Allied Health Professional case studies: Children and young people

Index:

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

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The hybrid dramatherapeutic use of paper airplanes during the time of COVID-19 with a group 5 young people aged 11 to 12

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Help Kids Talk – a community-wide initiative that aims to give every child the best start in life by prioritising speech, language and communication development

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Description

Help Kids Talk is a project within Early Intervention Lisburn (EIL) which is led by the Resurgam Community Development Trust (lead partners are the South Eastern Health and Social Care Trust (SEHSCT) Speech and Language Therapy Team and Early Intervention Lisburn).

The Help Kids Talk vision is that "everyone will work together to help kids talk".

The project is a community-wide initiative and aims to ensure everyone who has any responsibility for a child prioritises speech, language and communication development whether you are a parent, grandparent, childminder or work in an organisation that provides services for children.

By prioritising early intervention and speech, language and communication, there will be a positive impact across all areas of a child's life including: educational attainment, mental health and wellbeing, social relationships and employability later in life.

Context

Help Kids Talk aims to give every child the best chance in life by prioritising speech, language and communication development.

The purpose of Help Kids Talk is to:

- help children and young people to be the best they can be
- make it everyone's responsibility
- make a difference together

Main priorities are:

- Highlighting options of support
- Working together

- Learning for all
- Improving the quality of services

Help Kids Talk was co-designed following the extensive research report 'the Best for Every Child' (Courtney, 2012) which highlighted the issues children and young people faced growing up in Lisburn. At that time, 74% of young people were leaving the post primary sector (excluding Wallace and Friends) without 5+ GCSEs (including English and Maths). In 2013, a prevalence study carried out by the SEHSCT Speech and Language Therapy team indicated that 32% of children entering primary one in 9 schools in Lisburn had a mild to severe speech, language, and communication problem, of which, 74% were boys from disadvantaged areas (Jordan & Coulter, 2016).

Method

There are 4 main strands to Help Kids Talk:

1. 12 key messages were developed to support speech, language and communication. The 'message of the month' is circulated via email and social media as guidance to parents, caregivers and those working with children.

2. Basic Awareness Training was developed and is delivered on a monthly basis online. This aims to raise awareness of the importance of speech, language and communication for everyone who has any responsibility for a child. In the Basic Awareness, the 12 key messages are linked with Kate Cairns Associates five to thrive building blocks to highlight the connection between infant mental health, brain development and communication development. Further training is in the process of being co-designed and co-produced.

3. The ICAN (Speech and Language UK) programme, 'Early Talk Boost' is available in 11 playgroups and nurseries in Lisburn. It improves children's attention and listening and their understanding of words and sentences. It also improves speaking and communication.

4. The ICAN programme, 'Talk Boost' is available in 14 primary schools in Lisburn. It can boost children's ability in conversations, sentences, storytelling and social interaction by an average of 9 - 18 months.

Help Kids Talk is a partnership led jointly by the SEHSCT Speech and Language Therapy team and Early Intervention Lisburn. It is based on the successful 'Stoke Speaks Out' model of delivery which was set up in Stoke-on-Trent to help the high number of children with speech difficulties, by training parents, carers and families. After a seven year journey, the project was officially launched in March 2020. It is currently funded by Lisburn and Castlereagh City Council.

The steering group is comprised of representatives from community, voluntary, statutory and private sectors including: Public Health Agency, SEHSCT, Northern Ireland Childminding Association, Libraries Northern Ireland, Barnardo's, Sure Start and staff from the local schools and nurseries.

There are connections with parents and carers through 37 partners (early years' settings, playgroups, nurseries, and primary schools), social media, training, and a parent representative group.

Throughout the planning, implementation and development of Help Kids Talk, there has been a strong emphasis on co-design and co-production. The steering group and the parent representative group members have provided valuable insight and experience to inform the decision-making

process. This co-production has strengthened the project and ensures we are achieving our overall vision of everyone working together to provide better outcomes for our children and young people.

The project collates data on:

- social media engagement and growth – this is collated on a monthly basis through Twitter, Instagram and Facebook analytics so we can measure what posts are relevant for our audience and measure the reach of the project through social media platforms
- number of people attending Basic Awareness training and the difference it has made – this is collated using a registration form, a training database and an online survey
- number of children and number of settings who have completed targeted programmes (Early Talk Boost and Talk Boost) and the difference it has made – this is collated through an ICAN and Help Kids Talk report at the end of every academic year

Measuring outcomes at population level for early intervention is difficult however there is a commitment from partners across all sectors to provide sustainable support to ensure our children and young people have the best chance in life.

