicians in raising delicate issues. Patients should consult their GP if they fall or are attempting to lose weight.

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Clinical outcomes of patients referred to Speech & Language Therapy with Chronic Cough (CC)

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Background

The involvement of speech and language therapists (SLT's) in the management of chronic cough (CC) is evolving and SLT's with skills in voice disorders are increasingly seen as integral to the respiratory multi-disciplinary team (MDT). At Frimley Park Hospital there have been increasing SLT referrals from the Respiratory Team for people with CC.

CC impacts on quality of life and can cause embarrassment and avoidance which can lead to increased absence from work, social isolation and relationship breakdown (Raj and Birring, 2007). These factors can impact on employment due to interference with job performance and/or prolonged periods of sick leave. CC can also impact on mental wellbeing and is associated with urinary incontinence, voice problems, vomiting and disturbed sleep due to coughing which leads to fatigue, irritability and depression (French et al, 1998).
In terms of service impact:

- 40% of respiratory referrals are for Chronic Cough (Schappert et al, 2006). This is of great significance to healthcare and economic costs. Morice et al (2006) suggest that the cost to the UK economy is 979 million.
- 40% of referrals are unresponsive to standard treatment (Prater, 2006) and Respiratory Consultants are often at a loss to know what to offer to alleviate symptoms.

There is emerging evidence for SLT intervention for CC (Vertigan et al, 2006; Gibson et al, 2009). Research has also shown that combined SLT and Physiotherapy interventions achieve a 41% reduction in cough frequency (Chamberlin- Mitchel et al, 2016).

Aim

The aim of undertaking this evaluation was to determine whether SLT therapy yields beneficial outcomes for patients referred with chronic cough.

Methodology

The SLTs providing treatment were all specialist voice therapists with some training in management of cough/upper airways disorders. The patients were either referred from the respiratory team or from the Ear Nose and Throat team (ENT) with a specific problem of CC.

All patients had a long-standing cough that had not benefitted significantly from any other treatment to date. This was either a ‘stand-alone’ problem or occasionally in addition to other voice or breathing problems. All sessions were one-to-one and face to face.

Data was collected at initial assessment and end of treatment. This included the Leicester Cough Questionnaire (LCQ), as this has good repeatability and has a set threshold where a change in score of 2.56 is highlighted as significant. The L.C.Q. (Fowler, 2016) also records patient’s perceptions of their cough and its impact on their lives.

The Reflux Symptom Index (RSI) was also used to determine whether gastro oesophageal reflux was likely to be a significant contributory factor in CC. The LCQ questions include:
Sleep- In the last 24 hrs has your cough disturbed your sleep?
Well-being- In the last 24hrs has your cough interfered with the overall enjoyment of life?
Employment- Has your cough interfered with your job or other daily tasks?
Mental Health- Has your cough made you feel anxious?

Therapy input techniques were patient-specific and included reflux management advice, identification of irritants, laryngeal de-constriction techniques, relaxation/mindfulness training and cough inhibition techniques.

Results

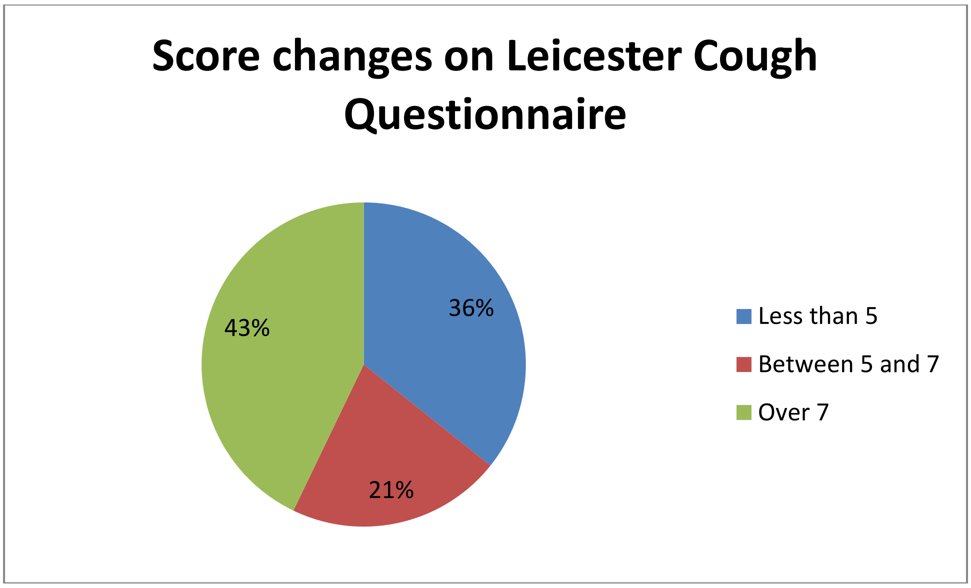
A total of 14 patients completed therapy for CC during a 9-month period.

The L.C.Q. outcomes were as follows:

The L.C.Q. has a set threshold where a change in score of 2.56 or more is considered significant. All patients treated showed a change of more than 2.56 on the LCQ, indicating a significant improvement in their cough. Sixty-four percent showed a change of more than 5 which is very significant (See fig.1). The average score change was 6.13.

The number of sessions required to achieve this varied from 1 to 6 (average = 3). Two patients only required one session for assessment and advice before discharge.
The pie chart (fig 1) below shows how all patients benefitted significantly from therapy and very high percentages of patients benefitted well above the significance level. Therapy therefore appeared to have a significant impact on quality of life for these patients.

Fig.1



RSI Outcomes

Patients who scored highly on the RSI at initial assessment were typically given dietary/lifestyle advice for reflux as well as advice to use an alginate (such as 'Gaviscon Advance'). Alginates have been shown to decrease the number of reflux events by forming a raft on top of the stomach contents and therefore offering a supplemental mechanism of action to acid suppression (Reimer et al, 2016). 50% of patient scores reduced to within the normal level. The remaining 50% did not reach 'normal' levels but showed at least a 9 point reduction in score, which is significant. It is therefore likely that therapy had a beneficial effect on reducing CC and the cycle of irritation.

Patients also commented:

'I am so much less worried about my cough now I understand it. My cough is linked to reflux and my reflux is worse when I get stressed. I understand that I can manage my cough best by using stress control strategies.'

'Now my cough is under control I am more positive more able to stand up for myself and less likely to be a victim'

'The therapist has provided me with exercises, tools and tips to help me get my coughing under control and hopefully keep it that way! She has made a huge difference to my work and home life – I am very grateful to her, and so is my husband!'

Learning points:

For some patients only one or two sessions were necessary therefore going forward an initial cough 'group session' giving information and advice will be offered at the start of therapy as this may be sufficient for some patients. This would be also be more cost effective. Anyone requiring further input will then be offered individual sessions**.**

Conclusions

Many of the patients referred had complained of CC for a number of years with no previous treatment options being helpful to alleviate symptoms. The outcomes achieved with SLT techniques supports the literature and represents a genuine and cost-effective treatment option for these patients going forward. The service has now been made available across the Trust and therapy usually starts with a group session which is currently done virtually.

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Developing a Foodtalk Game as a nutrition and health training tool for early years staff

Background:

In England there are approximately 105,000 childcare providers (NAO, 2016). A large proportion of the lives of under 5s are in the care of such providers and this period, prior to a child starting school, is one of the most influential times in relation to growth, development and dietary exposure. 'Nutrition Matters for Early Years' (2016) states that our health during childhood and adulthood are influenced by our established eating patterns in the first few years of life. Giving every child the best start in life is crucial to reducing health inequalities in the duration of life.

One in five children are already overweight before they start school. With a large proportion of children's nutrition being provided in child care, the responsibility of child health lies heavily within these settings. Yet, a survey of 700 early years settings conducted by the Pre-school Leaning Alliance and London Early Years Foundation (2016) found that the majority of settings (79 per cent) do not receive any external nutrition advice (EYNP, 2016).

Foodtalk is a Community Interest Company run by Paediatric Dietetics and specialising in community nutrition interventions for families. Foodtalk has worked with hundereds of early years practitioners, most of whom express concern about their lack of nutrition education, however they have neither the time, nor the funds, to commission traditional training modules. This shows the need for a simple and cost-effective tool that could train early years practitioners in the basics of nutrition and healthy habits for children aged 1-5. By increasing staff knowledge and confidence, there is potential to impact millions of children and thus, bring about real and measurable change.

Practice Development:

Our aim was to develop an interactive training tool to train early years staff in the basics of nutrition and health for ages 1-5. The process of developing an early years nutrition training tool started with a survey of early years settings to determine barriers to accessing nutrition training for staff. Cost was cited as the main barrier along with high staff turnover and lack of time.

This led to a review of innovative training methods and it was decided that an educational board game would be used. Research shows that board games as a method for training are proven to be engaging and significantly effective in improving both knowledge and confidence within health and social care workers. Additionally, they are low cost, can be used repeatedly by new members of staff.

The Foodtalk Game was developed in 2015 as an educational board game designed for anyone working in Early Years. It provides staff with a basic knowledge of early years nutrition and health, which can then be disseminated to both the children and their parents during informal conversations, developmental reviews or routine appointments. The game was designed to be grounded in current evidence, it is aligned to the 'Eat Better, Start Better' guidelines and it meets both local and national public health strategies including The 5 Year Forward View, Sustainability and Transformation Plans, Public Health Outcomes Framework and the Healthy Child Programme. Locally, the game aligns with most public health team's childhood obesity or early years nutrition strategies.

Once developed, the Foodtalk Game was piloted across 4 London boroughs, including staff in children centres, nurseries and a Health Visiting Team. In addition to playing the game and monitoring outcomes, participants were consulted on design, wording, topics, complexity of questions and game play. Over the course of a year, the development of the board game was shaped by the results of the consultation, as well as input from Dietitians, marketing experts and the board game development team.

Measuring impact:

The Foodtalk Game was commissioned by the London Borough of Brent to be integrated into their Healthy Early Years award. The game was played by early years staff in nineteen settings and results showed 78% of participants increased their knowledge and 86% increased overall confidence in supporting families.

> *"I played [the Foodtalk Game] with a team of 12 people and we loved it! Everyone was so excited and eager to find out what the next question would be. People talked about the answers and shared their opinions/knowledge on various things. The feedback from the staff was great and our action would be to play it with a targeted group of parents."*
>
> \- Children's Centre Manager

The game was also independently analysed by a team at Plymouth University. Analysis showed Median scores of all five knowledge questions combined increased from 1.0 at baseline to 5.0 ($p = <0.001$) post-intervention and median confidence scores changed from 3.0 at baseline to 4.0 ($p = <0.001$) post-intervention.

A small-scale (n=29) trial in Hertfordshire was conducted using the game as a method to train parent nutrition champions. Results showed **100%** of participants felt likely to share the knowledge they had gained with other parents. This demonstrates the game is also an effective method for disseminating important nutrition messages to families.

> *"it was a laid back way of learning important information, I think it will stick in my mind more than a factsheet or other ways of learning"*
>
> - Parent, Hertfordshire

The Foodtalk Game costs £60 and achieves comparable outcomes to traditional staff training modules which range from £300-£500. Additionally, it can be used as a Tier 1 childhood obesity intervention providing an even bigger return on investment for local authorities.

Learning:

Developing and evaluating the Foodtalk Game provided an opportunity for many key learning points and takeaways.

The first key learning point arose during the background research prior to developing the game. We knew that in order to develop a useful intervention is was important to conduct a needs assessment with the target audience (Early years practitioners). This was done through an informal consultation and questions around previous nutrition training and barriers to accessing nutrition training were asked. However, we did not ask any questions around how much of a priority settings place on nutrition training, or, in fact, even on what they define as nutrition training. Because of our internal biases around the importance of early years nutrition we unconsciously assumed that all early years practitioners would deem it important as well. However, this seemed not to be the case and a study conducted by our nutrition intern in 2017 showed that nursery staff put a very low importance on nutrition as part of their role. Many felt it was the role of the cook only and that frontline staff had very little to do with food and nutrition thus requiring no nutrition training. Additionally, most nurseries interviewed felt that Food Safety and Hygiene training was equivalent to nutrition training and sufficient for their staff. Had we known the low importance nursery staff place on nutrition training prior to devoping the game we would have included more questions and marketing material on why it is important and how nutrition training can improve your setting.

The second key learning point is around the use of an educational board game. Although board games are used for training in a variety of health and social care topics, they can still be seen as juvenile or childish. Because the Foodtalk Game is targeted at the early years, many settings assumed it was for the children and not for the staff. In retrospect, referring to the Foodtalk Game as an "interactive training tool" instead of an "educational board game" may have helped to avoid some of this confusion.

The third key learning, came during the development of the individual questions for the board game. As with any health topic, early years nutrition can often be complex with no specific right or wrong answer and as Dietitians we had a tendancy to want to display these complexities within the game and account for all eventualities. However, long complex questions and answers do not make for good game play and after much back and forth with the board game "experts" we eventually had to simplify both our topics and language resulting in much better game play.

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What is the impact of a Neurologic Music Therapy service on an inpatient acute Stroke Unit?

Ellie Ruddock, Angela Voyajolu and Emily White, Music Therapists, Chiltern Music Therapy.

INTRODUCTION/BRIEF DESCRIPTION

The UK Stroke pathway has been well developed since the introduction of the National Stroke Strategy in 2007 (Department of Health, 2007). Included in current National Clinical Guidelines for Stroke (Intercollegiate Stroke Working Party, 2016) are recommendations that patients have access to a range of Allied Health Professions (AHPs) including Physiotherapy, Occupational Therapy, Speech and Language Therapy and Dietetics. Music Therapy is an AHP that has less presence within the current stroke pathway. Music therapists use music to help their patients achieve therapeutic goals through the development of the musical and therapeutic relationship (British Association for Music Therapy, 2020). Neurologic Music Therapy (NMT) is a neuroscientific model made up of standardised clinical techniques and provides evidence and outcomes to demonstrate its positive impact in patients with neurological impairment in domains such as physical rehabilitation, cognition, speech and communication (Magee, Clark, Tamplin, & Bradt, 2017; Thaut, McIntosh, & Hoemberg, 2015; Thaut & Volker, 2014). In line with the national guidelines for Stroke rehabilitation (NICE, 2013), the NMT intervention targets specific patient rehabilitation goals integrating a multi-disciplinary approach to therapy. More generally, this approach also focuses on patient emotional well-being and psychological needs (NICE, 2013).

The following is an example of how an NMT pilot on an acute NHS stroke unit, which ran in 2015, led to an ongoing service as part of the unit’s multidisciplinary team. The service demonstrates how music therapy as an Allied Health Profession, can contribute to the National Clinical Guidelines for Stroke Recommendations (2016) suggesting 45 minutes every day of ‘each appropriate therapy’, through joint-working and goal-setting (p. xiv).

Context and Aims

Recent research has identified that research advancements into stroke rehabilitation (principally cognitive and physical rehab), could significantly reduce costs of care in the public realm (Stroke Association, 2017). Studies such as this, therefore, add significant value, not only improving quality of life for stroke survivors but offering cost effective, sustainable treatment at acute stages of care.

In 2015, Chiltern Music Therapy was funded by the Buckinghamshire NHS Charitable Trust to provide a pilot NMT service on Wycombe General Hospital’s acute stroke unit.

The aims of the pilot project were:

1. To explore accessible provision for further Neurologic Music Therapy on the ward
2. To fit in with general hospital aims of
    - developing their stroke services to patients
    - providing the highest level of rehabilitation care to patients through specialist provisions centred around the patients’ care needs
    - developing the skills of the dedicated workforce

METHOD

The music therapy pilot ran for a total of 12 weeks, with one Neurologic Music Therapy practitioner providing a service one day a week. The Speech and Language team manager acted as the liaison between Chiltern Music Therapy and the hospital therapy team, which included speech and language therapy, occupational therapy and physiotherapy. The service was set up on a referral basis, with a member of the therapy team referring patients dependent on patients’ needs and goals. The MDT used morning handover to refer patients to either individual or group NMT. The MDT member and the Music Therapist set session goals using the Goal Attainment Scale (GAS) measurement tool and planned which NMT techniques would be used with the patient in line with the MDT therapy goals. Music therapy sessions were all held with the MDT member who referred the patient. Following the session, a debrief was carried out, during which any assessment tools would be completed and the GAS outcome tool used to generate a score for goal achievement. Patient notes were jointly written.

Outcomes to explore how music therapy would fit in with the wider team and the needs of the patients included keeping a detailed log of patient referrals, gathering details on who referrals were made by and why patients were referred.

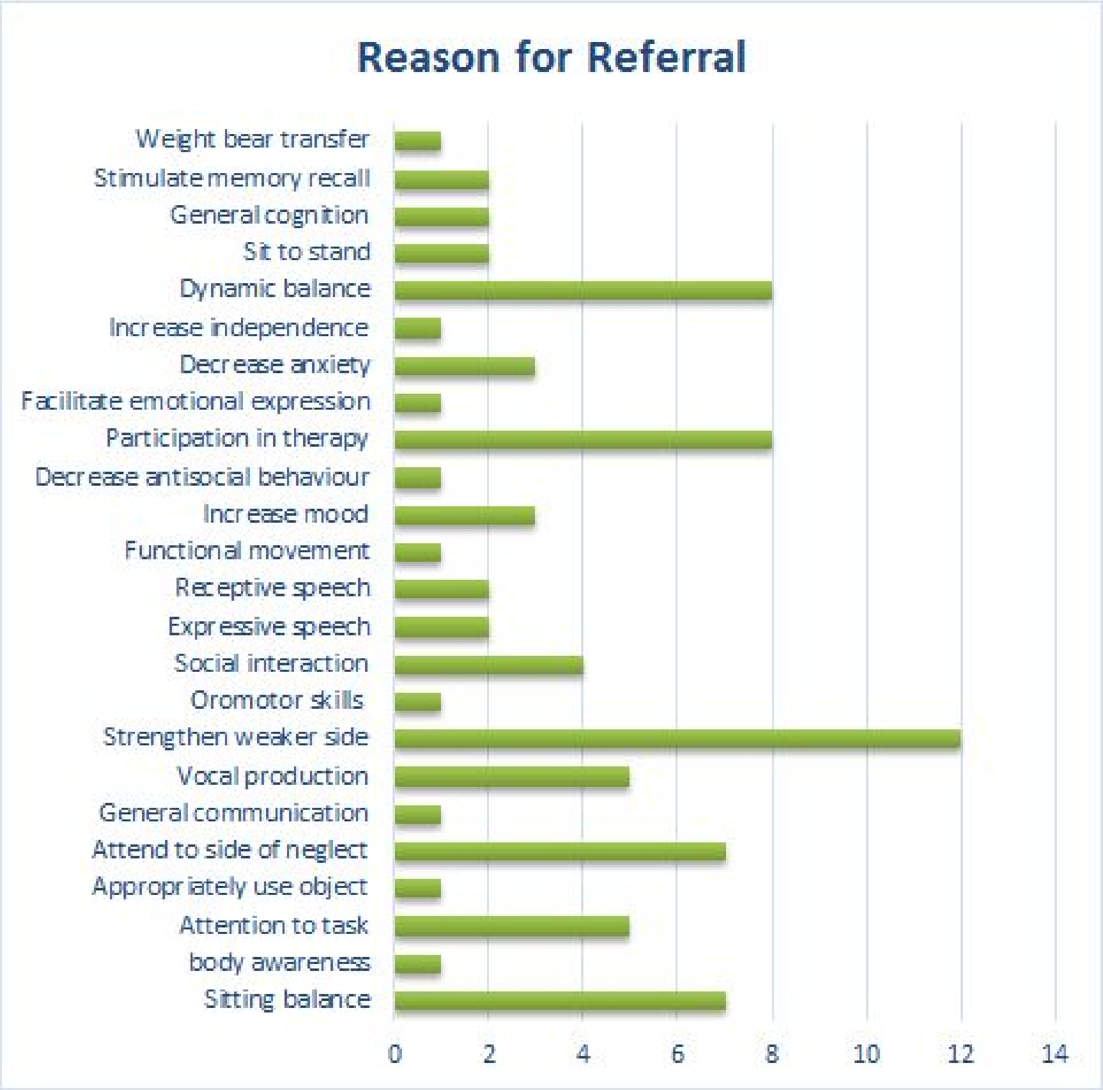
In order to explore the impact on meeting a patient's individual goals, carryover from musical exercises to non-musical exercises at the end of each session were documented. This data was gathered by providing staff with feedback forms (see appendix 1), which included documenting their observations of patient behaviour/performance in therapy and goal attainment, as well as any additional comments about the session. Patients were asked to score their satisfaction level at the end of the session using a visual scale consisting of high visibility animated facial expressions. Mood and anxiety levels were measured at the beginning and end of the session to ascertain Depression Intensity Scale Circles (DISCs) and Anxiety Scale Circles (ASCs) scores. Patients were asked if they would opt to come to music therapy again and to give verbal feedback if appropriate. Patient experience was then collated into quantitative data (satisfaction score, DISC scores) and qualitative data (verbal feedback).

RESULTS/OUTCOMES:

1. Referrals

18 patients either received group or individual NMT over the twelve-week period, with 3-4 sessions occurring on the allocated one-day service per week. Each session lasted approximately 45 minutes, depending on the needs of the patients.

Across the pilot, referrals were roughly equal among the three referring groups, with 32% of referrals coming from Occupational Therapy, 32% from Speech and Language Therapy and 36% from Physiotherapy. Reasons for referral from each discipline can be seen in the following charts below. The varied reasons for referral from each of the Allied Health Professions indicate an understanding that the music therapy service could be utilised to work on the functional goals of the patients in the areas of communication (for example apraxia and aphasia), cognition (i.e. attention and neglect) and physical function (i.e. upper body strength and standing balance). A portion of referrals also noted the inclusion of music therapy sessions for motivation in movement, with the underlying assumption that music may provide an impetus for movement or engagement in therapy.


Reason for Referral

2. Goal Achievement and Carryover

A total of twenty-one written observations were collected by occupational therapy, speech and language therapy and physiotherapy in relation to patients' responses to music therapy sessions as well as their goal achievement.

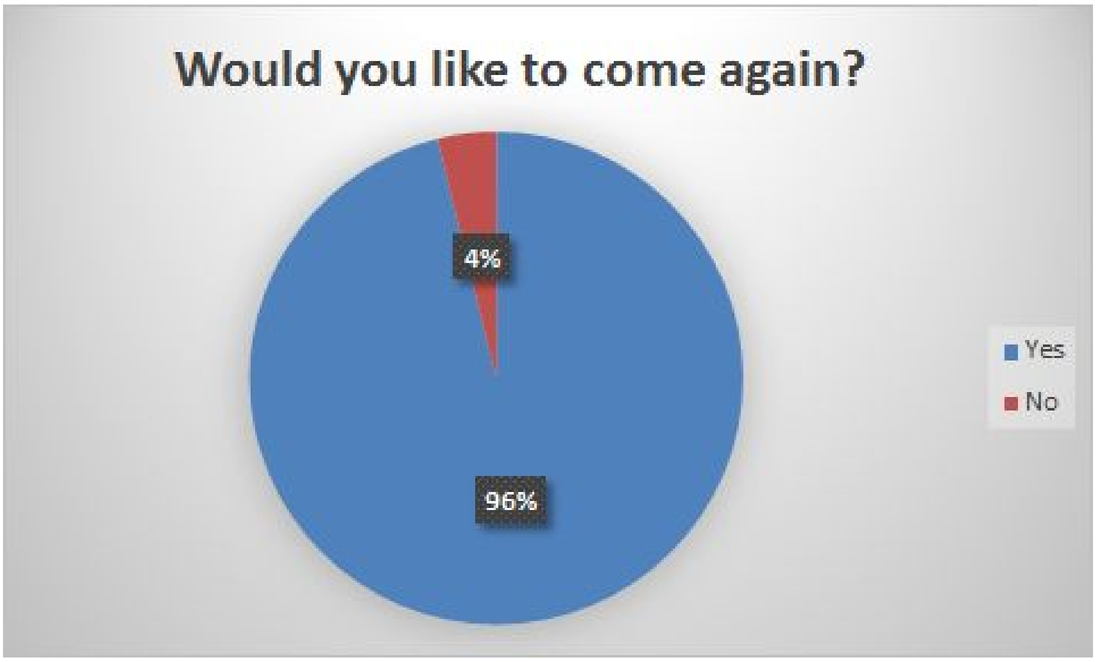
Upon reviewing the content, a number of themes arise. These are engagement, music and motor skills, communication and mood.