Outcomes

Social media

Help Kids Talk has over 3000 followers across Twitter, Instagram and Facebook (**79% increase** since August 2020)

Social media feedback:

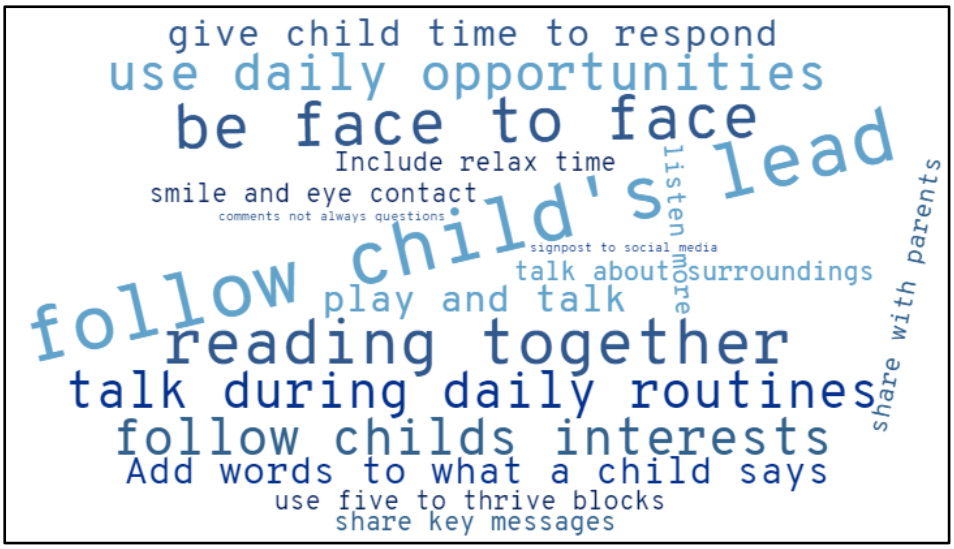
- *"I love reading all the insta posts as at 16mths my son was literally saying nothing so I felt myself reading all your posts about speech and development and was able to relate to a lot of them…he is now stringing sentences together*!"

Basic Awareness Training

725 individuals have attended Basic Awareness training since January 2020. Before training, **48%** participants rated themselves as mostly confident/confident supporting speech, language, and communication, this figure rose to **80%** after training.

Feedback following Basic Awareness training:

- *"I cannot thank you enough for creating that course last night. You were so engaging and everything I learned I have been implementing already at home and in playgroup"*
- *"I can now show these slides to hubby to show him I haven't completely lost it when I sing about her nappy as we change it"*
- *"This presentation highlights the importance of constant chat with wee ones and encourages everyone to develop talking skills"*

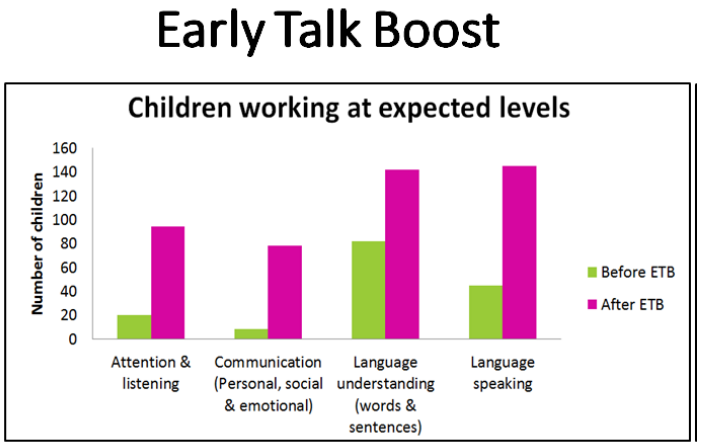


Word cloud showing strategies participants will use to support speech, language and communication skills following Basic Awareness.

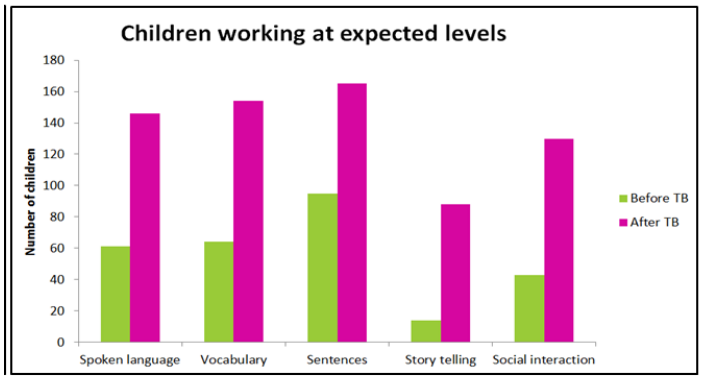
Targeted programmes

Just under **400 children** have received targeted support to support their speech, language, and communication. The graphs* below show the impact this has made for those children (*based on 203 children who have completed Early Talkboost and 179 children who have completed Talkboost from September 2016 to July 2021; this includes some pilot work pre-launch).

Help Kids Talk partners are supported to embed speech, language and communication support into their core work. In doing this, we create sustainable support for children's communication development. The link between infant mental health and speech, language and communication is a priority within the project. Creating better opportunities for bonding, attachment and communication leads to long term positive impacts for children's mental health and wellbeing.



Talk Boost



Investment in the provision of training and resources to our partners ensures children receive intervention as early as possible and reduces potential future education or healthcare costs. For example, a child in one of our local nurseries was identified as a candidate for special educational needs (SEN) provision. His speech, language and communication skills were supported by nursery staff, he completed Early Talk Boost and was given a place in a mainstream primary school. In primary school, he continued to receive support for his speech, language and communication and completed Talkboost. As a result, the child has remained within mainstream education and has not required a place within SEN provision.

Key learning points

Help Kids Talk developed a bottom-up approach by bringing together partners from across community, voluntary, statutory and private sectors to collectively plan and make shared decisions to improve outcomes for children and young people.

This partnership-working has moved organisations from working in silos to working together and will provide long-lasting benefits to those living within our local communities.

Sustainability has been a driving force right from the beginning of the project and all training and support provided is looked at through the implementation within core provision.

Further aims have been identified, eg the development of a project like Help Kids Talk to help and support all children in need including ethnic minorities and children with a disability such as autism, learning difficulties.

References and useful links

Courtney, R. (2012) *The Best For Every Child Report*

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https://ican.org.uk/training-licensing/i-can-programmes/early-talk-boost/

https://ican.org.uk/shop/talk-boost-ks1-intervention-pack/

http://www.facebook.com/helpkidstalk/

http://twitter.com/HelpKidsTalkNI

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 Changing 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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2. Royal College of Speech and Language Therapists RCSLT (2021). Measuring outcomes outside individualised care. Available at:

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Dietitian-led intensive lifestyle intervention programme for children identified as overweight or obese by NCMP in the London Borough of Brent: an overview

Background

Brent is one of the most deprived boroughs in London and has one of the highest rates of childhood obesity across all London Boroughs and in England[1,2]. Nutrition & Dietetics Brent (London North West University Healthcare NHS Trust) successfully bid for and delivered the **'Fit4Health' lifestyle intervention programme** from September 2015 to March 2016.

'Fit4Health' was designed to offer support to children identified as overweight and obese by the National Child Measurement Programme (NCMP)[3]. Provided by Dietitians and Nutrition Assistants, the programme encouraged positive lifestyle changes for the whole family through good nutrition and physical activity. A sub-contracted private company provided certified physical activity instructors for each session[4].

'Fit4Health' had these objectives:

Short Term:

- 300 overweight / obese reception and year 6 children to complete the programme
- Overweight/ obese children unable to attend but still interested given telephone advice on a healthy lifestyle and ways to implement daily activities.

Medium Term after 10 weeks:

- Improved nutrition and physical activity outcomes at 3 & 6 month follow ups
- Increased knowledge of behaviour change and goal setting
- Maintenance or reduction in waist circumference and BMI post programme and 3 & 6 month follow ups.
- 80% positive feedback from participants

Long Term if programme continued:

- Those children completing the programme who were identified as overweight or obese in reception will measure a healthy weight in year 6
- Increased engagement in publicly available nutrition and physical activity programmes

- Overall decrease in number of overweight and obese children in targeted schools

Practice development

Fit4Health' delivered structured group education sessions: a 7 week intensive after school programme for child and one family member based on:

- Behaviour change through goal setting and rewards
- Nutrition workshops & interactive cooking classes
- Fun and active exercise

The nutrition component was led by a registered Dietitian with a syllabus covering topics such as fats and sugars, label reading, fussy eating and managing mealtimes, Eat Well plate, portion sizes and healthy snacks. The practical component saw the preparation of healthy foods including yogurt sundaes, fruit kebabs and rainbow wraps which culminated in the children making a healthy snack at home to bring for a group healthy picnic.

The physical activity component was led by an independent organisation specialising in children's sports activities. Each session consisted of one hour of physical activity that the children could take part in together. The games required minimal equipment so that families could replicate them at home or in the park. Families were also taught the recommendations for physical activity and the risks of sedentary behaviour.

This **whole family approach** supports the adoption of healthy lifestyle behaviours and sustainability of the intervention[5]. With guidance from 'Fit4Health' staff at individual consultations, families were asked to create SMART goals the entire family would aim to complete by the end of the programme. These goals were reviewed in the final consultation to assess progress and offer any further support.

Schools identified by NCMP data[3] with the highest levels of obese children were given priority to participate. The programme was adjusted to include a Special Needs Primary School for the first time. 'Fit4Health' dietitians worked closely with school staff to ensure that appropriate adjustments were made.

Measuring impact

Overall, the 7-month programme reached 303 children and 338 parents, carers and family members.

There was a 66% attendance rate and the majority of children came from minority ethnic backgrounds and deprived areas. 'Fit4Health' worked with 13 mainstream primary schools, 1 special needs school and 2 community leisure centres.

Key outcomes of the 10 week programme:

- 78% maintained or reduced their waist circumference post programme indicating a reduction in adiposity, specifically in the central region.
- 63% maintained or reduced their BMI at the end of the programme. While lower than the desired 80% it is still a good result over a 10 week time period. As the participants are young children it would be expected for them to be growing in height and weight.
- 87% reported to have increased or maintained their intake of fruit since starting the programme

- 86% reported to have increased or maintained their intake of vegetables since starting the programme
- 85% reported to have increased or maintained their intake of water since starting the programme

All qualitative data was collected using validated questionnaires pre and post. These showed that 88% of families achieved at least one of their long-term SMART goals and 96% of participants would recommend the programme to a friend.