2.1 Engagement

An overarching positive outcome of the project saw a high level of engagement observed across the participant group in all disciplines. Specifically, engagement and attention was markedly higher in comparison to other previous therapy interventions (Physio, SALT, OT). In some cases, a higher level of engagement was seen in relation to previous therapy sessions. For example,

> "patient engaged in music therapy very well, demonstrated ability to use her left and to the rhythm of the beat. Patient previously has disengaged/got sleepy when using her left hand in activities such as cards. Dominoes." (OT)
>
> "This particular patient has been struggling to access traditional therapy. In this session he exceeded his goal" (OT)
>
> "It has encouraged patients to join in when other techniques have failed". (OT)
>
> "significantly improved sustained attention to task and patient's ability to engage in the task" (OT)

Patients were asked if they would like to come again. Of those asked,



2.2 Music and Motor Skills

The notion of music acting as an impetus for movement was noted in terms of rehabilitation in the both upper and lower limbs.

- "Initially requiring increased prompts to follow tasks and to attend to left side but with music was able to start following the task independently. Increased bilateral integration of upper limb when initially not engaging his left arm" (OT)
- We have been struggling with this patient and they are highly distractible. The minute the music started the patient moved to the rhythm and he walked across the gym with a significantly improved gait pattern. (PT)
- The sessions definitely made a difference to the patient's use of left hand. Although prompts were needed on some activities the rhythm encouraged the patient to use her left hand. (OT)

2.3 Communication

Goals met in the area of speech and communication were also described including automatic speech and fluency.

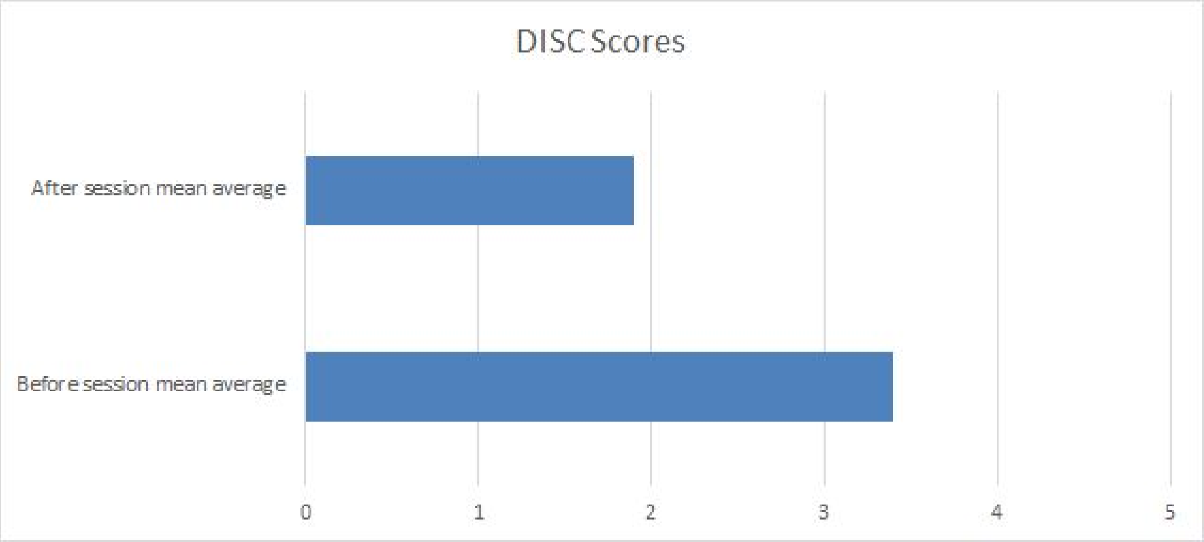
- "The patients I have been with have enjoyed the sessions, but we have also seen positive effects on their participation/attention/communication e.g. vocalizing/automatic speech" (SLT)
- The patient was able to make verbal choices with songs which he is struggling with previously) making choices) (SLT)
- Able to sing when talking is difficult due to dysfluency" (SLT)

2.4 Mood

While mood was not listed as a reason for referral, the particularly positive response in terms of patient's mood was described by staff. The effect of stroke on mood, including depression and anxiety has been documented (Robinson and Jorge 2016, Burton et al 2013) and the NICE (2016) Guidelines for Stroke include recommendations for psychological care. Staff responses in terms of mood included the following:

- The session had a positive impact on mood – patient was engaged, participated and attended'
- We saw the patient at bedside and patients in the bay commented positively about the music- lifted the move. Other patients keen to join in/have future sessions.'"
- Patients were engaging in session and with music therapist, it improved mood and motivation.

In addition, the responses to the DISCs showed a mean average change across participants from 3.4, "Fine" to 1.9, "Great" between the start and end of sessions.



Note: A lower score shows improvement in mood.

2.5 Additional outcomes

Staff responses also described taking on techniques used in music therapy and carrying on with these between sessions. This points to the aim of developing workforce skills, in this case through the use of shared practice.

- “We have been able to use the singing in our session which has been very helpful” (SLT)
- “SALT to compile list of favourite music and also use song in their SaLT sessions” (SLT)
- “We will continue to use the techniques to ensure generalization” (PT)
- “Patient was motivated by music; going to use in other therapy rehabilitation” (PT)

Word cloud showing some of the qualitative comments and data gathered in responses:

In summary, staff perception concluded that music therapy provided focus and motivation to help achieve goals across a range of areas including physical/ motor, cognition, speech and communication, and emotional wellbeing. Feedback gathered from the project suggests that Neurologic Music Therapy, alongside other AHP's and approaches, has the ability to positively impact on outcomes for stroke patients.

In 2017 The Stroke Association published projected costs of stroke over the next 20 years on The NHS, social care, informal care and lost productivity. Within this report they identified that research into 5 key areas, including cognitive and physical rehabilitation, would have a significant reduction on the financial burden of cost. In their 2019-2024 research strategy they identified one of their key goals as funding research into effective new ways to support stroke survivors and their families after stroke. It is hoped pilots such as this can contribute to the wide body of research within stroke rehabilitation and contribute to reducing financial burden and improving quality of life for stroke survivors.

LEARNING POINTS:

Upon completion of the pilot, a number of recommendations followed. First, the full day service was recommended to include the creation and handover of music therapy Home Programmes with staff and family members in order to enable patients to continue and maintain their rehabilitation once they have been discharged from the Stroke Unit. This was also important for carryover between sessions when the music therapist was not present.

It was also recommended that the Music Therapist attends team or department meetings as well as links in closely with one key member of staff within each therapy team: Speech and Language, Occupational Therapy and Physiotherapy, to ensure that the referral system is managed and implemented as effectively as possible.

Finally, further music therapy service pilots on stroke units would benefit from a standardised outcome to use alongside qualitative feedback in order to quantify outcomes, or to be included where standardised measures are used.

As well as providing services in Neurologic Music Therapy for patients, an innovative program led by CMT, entitled the iPod Pharmacy has also been implemented on the ward (as well as in other services provided by the organisation). The iPod Pharmacy is an initiative which takes unwanted MP3 players, cleans and loads them with a selection of tailored music to help stimulate, soothe and engage patients. For this particular patient population, research has suggested that music listening may improve mood for patients in the acute stages of stroke (Särkämö et al., 2008).

The pilot was mentioned in the Royal College of Physicians quarterly Sentinel Stroke National Audit Programme (SSNAP), where it gave the Stroke service an ‘A’ overall rating – placing it among the top 7% of stroke services in England, Wales and Northern Ireland. The music therapy service on the unit continues to evaluate and present its progress and challenges across nationwide platforms such as the Live Music Now conference at the Royal Society of Medicine in 2015, and the UK Stroke Forum Conferences in 2017 and 2018.

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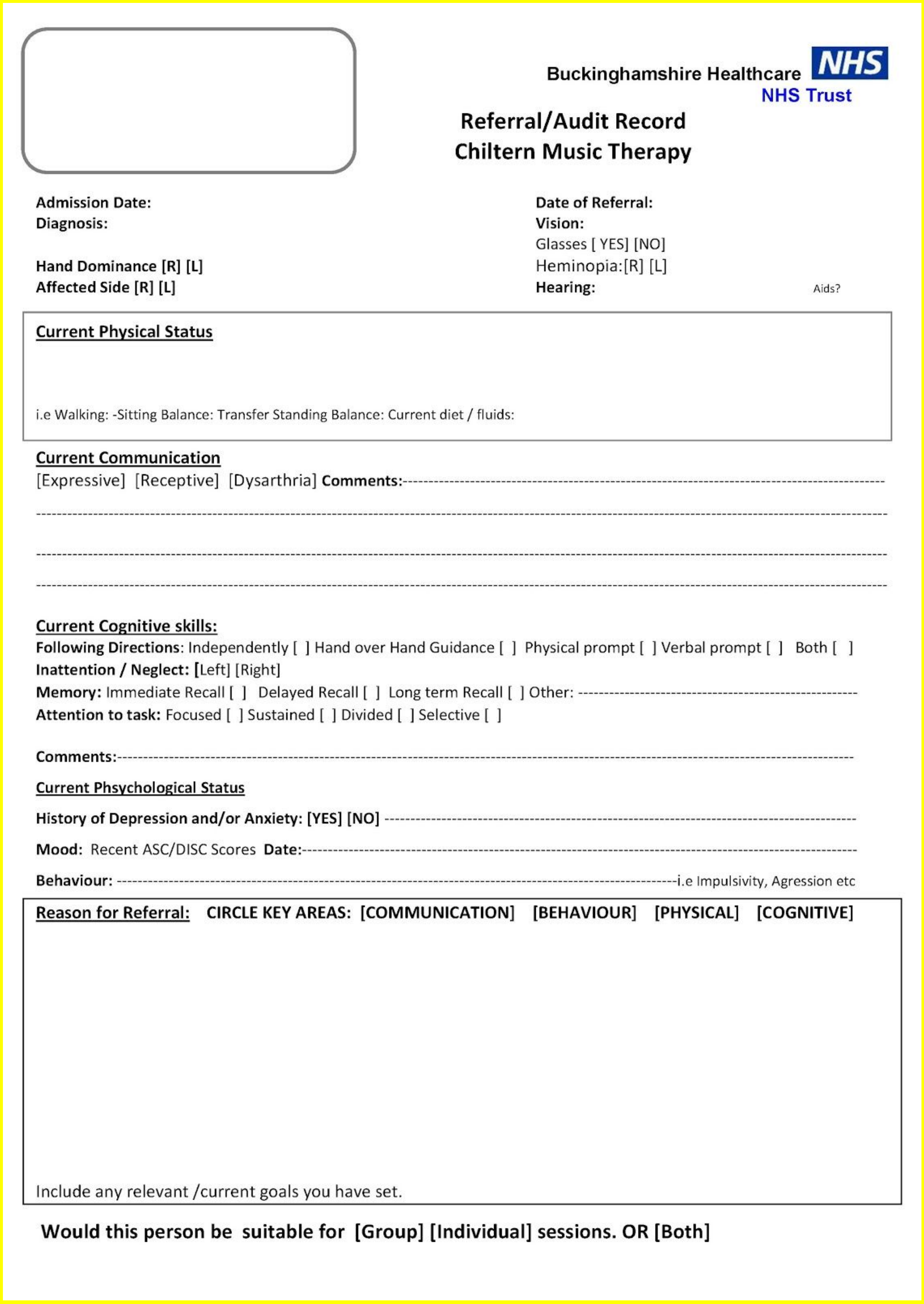
APPENDIX 1. STAFF FEEDBACK SHEET

Music Therapy Feedback

Why did you refer your patient for MT	
What aims did you have for your patient and were they met	
Do you think the MT service should continue – why?	
What improvements could be made to the MT service?	

APPENDIX 2. AUDIT SHEET



Buckinghamshire Healthcare NHS
NHS Trust

Referral/Audit Record
Chiltern Music Therapy

Admission Date:
Diagnosis:

Hand Dominance [R] [L]
Affected Side [R] [L]

Date of Referral:
Vision:
Glasses [YES] [NO]
Heminopia:[R] [L]
Hearing: Aids?

Current Physical Status

i.e Walking: -Sitting Balance: Transfer Standing Balance: Current diet / fluids:

Current Communication

[Expressive] [Receptive] [Dysarthria] **Comments:**------------------------------

Current Cognitive skills:

Following Directions: Independently [ ] Hand over Hand Guidance [ ] Physical prompt [ ] Verbal prompt [ ] Both [ ]
Inattention / Neglect: [Left] [Right]
Memory: Immediate Recall [ ] Delayed Recall [ ] Long term Recall [ ] Other: ------------------------------
Attention to task: Focused [ ] Sustained [ ] Divided [ ] Selective [ ]

Comments:------------------------------

Current Phsychological Status

History of Depression and/or Anxiety: [YES] [NO] ------------------------------

Mood: Recent ASC/DISC Scores **Date:**------------------------------

Behaviour: ------------------------------i.e Impulsivity, Agression etc

Reason for Referral: **CIRCLE KEY AREAS: [COMMUNICATION] [BEHAVIOUR] [PHYSICAL] [COGNITIVE]**

Include any relevant /current goals you have set.

Would this person be suitable for [Group] [Individual] sessions. OR [Both]

The following section to be completed by Music therapist /Key Therapist:

Date(s) of sessions attended	**Goals set during session(s)**

Music Therapy Techniques Used

Physical

RAS [ ]

*Cadence:*______*Velocity*:_______Stride Length:_____

TIMP [ ] *Metronome Marking [ ]*

PSE [ ]*Metronome Marking [ ]*

Other:____

____

____

Speech

MIT [ ] MUSTIM [ ] VIT [ ] TS [ ]

OMREX [ ] SYCOM [ ]

RSC[ ] *Metronome Marking* [ ]

Other:____

____

____

______

Cognition

MMT [ ] MSOT [ ] MNT [ ]

APT [ ] MACT [ ] AMMT [ ]

MEFT [ ]

Other;____

____

____

Emotional Well-Being

Music Assisted Relaxation [ ] Song writing [ ] Music Listening [ ] Lyric Analysis [ ]

Improvisation [ ]

Other:____

____

____

___

Instruments:

Keyboard [ ] Guitar [ ] Percussion {] ***Specify:*** ______________________________

____

Other [ ] ***Specify:***____

____

Placement of instruments [N/A]

____

____

Repertoire

Chiltern Music Therapy Assessment
OUTCOME MEASURES RECORD

Buckinghamshire Healthcare **NHS**
NHS Trust

Date:

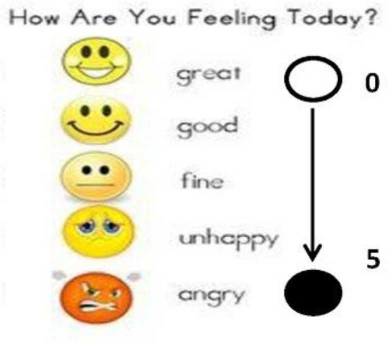
Goals Achieved were at : [ ]

Much Better outcome this is scored at: +2
Better than expected outcome this is scored at: +1
Expected level outcome this is scored at: 0
Worse than expected outcome this is scored at: -1
Much worse than expected outcome this is scored at: -2

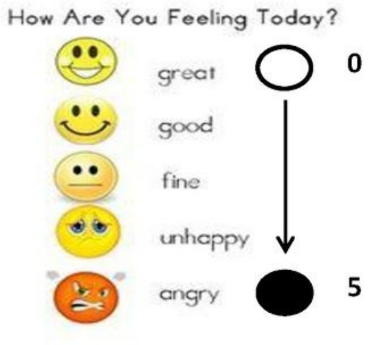
Verbal feedback from Client: --

Satisfaction Post session:
How helpful or enjoying has this session been to you today?

Feeling Before Session: ASC & DISC



Feeling After session: ASC & DISC



Would you like to come again? [Yes] [No] Why:--

Therapist Printed Name: **Signature:** **Designation:** **Date**

Art Psychotherapy in the community. Addressing health inequalities through Social Prescribing - an Asset Based Community Development (ABCD) approach

Vivienne Gibbons, Art Psychotherapist, LS14 Trust

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Description

The Art Room @ is an art psychotherapy practice run by the third sector charity LS14 Trust. It is designed to support people within their community addressing the impact their lived experiences brings to bare on their mental and physical wellbeing. Working in partnership with local community members, and strategic partners to form a range of locally driven initiatives including creative arts in health projects, addressing the wider determinants of health inequalities. Combining the Social Prescribing model and Asset Based Community Development (ABCD) approach as part of this psychotherapeutic intervention, supports clients to bring about sustainable behavioural change in addressing health inequalities for themselves and the local area.

Context

The Art Room @ is situated in the Killingbeck and Seacroft ward in Leeds.

The health profile (2019) for this ward indicates it has a GP registered population of 27,175 and ranked the fourth most deprived area in Leeds. GP recorded conditions for 2019 indicates a significant number of the local population have a diagnosis of obesity, COPD, diabetes, as well as both common and severe mental health conditions (Observatory Leeds, 2019) such as depression, anxiety, psychosis, personality disorders and trauma, including managing and maintaining physical wellbeing of diagnosed conditions.

The Art Room @ is a free service providing local and accessible psychotherapeutic support to adults aged 18+ living in Leeds who experience high levels of health inequalities. This service offers a 12 week course of group or 1-1 sessions for clients to explore, come to terms with, draw conclusions from and learn to find new ways of coping with their mental and physical health and overall wellbeing.

Art psychotherapy uses art materials as its focus for expression and communication, enabling individuals to use art to creatively express themselves. Art therapy is a part of therapy in many psychiatric conditions. Art psychotherapists are registered with the Health Care and Professional

Council (HCPC) and are one of the 14 Allied Health Professionals who provide a range of services in connection with healthcare both in the NHS and community settings.

Method

The Art Room @ adopts an Asset Based Community (ABCD) approach to community development (Nesta, 2020). Initially the service was set up as a pilot project in 2015 delivered by a trainee Art Psychotherapist who was also an LS14 Trust volunteer, funded by the local Council Housing Advisory Panel (HAP). The success of the service has grown year on year and is now contracted by Leeds City Council through Live Well Leeds (LWL) to deliver this programme over a 5-year contract ending in 2023.

The referral process is predominantly based on social prescribing from a range of different pathways, i.e. GP social prescribers, LWL, statutory and third sector, personal recommendations from community members and self-referrals. Social prescribing aims to holistically address the needs of an individual enabling them to take greater control of their own health.

Social prescribing – addressing people's needs in a holistic way

GPs and other health care professionals can refer people to a range of local, non-clinical services, supported by a link worker or connector

GPs and other health care professionals can refer people to a range of local, non-clinical services.

Figure from: Public Health England (2018). *Health matters: community-centred approaches for health and wellbeing*

In excess of 50 referrals are received in any one year and approximately 40 clients a year engage in the programme. Average attendance is approximately 74% over the course of a 12-week programme. The project currently employs one art psychotherapist for 3 days per week.

The service is based in a community building with a café space offering a range of engagement opportunities in creative arts in health activities, community development, volunteering, training programmes, access to digital inclusion and agencies addressing social and economic need. People receive support holistically and seamlessly across their life course, enabling therapy to become an inclusive option for all at any point during their lives.

Evidence suggests that psychosocial pathways are integral to health inequalities and as such should be the focus of consideration in contributing to the reduction of inequalities, including addressing social determinants of health, early intervention, and developing a comprehensive pathway across the life course as a whole (Public Health England, 2017).

The symbiotic relationship between art therapy and arts in health programmes, in particular, and social prescribing, allows people to engage in community life, balance access to support services when needed and take part in social activities for enjoyment and pleasure. Social prescribing allows a two-way flow both in and out of the therapy, allowing clients to go beyond the therapy space and continue to further develop behavioural change.

Outcomes

To date a range of improvements have been recorded ranging from:

- Maintaining work life balance,
- Strengthening family relationships and widening social networks,
- A reduction in: substance dependency, prescribed medication, self-harm, suicidal thoughts and ideations, social isolation,
- An increase in: volunteering and employment, engagement in wellbeing activities, referrals to financial support services such as housing and councillor surgeries, engagement in further education opportunities.

Star Recovery is the evaluation tool and uses point score differences as a measurement of outcomes. By far the most effective illustrative evaluation, in this services experience, is personal client narratives. Greenhalgh (2016) cites narrative as “an essential tool for reporting and illuminating the cultural contexts of health” and “used appropriately, stories can complement more conventional forms of research.”

One such client, Andrea (pseudonym) 57 years old. From attending art therapy in 2015, referred through GP social prescribing experienced stress, anxiety and an underlying undiagnosed stomach complaint. Andrea was referred through her local GP social prescriber. At the end of therapy she recorded a point score increase of 3 in confidence and self-esteem, 2 in relationships, 5 in area of work. Andrea progressed from art therapy to volunteering, further education and training, has become self employed as a community aromatherapist, no longer requires medication and no longer under a hospital consultant. Andrea says her journey to recovery began in taking part in art therapy which offered opportunities beyond the therapy room in the same place, illustrating that “Community-centred ways of working are important for all aspects of public health, including health improvement, health protection and healthcare public health” (Public Health England, 2018).

Key learning points

The LS14 Trust became the host organisation for the Ward Covid Response Hub during 2020/21. The community, through the collaboration of all organisations involved, is beginning to see positive effects of this way of working.

Overtime it would be beneficial to scale-up a whole-system community-centred approach, a ‘challenge’ cited by Public Health, that many localities face (Public Health England 2018). There is the potential to develop a ward-wide wellbeing engagement strategy developed at local level encompassing a variety of support services and engagement activities including a range of therapy services, including all arts therapies modalities, such as drama, music, art, dance and movement, including environmental and talking therapies. Aiming to embed a model of therapies working alongside arts in health and socio-economic support and health care services, developed by and with community members.

It is clear the Art Room service addresses, to some degree, health inequalities and the public health model. A healthy number of referrals continue to be maintained through social pre scribing. Approximately three quarters of those referred go on to receive a programme of support during therapy. Beyond therapy a number of clients continue to benefit as they are referred to additional services or engagement opportunities.

There are gaps in referrals that would benefit from collaborative working with other AHPs and health professionals both at local PCN and Trust levels. Referrals from Occupational Therapists, Community Mental Health Teams (CMHT), Community nurses, Therapeutic Nursing Team, Dieticians, Paramedics as examples. The aim would be to co-ordinate and design art therapy groups that encompass a psychoeducational approach, developing patient understanding of their conditions, build confidence and autonomy to elicit behavioural change. Working with groups recently diagnosed with an illness, experiencing chronic pain, recovering from surgery, living with mental health, people in the ECV category and improving better health outcomes, reducing dependency on services for non-clinical conditions as examples.

Return on investment (ROI) has not yet been undertaken. It can be seen that aspects of ROI are present. This would be an area of focus service development, strengthening future commissioning opportunities. The infographic below demonstrates the impact of the Arts on social and health determinants in addressing health in equalities.