Participant comments included:

"The programme has really helped my child try new foods. Before I was cooking a meal for us and a separate meal for my son but now I only have to cook the one meal because he is more willing to be adventurous with his food."

"The programme is really starting to make a difference. We have taken the messages on board as a whole family. I didn't expect it to have such a big impact. We make sure we do our goals each week."

Learning points

The clinical outcomes and participant feedback indicated that 'Fit4Health' programme methodologies can have a beneficial and lasting impact upon families to prevent childhood obesity. However there is an urgent need to continue involvement with families on a long term basis in order to have a sustainable influence on the health and weight throughout the growing years and into adult hood. This approach is only possible with longer term investment in the commissioning process for whole systems care pathway for obesity.

If 'Fit4Health' were to be commissioned in the future the following recommendations should be considered:

- Incorporate the use of gym equipment and sports (eg. volleyball) into the physical activity component of the sessions for year 7 children. Feedback from both parents and children indicated the decline in attendance that took place with the year 7 children was due to the Activity Instructor-led games being played repeatedly were not suited to the older age group. The use of the gym equipment would allow the year 7 children to feel more like young adults rather than young children and would be likely to promote continued attendance.
- Physical Activity Instructors to give renewed focus to addressing the benefits of physical activity to parents and ways to incorporate physical activity into their day to day lifestyles.
- Special Need Schools should be included as part of the mainstream programme to ensure children with special educational needs are not excluded and therefore encourage health equality.
- Comments from teachers indicated a number of overweight and obese children not identified by the NCMP hence not invited to take part in the programme. In future, would encourage other children not identified to take part in the programme to ensure all children and families are being reached. Teaching staff and health professionals are in an excellent position to assist with this.
- Use a total wellbeing approach to the programme rather than the whole emphasis of the programme being on overweight and obese children.

- Consider conducting the one to one consultations as a group consultation- this will allow parents to share concerns and possible strategies when dealing with the overall health of their children. It may also allow parents to feel as if they are not alone in their concerns and struggles around their child's diet and physical activity lifestyles.
- Efforts need to be focused on the Early Years settings and Year 1 children (primary prevention) in order to prevent childhood obesity in the first instance. Therefore, a combined approach is required in order to have an effective influence on reducing childhood obesity - targeting families in the early stages and secondary prevention measures to target those older children who have been identified as overweight or obese.
- A long term, well designed and streamlined approach to childhood obesity across all the life span stages is in need if we are serious about preventing or reducing the levels of the UK's childhood obesity with parental involvement and responsibility of paramount importance.

References

1 Annual Report 2014/15, Brent Clinical Commissioning Group. pp. 5

2 Brent Joint Strategic Needs Assessment (JSNA) Overview Report: 2015/16. pp.28

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An Impact Evaluation Report on the 'Healthy Little Eaters' nutrition education cooking programme in Children's Centres in Brent

Context

The London Borough of Brent is one of the most deprived boroughs in London and has one of the highest rates of childhood obesity in England. Obesity unjustly affects children in more deprived area, who are more than twice as likely to be obese. Once established, obesity is notoriously difficult to treat, so **prevention and early intervention** are paramount. Tackling childhood obesity continues to be a priority for Brent Council and Brent CCG.

In Brent, 27% reception and 40% year 6 children are overweight or obese compared with 22% reception and 35% year 6 in England.

Early Years settings play a critical role by establishing a safe and supportive environment that promotes healthy behaviors (including healthy eating). Nutrition & Dietetics Brent (London North West University Healthcare NHS Trust) successfully bid for funding over a period of 8 years (2008 – 2016) to provide '**Healthy Little Eaters'**: a nutrition education and cooking programme for children from 1-5 years & parents in Children Centres.

It aimed to improve nutritional health and wellbeing of children under five and their families. Each session focused on a different nutrition topic, cooking with children and parents (familiarising them with real foods) and - of course - eating!

Participant recruitment was carried out by Centre staff, with promotional material provided by our team.

Practice development

'Healthy Little Eaters' was set up in Children's Centres across Brent and aimed to improve health and wellbeing of children under 5 and their families and ultimately reduce the rates of obesity in Brent. It was delivered over 8 weeks, each session focusing on a different nutrition and eating topic including: reducing sugar and salt, foods for bone health, label reading, importance of fruit and vegetables, preventing iron deficiency, fussy eating and weaning.

The programme team included Dietitians and Nutrition Assistants, working closely with Centre staff to deliver the agreed syllabus.

Each 2-hour session included a nutrition topic, learning through facilitated discussion, preparing from a healthy recipe and eating the food together afterwards. The recipes were cooked with the children, encouraging participation and were low budget, healthy, quick and easy. The classes were

free of charge and open to families that visited each centre. Working in partnership, Brent's Oral Health Promotion Team attended a session to promote good oral health.

Programme objectives agreed with Brent Council were to increase:

- understanding of the Eat Well Guide
- portions of fruit and vegetables
- knowledge of healthy eating and physical activity for children
- understanding on ways to eat healthily on a budget
- understanding of food labelling, selecting healthier options, the benefits of cooking from scratch, food hygiene and safe preparation of food

Each 'Healthy Little Eaters' programme could accommodate up to 15 families per cohort. Although the standard syllabus was created and continuously reviewed by the team, there was room to individualize some aspects depending on the needs of centres (eg some did not have facilities to cook food and so cold recipes used instead).

Since the commencement of the 'Healthy Little Eaters' programme in 2008 the team have delivered more than 500 programmes across 15 Children's Centres in Brent, reaching approximately 1000 families.

Measuring impact

An evaluation questionnaire was undertaken during the final week. Across all centres the 'Healthy Little Eaters' intervention resulted in positive changes:

- 65% reported an increase in pieces of fruit consumed per day (0.9 pieces of fruit a day)
- 75% reported an increase in serves of vegetable consumed per day

(0.75 serves of veg/day)

- 67% reported a decrease in days families add salt to meals per week (1.46 decrease in days not adding salt)
- 47% reported a decrease in days a child refuses food or meals per week (0.61 decrease in days a child refuses)
- 63% reported an increase in the frequency the child is included in a food preparation in a typical week (increase by 1.38 days per week)
- 87% reported an increase in confidence when reading food labels

As a result, family mealtimes became more relaxed and happy. Parents reported to be more trusting of children with regard to their eating and felt confident in giving smaller portion sizes:

"I've learnt not to stress when he doesn't finish a meal. Before I used to think 'oh he hasn't eaten' I will give him more milk and then he wouldn't eat properly afterwards, so I have learnt not to force them."- Mother, Alperton Children's Centre

The cooking part of the programme demonstrated ways to include children in the preparation and thereby increasing exposure to children and ultimately increased food acceptance. The programme

was seen as an opportunity to turn cooking into a positive family experience through increased skills and confidence, a broadened cooking repertoire and less reliance on takeaways.

"You get out of the habit of buying ready made things – you can make from fresh. For instance if I was going to give them dahl I would have got it readymade from the fridge section". Mother, Hope Children's Centre

Learning Points

Overall, the results reflect the positive impact of 'Healthy Little Eaters' to equip participants with the knowledge, skills and confidence to cook; also to change cooking, eating and purchasing behaviours towards a healthier diet.

Learning / Considerations:

- 60% of families finished the full programme at week 8. This varied between centres – possibly due to advertising methods, presence or absence of weekly reminders and commitment of parents.
- Certificates at the end of the session were given with a sticker of their choice. However, no other incentives were used to promote completion of these cohorts. Incentives had been used in previous cohorts and shown to work well (eg children's cooking aprons featuring our 'Healthy Little Eaters' logo). Wykeham Children's Centre uses a £5 refundable deposit scheme and has shown to have good retention rates.
- Recruitment via word of mouth from staff and other parents appears to be the most successful method. If time permits it would be useful for the dietitian to visit centres and promote the session to staff and encourage recruitment. If no more than 5 parents are signed up the programme should be postponed.
- There is a need for simplified evaluation forms especially for those who do not have English as a first language.
- To overcome this barrier a focus group was conducted to capture more in depth data and enable those with a low level of English be able to express themselves without the need for literacy skills.
- Whilst we would continue to provide evaluation forms pre and post intervention to ensure equity we would consider conducting focus group or interviews / recording quotes to gather data from parents with low literacy and/or to explore outcomes.
- In the evaluation, parents reported a preference for 11-1pm sessions and our past experience is that poor attendance rates occurred when sessions started in the afternoon (perhaps to avoid school-run times in future).
- At the end of each session the dietitian or crèche worker led on a rhyming session. This was a great opportunity for families to bond and provided a sound closure to a session and is something we would continue to develop in future.
- Sessions held at Centres without hot cooking facilitates were limited and overall the retention rates weren't as high as others with hot cooking facilities. Parents reported to have enjoyed the food preparation and requested more recipes.

The early establishment of healthy nutrition practices should be seen as an integral component to any local and national strategies to prevent and manage childhood obesity. It is evident that 'Healthy Little Eaters' sessions had a positive impact on family's health behaviours and therefore the programme needs to become part of a key core component of the Children's Centre yearly programme. Commissioners should consider the constant roll out of these sessions at Children Centres in Brent to continue momentum, reduce staff turnover, maintain relations and to gain more traction from all stakeholders. 'Healthy Little Eaters' was a clinically effective programme and can be scaled up.

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.