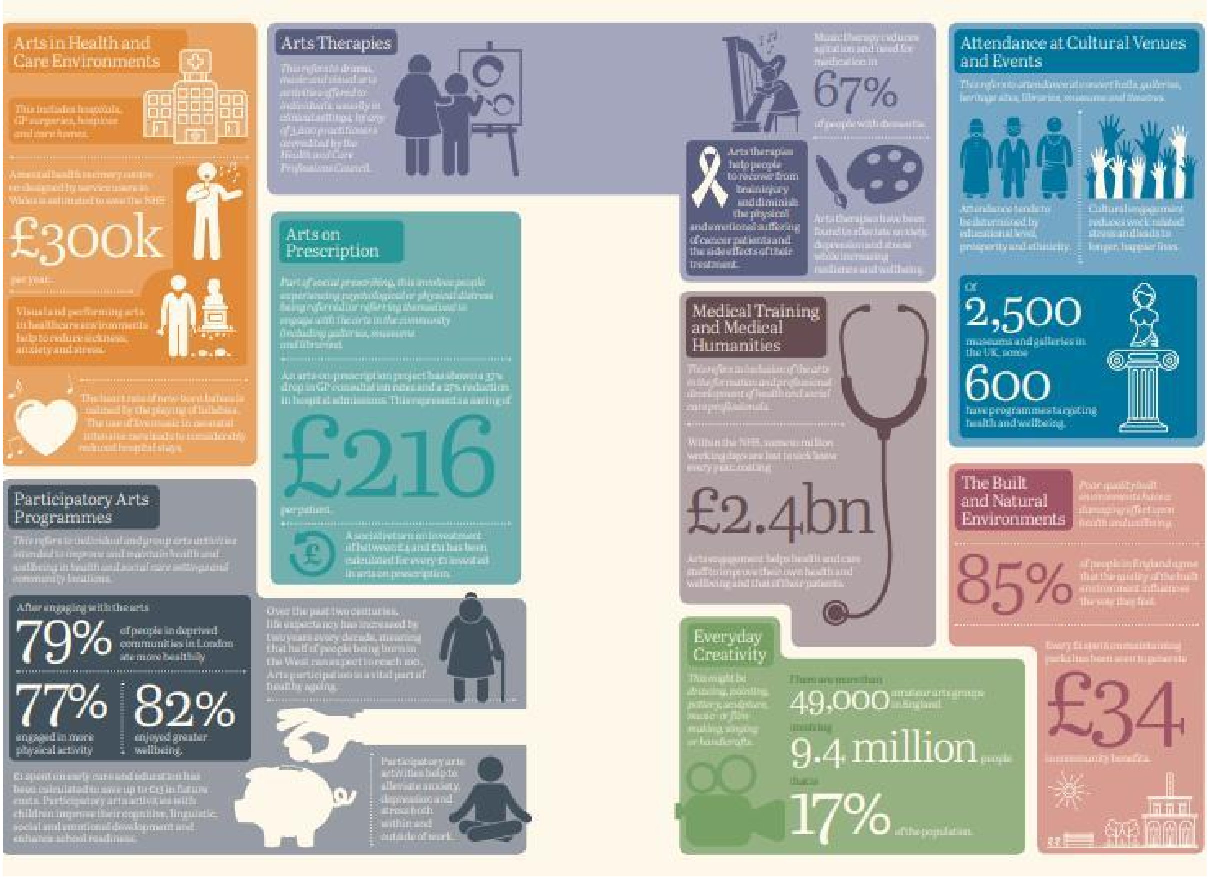

Figure from: Culturehealthandwellbeing.org.uk. (2014) *All-Party Parliamentary Group on Arts, Health and Wellbeing*

An expansion of the service with more practitioners across all modalities of therapy would provide diversity enabling people to engage in therapy suited to their needs, addressing the NHS Long Term plan to personalise recovery pathways that bring about personal and community growth by holistic, systemic change in addressing health inequalities.

Longitudinal research would be beneficial to explore sustainability of behavioural changes made in the art therapy programme. Working with clients over a timeframe between 12 weeks to five years, using robust arts therapy based evaluation and research. Demonstrating how art therapy can contribute to addressing health inequalities through a community-based approach is, I suggest, the way forward.

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Evaluating the Impact of Music Therapy for Children with Dementia

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Description

Batten disease, a rare neurodegenerative condition, currently affects around 200 children in the UK. Children experience gradual loss of sight, speech, understanding, memory and mobility, and the disease causes shortened life expectancy. Care pathways for children with this disease, are focused on isolated symptom management, and a more holistic, pre-emptive approach to care, therapy and education is needed. Current research into therapeutic care is limited for this population, yet there is emerging evidence suggesting benefits of music-based interventions. This project aimed to ascertain the benefits of music therapy on the key functional areas of cognition, speech, and movement to improve health outcomes for children affected by Batten disease in the UK.

Context

Principally, healthcare research for children with Batten disease is currently focused on curative pharmacological interventions and the care pathway is largely focused on symptomatic management or palliative care solutions (Augustine, Adams, & Mink, 2013). This means many families and children living with Batten disease, lack consistent support in terms of care and education and many feel they must navigate their own pathway of care when they need help (von Tetzchner, Elmerskog, Tøssebro, & Rokne, 2019). Unpredictable deterioration can create anxiety, psychological distress and trauma for affected children and their families, yet formal recommendations for wellbeing activities are non-existent for this population.

Emerging research has demonstrated the positive influence of pre-emptive education strategies and the significant impact that music can have on a child's wellbeing (von Tetzchner et al., 2019). Incorporating pre-emptive teaching into a child's education and therapy curriculum could help anticipate difficulties or challenges experienced later in a child's life (for example introducing Braille skills, cane and orientation skills, speech activities or independent mobility aids). As yet, research into music and wellbeing activities are non-existent, and this project, therefore, aimed to address this gap in knowledge in order to guide families and professionals supporting children with the disease.

Method

The three-year project observed children with Batten disease in weekly music therapy sessions. Drawing upon assessment measures from both the clinical and music therapy domains, the project explored how functional skills in music therapy could change over time in comparison to standard clinical assessments, in order to improve wider health outcomes for affected children. Data used in this project formed part of a larger study looking into the impact of music for individuals with Batten disease, where ethical approval was granted by the University of Roehampton Ethics board in 2016 (Ockelford et al., 2019).

Participants

Twelve children with Batten disease (aged between 3 to 18 years) took part in the research, and from the fourteen variants of Batten disease presently known, the children represented five different types. Ten music therapists and one music teacher were involved in the delivery of music therapy and music lessons over the three years.

Intervention

Children received weekly music therapy sessions over the course of three years primarily in an education setting. Sessions focused on a suggested practical framework to facilitate speech and language, cognition, creativity, movement and wellbeing. The team of researchers made observation visits once every school term and practitioners also sent session videos at quarterly intervals each year for additional analysis.

Assessment Measures

The standardised Hamburg Clinical Rating Scale for Batten disease (Kohlshutter, Laabs, & Albani, 1988) was used every 12 months to record speech, movement and cognition. In addition, a new bespoke music therapy assessment tool (Chiltern Music Therapy Outcome Measure (CMTOM), Atkinson, 2018 [see appendix 1]) was used to analyse each video recording of children's sessions. To demonstrate validity of the CMTOM measure in the study, validation exercises were carried out to determine appropriateness, relevance, and feasibility of the measure for music therapy sessions. Results from the validation exercise indicated positive results with regards to the reliability (Intraclass Correlation Co-efficiency) and face validity (practitioner questionnaires).

Outcomes

The Impact of Music Therapy

Clinical Assessment

In all areas of the Hamburg Clinical Scale, average mean scores showed consistent deterioration in the areas of cognition, communication, and mobility. As can be seen in Figure 1, average mean scores ranged 0.4 – 2, and plot lines show a downward deterioration across all domains.

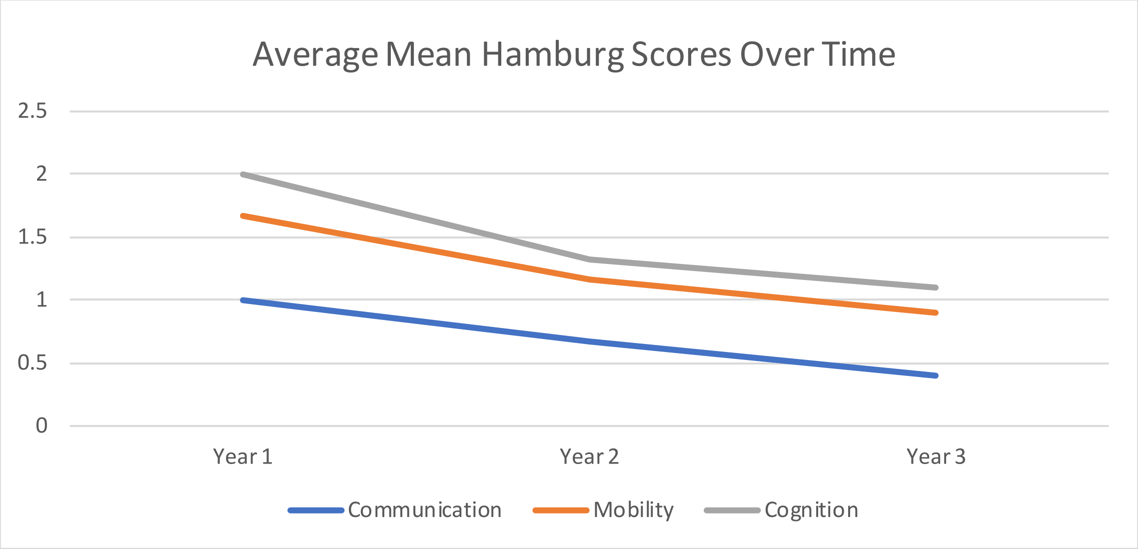

Figure 1: Average Hamburg Scale mean scores for communication, cognition and mobility across 3 years.

Music Therapy Assessment

By contrast, average mean CMTOM scores showed a different picture. As can be seen in Figure 2, the graph demonstrates a smaller range of scores (1.47-2.83) and a plateau effect occurring in the mid stages of the three-year project (time points 3-13). It was observed that there was a period in music therapy sessions, where children's average mean scores remained stable, and skills were seemingly maintained.

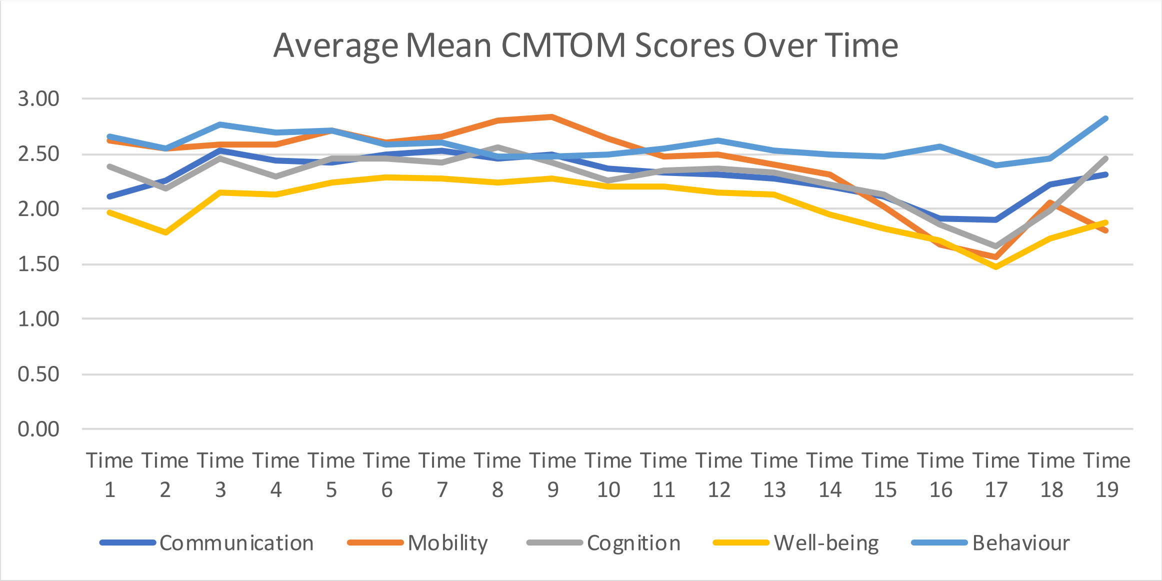

Figure 2: Average CMTOM mean scores in communication, behaviour, emotional wellbeing, cognition and mobility across 3 years.

Results perhaps indicate that a child's skills, within the context of music therapy, deteriorate to a lesser extent than skills measured in a clinical context. The marginal declines and periods of maintained skills in the CMTOM (when compared with sharp declines on the Hamburg scale) suggest that the impact of music therapy could help slow the decline of skills and offer periods of stability. Moreover, marked differences in the rate of deterioration on the Hamburg Clinical rating scale and CMTOM, suggest that a wider understanding of the child's abilities and capacities, can be picked up in a music therapy assessment framework in comparison to the standard clinical test. It could be suggested that without music therapy input or music-based assessment, children affected by Batten disease could be perceivably deteriorating faster over time, which could significantly impact the approach to their care and education.

Practical Activities

Observations from the session videos, highlighted key musical activities found to be of benefit to the children. As reported in the full research study (Ockelford et al., 2019) particular activities were found to help support language, memory and wellbeing.

Music to support language

Drawing on the principles of Neurologic Music Therapy (Thaut, 2014), music and language activities focused on scaffolding language in song, rhythm or melody. For example, key meaningful phrases (such as family members' names, preferences, or activities) were formed into meaningful, memorable melodies and songs to help support memory retrieval. Previous parent accounts also support this finding:

> "Music was very important – she enjoyed listening and singing. Long after her speech went she was still able to sing or mouth the words to 'Happy birthday'" (von Tetzchner et al., 2019: 348).
>
> "…lyrics came out clearly, even though her speech was so little, stuttering and slow" (von Tetzchner et al., 2019: 348).

Techniques of Music Speech Stimulation (MUSTIM) and Rhythmic Speech Cueing (RSC) were used to help children complete their sentences with prompts or pace their speech with a metronome tempo. To encourage carryover, further research would investigate the carryover of such techniques and whether they could be introduced by teachers or other allied healthcare professionals.

Music and memory activities

Music, songs and melodies were also used to support recall and memory retrieval. Particularly when children were showing symptoms of memory loss or confusion, often music was used to help orient the child i.e., songs for activities throughout the day, or songs for each day of the week etc. This concept was also demonstrated in previous parent feedback:

> "Music is used every day. He has special songs to fall asleep to; different songs have been used in different situations (pee song, wake up song, be together song)" (von Tetzchner et al., 2019: 353).

Additionally, practitioners in the research created memory books for children based on experiences, memories, or key pieces of information (i.e. family members). These were multi-sensory in nature drawing upon braille, audio clips, tactile objects and accompanying musical recordings. Professionals reflected on the positive impact of memory books:

> "This fully interdisciplinary approach involving music, English, braille, and art was motivating for her and as her disease progresses further, the book will be there to aid her in remembering her favourite songs, through listening to her own voice and by feeling the tactile materials that she has so carefully chosen" (Ockelford et al., 2019:32)

Despite early visual deterioration, sessions also utilised the child's unimpaired hearing to support choice-making or to indicate preferences. By presenting different instruments in different auditory fields, children were encouraged to use gesture to indicate preferences. With pre-emptive teaching, instruments could be extended to sounds or voice notes, to represent activities, place, or people in order to develop independent choice-making for children for longer. Although further research is needed with regards to these activities, they could be translatable to allied health or education or home contexts to support independent choice-making and enhance quality of life for affected children.

Music and wellbeing

Generally, music was found to help support relaxation, stimulation and comfort, and previous parent feedback supported this concept:

> "[Music] really calms him down, and he gets so upset when we try to turn it off…… It really calms him down when he's agitated or in pain" (Ockelford et al., 2019: 33).
>
> "We usually use music to create a calm, relaxing environment… but a fast song with a strong beat will usually get her to open her eyes." (Ockelford et al., 2019: 33).

Using music to support wellbeing is one area particularly transferable to other areas of education, therapy and care, and the simple act of interactive music listening alongside family members of professionals, could significantly enhance wellbeing for children affected by Batten disease.

Key learning points

Findings from this initial research project unearthed many learning points which could have a positive impact on the future care and therapy for children affected by Batten disease. They are summarised as follows:

- There is seemingly a positive impact of the long-term music therapy for a child's speech, cognition, mobility, and wellbeing.
- Current standard clinical assessment measures for children affected by Batten disease could be limiting and misrepresentative.
- Activities such as memory books, using music to support key phrases, songs for activities, auditory choice-making and music for relaxation received positive feedback from parents and staff.
- Music activities could be transferable to other therapy, care, allied health settings or education contexts to provide a holistic joined-up approach to healthcare and education.

- Parents, families, and caregivers could integrate the music activities outlined here, to enrich interactions in the home environment.

- Future research would aim to develop a systematic and consistent approach to music therapy sessions (i.e., sessions would be delivered by the same practitioner or follow a set protocol).

- Follow on validation exercises would aim to strengthen the validity and appropriateness of the CMTOM for other neurodegenerative patient groups.

- Introducing music-based activities earlier on (before skills are lost) could support children's memory, communication, and wellbeing for longer.

- Ongoing research is needed to explore the impact of specific music-based language exercises for affected children.

Findings from the research will be shared with other allied health care settings, parent advocacy services, and music therapy learning communities in order to improve approaches to education and therapy for affected children. Findings may also be relevant for other paediatric and palliative care settings, other rare or neurodegenerative conditions, and dementia care sectors.

Further research will focus on creating and developing a music therapy program for affected children that is transferable to other healthcare and education settings. Research in this area ultimately aims to provide families, health professionals and educators with music-based activities to enhance wellbeing, increase quality of life, and improve health outcomes for children with Batten disease.

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Appendix 1 - Chiltern Music Therapy Assessment Tool

The CMTOM was used to assess and monitor developments and changes in relation to music-based skills within the clinical areas of speech, cognition, movement. The CMTOM was by CMT practitioners, with the aim of capturing behaviours and skills in a music therapy session. The matrix is intended for multiple populations, but specifically enables skills to be tracked over time, so that it can be used with neurodegenerative populations. The use of the matrix provided an opportunity for more in-depth and regular analysis of each child within sessions and captured a detailed picture of musical skills (i.e. singing abilities), beyond that which was captured using the Hamburg Scale.

Observations			
	DATE		**DATE**
0 = never, 1 = rarely, 2 = sometimes, 3 = often, 4 = consistently	**Score**		**Score**
1. Communication & Social interaction		**4. Emotional Expression**	
Appropriate eye contact OR tracking of visual stimuli		Verbal expression of mood	
Appropriate use of gesture		Physical expression of mood	
Vocalisation (any sound)		Musical expression of mood	
Verbalisation (use of speech)		Choice of instrument / art material / object / preference	
Singing		Use of voice/ sound making tools for expressing self	
Awareness of others		Able to tolerate sound(s), art form, types of media used	
Ability to interact non-verbally / verbally		Insight into difficulties & strengths	
Interaction with staff		Ability to explore and discover	
Ability to Initiate interactions		Shows capacity to improvise / free play	
Behaviour / music to therapist appropriate?		Can differentiate between real and imagined	
Notice, tolerate, accept, aware of others		Has enthusiasm, shows pleasure, fun, enjoyment	
Ability to participate / join in			
Sharing emotions, thoughts and ideas		**5. Sense of Self**	
Being able to think about others - show empathy		Ability to participate, initiate, choose, lead	
		Shows appropriate level of self confidence	

2. Behaviour	
Trigger observed to changed behaviour?	
Any verbal aggression noted	
Any physical aggression	
Behavioural response to musical components noted?	
Ability to express / control self in an appropriate way	
Expression of feelings of distress, agitation, anxiety	
Expression of feelings of depression, trauma, loss, bereavement	
3. Physical Presentation	
Active movement noted?	
Core/trunk stability noted?	
Head and neck stability noted?	
Use of weaker limbs noted?	
Bilateral (both hands) coordination noted?	
Hand-eye coordination noted?	
Ability to cross mid-line - movement R-L or L-R	
Fluency of gait movements?	
Ability to grip in RH	
Ability to grip in LH	
Individual finger movements noted for use with piano, assistive or music technology?	
Oral motor control noted?	
Breath control and regular respiration noted?	

Is resourceful, decisive and can work autonomously / independently	
Demonstrates appropriate levels of assertiveness	
6. Cognition	
Follows verbal instructions	
Makes choices	
Ability to attend to task	
Recognition or carry over of previous material	
Engages appropriately with instruments	
Any memory recall noted? (rhythmic recall etc.)	
Sustains attention	
Shows interest and is inquisitive	

Hand-over-hand or facilitated movement needed to participate in music making?	

The Get Going Group: dramatherapy for people with learning disabilities and mental ill health

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Description

The Get Going Groups were developed following the Department of Health's national bed closures in 2015, with the intention of reducing institutionalised care and improve community provision. Patients on specialised Assessment and Treatment Units, designed for people with learning disabilities are first introduced to the Get Going groups when preparing for their discharge and then supported to attend post-discharge. The aim of using this process was to allow people's care to be monitored in the early stages of moving back to communities and to highlight concerns about their transition in the early stages. We know that people with learning disabilities and mental ill health find it difficult to integrate into the community (Mental Health Foundation, 2021) particularly after psychiatric admissions. These groups provide facilitated spaces to meet similar people who understand what they have experienced. This process is important in reducing isolation and loneliness once people leave hospital, as loneliness can be a significant driver of poor wellbeing among people with disabilities (Emerson et al, 2021).

The dramatherapy groups with the use of storytelling and drama methods such as role play provide people a space to meet new people. Dramatherapy is a psychological therapy that offers people with limited cognitive ability a way to communicate and express themselves when written or verbal communication is challenging. It is particularly suited to people where language acquisition and cognition is impaired, as it offers alternative ways of engaging (Beail, 2016). The Get Going groups allow people with learning disabilities an opportunity to communicate and engage with their peers, share their experiences and build friendships outside of hospital.

Context

Approximately 1.4 million adults in the UK have a learning disability defined as a significant reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood (Mental Health Foundation, 2021). Approximately 40% of people with learning disabilities experience psychological distress and mental illness, which is more than double the rate of the general population (Bourne et al, 2020). Co-morbid health conditions and challenging behaviour can mask mental health problems and complicate treatment, which has meant this population have a history of institutionalisation and unnecessary hospital admissions (Mental Health Foundation, 2019).

In 2011, the ‘Winterbourne View Scandal’ revealed people in a private inpatient unit were experiencing abuse from staff (Delamothe, 2013). The subsequent review highlighted the lack of progress in services and the government made a commitment to transform care and build up community capacity by March 2019; which included a national bed closure of 35% to 50% of in-patient beds with the aim that people should be moved to local communities with individualised packages of care. Eight years on the BBC’s Panorama again exposed abuse and mistreatment of adults with learning disabilities and Autism at another privately-run NHS funded unit, Whorlton Hall; with video footage revealing staff intimidating and mocking patients, unnecessary restraining of patients and ‘psychological torture’. There was a recognition that community provision was deficient, in terms of both quality and access there was a fundamental need for changes in provision of care. More recently the Covid 19 pandemic has once again highlighted inequalities in health care for this population.

Historically people with learning disabilities have not received much in terms of psychological treatment (Beail, 2016). Recent Government policies were set to improve services by prioritising research into the prevention of mental illness and core policies stating the importance of people with a learning disability accessing all forms of psychological treatment. The National Institute for Health and Care Excellence’s (NICE, 2016) guidelines for psychological interventions for people with a learning disability and mental illness suggests when delivering psychological interventions, treatment should be tailored to their preferences, understanding, strengths and needs. Unfortunately, current mainstream services are not always appropriate or equipped; with traditional talking therapies difficult to engage with, even after adaptions (Bourne et al, 2020).