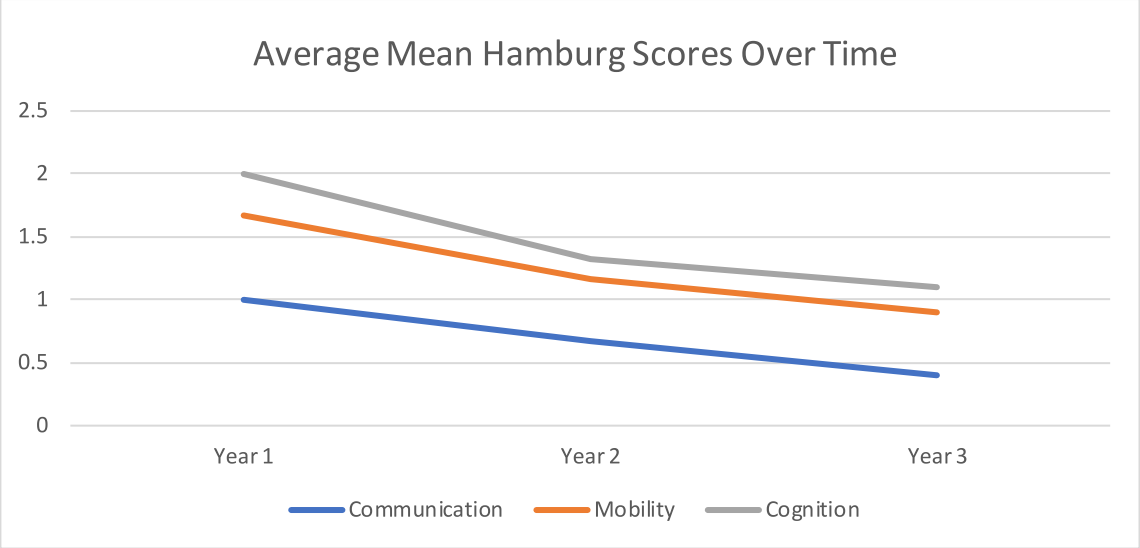

Figure 1: Average Hamburg Scale mean scores for communication, cognition and mobility across 3 years.

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.

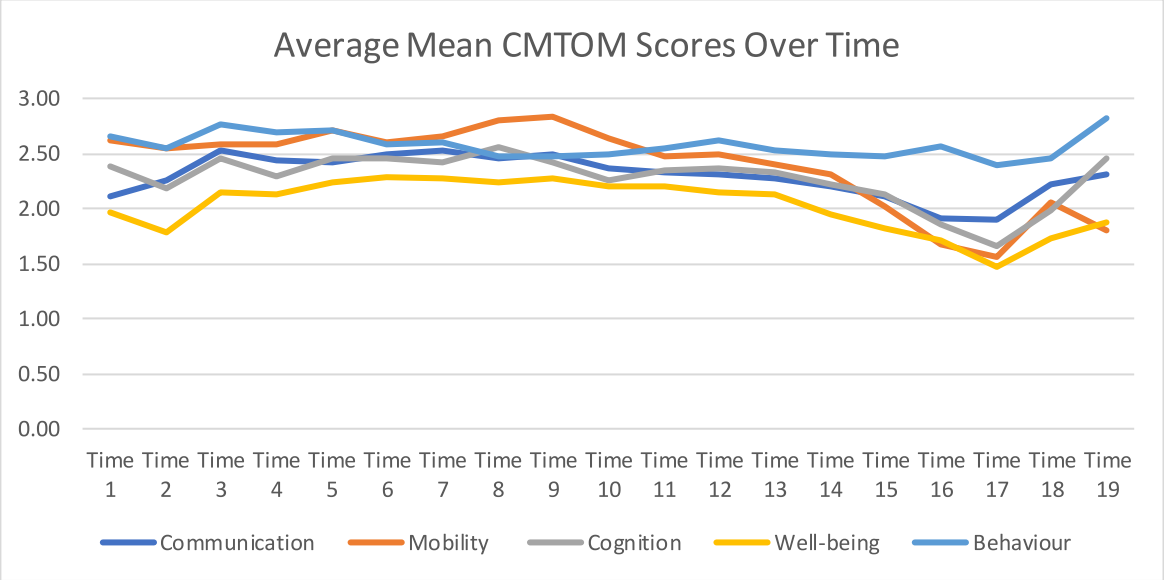

Figure 2: Average CMTOM mean scores in communication, behaviour, emotional wellbeing, cognition and mobility across 3 years.

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		Is resourceful, decisive and can work autonomously / independently	
Trigger observed to changed behaviour?		Demonstrates appropriate levels of assertiveness	
Any verbal aggression noted			
Any physical aggression		**6. Cognition**	
Behavioural response to musical components noted?		Follows verbal instructions	
Ability to express / control self in an appropriate way		Makes choices	
Expression of feelings of distress, agitation, anxiety		Ability to attend to task	
Expression of feelings of depression, trauma, loss, bereavement		Recognition or carry over of previous material	
		Engages appropriately with instruments	
3. Physical Presentation		Any memory recall noted? (rhythmic recall etc.)	
Active movement noted?		Sustains attention	
Core/trunk stability noted?		Shows interest and is inquisitive	
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?			

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

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.