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) developed two dramatherapy groups as a proactive approach to provide support to people with a learning disability after a hospital admission. People are first introduced to the groups, when preparing for their discharge and then supported to attend once they move to local communities. This approach allows their care to be monitored in the early stages of leaving hospital and any concerns highlighted about their transition.

The Get Going Groups have been running for five years, they are part of a Trust’s discharge pathway from an Assessment and Treatment Unit (ATU). ‘A Shinning a light’ award was awarded to the group by the Trust for its mutual support approach.

Method

Adults with a learning disability diagnosis and a mental health condition were engaged with this service.

Questionnaires were delivered at the start of treatment and repeated after the intervention (The Rosenberg Self Esteem Scale, The CORE LD, The Glasgow Anxiety Scale and The Glasgow Depression Scale).

The dramatherapy groups were delivered over twelve-weeks with sessions lasting 90 minutes. The community dramatherapy group is a manualised complex intervention with a large component following a mutual and peer support model. Mutual support is a model of peer support by and for people with learning disabilities with involvement of non-disabled people as allies. Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility and mutual agreement of what is helpful. At the group the expectations include support staff forming part of the group, which brings a new dynamic and understanding between participant and care staff. This mutual support model offers a space for positive relationships to be built, which extend out into further community activities.

The session structure was familiar each week, to help with feelings of uncertainty: all sessions included a welcome, familiarised warm up game, story making and an ending with reflections. The group content and structure were based upon story development using 'the six-part story' method (Hackett & Bourne, 2014) which has component parts of a story: a character, a place or land, a goal, an obstacle, with some help to overcome the obstacle. This approach generates stories about a situation where a character or characters face a challenge and then requires some support. These stories form the basis for discussions at the groups as people are invited to debate how characters experienced help and what the nature of the help was (Hackett & Bourne, 2014). The stories offered insight into a person's difficulties so that constructive dialogues could be opened up and appropriate support identified. As the weeks progressed and stories developed, the story re-enactment stage was introduced which offered a brief role play, where people witnessing and discussed people's stories which helped enable peer and mutual support (Bourne et al, 2020).

Outcomes

Evaluation shows the groups offer clinical benefits.

Findings from twenty people over a two-year period show:

- **Significant improvements** in self-esteem (mean = pre-intervention 21.35) following the intervention (mean = post-intervention 24.75), with a P value of $p < 0.01$.
- The CORE LD (covering well-being, problems, life functioning and risk to self and others) shows a **mean reduction** from 10.95 to 7.63.
- 'The Warwick-Edinburgh Emotional Wellbeing Scale' (WEMWBS) shows a **mean score increase** of 7.1 post group, indicating improvements in mental well-being.
- A **decrease in anxiety** (Glasgow Anxiety Scale - GAS) with a mean reduction of 4. 8 post-group.
- A **mean decrease in depression** symptoms (Glasgow Depression scale -GDS) of 5.53 with a P value of $p < 0.2$ indicating a significant statistical difference post-group.

Qualitative data (Bourne et al, 2020) from support staff who supported a person with a learning disability to attend the dramatherapy Get Going groups found the groups beneficial particularly the link with professionals.

> P3….. "I think she's coming to a dip and I think coming to the Monday group when she's coming to a dip I've got somebody to talk to, so I will mention it to somebody".

> P2………. "I've worked for the Trust for thirty years now and its very different world to when I started, and you see groups like this getting together and people working together with clients and you don't have an 'us' and 'them', everybody is looking after each other. I think its brilliant – it's all coming together."

Key Points

Manual-based psychological treatments have significant impact on clinical research and practice, advantages including; efficacy, less reliance on intuitive clinical judgment, a greater ease in training and the supervising of therapists in specific clinical strategies and techniques. Theory- driven, manual-based treatments are a defining feature of evidence-based treatments due to their robust evaluation process, particularly in RCTs. In the future we plan to run a Randomised Controlled Trial (RCT) methodology to test the effectiveness of the manualised dramatherapy groups. Given the psychological clinical need for this population an RCT would result in a tested dramatherapy group-work manual for practice and an intervention identified for this population.

We have adapted the group during the Covid 19 pandemic and delivered it online. Pilot evidence suggests that the group was still able to support people during this difficult time. We hope to continue delivering groups remotely and gather further data to evidence the dramatherapy manualised group work for this population can continue to be accessible.

Benefits & Learning

- People with a learning disability and mental illness find it difficult to integrate into the community after a psychiatric admission and need facilitated spaces to meet.
- Dramatherapy groups can be used to help support people back into the community after a long hospital stay.
- The Get Going groups allow a person's care to be monitored and concerns highlighted to the wider professional care team.
- Using a mutual support model can help people to feel valued and supported.
- Storytelling, play and role play can help people to share experiences when verbal communication is difficult.
- The Get Going Group manual can be adapted to be delivered online when people cannot get to a designated venue.

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Nourishing the soul: Art therapy with EMDR for the treatment of PTSD and bulimia in an adult mental health service

Please note: this case study explores a client's experience of sexual violence and contains trauma-related imagery

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Description

This case study was written by an art therapist who works for Devon Partnership NHS Trust, in a community psychological therapies service for adults with severe and complex mental health difficulties. Most of the clients referred to this service have experienced childhood trauma, and can therefore find it difficult to access talking therapy due to elevated levels of distress and emotional reactivity. Clients must be seen by secondary mental health services and be under the care of the community mental health team in order to be referred to art therapy. Art is a helpful way for clients to begin to express and share their experiences, and the setting is designed to provide a sense of safety and containment.

Many of the people referred to the service have a diagnosis of personality disorder and the department aims to meet the National Institute of Clinical Excellence (NICE) guidelines by giving clients choices about their preferred treatment and access to longer-term interventions. The writer sometimes combines art therapy with Eye Movement Desensitisation and Reprocessing (EMDR) for a holistic trauma-focused intervention with this complex client group, especially as there are often multiple comorbidities. This can help clients to process their experiences and difficulties on a cognitive, creative and embodied level.

In this case study, the art therapist wrote about a client who asked to be called 'Ezrah' (a pseudonym) to protect her confidentiality. She was referred due to historic trauma and posttraumatic stress disorder (PTSD), emotionally unstable personality disorder (EUPD), and longstanding difficulties with bulimia and disordered eating. Her bulimia had previously led to emergency hospital admissions, concerns about damage to her heart and internal organs, and input from specialist eating disorder services. Ezrah has given full consent to use her story and images in this case study, alongside a paragraph she wrote about her experience of therapy, in order to share the service user's perspective with the reader.

Context

Unprocessed trauma can manifest as a variety of symptoms, many involving the body (van der Kolk, 2014), and can damage interoceptive skills (*interoception* is the ability to sense internal bodily states – Craig, 2015). It was therefore important for the therapist to shift the focus away from Ezrah's obsessive preoccupation with food and weight loss to the difficulties and emotions underneath. Ezrah was aware of professionals' duty of care to keep her safe and it was agreed that the therapist would contact her GP to share any health concerns related to her bulimia. Ongoing risk assessment and liaison with her care coordinator were an important part of the work, as was regular monitoring of the severity of her eating disorder. The eating disorder charity BEAT estimates that only 45% of people diagnosed with bulimia make a full recovery; it was therefore important to ensure Ezrah did not expect art therapy to provide her with a guaranteed "fix" (as she referred to it at the start, asking if the therapist was going to "fix her"), but a space to think differently and develop new ways of coping with her difficulties.

Although she was ambivalent about therapy at first, Ezrah soon settled into a reflective way of working and became increasingly curious about her own responses and thought patterns. She was aware that her eating disorder and PTSD began after a sexual assault in her early adolescence, and agreed with the art therapist that the goals for the intervention were to help her to understand and process her traumatic experiences – while using creative expression, rather than bulimia, as an outlet for strong emotions.

Method

Ezrah had 50 sessions of individual art therapy, some of which were combined with EMDR. She drew images spontaneously in the sessions. Several of her powerful images are included, to demonstrate the art therapy process.

Image 1 is Ezrah's 'safe place': a swing near her childhood home. She said she enjoyed the motion of being on the swing as a child and felt free and happy when she was there, often singing out loud. It was an important image which was used in therapy to help Ezrah regulate her nervous system and connect with feelings of safety and joy, in order to counterbalance and soothe the distress which emerged during trauma processing. Learning to access this sense of safety enabled Ezrah to feel more settled, even when faced with overwhelming emotions.

Image 2 is a drawing of the traumatic event, made in preparation for trauma processing with EMDR. Ezrah's PTSD symptoms included intrusive imagery and flashbacks of her sexual assault, as well as shame, blame and self-loathing which were expressed through the eating disorder. Using EMDR, she processed this memory so that it no longer held so much power over her. This helped her to realise that what happened was not her fault and to become more self-compassionate and less fearful.

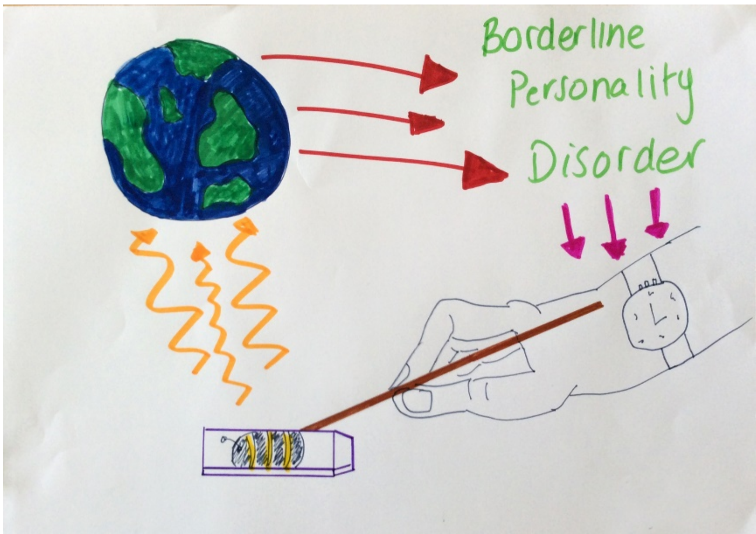

Image 3 represents Ezrah's experience of living with EUPD (also referred to as borderline personality disorder, e.g. BPD): she is the bee in a box, feeling trapped and easily agitated. When things go wrong, she experiences this as being poked with a stick which leads to further agitation and tension. This is expressed through angry outbursts which go out into her world – those around her – and the guilt she feels about this reinforces a vicious cycle of shame, and of feeling overwhelmed and struggling with relationships.

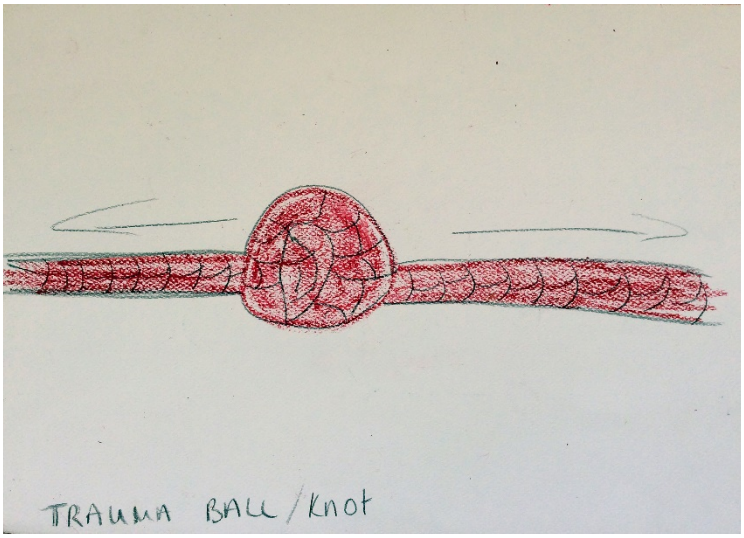

Image 4 is titled *The trauma knot/ ball.* This is an example of 'interoceptive imagery' (Sigal, 2021) – a visual depiction of an internal mental state which Ezrah experienced as a tight, pulling, painful and raw knot in her intestine. This is where the physical sensations related to the trauma and the body memories of the event were held in her body. When these sensations became unbearable, she would binge and purge.

Image 5 is a photograph of a figurine Ezrah found and brought to therapy. It resonated strongly with her and she reflected on the way it has no abdominal area – no core, no intestines, no genitals. It seemed to represent the other extreme of the 'trauma ball' in terms of Ezrah's way of coping with these difficult sensations: she would either overly focus on these parts of her body and hurt herself through disordered eating, or she would seek to fully control her needs and emotions by disconnecting from these parts of her body completely.

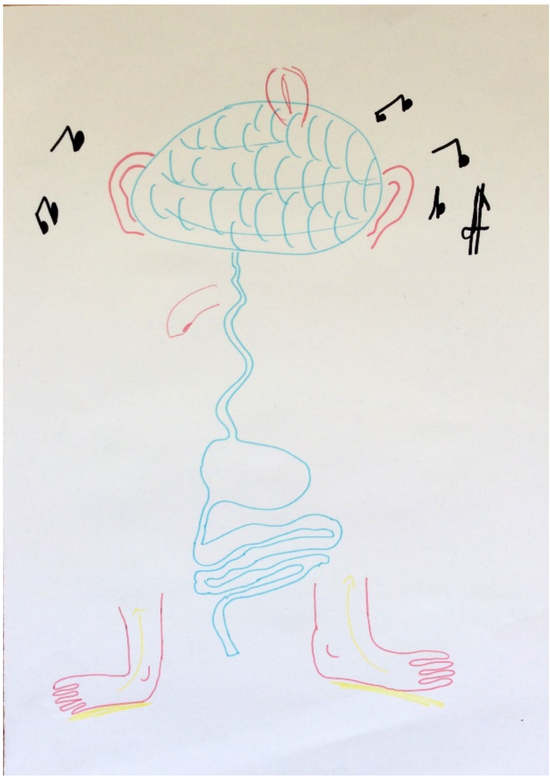

Image 6 is another interoceptive image, depicting Ezrah's fragmented sense of her own body. She drew the feet and the brain, the intestine, then the nose and ears for sensory perception; she added musical notes to represent earworms she would sometimes struggle with, and a vagina (drawn above the brain) to represent the intrusive thoughts about her trauma. The rest of the body is missing and she talked in the session about feeling that she eats to soothe her mind, not to meet her physical needs. Drawing this image made her realise that she was unable to recognise physical hunger, and that her eating was led mostly by emotional drivers. This led to a stronger focus in therapy on improving her interoceptive skills, and especially her ability to notice hunger. She continued to work on being more present in her body after therapy ended.

Outcomes

According to NICE, only 30–60% of people with bulimia nervosa make a full recovery with treatment. Devon Partnership Trust's psychological services often use CORE Outcome Measure (CORE-OM) forms to monitor progress, and Ezrah's overall levels of distress moved from 'moderate severe' to 'mild' by the end of the intervention. She processed her trauma and as a result her PTSD symptoms improved significantly; she also reported a reduction in symptoms related to her eating disorder and increased self-compassion. Ezrah did not have any hospital admissions for her eating disorder during the intervention or since it ended, and has not been re-referred to secondary mental health or specialist services, demonstrating a reduction in her use of both physical and mental health services. She remains well despite minor relapses, and reports that her relationships have improved and that she had less time off from her work in the healthcare sector - thereby benefiting the wider community.

Ezrah said that having an intervention which considered the underlying reasons for her difficulties, rather than focusing only on the eating disorder, was one of the things she found especially helpful. She said her symptoms would have potentially shifted to another type of self-harming behaviour otherwise, whereas re-framing her bulimia as a coping strategy meant she was able to ‘let go’ of it when she felt safer in her body and in the world. She found that therapy made her pay attention to interoceptive processes – her physical sensations and her body – instead of wishing to be ‘cut off’ from them. This included hunger, a sensation she was so disconnected from that she lost the ability to *sense* it on a physical level. It is worth noting that improvements in interoceptive ability are considered predictive of improved mental health overall (Sahib et al., 2018).

Ezrah provided written feedback for this case study in March 2021:

“I utilised Art Therapy for almost two years. The idea of being able to put my mental imagery and emotions into another media was a novel experience for me; it took time for me to embellish and learn to control what I wanted to display in a visual form. The concept of 'seeing' my pain rather than just feeling it was a bizarre and overwhelming experience. I was able to create pictures that had been sat within me and manifested in awkward and upsetting ways. I think that by drawing and literally throwing shapes and words onto paper passionately and whole-heartedly, I could start to understand myself more. It triggered parts of my thinking process I had never or barely used before, a new kind of expression, one not so familiar to me.

With light conversation I was able to relax, only mention things I felt I wanted to control and only disclosed what I felt able to. I've never enjoyed art or was able to use colours in a way that described my thoughts, but by using only white paper and a pencil I could see myself and for the first time, even feel sympathy and ache for the young child's pain I had drawn. I was no longer the adult screaming for attention, but the traumatised child looking for a reason for so many unanswered questions. After a few months, I felt a yearning to want to change the way I saw the world, other people and myself. There was no longer a need to keep harming myself but to take an active interest in who I had become as a person and view my life through a different window.”

Key learning points

The client reported sustained improvement over a year after therapy ended, indicating that the intervention was beneficial. As trauma is often experienced on a physical level through body memories (Rothschild, 2000), the use of interoceptive imagery and embodied processes can be an important part of the work.

Art therapy seems to be in a unique position to offer an intervention which can address difficulties across a variety of presentations; art therapists work with complex clients and with comorbidities, where trauma and distress can manifest as a range of mental and physical health conditions. Art therapy can also be helpful for clients who struggle to utilise talking therapies, either due to being too disconnected from (or overwhelmed by) their emotions to access and discuss them directly, or if they struggle to use language to describe mental states.

The focus on imagery and creativity means that self-expression is possible even if clients have no words to describe what happened to them, or how they feel about it. They can put it to paper and, as Ezrah said, learn to “see” their pain and understand themselves more fully. It can give them the opportunity to share their experiences and tell their story in their own way.

As demonstrated in this case study, art therapy can also be used with trauma-focused approaches such as EMDR to provide an effective, holistic trauma-focused intervention. As eating disorders clearly involve both body and mind, and as some clients with eating disorders have a trauma history (and others might be traumatised by forced interventions or the health consequences of their eating disorders), it might be helpful to increase access to art therapy, embodied and trauma-informed approaches in community mental health and specialist eating disorder services.

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Nutrition Skills for Life®(NSFL): Providing quality assured nutrition skills training for community workers and support for the development of community food and health initiatives

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Description

NSFL is a programme of nutrition training for health, social care and third sector workers, developed and co-ordinated by dietitians working in the NHS in Wales. Working with local communities and partner organisations, ***NSFL*** aims to build community capacity to access a healthy balanced diet, a major determinant of health, wellbeing and quality of life.

NSFL trains frontline workers, volunteers and peer leaders to promote healthy eating by incorporating evidence-based food and nutrition messages into their work. There are two key aspects to the programme;

1. Accredited nutrition skills training for community workers to help them to competently cascade nutrition messages and to support those working in community settings to provide healthy/nourishing food and drink options e.g. in nurseries, play groups, after school clubs, residential homes and care settings for older adults.

2. Co-production of healthy eating initiatives with community groups. This can include offering accredited practical cooking skills, nutrition skills or weight management courses depending upon identified need. All courses are accredited by the Welsh awarding organisation, Agored Cymru, enabling people to gain credit for learning; a potential route into further learning and employment opportunities.

Context

Launched in 2006, funded by Welsh Government and evaluated by Glyndwr University[1], ***Nutrition Skills for Life®*** operates in all seven NHS Health Boards in Wales.

Nutrition Skills for Life® aims to build capacity of communities to support healthy eating and prevent malnutrition.

The objectives are to:

- Increase the capacity of the community workforce in Wales to inform and support communities in healthy eating and prevention of malnutrition

- Develop a standardised approach for accredited nutrition training across Wales, promoting consistent nutrition messages and contributing to preventing nutrition related disease
- Support the development of healthier environments and improved access to nutritious foods through training and professional advice
- Support local action e.g. supporting development of local community food initiatives ensuring they are evidence based
- Support local partnerships to raise the profile of nutrition and help to achieve better outcomes in relation to nutrition and health for their population
- Focus on lower socioeconomic/hard to reach groups
- Focus on 0-25's and vulnerable older people

Poor diet is a risk factor for obesity and other chronic conditions such as type 2 diabetes, hypertension, cardiovascular diseases including heart disease and stroke, respiratory problems, joint problems, lower back pain, and some cancers e.g. breast and colon cancer. In Wales 61% of adults are overweight or obese, including 25% obese[2]. More than a quarter of 4-5 year olds are classified as overweight or obese (26.4%) including 12% obese[3]. Obesity is steadily increasing with greater prevalence among lower socio-economic groups. Prevalence of obesity in 4-5 year olds is 6% higher in those living in the most deprived areas. This rises to a 13% difference in adults. High Body Mass Index (BMI) is the leading risk factor for Years Lived with Disability (YLD). The top 3 risk factors are directly linked to diet and obesity[4].

Method

Dietetic services in Wales experienced increasing demand from partner organisations for quality assured nutrition training. The development of the health care support worker role and national programmes in Wales including Flying Start[i] and Families First[ii], provided significant opportunities to train the wider workforce in nutrition. The development of a national nutrition skills training programme would provide a standardised, consistent, evidence-based approach to meet this increasing demand. Utilising dietetic expertise to train and support community workers to cascade evidence-based nutrition messages would reach more people than the dietetic service would be able to do alone.

During 2005, Public Health Dietitians in NHS Wales worked in partnership with Welsh Government, Agored Cymru and community workers to plan, develop, deliver and evaluate an accredited nutrition skills training programme. Since launching in 2006 a range of standardised learning, teaching and assessment resources including tutor facilitation manuals, learner workbooks and evaluation tools have been developed for all courses. This 'once for Wales' approach avoids duplication and benefits from economies of scale in line with prudent health care principles. The training model successfully supports implementation of nutrition elements of national schemes including the Healthy and Sustainable Pre School Scheme, Designed to Smile oral health projects, Welsh Network of Healthy Schools Scheme, Corporate Health Standard and the implementation of the Best Practice Guidance for Food and Nutrition for Childcare Settings[5] and in Care Homes for Older People[6]. ***NSFL*** has achieved recognition as a model of good practice at local, national and UK wide level*. It has been successfully embedded into national programmes in some areas e.g. Flying Start and Families First and is firmly embedded in Welsh Government strategic priorities e.g. digitalisation of ***NSFL*** is a commitment within the Welsh Government's renewed priorities for ***Healthy Weight: Healthy Wales 2020-2022***[7].

Outcomes

External evaluation was undertaken by Glyndwr University from 2006-2010. Since then annual reports are submitted to Welsh Government. The Results Based Accountability approach to programme performance monitoring is used to monitor the extent to which ***NSFL*** programme objectives are being met and to ensure a standard all Wales approach.

Performance measures have been identified by Public Health Dietitians in Wales and data is collected using standard evaluation questionnaires and databases.

Evidence of impact between April 2018 and March 2019 includes:

- **91** Level 2 accredited courses were accessed by **902** staff
- **174** Level 1 nutrition skills courses were accessed by **1150** members of the community
- **157** non accredited training sessions were accessed by **2839**
- **100%** staff attending Level 2 courses rated the course as good (**16%**) or excellent (**84%**)
- **100%** staff attending Level 2 courses reported they would recommend the course to others
- **99%** individuals attending Level 1 courses rated the course as good (**13%**) or excellent (**86%**)
- **97%** staff accessing Level 2 courses gained credit for learning
- **84%** individuals accessing Level 1 courses gained credit for learning
- **99%** staff completing Level 2 CFNS training reported feeling confident (**72%)** or very confident (**27%**) to deliver the Level 1 accredited course
- **91%** reported learning something new about food and nutrition as a result of attending Level 1 course
- **88%** reported making changes to what they eat as a result of attending Level 1 course
- **94%** reported making changes to what their family eat as a result of attending Level 1 course
- **79%** reported eating more fruit and **70%** eating more vegetables as a result of attending Level 1 course
- **83%** reported eating less fatty /fried foods and **84%** less sugar/sweet foods as a result of attending Level 1 course

Key learning points

- We have worked nationally as a profession, avoiding duplication, sharing good practice, and collaborating to continually update and develop standardised, national nutrition learning and teaching resources.

- Working in partnership with an awarding body -Agored Cymru- enables learners to gain credit for learning and has ensured the quality and integrity of the programme is maintained.

- Continued to develop to support new initiatives e.g. the infrastructure has supported the roll out of other programmes utilising the same model i.e. 'Foodwise for Life' structured weight management programme and the School Holiday Enrichment Programme (SHEP).

- Maximised opportunities for partnership working with other organisations and initiatives to strengthen the nutrition component e.g. Flying Start, Welsh Network of Healthy Schools Scheme, Healthy and Sustainable Pre School Scheme.

The programme stalled during 2020 due to the Covid-19 pandemic. With physical distancing requirements likely to continue for some time we needed to transform our accredited traditional face-to-face training to online teaching and virtual face-to-face delivery to continue to reach communities to support healthy eating.

The Welsh Government has committed to *'Invest in fully digitalising the all Wales* ***Nutrition Skills for Life®*** *programme, enabling continuation, through virtual delivery, of all community-based initiatives including Foodwise for Life, Foodwise in Pregnancy and Community Food and Nutrition Skills programmes'.*

Our future priorities are:

- Ensure every child has the best start in life by optimising nutrition in the first 1000 days.
- Ensure the early years and childcare workforce and those caring for older people have the knowledge and skills to be able to improve nutrition and hydration for those they care for.
- Embed healthy eating into the school curriculum by training others to deliver nutrition and food skills training for children and young people, including the School Holiday Enrichment Programme.
- Widen access to accredited Level 1 nutrition, practical cooking skills and weight management course enabling more people to gain credit for learning.

The programme is on track to be fully digitalised by April 2021. This will provide renewed opportunities to further integrate nutrition skills training into local and national initiatives in Wales and to have far wider population reach.

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Finalist in the Royal Society of Public Health- Health and Wellbeing Awards 2017
https://www.rsph.org.uk/about-us/news/health-wellbeing-awards-2017-shortlist-announced.html

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[i] Flying Start is a Welsh Government funded programme and is available in targeted areas supporting all families to give children aged 0-3 year 11 months a Flying Start in life.

[ii] Families First is a Welsh Government funded programme designed to improve outcomes for families with children & young people aged 0-25 years. It places emphasis on early intervention, prevention and providing support for whole families, rather than individuals helping families become confident, nurturing and resilient.

Slow cooking for communities, Northern Ireland

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Introduction and context

In February 2019, the Cook it! Team in partnership with North Ballymena Community Cluster (NBCC) group devised a cross community project "Slow cooking for communities" in the Dunclug & Doury Road areas in Ballymena. The NBCC aims to "increase social cohesion within the North Ballymena Area, reducing anti-social behaviour and sectarianism and increasing community confidence and wellbeing" [1]. Dunclug was identified as one of the most deprived super output areas within Mid and East Antrim for four of the seven domains including health and disability, income, education, skills and training and crime and disorder, resulting in them reaching the top 10 multiple deprivation list [2].

Evidence shows those living in deprivation are 47% more likely to be obese than those living in non-deprived areas [3]. Obesity is a significant health concern in Northern Ireland with 65% of adults being overweight or obese.

The National Diet and Nutrition Survey Northern Ireland shows that food energy from saturated fat exceeds the recommended maximum level, by 15-20% in children aged 4 years upwards and 20-27% in adults. Excessive amounts of saturated fats are linked with cardiovascular disease [4].

Conversely, AOAC fibre intake (American Association of Analytical Chemists method) and fruit and vegetables intake, did not meet recommended levels [5].

An interactive cooking class was the chosen programme design as research has shown that this type of intervention can improve confidence with cooking as well as improving dietary intake [6]. It was felt slow cooking was a convenient and cost-effective way to encourage families to cook from scratch whilst reducing reliance on processed convenience foods and takeaways. These foods tend to be higher in saturated fats and salt, and red and processed meats in excess is linked to an increased risk of colorectal cancer [7].

Method

An open invite was sent via WhatsApp and word of mouth by a NBCC community worker to two housing areas within the NBCC catchment area. An informal coffee morning was set up to allow participants to find out more about the project, get to know the Cook it! team, choose their favourite recipes and if desired, to sign up to the programme.

Four weekly interactive sessions lasting 2 hours were delivered by a Registered Dietitian covering theory on food safety, how to use a slow cooker, general healthy eating principles, sustainable diets, sugar, and fat. We used the British Dietetic Association's environmentally sustainable diet project, 'One Blue Dot' to demonstrate how sustainable eating can also be cost effective and good for one's health. A group activity demonstrating how useful store cupboard items can be in creating multiple dishes was included. Visual displays demonstrating the sugar and fat content of foods was discussed with participants.

During each session, the group prepared a recipe as a team. At the end of the session, they were encouraged to taste the recipe - a batch pre-prepared by the Cook it! Team. Participants who did not own a slow cooker, were provided with one funded by NBCC. Ambient ingredients were provided for each attendee to encourage replicating the recipe at home. The Cook it! team decided against providing high-risk foods, such as beef or poultry to minimise the risk of food poisoning.

A WhatsApp group was set up and managed by NBCC, to encourage group interaction and social cohesion. Each participant received a copy of the Causeway Coast and Glens Borough Council Slow Energy Efficient recipe book [8] and some kitchen utensils.

An intervention specific questionnaire was carried out pre and post programme, using remote devices from Turning Technologies. This allowed responses to be kept anonymous.

Outcomes

Despite the small pilot size, this programme showed promising results. Following the programme participants reported a 57% increase in cooking from scratch, 100% participants felt confident using a slow cooker and using a slow cooker once a week or more. 80% of participants reported making healthy changes to their diet and reported improved awareness of healthy eating. Takeaway consumption reduced from 86% of participants purchasing 2-4 times per week to 80% having takeaways once or less per week, with the remaining 20% having takeaways no more than twice per week. There was a reduction in the use of processed foods. At baseline, 43% of the group consumed processed foods daily, this reduced to 100% consuming these foods twice or less per week, following the programme. A study by Mills et al (2017) supports home cooking for health.

"…eating home cooked meals more frequently was associated with better dietary quality and lower adiposity" [9].

Fruit and vegetables intake did not change with 100% of the group consuming 0-2 portions per day.

Participants from both communities attended and interacted well with each other, sharing ideas on WhatsApp and working together.

A focus group at eight months post initial intervention revealed:

- 100% of participants would recommend the programme and the use of a slow cooker to their friends/family.

- 50% of participants have used their slow cooker at least 1-2 times per week since attending and the remainder used it at least a few times.
- 57% reported consuming takeaways once or less per week.
- 57% reported consuming processed foods once or less per week.
- 100% found the sessions interesting and enjoyed learning more about food and nutrition.
- The group enjoyed practical cooking, food sampling and interactive displays.
- No one used the Causeway Coast and Glens Slow Energy Efficient recipe book.

Key learning points

The group reported enjoying the short interactive educational sessions on healthy eating, followed by a practical cooking session. A slow cooker is not required for everyone and participants indicated they would have attended irrespective of the provision of a slow cooker, therefore the need for this could be checked at registration. Ambient ingredients did not have the positive impact of encouraging the recipe replication at home, therefore we would review the provision of these items in future.

A printed recipe book was provided to each member. However, from feedback these were not used. Supplying a PDF version via the group WhatsApp or use of online resources would save cost and would be more environmentally friendly. Participants suggested a series of ‘fake-away’ recipes would be useful to include in future recipe books.

It is widely accepted that the cause of obesity is multifactorial but participants provided feedback they would like to know more about portion sizes and calories .[10] Although obesity rates in this group were not reviewed, this desire to increase knowledge of portions sizes and calories is encouraging, given the link with larger portion sizes and increased energy intake.[11]

Follow-up at 8 months showed the sustained use of the slow cooker. However, we did not review the type of recipes being prepared in the slow cooker. This would have been useful to review to understand more detail on the types of food prepared.

This pilot was presented to and reviewed by our regional colleagues in the Public Health Dietitians group in Northern Ireland and has since been adapted into a train-the-trainer model, with training sessions being delivered virtually and knowledge passed on to groups, including those from socially deprived areas, throughout Northern Ireland.

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Title: *'Chat with Me' book series: 3 books that support parents to share books and extend conversations with their 2-3 year olds in Sure Start Areas in Belfast*

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Description

The 3 books 'Chat with Me'; 'Chat with Me at Christmas'; Chat with Me about Preschool' provide tools that make it easier for parents to interact with their children and to share books together. They also give parents ideas about opportunities to chat with their child throughout the day.

They are designed around research findings that 'contingent talk'[1] and 'conversational turns'[2] are key ingredients in positive parent child interactions leading to improved language development and enhancing parent/child relationships*.

(*Sure Start operates in the top 25% most deprived ward areas in Northern Ireland. Research clearly identifies speech, language and communication need as being a risk to children living in areas of social deprivation and so Sure Start SLTs aim to support parents to provide language rich environments.)

Each double page spread has the same layout: the left page is a composite picture of the part of the day described by the 4 lines of text. These 4 lines can be read if desired. They can also be sung. The right page contains detail relating to the main picture, providing more opportunities for conversation. On the back of each book a QR code links to a YouTube video of the book and accompanying song (the words in the book). A second QR code links to a Parent/Staff Guide explaining how to use the book i.e. don't worry about reading the words; notice what your child is interested in and chat about that.

There are also 4 short videos (less than 2 minutes) that explain how to get the most from the books.

Context

One of Sure Start's overarching objectives is to improve language skills of children in Sure Start areas and so help end the intergenerational cycle of language deprivation. In Sure Starts in BHSCT area, around 70% of children entering the Developmental Programme for 2-3 Year Olds have delays in speech, language and communication. The role of the Sure Start SLT is to improve the language skills of children living in Sure Start areas by increasing the relevant knowledge and skills of those most proximal to the child i.e. parents, Sure Start staff, and members of the community.

Insights from parents in a previous coproduction highlighted factors that led to behaviour change i.e. the importance of a) giving parents tools to help them do things differently rather than just giving advice and b) giving something that makes it easier to get through the day. The books were developed to provide parents with a tool to

- Increase amount they share books with their children
- Increase parent/child conversation when sharing books together
- increase the variety of ways to extend the topic eg talking about the past of future
- Encourage parents to sing/make up songs with their children
- Provide ideas about things they could do with their children

They were also designed to provide a tool that supports staff in developing their skill to give children language they can learn from. This had been identified by the Sure Start SLT and Early Years staff as an area that staff find difficult, particularly for those who are already using sentences. Staff observations, reflections and progress monitoring data all suggested that it was more difficult for staff to extend the topic when children were already using sentences.

Method

Partnerships with an artist and a music therapist were established; the objectives were shared with these partners and the concept of a 'Chat with Me' book evolved. Sure Start parents of 2-3 year old children were contacted by trusted Sure Start staff and asked to share topics/activities that created the best conversations with their children. Parents' suggestions were grouped into themes to form the basis of the illustrations and text for the book. The lyrics/text were written by SLTs and Music Therapist in consultation with the artist who then created detailed illustrations with opportunities for conversation. Using research evidence[3], 9 ways were identified that adults can provide language children can learn from. Each illustration needed to provide clear opportunities for these types of responses. Information on these 9 types of responses formed the basis of the parent/staff guide and of staff training.

The Music Therapist composed a melody so the text in the book could also be sung, reinforcing key Sure Start messages to smile, talk, laugh and sing anytime. On the back of the book, 2 QR codes link to

- a YouTube video of the book being sung
- a Page Tiger Parent/Staff Guide.

A trusted staff member introduces the book to parents along with explanations of key principles

- You don't have to read the words
- Notice what your child is interested in and chat about that

Following evidence of behavior change, it was decided to create 2 more books: Chat with Me at Christmas and Chat with Me about Preschool (to support transitions). The working group for the preschool book included the original core group and also a parent, a Sure Start Early Learning Coordinator and a Nursery School Principal. This ensured the book covered the most important messages about supporting a child's transition to preschool.

Outcomes

Aim 1 – Increase amount parents share books with their children

Aim 2 - Increase parent/child conversation when sharing books together

Aim 3 - increase the variety of ways to extend the topic eg talking about the past of future

Aim 4 - Encourage parents to sing/make up songs with their children

Aim 5 - Provide ideas about things they could do with their children

Parent outcomes are being gathered in 3 ways (as per RCSLT Framework: Measuring Outcomes outside individualized care, June 2021)[4].

a) Quantity of information shared
Approx 500 children received a copy of each book in the 21/22 year in Belfast area. Every library in NI also has a copy of each book.
Views at Nov 2022
Chat with Me song video on YouTube – 705
Chat with Me Parent Guide – 527
Chat with Me at Christmas song on YouTube – 273
Chat with Me at Christmas Kitchen Disco – 322
Chat with Me about Preschool song on YouTube – 275
Chat with me about Preschool Parent guide – 222

b) Parent report of behaviour change as captured by parent questionnaire (***49 parents responded to the initial questionnaire. Further feedback was received from Parent feedback questionnaires following Parent Workshops or Parent Programmes)***
\- 98% said they share books more often since receiving the book
\- 98% said the books helped them to chat more when sharing books
\- 98% said the books had given them ideas about things to do with their child
\- 77% said they had used the Christmas Kitchen Disco to dance and sing with their child
\- parent comments give evidence of behavior change eg 'when I read other books to my child now I just don't read the words, I ask him questions and tell him things that we see in the picture'; 'she never used to sit during a book and now we would read this nearly every night'.

c) Individual examples of change as captured by staff observations and parent stories – feedback from a Family Support Worker
"A Grandmother was given a Chat with Me book. She has poor literacy and would tend to steer clear of books because of this.
When she came back to parent and toddlers she said that she really liked the book, she expressed that she was less intimidated with the book due to the colourful pictures and how expressive/real the pictures were so she felt that she could read her grandchild the story using her own words. She also said that it has given her the confidence to read other books to her grandchild using the pictures"

Aim 6 – Provide a tool that supports staff in developing their skill to give children language they can learn from.

Work in this area was delayed due to the impact of Covid – SLT support to staff had to focus on 'back to basics' and supporting signposting for the many children presenting with speech, language and communication need who were not known to any service. In a few Sure Starts, SLTs were able to do some work on this aim and observations indicated more intentional planning for language/conversations when planning activities.

Key learning points

- Parents are most likely to do something if they are not just told what to do, but given a tool to help them do it (insight given by East Belfast parents in previous codesign group). The books provide a tool to make it easier for parents to have a conversation with their child.
- Involving parents e.g. getting ideas for the scenes in the books, makes a difference. The parents know what their children are interested in.
- Parents engaged with the book when it was given by a trusted person e.g. Family Support Worker or Early Years Practitioner. Greatest behavior change seemed to occur when the book was integrated into a Parent/Child Programme rather than just handed out.
- Effective partnerships are crucial – the artist and Music Therapist were selected because they were known to have an interest in and deep understanding of this area of work. They were key to the whole development process rather than simply being given a ‘brief’ to work to.
- Resources like these books have added value when they are part of an overall strategy and link to other messages that parents have received e.g. ‘Anytime is Chatting Time’; smile, talk, laugh, sing and share stories anytime.
- Parents need more specific support to make up songs with their child to help make tricky times easier and to enrich the language environment. A specific piece of work around this is now in progress.
- There is an appetite for these books. They have been purchased by Sure Starts across Northern Ireland and by many Nursery and Pre Schools. An Irish Language version has now been created and is used in all Irish medium Preschools in Belfast area.

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Title: Get Nourished: preventing, identifying and treating malnutrition in older people in Dundee

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Description

This project used five initiatives to prevent and improve the detection and management of malnutrition in older people in Dundee. The project had started in 2019 and it was predicted that the emergence of the COVID-19 pandemic would exacerbate nutritional risk in older people due to restricted access to shopping and a reduction in essential care and support. Restrictions on face-to-face activities required innovative ways of working and partnership with a number of organizations. It has resulted in increased awareness and detection of malnutrition risk, improved access to first line nutritional advice, improved nutritional intake, reduced social isolation and enabled delivery of accessible, consistent nutritional training.

Context

It is estimated that one in ten people over the age of 65 are malnourished or at risk of malnutrition. It is both a cause and consequence of ill-health but is often overlooked[1]. Research has shown that providing timely first line nutritional advice can prevent further disease as well as protect people from falls and frailty and improve recovery time following illness[2].

It was predicted that the COVID-19 pandemic would exacerbate nutritional risk due to limited access to shopping and a reduction in essential care and support[3]. Restrictions on face-to-face activities required innovative ways of working and partnership with a number of organisations.

The aim of this project was to prevent and improve the detection and management of malnutrition in older people in Dundee, while working within the restraints imposed by the COVID-19 pandemic, and consisted of five objectives:

1. To increase awareness and detection of malnutrition risk through use of nutritional screening
2. To increase access to nutritional advice by establishing a telephone advice line
3. To deliver nutritious snacks (Boost Boxes) to people identified as being at risk of malnutrition

4. To provide support to vulnerable people through a weekly meal delivery service and social check in
5. To increase access to standardised nutrition training by developing online training videos

Method

Staff from the NHS Tayside Falls Prevention Team and volunteers from the Royal Voluntary Service were trained to use the Patients Association Nutrition Checklist (PANC)[4] to identify people at risk of malnutrition, give basic advice and signpost to services for further support. PANC was chosen instead of the Malnutrition Universal Screening Tool (MUST) as it is simpler to complete remotely because it does not require measurement of height or weight. PANC has been shown to have moderate agreement with MUST when used to screen for the prevalence of malnutrition risk in older adults in the community[6].

A telephone advice line was established for people concerned about malnutrition risk either in themselves or someone they care for. It was manned by trained healthcare support workers for three hours on three days per week. Additionally, the service could be accessed via a dedicated email account. Information was gathered from individuals using a locally produced, standardised form and they were then provided with first-line nutritional advice and signposted or referred to other services where appropriate. The advice line was publicised using posters in GP surgeries and community pharmacies, social media platforms and emailing multiple partner agencies.

People identified as being at risk of malnutrition either through nutritional screening or after calling the telephone advice line were offered Boost Boxes. These contained 14 high energy/ high protein snacks such as milk puddings, malt loaf, dried fruit and drinking chocolate powder and were designed to provide extra nourishment when appetite was reduced. The content of the boxes was adapted for anyone with special dietary requrements. Trained volunteers from Dundee Volunteer and Voluntary Action delivered the Boost Boxes, reviewed their use weekly and refilled the boxes where appropriate for up to three weeks. Ideas for suitable snacks were discussed if appetite remained reduced after the three-week period, enabling self-management of long term conditions to prevent avoidable admissions to hospital or care homes.

An existing supper club, which had been providing a fortnightly evening meal to 30 diners, was adapted to provide a weekly meal delivery service and social check-in. People who were idenitifed as at risk of social isolation by partners or community members were referred to the Community Development Worker, who would then assess whether the service was appropriate for the individual. Meals were cooked by staff in a local school that had been furloughed and delivered by healthcare support workers. Additionally they received weekly telephone calls to reduce social isolation. Funding for the Boost Boxes and meals was obtained from the Scottish Government Covid Response Fund.

Short training videos were developed and made available on YouTube to address the following topics:

- Signs and symptoms of undernutrition
- Food Fortification
- Nourishing Drinks
- How to fortify your milk
- Get Nourished Advice Line

Outcomes

Feedback from those trained to use the PANC[4] indicated that it was easy to use.

Over a one year period, 70 people called the advice line, with the majority of callers (80%) seeking advice for themselves. On review, 51% of callers reported that they had been able to fully implement the advice provided and 25% had implemented it partially. Twenty-two percent of callers were referred to the Nutrition and Dietetic Service for more specialist support. Almost half of the callers had been signposted to the advice line by the Falls Prevention Team.

Over a one-year period, 48 people were identified as requiring support due to poor appetite and over 150 Boost Boxes were delivered as some required support for longer than three weeks. No referrals to other services were required. Initially there were regular referrals but this decreased over time. Approximately seven people were receiving Boost Boxes at any one time.

Between March and October 2020, over 3000 meals were delivered and over 1600 phone calls were made, providing support, advice and companionship to older people across Dundee. An evaluation survey was issued to 24 households and 16 responses were received. These 24 households were selected as they were within the geographical area of the existing supper club. The survey asked in which ways the service had helped them and the results are shown below.

	Yes	No
I am better nourished	15	1
I am more socially connected to my community	16	0
I am physically healthier	15	1
My mental health has improved	15	1
My general and emotional wellbeing has improved	14	2
I am less lonely	14	2
I feel valued and supported by the community	16	0
My overall morale has improved	16	0

One recipient commented “It has helped me a great deal especially as I have no family nearby. Getting a phone call and knowing where to turn for support is brilliant. I really appreciate everything. I would like to come to the supper club when it starts up again.”

Use of videos enabled training and information to be shared quickly, efficiently and consistently. Each video has been viewed approximately 100 times and care home staff reported that they found the one on Food Fortification particularly helpful.

Key learning points

Five partner organisations were involved in this project and it would not have been possible without strong partnership working.

There have been fewer calls to the advice line than expected. This highlights the need for a communication plan to ensure greater awareness of the service. Red flag signs should be agreed to allow identification of those requiring urgent referral to other services.

Many people offered Boost Boxes were given advice to fortify their milk. Therefore, skimmed milk powder was later added to the boxes to make it easier to implement this advice. Some of those referred for a box had often complex and chaotic lives and food insecurity was the main issue rather than poor appetite. Availability of Boost Boxes needs to be continuously advertised to promote their use.

As restrictions were eased, the supper club was replicated in other areas within Dundee.

As a follow-up to the videos that were developed in-house, a series of professionally produced training videos[6] on preventing, identifying and treating malnutrition have now been developed. These are endorsed by the Care Inspectorate and care providers across Scotland include them within their mandatory training.

This project was undertaken at a time when restrictions imposed by the COVID-19 pandemic necessitated a change in working practices. If circumstances had allowed collection of baseline data and evidence of ecomomic impact, this would have strengthened the outcome data of the project.

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Addressing health inequalities in a Specialist Burns Unit

Katie Betteridge, Senior Therapy Assistant

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Description

The purpose of this case study is to demonstrate collaborative working within a multi discipline role in a specialist acute area. This case study will highlight the role of a Senior Therapy Assistant, who works with a diverse patient population in the multi-cultural city of Birmingham at the Regional Burns Centre.

Aims and Objectives

- To raise awareness of a multi-disciplinary role within a specialist area and how this impacts on the patient's in-patient journey during the acute stage of their rehab.

Context

The purpose of this case study was to focus on the experience of a patient who sustained a significant burn injury. This individual faced a number of challenges related to his ethnic background such as communication and lack of comprehension, limited support network and socioeconomic status. This patient required an MDT approach to treatment in resuscitation and rehabilitation following the burn injury, to ultimately save and enhance their quality of life. *Approximately 250,000 people experience burn injuries in the UK each year, varying from small burns requiring minimal treatment to major burns which require intensive and prolonged hospital care*.