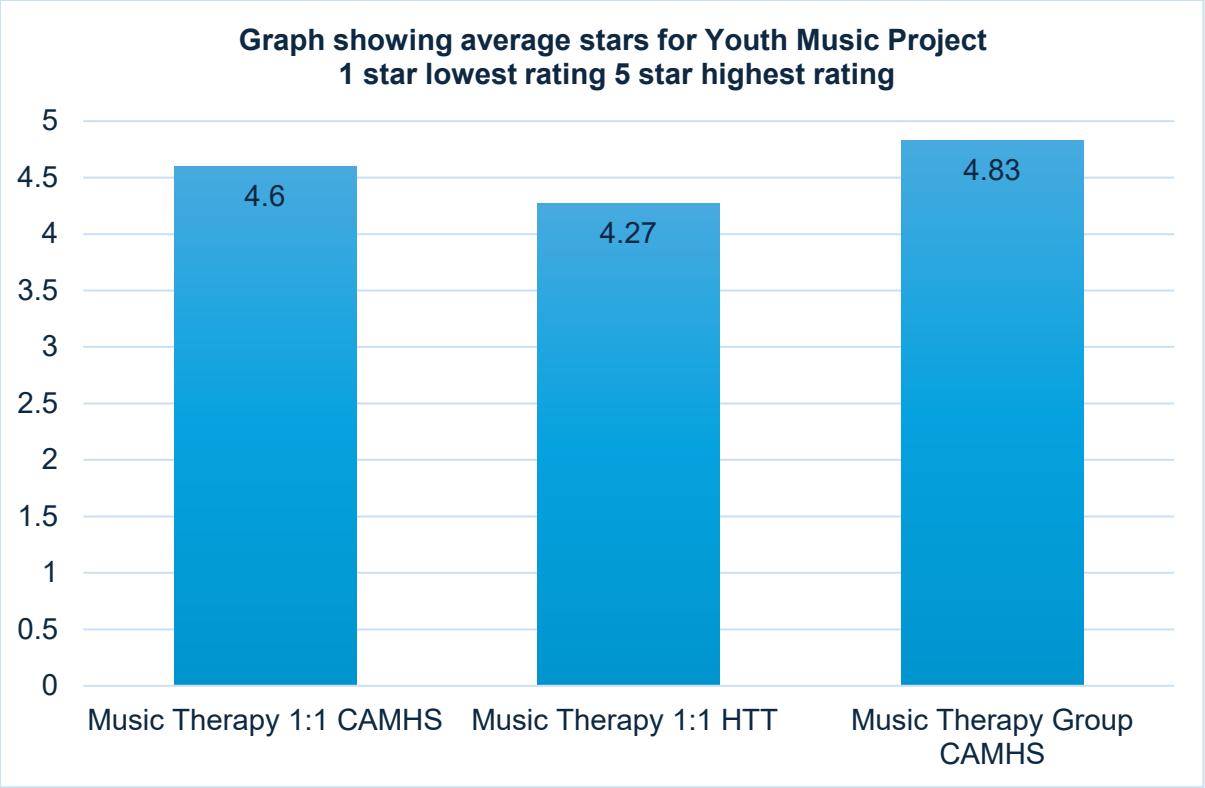
To assess impact, a Patient Reported Experience Measure (PREM) was used after each session. This was a card developed by CPFT Arts Therapists and used throughout the service. The team refer to the "star card". The star card was filled out by children or their carers. The star card had a star rating from 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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Title: The hybrid dramatherapeutic use of paper airplanes during the time of COVID-19 with a group 5 young people aged 11 to 12

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Description

This case study explores the use of paper airplanes used in a dramatherapy group delivered to five young people (aged 11-12) attending a UK secondary school.

The group of children were put together for dramatherapy in the autumn of 2020 when the schools were returning to in-person teaching following the first lockdown. Due to individual circumstances, some children were still unable to attend school in person and so the sessions were held in a hybrid fashion (i.e. both online and face to face).

As the dramatherapy sessions had to incorporate the children who were in the room as well as those who were on screen, it was important to find ways to cooperate and share with each other in a safe and therapeutic way.

Many different activities and ideas were suggested by the group members. The first one was making and playing with paper airplanes as this was something that was accessible for all. Making and flying paper airplanes provided a creative outlet, which everyone could do, whilst also creating a talking point. In particular, the activity provided humour and allowed the group to bond and build relationships with each other. (Malik, 2021)

Context

The overall aim of the dramatherapy group was to help a group of Year 7 children (aged 11 and 12 years) to develop peer relationships as they returned to full time education. It is important to note that the children had not had the 'usual' transition to secondary school due to the first COVID-19 lockdown of 2020.

As we know COVID-19 and the subsequent closures of schools had an impact on children's mental health. (Kauhanen, et al., 2022) The school identified children who were at risk of poor wellbeing and would find the transition to secondary school more challenging. The children were selected by the pastoral team at the school based on information from their primary schools. Some had family members who were vulnerable to COVID-19 and others had English as their second language. They wanted the children to begin to build relationships with their peers through the therapeutic process.

The school was a respected state-run school of approximately 900 children. Their enrolment criteria meant that children attended from various parts of the county. Most children who started at the school in year 7 did not attend the same primary school as others in their year group and so building healthy relationships for the students was an important task of the first term.