A 31-year-old man was admitted into hospital following a gas explosion. The individual sustained 90% TBSA mixed thickness burn (deep dermal to full thickness) with some areas of superficial skin damage. The patient was transferred to ITU following the injury and was intubated and required vasopressor support. The patient was not for surgical intervention and required conservative management.

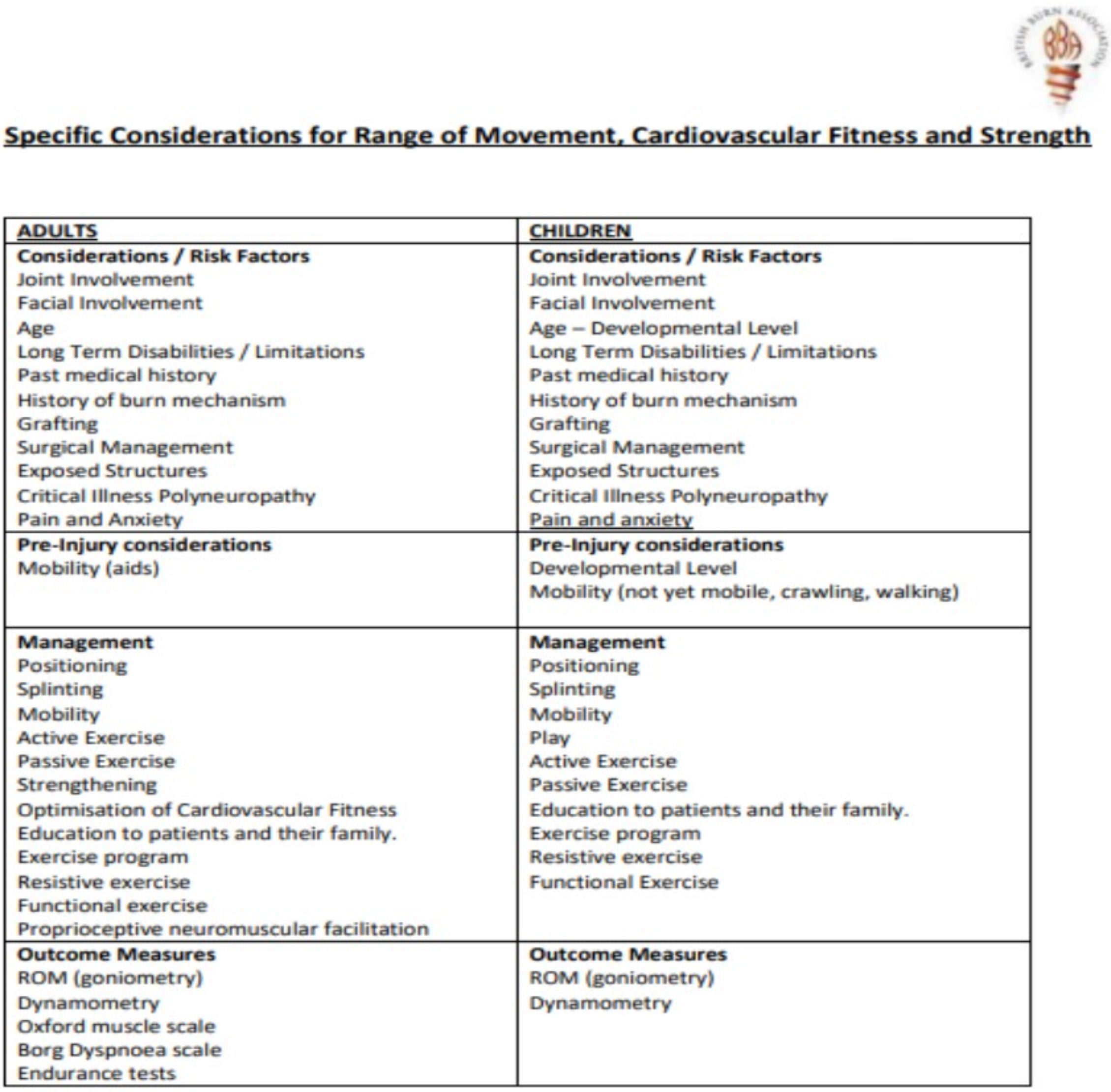
As part of a multidisciplinary team, four Allied Health Professionals (AHP) were involved with the rehabilitation process: Physiotherapists, Occupational Therapists, Dietitian and Speech and Language Therapists. A Senior Therapy Assistant (STA) who works across all four disciplines worked closely with this individual for continuity. *The Burn Therapist plays a vital role throughout the recovery from burn injury and the emphasis will change throughout the rehabilitation process*.

The initial assessment was led by a Registered AHP, prior to delegation to the STA who continued to deliver the detailed treatment plan. The STA's involvement began in ITU and continued when the patient was transferred to the high dependency unit (HDU). Initial treatment included obtaining a detailed social history and lifestyle questionnaire from the patients NOK; which was vital for goal setting and treatment planning.

Treatments completed by the STA included reviewing splints, daily orientation for delirium management post ITU, and progression of mobility and strengthening, support with swallow rehabilitation and communication post tracheostomy decannulation. Regular range of movement and positioning charts for oedema management. Passive and active range of movement, skin hydration and scar management which included massage and education.

Proper and early positioning is integral to the successful rehabilitation of a patient with a burn. The position of comfort after burn injury is typically the position that promotes deformity and therefore should be avoided. Therapeutic positioning is designed to reduce oedema by elevation of extremities and to preserve function by proper body alignment and the use of anti-contracture positions.

Outcome measures such as Kapandji, Goniometry and Manchester Mobility Scale were used.



Specific Considerations for Range of Movement, Cardiovascular Fitness and Strength

ADULTS	CHILDREN
Considerations / Risk Factors Joint Involvement Facial Involvement Age Long Term Disabilities / Limitations Past medical history History of burn mechanism Grafting Surgical Management Exposed Structures Critical Illness Polyneuropathy Pain and Anxiety	**Considerations / Risk Factors** Joint Involvement Facial Involvement Age – Developmental Level Long Term Disabilities / Limitations Past medical history History of burn mechanism Grafting Surgical Management Exposed Structures Critical Illness Polyneuropathy Pain and anxiety
Pre-Injury considerations Mobility (aids)	**Pre-Injury considerations** Developmental Level Mobility (not yet mobile, crawling, walking)
Management Positioning Splinting Mobility Active Exercise Passive Exercise Strengthening Optimisation of Cardiovascular Fitness Education to patients and their family. Exercise program Resistive exercise Functional exercise Proprioceptive neuromuscular facilitation	**Management** Positioning Splinting Mobility Play Active Exercise Passive Exercise Education to patients and their family. Exercise program Resistive exercise Functional Exercise
Outcome Measures ROM (goniometry) Dynamometry Oxford muscle scale Borg Dyspnoea scale Endurance tests	**Outcome Measures** ROM (goniometry) Dynamometry

Method

Due to the language barrier experienced by the service user, it was important for the STA and Therapy team to develop a strong rapport with the patient to gain an understanding of their needs. The patient felt comfortable with the therapist and was able to express concerns, such as experiencing flash backs, which is very common for individuals who have experienced a traumatic event. *Burn survivors who have a history of traumatic events and past PTSD are also at risk for developing PTSD from the current burn injury. In fact, a current burn injury can trigger nightmares and flashbacks from a past traumatic event*.

Psychosocial support was offered to the patient, the STA completed well-being sessions with the service user which included leaving the ward as part of social reintegration and addressing body image(instead of due to their length of stay). The patient enjoyed some time away from the Burns unit which included visiting Costa coffee and going outside in the snow, which he had not seen in a long time. During this time, the patient had shared his in-patient experience with the STA and stated “I would like to work in health care one day to help other Burns Survivors”.

Outcomes

This individual was an inpatient for three months following a major burn injury. The case study demonstrates the impact that Burn Therapists have with patients in the acute setting. Working as a Senior Therapy Assistant within a multi-disciplinary role, it is evident that the patient was able to gain access to regular rehabilitation to address their needs holistically by considering physical and psychosocial needs. Following their hospital discharge, the patient was transferred to an enhanced assessment bed whilst waiting to be rehoused and will be reviewed by the therapy team as an outpatient for ongoing scar management.

Key learning points

Reviewing the patient frequently to measure and record their outcomes played a significant part to this service user's rehabilitation. It is essential that documentation detailing techniques and outcomes are recorded within 24 hours to ensure accuracy to appropriate continuation of the treatment plan.
Having a STA based on the Burns Unit enables non-registered therapists to work collaboratively across all four disciplines in order to deliver a person – centred approach to patient care. The STA was able to develop their skills and knowledge, particularly on hand therapy following a burns injury.

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Maximizing the sight of young children to achieve their academic potential

Catherine Siemaszko, Orthoptist Assistant

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Description

Provide orthoptist support testing vision for children from 2.5 yrs upwards. Once a child is diagnosed with a problem requiring patch treatment, the orthoptic assistant provides follow up care.

As an Orthoptic Assistant, I support vision testing for children from 2.5 years upwards within the Orthoptic Departments across the 3 hospitals in the Hampshire Hospitals trust. If a child is diagnosed with a binocular vision condition requiring occlusion therapy, I can start them on this course of treatment and provide follow-up care, with guidance and supervision from the Orthoptists. I have also completed a training course to allow me to carry out specific tests with children and young people who have problems with reading, tracking and visual processing difficulties.

The child that this case study is focused on is 5 years old, and has been under the care of our department since the age of 1. They are seen approximately 3 times every year by the Orthoptics department and once a year by the Ophthalmology team

Context

Children from all walks of background with different abilities and varying social, economic and environmental factors.

- The aim of amblyopia therapy, is to allow the affected eye to achieve it's maximum potential. (Reference 1)
- From this child's first visit with us when they were 1 year old, it was suspected that they would have a binocular vision problem, however at that young age, it is difficult to prove with certainty, due to lack of compliance with testing. It was during subsequent visits, as the child got older and testing got more reliable, that glasses were prescribed when the child was aged 2. However, compliance with glasses wear was not good and attendance to appointments was very sporadic for the next 12 month period. During an appointment with the Orthoptist when the child was age 3, Mum informed the Orthoptist that a stressful family situation had had a negative impact on the child's behavior and compliance with their glasses. Mum also told the

clinician that the child had been given the diagnosis of ASD. During an Orthoptist appointment when the child was age 4, a “formal” visual acuity was gained for the first time. This means that a reliable, monocular visual acuity test has been carried out, and it demonstrated that the vision in the child’s left eye was significantly reduced, compared to the right eye. It was at this visit that atropine occlusion was started. At the follow-up visit 6 weeks later, the visual acuity in the left eye unfortunately had not improved as would be hoped, but it was revealed that compliance with the atropine treatment had not been good. Instructions for the treatment were reinforced and a follow-up appointment booked for 6 weeks time. Unfortunately after this, the patient was not brought to a number of appointments and they were then not seen for 10 months.

Method

- When the patient next attended their appointment, atropine treatment had not been carried out as they had run out of drops, and unfortunately the vision in their left eye had deteriorated further. It was at this appointment that I met the patient. Our Orthoptist had instructed to start the patient on patching therapy for 6 hours every day, rather than atropine occlusion, due to the level of their vision now and poor compliance with atropine drops previously.
- I explained to the patient and Mum how to apply the patch, which eye to put the patch over, that the patch and their glasses need to be worn at the same time, I ensured that the patient understood why we were asking them to patch, in words and language that they understood (they were now 5 years old by this stage). I explained to Mum the importance of this patching therapy being carried out consistently everyday, for the 6 hours specified and explained about the visual system development. I supplied Mum and the patient with 2 boxes of Ortopad sticky patches and a motivational poster to stick the used patches on each day, once the patching has been completed. I arranged an appointment for them to come back and see me in 8 weeks time

Outcomes

- At this follow-up appointment, there was an excellent improvement in the left visual acuity. The patient came rushing in to see me, they were so proud of what they had achieved and couldn’t wait to show me their completed poster full of used patches. Mum said she had seen a great improvement in the child’s reading at home and that school said their concentration levels in class had gone up. The patient still needs to continue patching therapy; there is still a way to go, but it shows the importance of compliance for treatment and how successful it will be. Mum also said that the child was so excited to come in and see me, and show me the poster, and she felt that that really made a difference for her child, so it’s about being aware of what motivational tools could work for different children.
- Relating to cost-effectiveness, when I see a patient for an appointment as a Band 4 clinician, I am ultimately saving the Trust money, because otherwise the patient would be booked in with a Band 6/7/8 Orthoptist/Clinician.

Key learning points

- I think for me, my key learning from this particular patient is not to unconsciously judge the parents/family/child based on their past behaviours. Looking at this case and their poor attendance to appointments, poor compliance with glasses wear and poor compliance with atropine therapy, I would not have expected such brilliant results we are seeing now with glasses wear and patching therapy.
- Atropine therapy did not work well for this patient/family and patching therapy has. For some patients/families it is the other way round. So it is important to have a discussion with each family to determine which method would work best for them and their child.

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Developing cancer prehabilitation and rehabilitation programmes to optimise physical and psychological health and reduce healthcare utilisation.

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Description & Context

These pilot programmes were designed to evaluate and demonstrate the effects of multimodal prehabilitation and rehabilitation on the health-related quality of life (QoL) of people affected by cancer. Programmes were delivered by a Lead Senior Physiotherapist and an Allied Health Professional (AHP) Cancer Assistant Practitioner. People diagnosed with colorectal or breast cancer, and listed for surgery, were invited to join programmes consisting of education and supervised exercise specific to each tumour site. Upon completion of the programmes people reported an improved QoL, reduced fatigue, anxiety and depression. People who completed the breast cancer shoulder programme reported a reduction in upper limb disability.

Following colorectal prehabilitation, people demonstrated an improvement in their physical fitness levels reflected by a reduction in average hospital length of stay by at least two days. Post-surgery, where a rehabilitation component was not provided, people reported regression in pre-intervention levels of fatigue, anxiety and depression, highlighting a need for a restorative component to treatment optimisation approaches. Moreover, people attending the programme reported that the peer support of others with a similar diagnosis had a positive effect on their motivation and emotional wellbeing.

The NHS Long Term Plan[1] outlines an ambition to enhance cancer survival and QoL. It is recommended that to achieve this, people should have access to physical, nutritional and psychological optimisation[2]. Within a Macmillan funded two-year scoping project, two AHP-led pilot programmes were developed based on the requirements of people affected by cancer in a district general hospital in North Derbyshire, a breast prehabilitation and shoulder rehabilitation programme and a colorectal prehabilitation programme. These particular tumour sites were selected as patients require contrasting management approaches and primary treatment is delivered at Chesterfield Royal Hospital (CRH). Studies have demonstrated clinically significant physical and psychological health improvements in both tumour sites[3,4,5], with reduced healthcare utilisation post-operatively[5,6], the pilot interventions provided an opportunity to explore and test these concepts locally.

The aim of the pilot programmes was to deliver personalised, AHP-led interventions which would:

- Increase treatment options for people considered “high-risk for surgery”.
- Improve post-operative outcomes.
- Improve QoL and experience throughout and after treatment.
- Reduce length of stay.
- Support the cancer pathways.

Treatment complications lead to poorer health related QoL, increased length of stay (LoS) and increased overall expenditure on health care[7]. Advanced age and frailty are associated with increased risk of developing post-surgical complications, longer LoS and discharge to a care facility[8]. Approximately 30% of people in North Derbyshire are aged 65 years or older, compared to the national average of 18%[9], suggesting a need to optimise the local population prior to cancer treatment.

People affected by cancer in North Derbyshire report that they do not know what they can do to improve their own treatment outcomes. Up to 82% of people undergoing cancer treatment do not meet physical activity guidance and many patients do not understand the benefits of lifestyle changes to mitigate the long-term risks of cancer treatment[10]. Fatigue, managing symptoms, nutrition and “how to be more active” are among the top five information needs reported by people affected by cancer in North Derbyshire during holistic needs assessments[11]. AHPs are well placed to support people with all aspects of their physical wellbeing, however prior to these pilot interventions, there were only very limited AHP services implemented within cancer pathways at CRH.

Method

Each programme was co-developed with the respective MDT to define pathways which would allow the minimum required time to stimulate fitness improvements, whilst minimising delays to surgery. Patient and public involvement was also incorporated throughout, utilising surveys, interviews and focus groups. A key focus from this feedback was to provide information at the right time and minimise hospital attendances. The unique requirements of each patient group resulted in two very different programmes.

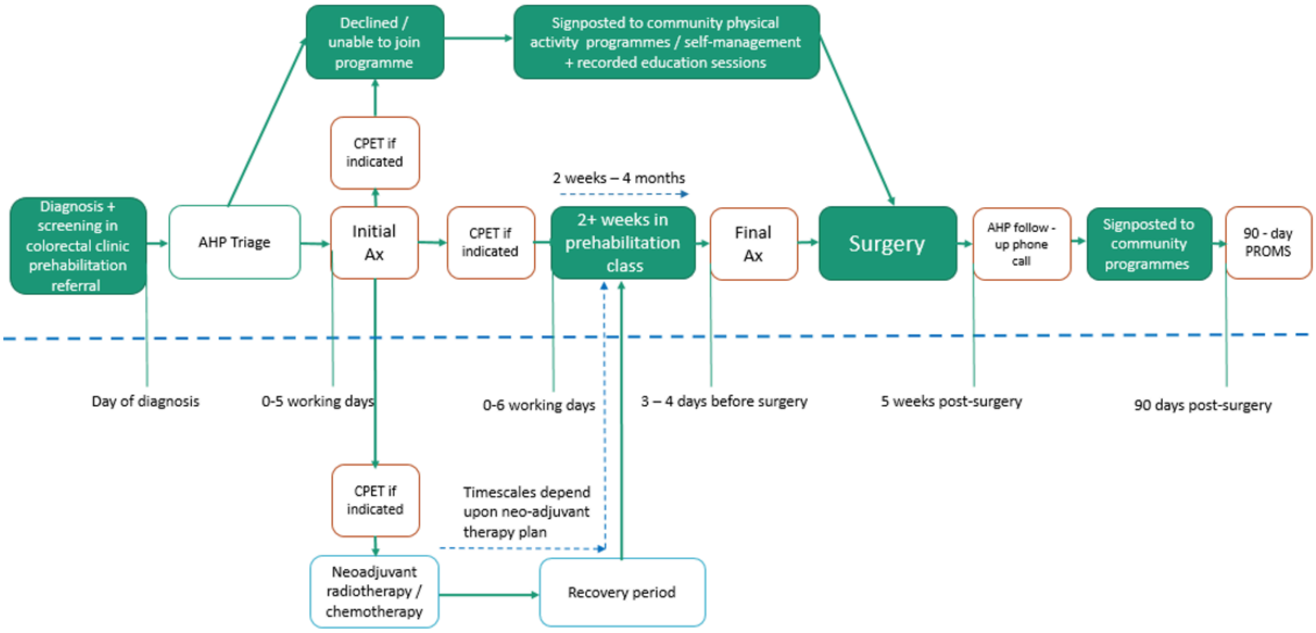
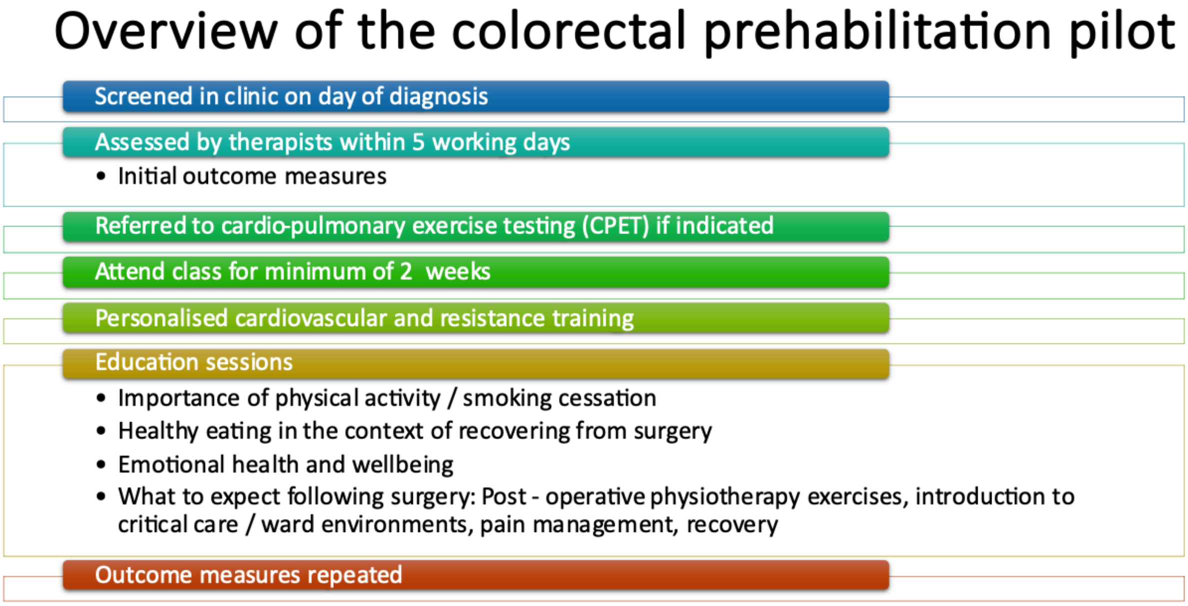


Figure 1: Colorectal Prehabilitation Pathway

Colorectal cancer

The colorectal programme (figure 1) provides supervised exercise for people considered "high risk" for surgery, those considered lower risk are also invited to join or are provided with a home exercise programme. Education sessions are provided before each class covering four core themes, to help people to prepare for their surgery (figure 2).



Overview of the colorectal prehabilitation pilot

Screened in clinic on day of diagnosis

Assessed by therapists within 5 working days
- Initial outcome measures

Referred to cardio-pulmonary exercise testing (CPET) if indicated

Attend class for minimum of 2 weeks

Personalised cardiovascular and resistance training

Education sessions
- Importance of physical activity / smoking cessation
- Healthy eating in the context of recovering from surgery
- Emotional health and wellbeing
- What to expect following surgery: Post - operative physiotherapy exercises, introduction to critical care / ward environments, pain management, recovery

Outcome measures repeated

Figure 2: Overview of the colorectal prehabilitation pilot

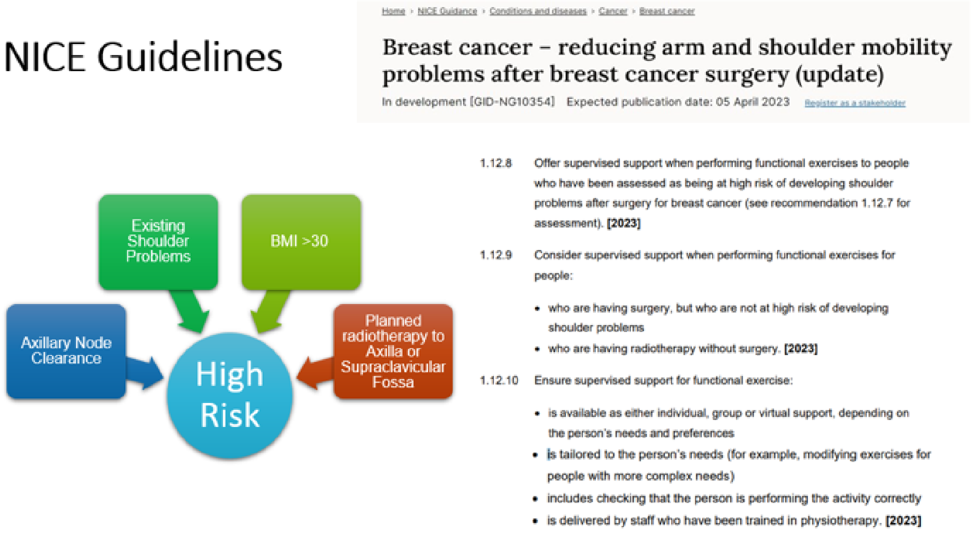
Following surgery, people are visited on the ward by the team and where indicated, ward-based rehabilitation is provided. Working with therapists with whom patients already have an established rapport eliminates barriers to early mobilisation, particularly where people are anxious or experiencing delirium. Each person is contacted by telephone five weeks following surgery for a progress check and at this point are sign-posted to local physical activity or other wellbeing programmes as required.