The group was made up of 5 children, 2 of whom were boys and 3 of whom were girls. A total of 12 dramatherapy sessions were offered to the group. The children had a range of social and economic background demographics. The school's pastoral team had ascertained that these children were more marginalized based on information from their primary schools. One child did not want to attend school because of the risk of passing COVID-19 to her vulnerable mother. Another had parents who were front-line workers and thus, were unable to bring their child regularly into school as the school transportation system wasn't functioning properly. It was for these reasons that the group was required to be hybrid.

Before the group got underway, each child had been assessed individually, with support of the school's pastoral team, to ascertain if they would benefit from a 12 week dramatherapy group. Through discussion with myself and the team around the children we agreed that the objectives of the intervention were -

- social interaction and bonding with peers.
- have a creative outlet for emotional expression
- explore anxiety and stress related to the COVID 19 pandemic

As the children had not met before, they did not know anything about the other group members. Having activities each person could be involved in was of paramount importance, as was being able to do the activities online. In this assessment, it was agreed that each child would have access to paper and pen if they were online and that this would be provided for those who were at school. As such, making paper airplanes as a suggestion during the first dramatherapy session and were deemed an accessible activity for all.

Method

The first session was attended by all children with 3 children being in the room and 2 online. We began with brief introductions of each person, including myself as the therapist. The idea of making a paper airplane was introduced straight away by myself. The group discussed their experiences of making and throwing paper airplanes. I showed the group in the room and those online the basic way to fold a paper airplane. Everyone had a go and showed us how far their plane travelled. This led to a discussion on different ways to fold the paper to improve the distance travelled.

One boy, who was attending the group online, demonstrated to us a different method to fold the paper. We all tried to follow his instructions, and this encouraged clear communication, which could have been difficult due to the hybrid nature of the group. It also led to miscommunication, where some of the planes did not look the same as the one the boy online had created. This made the group laugh and they shared their positive and negative experiences of origami.

The group were beginning to bond and laugh with each other. Developing the session, I suggested we start adding art work or words to the planes they had made. I asked the children to think about parts of their life before the lockdown they would like to keep and what they would like to leave behind and to represent this on their planes. At the end of the session each child agreed to share their plane and artwork with the rest of the group.

Outcomes

At the end of the session, I asked the group what they would like to do with their paper planes. All of the children decided to keep them. One particular boy, who attended the group online, consistently displayed his paper airplane on his shelf behind his desk and it was always on display every time he attended one of our sessions; thinking therapeutically, this may indicate that he valued the sessions. One girl, who had been present in the room during this first session, had managed to throw her plane out through the crack of the external door and it floated into the car park. This became a joke within the group that if there was something that had come to an end, they would suggest that we 'just throw it out of the door'. This became an 'in-joke', and a metaphor within the group. This built common connections and group language, giving the clients a way of bonding (El Bitar, 2022). This creative expression helped to support the groups bonding.

Another child had decided to give their paper airplane a name and it became personified by the client. Personification of an object is considered an important part of dramatherapy. (Jones, 2007). During each subsequent session someone in the group would ask how the plane was doing. We subconsciously created an imaginary member of the group. The child would tell us a story about something that had happened during the week that the paper plane had witnessed. This brought great humour and helped the group to bond with someone who was not always able to attend the group in person. Humour in dramatherapy can help the building blocks of a therapeutic relationship (Vávra et al, 2020). This was the case with the dramatherapy group. The imaginary member of the group, the 'in joke' comments, and the airplane character added more substance to the therapeutic relationship. The metaphor and symbolism of them helped the bond the group, create a community language and develop valuable healing during a challenging time. (Mann, 1996).

Key learning points

The lockdown relating to the COVID-19 outbreak has given dramatherapists a new way of working. (Christiana, 2024) . This case study is an example of how hybrid dramatherapy work can be effective. Working with a group of children to build relationships with each other during a vulnerable time and being able to make them feel included when they were both online and face to face is not an easy task. However, using simple creative activities such as paper airplanes can develop initial bonds which, ultimately, bolster the beginning of a relationship.

Through this activity, the group developed their own shared language, relating to their paper airplanes following this session. This included personifying an airplane, and using the experience of throwing one to describe other events which emerged throughout the therapy. Through these shared experiences the group members were able to make each other laugh and communicate with each other in a way that only they understood.

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The school year post lockdown for these young people was made less stressful due to the intervention of this dramatherapy group. They were able to make new friends in their new school even when not meeting face to face.

The client demeanour changed from appearing to be anxious and nervous about this new way of working to engaged and actively participating in activities in both the therapy session and at school. The pastoral team at the school, who referred the children to the group, noticed a marked improvement and enthusiasm for coming into school even during the continuously stressful time of lockdowns and COVID outbreaks.

This case example relates to the practice of dramatherapy and hybrid working. It demonstrates that, embedding creativity into clinical practice, no matter how simple the activity, can be an effective means for relationship building and for, ultimately, reaching therapeutic and clinical goals.

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