Breast cancer

In the breast cancer programme, every person who will undergo primary breast cancer surgery is invited to join an online webinar (figure 3) which contextualises the importance of physical and emotional wellbeing and signposts to relevant local services, to increase resilience to treatments.

Figure 3: Breast prehabilitation webinar content

People considered at “high risk” (figure 4) of developing shoulder problems[5,12] are provided with an outpatient physiotherapy appointment approximately seven days following their surgery.



Breast cancer – reducing arm and shoulder mobility problems after breast cancer surgery (update)

In development [GID-NG10354] Expected publication date: 05 April 2023

1.12.8 Offer supervised support when performing functional exercises to people who have been assessed as being at high risk of developing shoulder problems after surgery for breast cancer (see recommendation 1.12.7 for assessment). **[2023]**

1.12.9 Consider supervised support when performing functional exercises for people:

- who are having surgery, but who are not at high risk of developing shoulder problems
- who are having radiotherapy without surgery. **[2023]**

1.12.10 Ensure supervised support for functional exercise:

- is available as either individual, group or virtual support, depending on the person's needs and preferences
- is tailored to the person's needs (for example, modifying exercises for people with more complex needs)
- includes checking that the person is performing the activity correctly
- is delivered by staff who have been trained in physiotherapy. **[2023]**

Figure 4: High risk of developing shoulder problems and relevant NICE guidelines

Outcome measures (figure 5) were chosen to reflect physical improvements, the perceived impact upon each person's quality of life and to benchmark with other established services and current evidence. Physical testing takes place during assessments, with questionnaires completed for each patient related outcome measure (PROM). PROMs are then repeated via post following discharge, to evaluate the longer-term impact of interventions.

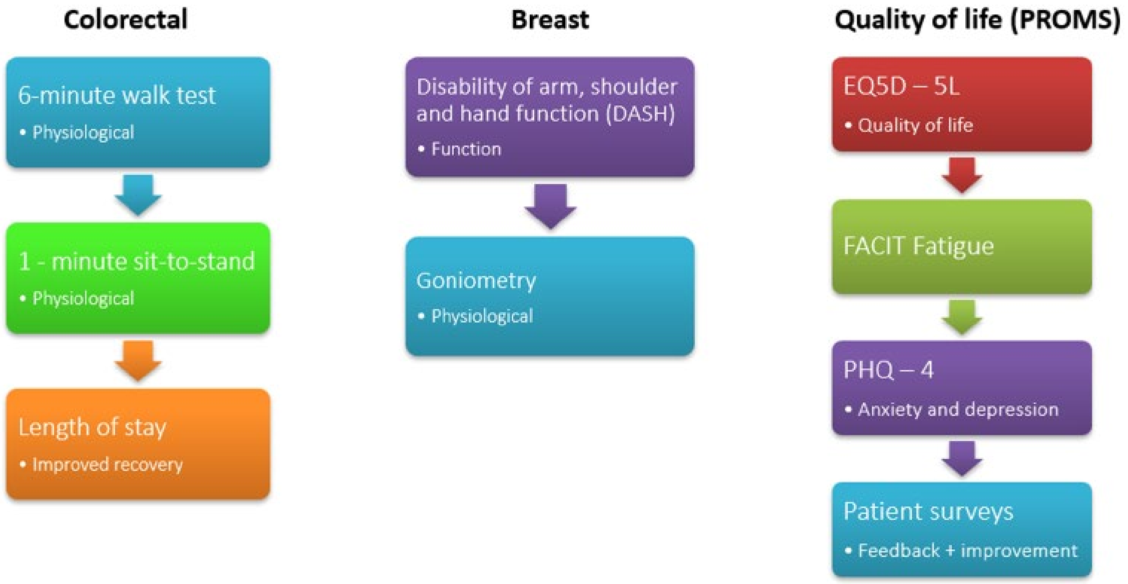


Figure 5: Outcome measures for pilot programmes

Outcomes

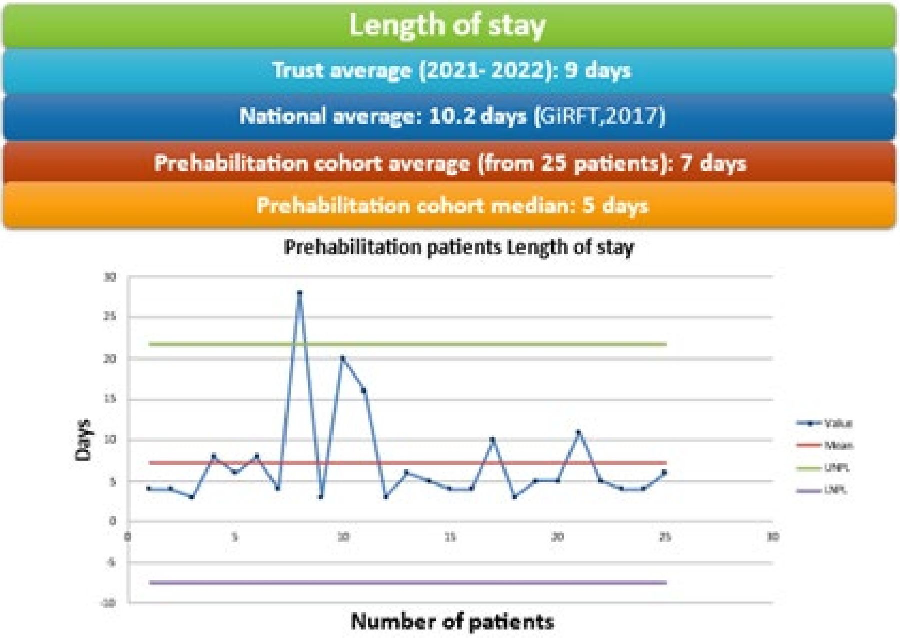
Colorectal programme

People demonstrated clinically significant improvement in fitness reflected by improvement in six-minute walk tests (6MWT) and one minute sit-to-stand scores (figure 6).

South, Central and West Commissioning Support Unit, (2022)

Figure 6: Colorectal prehabilitation physical outcome measure results

The average length of stay was reduced by two days versus CRH legacy data (figure 7) and correlates with an average 6MWT distance improvement above 42 metres, as demonstrated in other independently evaluated services[6].



Length of stay

Trust average (2021- 2022): 9 days

National average: 10.2 days (GIRFT,2017)

Prehabilitation cohort average (from 25 patients): 7 days

Prehabilitation cohort median: 5 days

Figure 7: Length of stay comparisons

Breast programme

DASH scores improved with clinical significance at the point of discharge, which compares well with the study on which the programme was based[5]. However, outcomes in the study are based on surveys at 12 months, in this programme surveys are returned between four and six months.

PROMS

A clinically significant QoL improvement was observed in both programmes[13], whilst anxiety and depression scores reduced to within a “normal” range on final assessment following the colorectal prehabilitation programme (figure 8). This suggests that, despite being closer to surgery, people feel better prepared and less anxious and depressed, potentially contributing to enhanced recovery times (as demonstrated in multimodal prehabilitation randomised control trials in colorectal cancer patients)[14].

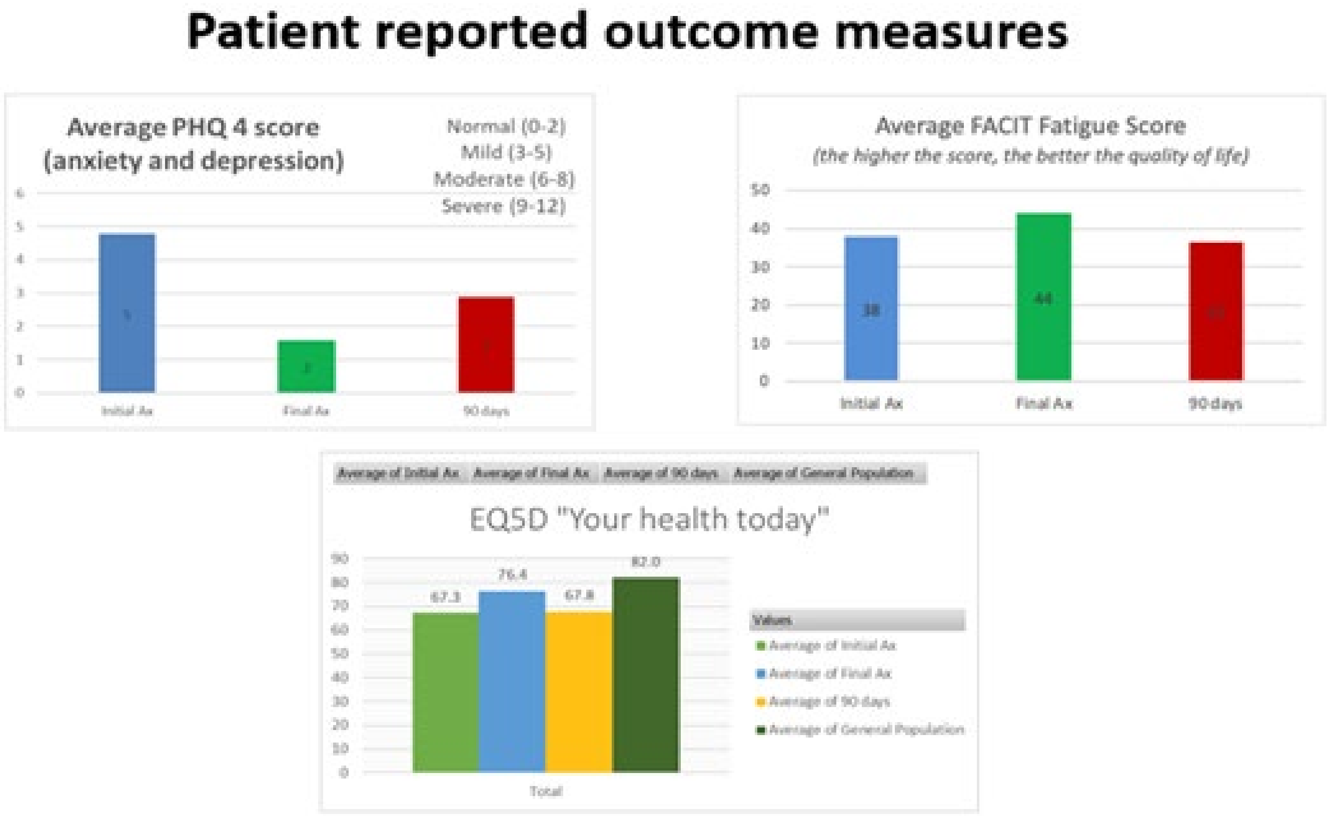


Figure 8: Patient reported outcome measures

Patient and staff evaluation

A number of themes were highlighted during evaluation of the interventions (figure 9).

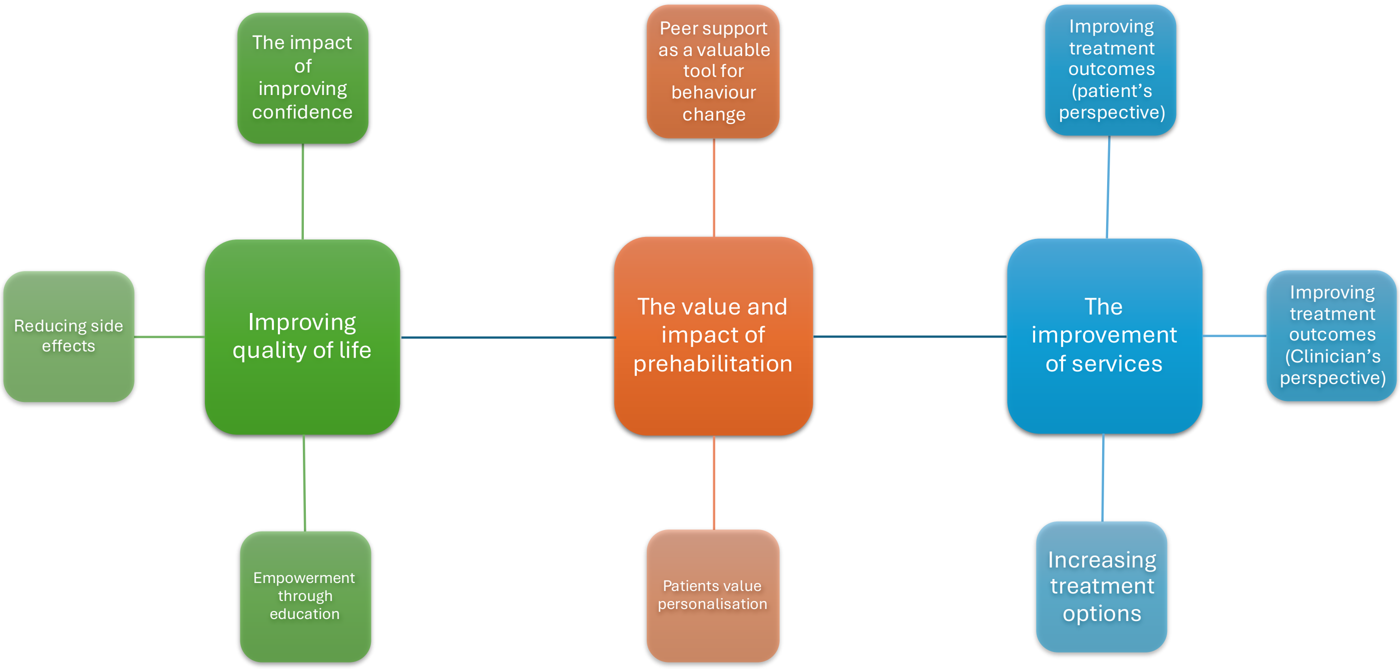


Figure 9: Thematic map of service evaluation

Patients highly valued the opportunity to partake in each programme, citing the opportunity to be supported by others sharing a similar experience particularly beneficial. Improved 6MWT values combined with education, reportedly made people feel more confident, better prepared for and less anxious about their treatment. 92% of patients reported a better understanding of what to expect from surgery and 100% would recommend the programme to others.

Figure 10: Patient feedback

The results observed in physical and patient reported outcome measurement are echoed in feedback surveys of people who have completed the programme. Physical improvements and peer support contribute to improved QoL and longer-term behaviour changes (figure 10).

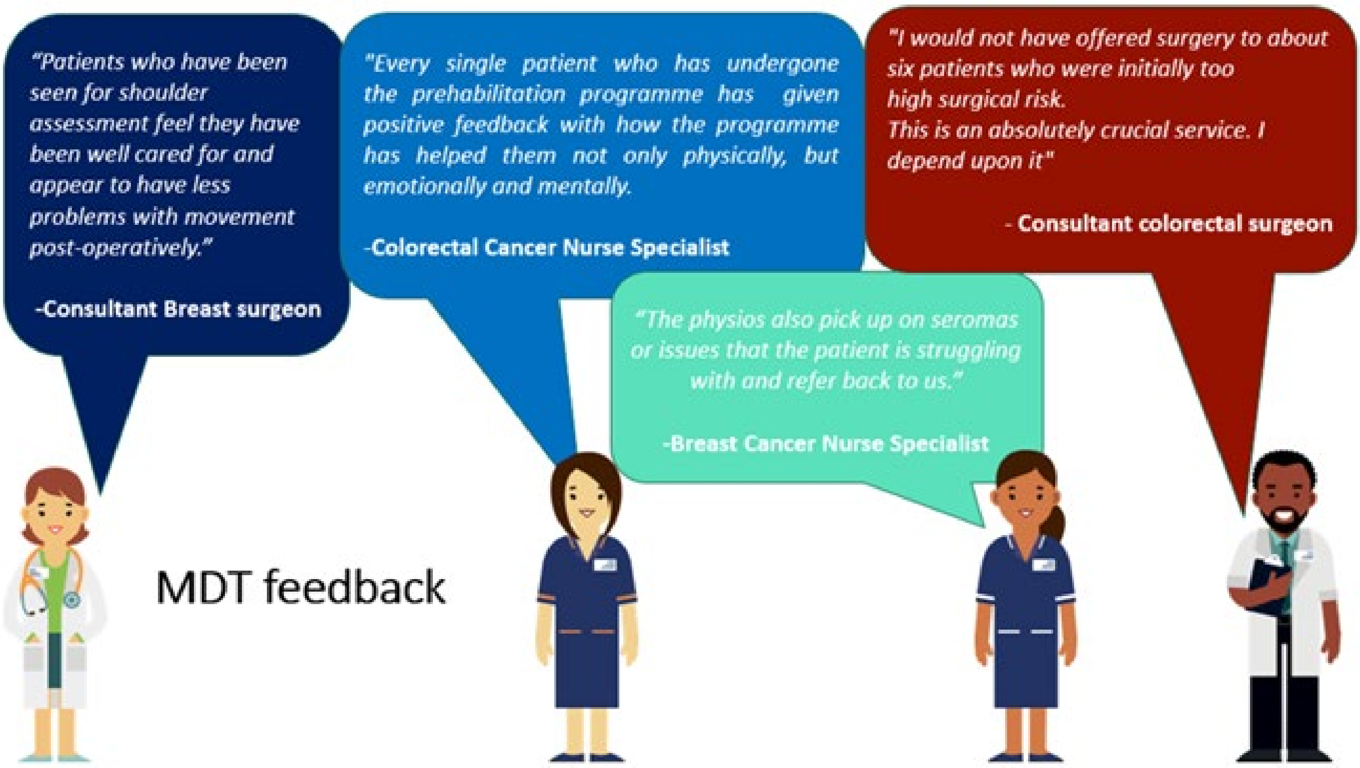


Figure 11: MDT Feedback

Crucially, the MDTs of each tumour site have seen the impact of the interventions on their patient groups, enabling an ongoing collaborative approach. AHPs were not involved in either pathway prior to these pilot programmes but are now considered to be integral to each pathway, as part of high-quality patient care (figure 11).

Return on investment

Capacity	Length of stay (CRH)	Re-admissions (CRH)	ED attendances (CRH)	Critical care (CRH)
Colorectal	296	15	15	22
Breast	-	-	20	-

Table 1.1: Estimated capacity savings at CRH through prehabilitation / rehabilitation programmes

Based on the evidence of these pilot interventions, relevant RCTs[5] and independent evaluations of larger scale services[6], it is hypothesised that bed capacity would be increased by a minimum of 296 days and 22 critical care days at CRH, with reduced re-admissions and ED attendances (Table 1.1). Based on economic analyses[5, 6] and 2022/23 tariff tables, financial savings would be expected as consequence of the efficiencies associated with improved outcomes (table 1.2).

Tumour site	Estimated annual financial savings
Colorectal	£152,179
Breast	£27, 090

Table 1.2: Estimated cost savings for from CRH prehabilitation /rehabilitation programmes

The implementation of AHP-led programmes shows a positive influence on the capacity of cancer MDTs by adding an extra network of professionals to support case management. Those patients who do experience side effects receive rehabilitation and support, improving outcomes and reducing calls and clinic appointments longer term.

Key Learning Points

Despite the challenging financial climate, the impact of these interventions on people’s QoL, in combination with the efficiency savings to the healthcare system has resulted in substantive funding of an “Oncology Prehabilitation and Therapy Service” at CRH. The service will see these pilot interventions developed into comprehensive services; however, work is ongoing to develop programmes to support other tumour sites, to minimise healthcare inequalities. Much has been learned throughout this process in terms of gaps in healthcare provision, service development and maximising the effectiveness of behaviour change interventions (figure 12).

The importance of a collaborative approach from the outset

- With MDTs and patient groups
- Improved understanding of roles, service delivery and "buy-in" to service change / improvement

Importance of outcome measures

- Using a range of validated outcome measures was key to corroborating a qualitative narrative of these services being "the right thing to do"

Stakeholder engagement

- There are always "hidden stakeholders"
- Communicate a vision for a service development project early, provide regular updates and present to various forums / stakeholder groups
- Gathering support for new services is crucial to their success, paticularly if they will require funding

Peer support

- Key to sustainable behaviour change
- People highly valued the opportunity to attend webinars / exercise classes with people going through similar treatments / experiences
- People developed helping relationships with peers which lasted beyond treatment completion and promoted ongoing physical activity in the community setting

Rehabilitation remains an essential component

- In the colorectal programme, which was prehabilitation only, people reported increased fatigue and anxiety and reduced quality of life at 90-days post-operatively.
- There is an apparent need to offer restorative input based on this small scale pilot
- Physical capacity was not assessed at 90-days post-operatively during this pilot

Figure 12: Learning points from pilot oncology prehabilitation and rehabilitation programmes

Perhaps the key learning point is the power of peer support in motivating people to make and sustain a behaviour change and the long-lasting effect this can have. This is something that the team is very keen to promote and underpins the ethos of the Oncology Prehabilitation and Therapy Service. There were initial challenges in engaging the MDT in the absence of established AHP roles within cancer pathways. This was overcome over time through engagement exercises identifying perceived gaps in the pathways; from a clinician's and patient's perspective, providing an opportunity to highlight how AHPs may provide services to fill these gaps. Ultimately, delivering successful pilot interventions as a proof of concept, served to develop trust and understanding and now AHPs are considered a key part of each respective MDT.

Final advice

For those looking to do similar work in future, the advice would be to cast a wide scoping net, learn from what others are doing (or would like to do!) Select outcome measures which allow benchmarking with other services, but also provide information that is clinically useful. Communicate the vision and the progress that you make to all stakeholders; to generate support and engagement with the intervention longer term. Peer support is invaluable to patients, but also for healthcare professionals, so develop a support network of people working on similar projects.

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Title

Applying a novel outcomes based public health model to co-design nutritional resources and information in Sickle Cell Disease

Name and job title of Case Study Author

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Description

This case study outlines how a novel outcomes-based model and a participatory learning alliance methodology was effectively applied to co-develop evidenced based nutritional resources and information, to address key knowledge and information gaps affecting people living with Sickle Cell Disease (SCD). The case study project was underpinned by the findings of a recent qualitative study conducted by a dietitian, to identify influencing factors affecting the integration of nutrition into standard care in SCD.

Four main themes were identified following data analysis including the following: invisibility of SCD, under recognition of the importance of nutrition, lack of priority to nutrition and the multifactorial factors affecting nutrition and service provision. These themes reflect both the complexity of sickle cell nutrition and myriads of knowledge and care gaps impacting on the safety and quality of care available to this patient population.

Further analysis of these themes resulted in the development of the concepts of Prevention, Education, Empowerment, Contextual Factors and Engagement (PEECE) model. The PEECE model was used as a health improvement strategy for the case study project to address the knowledge and information gaps in sickle cell nutrition to improve the health and wellbeing outcomes of the sickle cell patient population

Context

SCD is a marginalised[2] genetically inherited red blood cell disorder, the fastest growing genetic disorder in the UK[3], with an estimated 17,500 people living with the condition. The main clinical features of SCD, chronic hemolysis, vaso-occlusion and impaired immunity are directly responsible for the medical and nutritional implications in this condition[4]. However, nutrition in SCD is overlooked, underdeveloped and not part of standard care provision resulting in the lack of nutrition services, poor knowledge, awareness, information and resources surrounding nutrition available to the SCD patient population, impacting their health and wellbeing outcomes[1].

A recent participatory qualitative study[1] confirmed several knowledge and care gaps in sickle cell nutrition. The findings revealed that both the sickle cell service user/carer participants had to self-research what they know about SCD and nutrition online, general and often unverified sources, leaving patients at risk of misinformation to self-manage their complex nutritional problems/risks. Similarly, the provider participants had to self-research SCD and nutrition– identifying serious concerns about the level and quality of nutritional care in SCD, necessitating urgent action to improve the health and wellbeing outcomes of people affected by SCD and empower them to better self-manage their condition.

Poor access to health and education are recognised determinants of health[5]. As such the lack of nutrition knowledge, awareness, information and resources adds to the health inequalities experienced by people affected by SCD, negatively impacting their experience, access and outcomes of nutrition[1]. Therefore, the PEECE model, an outcomes-based model, was used in conjunction with the learning alliance methodology to address the knowledge gaps in SCD. The case study, a co-design project in collaboration with sickle cell patients and carers, aimed to co- develop nutritional resources and information to address the knowledge, resources and information gaps in SCD, to improve patient outcomes on a population level.

Method

The methodology and methods adopted for the project were largely determined by the co-design approach to the project to foster high levels of engagement, collaboration, knowledge sharing and empowerment. To ensure a wide-ranging patient/carer participation, recruitment of participants was undertaken in collaboration with the network managers of the 10 NHSE Heamoglobinopathy Coordinating Centre's (HCCs) in England, recognised as key gatekeepers to ensure good representation from across England.

The project was designed as a four phased participatory learning alliance methodology[6] (LAM), an emerging methodology in healthcare research and effective when working with participants from Black and Minority Ethnic (BME) groups. Four focus groups (Phase 1), co-design of resources (Phase 2), evaluation of the resources (Phase 3) and wide dissemination (Phase 4) were the main methods and processes used in the project, facilitating high levels of participant engagement, knowledge sharing and learning thereby promoting co-development.

A key motivation for using the PEECE outcomes-based model as the implementation strategy of the project is the participatory methodology with the study participants (sickle cell patients/carers). The PEECE model reflects key principles of healthcare management, public health (prevention), health promotion (education and empowerment), personalised care (contextual factors), co - production (multi-stakeholder engagement) and knowledge sharing.

Therefore, the PEECE model helped to facilitate the co-development of nutrition resources, personalised and tailored to the unique nutrition needs, risks and challenges of the sickle cell patient population. The model helped reinforce the concepts of prevention, education and empowerment, whilst also learning firsthand from the participant's perspectives, the multiple contextual factors influencing their nutritional needs.

The participatory co-design approach was successful in supporting the co- development of nutritional resources and information tailored to the needs of the sickle cell population, thereby addressing the knowledge, resources and information gaps and improving patient health and wellbeing outcomes.

Outcomes

The initial insights shared by the participants about the project being a vehicle through which their voices could be heard and their nutritional needs identified and recognised as a problem to be addressed, shed light on the project's value and importance.

These are reflected in the comments from sickle cell service user/carers (SU-C) and service providers (SP), from a recently published study[1] -

SU-C (6) – "nutrition for me I think plays a major part in staying well ...I've never directly been asked about my nutrition and how I eat...I've kind of looked up myself".

SU-C (6) – "I think it boils down to availability of the information".

SU-C (3)- "... nutrition has been a massive part of my mental health".

SP (1) – "I work in the community, it's not very well managed to be honest… nobody really knows what I know, it was just what I've kind of researched myself".

A total of eight leaflets and two infographics were developed as the main outputs of the study, targeting an audience that includes both patients, caregivers, providers, health planners and policy makers. Plans are in place to produce short and longer videos on the topic. The following participant perspectives: *this is groundbreaking stuff'*; *thank you, I didn't know about pica, I'm so glad I was part of this project'*; *I really found the information very helpful'*; *we need to share this nationally'*, illustrates the impact of the resources.

Moreover, the participant perspectives demonstrate the impact of the project to address the knowledge and information gaps affecting the health and wellbeing outcomes of the sickle cell patient population, whilst also informing a wider audience. Thus, this pioneering project has the potential to make a valuable contribution to improving the health and wellbeing outcomes of the sickle cell population in the UK and globally.

Key learning points

The project provided a few key learning points, the first being accounting for the time delays from confirmation of the project to conducting the focus groups, that has resulted in many participants not being available when the focus groups were eventually scheduled. Other learning points included having support with the project proposal costings, and importantly, having a clear vision for achieving the aims and objectives of the project.

Time and money were saved on recruitment, having the support of all 10 HCC Network managers, and having available a project information sheet with clear aims and objectives for the project and the time commitment. Holding online focus groups enhanced participant participation, which was facilitated by a student dietitian who made additional field notes.

Not being able to secure enough participants to attend the in-person co-design meeting was a challenge. To overcome this limitation, those who attended in person focused on designing the resources and a follow-up online meeting was scheduled with the remaining members to discuss what was designed and provide their input and suggestions for the designs to be taken forward.

Future project considerations include, having more representation from all patient cohorts especially the paediatric and pregnancy groups. All the resources are now available on a dedicated online platform – The Optimising Sickle Cell Nutrition Compendium (https://bit.ly/scnacomp) hosted by a non-profit organisation, Sickle Cell Nutrition Academy. These resources are the first of its kind and having a dedicated website will enhance the patients' access to these and future reliable evidenced based nutritional resources and information.

Dissemination of the resources include key strategic and statutory organisations, including the SCD and thalassaemia APPG, NHSE HCC's and the UK Forum for Heamoglobinopathy Disorders. A key lesson learnt is not being afraid to ask for help and having a clear vision and mission for change.

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Submitted as abstract and peer reviewed publication

Title of Abstract

The Impact of a High Intensity User Programme for Frequent Callers to the Northern Ireland Ambulance Service

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Citation for published abstract:

Hallowell C, Smylie J, McDonnell A, McNulty A, Dunlop K and Wolfe J. PP38 The impact of a high intensity user programme for frequent callers to the Northern Ireland ambulance service. *Emergency Medicine Journal* 2024;**41:**A17.

Link to published abstract:

PP38 The impact of a high intensity user programme for frequent callers to the Northern Ireland ambulance service | Emergency Medicine Journal

Background: The Northern Ireland Ambulance Service Health and Social Care Trust (NIAS HSCT) receives over 20,000 emergency calls per year from a cohort of service users who seek assistance on a frequent basis. The NIAS Complex Case Team (CCT) seeks to address the needs of Frequent Callers (FC) and the subsequent impact this cohort has on service provision (McDonnell et al. 2022). The FC National Network have defined a FC as 'Anyone over the age of 18 who calls for an emergency ambulance more than 5 times in one month' (FreCaNN, 2021). It has been reported that ignoring the challenge of inappropriate use of emergency services leads to inefficiencies, poor patient experience and clinically unsafe environments (Smith and McNally, 2014).

The CCT engages with FCs, establishes appropriate care pathways with statutory and voluntary organisations, utilising a multidisciplinary approach, with wide ranging benefits for patients and stakeholders. Since the CCT was formed in 2017, over 1800 people across Northern Ireland (NI) have met the national criteria. Service users who meet this threshold receive a visit from the CCT. A holistic assessment is undertaken and a profile of the individual and underlying reasons for their use of emergency and unscheduled care services is developed. With the person's written consent, referrals are then made to the most appropriate care services to meet their individual needs.

In 2022, funding was secured from NHS Charities Together for a 15-month project conducted in collaboration with the British Red Cross (BRC). NIAS worked closely with the BRC to provide bespoke, person centred, support for service users through a High Intensity User (HIU) programme called Interact. Using this person-centred approach, services can work together to ensure that the person's core needs are being addressed, at the same time, reducing the demand being placed on the emergency services and unscheduled care services (Smith and McNally, 2014).

Methods:

The Interact HIU programme was delivered by way of intensive support from a dedicated key worker, to assist with complex unmet health and social care needs known to be associated with FCs (Moseley et al, 2024). The BRC project team consisted of one manager and three keyworkers who engaged with 48 FC. Interventions included assistance with attending key appointments, helping the service user reconnect with community services and empowering individuals to take back control of their own health and social care through motivational interviewing techniques. This programme is a first of its kind in NI for this cohort of service users.

Results:

There was an overall reduction in emergency calls made by the cohort from 1242 calls to 557, a decrease of 55.2%. Ambulance resources dispatched decreased from 443 to 148 (66.6%). Fewer FC were transported to an Emergency Department (ED) with numbers falling from 208 to 81, a reduction of 61%. At the end of the project the Net Cost & Improvement Savings per annum (for 48 individuals) was estimated at £1.94 million.

Further to economic benefits to the health and social care trusts, patient reported experience measures (PREM) have shown a ubiquitous improvement to service user health and wellbeing. Whilst cost-effective, the importance of the financial savings pale in comparison to hearing quotes such as; “You have played a huge part in… helping me when I was at my lowest ebb” and “You have turned my life around” (NIAS HSCT Independent Evaluation, 2024). These improvements are a result of a patient focused, de-medicalised, de-criminalized approach, with interventions specifically identified to meet the service users health and social care needs.

Conclusion:

The BRC HIU programme took a person-centred approach to dealing with FC in NI, complimenting the ongoing work of the CCT. Through positive interaction with both service users and colleagues in partner agencies, an ethos of wraparound care was promoted. This patient-centric approach led to improvements in patient's overall health, well-being and life circumstances, with a subsequent reduction in contact with emergency services. There was a reduced demand on both NIAS and the wider system in a time when it is needed more than ever.

The model of care piloted in this process has the potential for immediate scale and spread throughout the NIAS operational area. Considerations are being explored to source a permanently commissioned workstream to ensure this HIU programme becomes business as usual.

Impact: Our work is -

- Sustained - through a reduction in demand, leading to a financial saving and keeping ambulances available in the community.
- Transferable - through positive outcomes across public sectors, not just within NIAS or healthcare.
- Scalable - through its growth from one pilot area into a regional service with positive outcomes in all geographic locations across Northern Ireland.

Funding - Funding for Interact pilot provided by NHS Charities Together

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Submitted as a peer reviewed publication

- Presented as an oral presentation at the NI AHP Research and Innovation Conference in Belfast on 11th September 2024.
- Presented at the NHS Charities Together Round Table and Project Showcase Event in Antrim on 13th September 2024.
- Presented as a moderated poster at the 999 EMS Research Forum Conference in Cambridge on 18th September 2024.
- Published in EMJ supplement:
  Hallowell C, Smylie J, McDonnell A*, et al*
  PP38 The impact of a high intensity user programme for frequent callers to the Northern Ireland ambulance service
  Emergency Medicine Journal 2024;**41:**A17.
  PP38 The impact of a high intensity user programme for frequent callers to the Northern Ireland ambulance service | Emergency Medicine Journal

AHPs 4 Public Health

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VISION, VOICE AND PRACTICE

Title: Improving Access to Music Therapy for Children and Young People - An Arts Therapies at Cambridgeshire and Peterborough Foundation Trust (CPFT) and Head to Toe Charity Initiative

Name and job title of Case Study Author : Aimee Yates & Valentini Toumpari; Music Therapists at Cambridgeshire and Peterborough NHS Foundation Trust.

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Description

The Youth Music Project was an initiative that aimed to address health inequalities by delivering music therapy across children's community mental health. Prior to this pilot project, music Therapy was limited to inpatient settings in Cambridgeshire and Peterborough, neglecting its potential for early intervention. Music Therapists within CPFT's Arts Therapies Service worked with CAMHS community teams to implement music therapy within CAMHS and assess the outcomes.

The project aims were to:

- Assess the impact of children and young people accessing music therapy in the community with both physical and mental health needs
- Pilot an effective delivery model to provide community-based music therapy to children and young people
- Improve communication and joint working with families and clinical community NHS teams
- Provide education on music therapy via continuous professional development (CPD) to relevant clinical teams

- Collaboratively set psychological goals to be met through music therapy
- Evaluate the project using a Patient Reported Experience Measure for children and young people and to collect feedback from families, carers and clinicians

Context

Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) is a health and social care organisation providing services in inpatient, community and primary care settings. The population served is just under 1 million across a diverse geography across Peterborough and Cambridgeshire. The Arts Therapies Service is one of the specialist services within CPFT, which includes music therapy, and provides input for tier 4 children and young person's inpatient settings within CPFT. Central funding for music therapy has not been able to stretch to cover music therapy for CAMHS and Paediatrics in addition to the inpatient settings. However there continues to be a need for music therapy across community settings. A pilot partnership was set up involving the Trust's Head to Toe Charity, Arts Therapies Service and CAMHS and Paediatrics services. This was supported by the charity Youth Music and using public funding from the National Lottery through Arts Council England. The Arts Therapies Professional Lead had oversight to ensure equitable access across services.

Literature and research have shown the effectiveness of music therapy for children and young people with a variety of mental, emotional and behavioural problems, improving self-esteem and communication and reducing anxiety and depression (Porter *et al.* 2017; Belski *et al.* 2022). Music therapy is a treatment for trauma that is understood to be experienced bodily at a preconscious, non-verbal level (Perry, 2014). Perry (2014) states that we need "*patterned, repetitive, rhythmic somatosensory activity,*" to treat developmental trauma and that music therapy can provide this. There is also a body of evidence, cited by Stegemann *et al.* (2019) for the effectiveness of music therapy in paediatric physical healthcare, including physical illness and disability, as well as neurological issues.

There is a lack of literature assessing the effectiveness of music therapy for children in community settings. However, the need for psychological intervention at an early stage has been cited (Worrall Davies *et al.* 2004; Vusio *et al.* 2020). In CPFT, music therapy was only accessible in inpatient units making access to early intervention and its potential benefits impossible. The Youth Music Project was established to address the health inequalities that existed due to children and young people being unable to access music therapy in a community setting.

Method

Funding for the project was provided by CPFT's official charity, Head to Toe, supported through Youth Music's Trailblazer Fund. The overall purpose of the project was to address the inequality of the availability of music therapy to children and young people within Cambridgeshire and Peterborough.

Three music therapists provided the equivalent of two days per week of time to support the delivery of music therapy across Cambridgeshire and Peterborough. Each music therapist was assigned NHS community teams across different geographical areas to ensure equitable access.

Each music therapist collaborated with their assigned NHS community team to

- Set up clear and ongoing communication channels
- Promote and educate on the benefits of music therapy
- Develop a leaflet and questionnaire to be given to patients and families
- Produce a clear referral process

Safeguarding was met by ensuring that children and young people had an established care co-ordinator in place who was in close liaison with the relevant music therapist.

Each child or young person was given a leaflet and questionnaire to establish collaborative therapeutic working from the outset. The questionnaire gave young people an idea of what music therapy could involve and asked if they would be interested in any specific medium. The therapist used this to inform their approach. This was intended to empower the child and reduce anxiety by offering an idea of what music therapy may involve. It was hoped that this would also increase engagement.

The music therapists contacted families or carers and collaboratively decided whether group or 1:1 therapy would be beneficial. Six weeks of music therapy was initially provided, subject to review. Goals were established between the therapist and the patient. Progress was monitored throughout by the therapist, patient, family/carers and the multi-disciplinary team.

Prior to and throughout the project, Music Therapists provided educational and experiential workshops to members of the clinical team with the aim of informing them about the potential benefits of music therapy, to help generate referrals, as well as supporting their own well-being. One team chose to use the workshop to write a song to welcome children to their service in many languages.

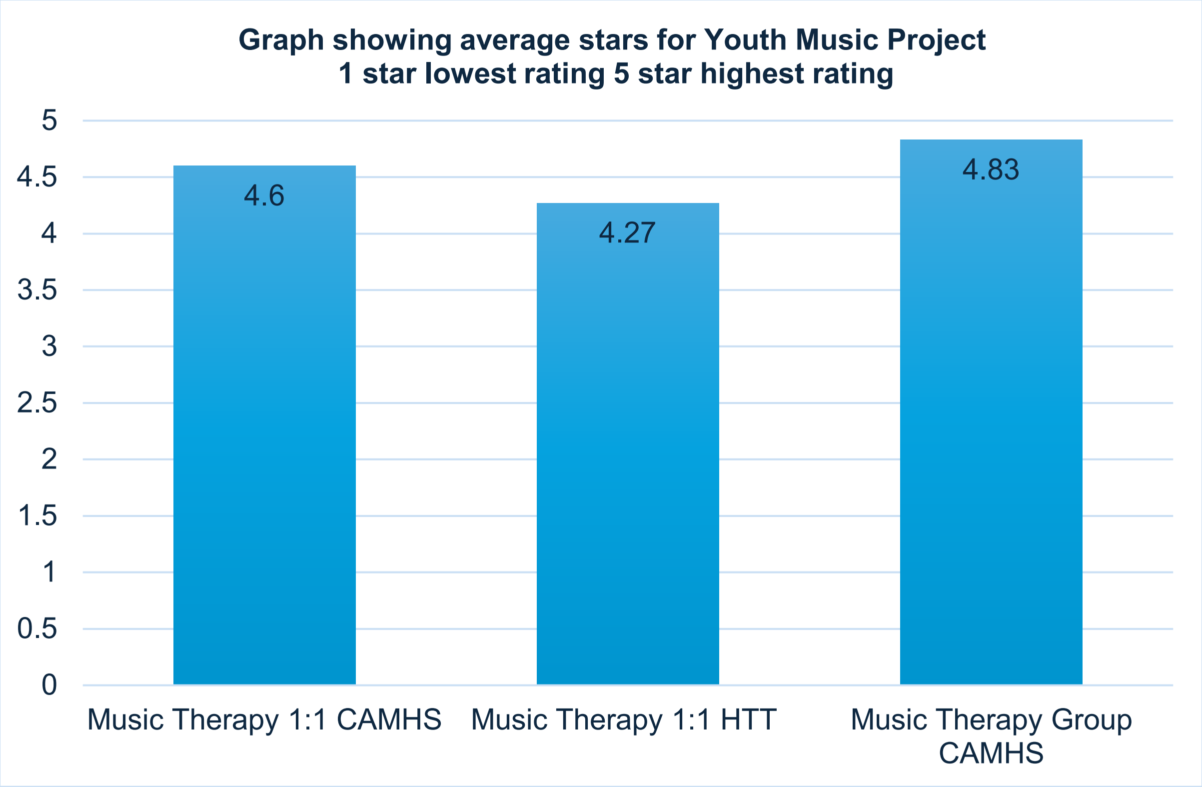
To assess impact, a Patient Reported Experience Measure (PREM) was used after each session. This was a card developed by CPFT Arts Therapists and used throughout the service. The team refer to the “star card”. The star card was filled out by children or their carers. The star card had a star rating from 0-5 and optional comments. This rating system had been found to be effective in the CPFT Arts Therapies service and accessible for children and young people. Some NHS community teams used Children’s Global Assessment Scale (CGAS) which was collected at baseline and end of treatment. Written and verbal feedback from carers and clinicians was collated, much of which came from discussion with key professionals, post session.

Data was collated to monitor reasons for referral, numbers of referrals and the ethnic and gender diversity of children and young people referred. Data, feedback, impact and adaptions needed were discussed at a monthly steering group.

Outcomes

263 1:1 therapy sessions, 13 group sessions and 12 CPD sessions were delivered and evaluated. Key findings were that there is a need for music therapy in community children’s services and that music therapy was particularly effective for children who could or did not engage in other forms of therapy.

The Patient Reported Experience Measure showed that 94.8% of children rated music therapy 5/5 stars. This graph shows the stars given for group and individual music therapy in Core CAMHS and CAMHS Home Treatment Team.



Feedback from young people, families and clinicians about the impact of music therapy sessions was overwhelmingly positive. Collating comments from children, they could be categorised as:

- Having fun
- Learning new music skills
- Learning strategies to support their mental health
- Feeling listened to
- Being able to express their emotions through music
- Completing a composition or song
-

Quotes from children, young people and carers

A child said, *"felt awful coming in, feel less awful leaving…playing music is the way I need help a lot."*

A carer said, *"Delighted at access to music therapy which increased confidence."*

Quotes from staff

"I see diverse mental health presentations and often there is locked trauma or blocked feelings. In music, children and young people can use sound and rhythm to express how they feel…This is the only CAMHS therapy the YP has engaged with, and they have been open to CAMHS for a significant period of time. Talking therapy and art therapy was offered, but erratic engagement".

Young Person Case Example
B was a non-verbal girl with complex neurodisability, gut dystonia and pain. She was referred to have music therapy by the community paediatrics team to use music as a means of communication, self-expression and interaction and soothing. Initially, the focus was assessing response to different musical stimuli and establishing a safe space. Repetition appeared to elicit a strong response to improvised music. Dynamics, tempo and melody played by the therapist, were based on B's vocalisations and movements. Initially, the therapist mirrored B's communication cues, but this progressed to the therapist initiating musical cues to assess response. The following song was used in each session, the words being adapted to B's physical and vocal cues. B would show expectation through facial and limb gestures before laughing at certain points of the song. As the sessions progressed, the therapist gained awareness of B's mood and level of stimulation, responding flexibly to calm or engage. In the therapeutic process, echoing vocalisations, while playing a calming melody and mirroring her breathing appeared to have a positive and soothing effect. This was seen with more relaxed body language, arm movements and facial expressions.

Community practitioners said:
"(*Music therapy) has been the single intervention that has been successful for this specific young person who struggled to make sense of themselves due to adverse experiences"*

"The sessions are truly person centred and have positively impacted not only on the young person but her mother, carers and our staff team. The safe space has given the young person a medium to communicate and express herself and enjoy being in the company of others. It has given her mother space to be a Mum and not a carer and enjoy time with her daughter"

Key learning points

Overall, it was found that children and families highly rated music therapy in community services, finding that it improved mood, anxiety, confidence and connection. Music Therapy also aided young people in transitioning effectively from inpatient to community care. Star cards were an effective way for children to communicate these thoughts. CGAS provided little information due to it not being used by all services and music therapists finding it difficult to complete because they were required to assess a larger area of functioning than they could observe.

It was found that, for some young people, this was the first time they had engaged with therapy, having refused other CAMHS support. Therefore, once they were engaged and music therapists were able to build relationships, young people often requested more than six sessions. The programme was adapted by offering twelve sessions to most young people which impacted on the number of individuals that could be seen. However, those children and young people accessing music therapy took part in an intensive therapeutic programme, allowing more time to build coping strategies and resulting in a stronger relationship with CAMHS' ongoing support.

It was clear that some services were more proactive with making referrals than others. Meetings were held with less active services to understand why this was the case. Often, staff shortages and pressures meant there was not time to make referrals. This disparity led to adaptations, ensuring that music therapist's time was utilised in other services so that young people were reached. Staff engagement sessions and drop-ins were also set up to raise awareness, build relationships and support their teams in understanding the benefits of music therapy. It seemed that having one or two identified 'champions' within the team who can promote the service at team meetings was an effective way of engaging particular services.

Assessment of data showed that most young people engaging in the programme were female, White British and between the ages of 12 – 15. This data, alongside service data, is being reviewed to plan how to reach a wider group of young people from different backgrounds. This may involve promoting the service in particular geographical areas and raising awareness with staff members around ensuring referrals are accessible and reach more isolated groups.

This project has resulted in many benefits for our organisation and community, some in addition to the project's original aims. We have seen an increased awareness and understanding of the power of music therapy. More teams are coming to us with referrals, and this project has directly led to the development of two new projects to support Children in Care and children and young people on CAMHS waiting lists. It has been shown that this project has equipped patients with skills and strategies that will stay with them for life, and we hope that with continued funding we'll be able to reach more of our community.

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Acknowledgements: Sreeraj Kollurakandy& Emily Corke; Music Therapists. Kimberley Iyemere; CPFT Arts Therapies Professional Lead and Manager. Alex Gordon; Head to Toe. Caroline Stackhouse; CPFT Deputy Director of AHPs.