Allied Health Professional case studies: Mental health and wellbeing

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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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Implementing a public-health style questionnaire into the Orthoptic case history: A prospective case report

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Description

Case history taking is the first line of contact we have with our patients and sets the scene for open conversation. As Orthoptists, we often focus on specific medical-related questions which enable differential diagnosis and management. However, to Make Every Contact Count (MECC) we should be giving patients the opportunity to raise wider health concerns (physical, mental or social) so we can signpost to support services. Due to the COVID-19 pandemic, face to face contact has been kept to a minimum with patients often feeling rushed or confused without opportunity to have a conversation with healthcare professionals. A recent study showed 80% of patients reported a decline in their mental, social and physical health throughout the pandemic.[1] It therefore raises the question of the best method to gather enough information to ensure MECC can be utilised for all patients within their allocated appointment time in the outpatient environment. In this case study, a pre-consultation public health questionnaire designed to focus on wider patient well-being is proposed. This case study is a prospective review and a follow-up report will be published with recorded outcomes of the service evaluation.

Introduction and Context

A conventional case history typically takes the form of a 5–10 minute conversation at the beginning of the consultation involving closed questions directed to the patient, often focused on specific ocular symptoms. As part of a proposed service improvement, a pre-consultation questionnaire will be implemented to gather wider public health information before seeing the patient. The aim is to keep the questionnaire informal and non-invasive whilst giving patients the opportunity to voice any wider health concerns including mental health and quality of life as part of MECCs. We have also developed 'business card' style leaflets with targeted public health information which can be given to the patient dependent on the questionnaire responses. The questionnaire has been designed specifically for the service improvement, using a similar style to pre-existing, validated public health questionnaires.[2] Kobashi et al showed that 64% (n=46) of patients with a nerve palsy had 2 or more modifiable risk factors such as diabetes, hypertension, hyperlipidemia, smoking, alcohol abuse, depression and obesity.[3] Furthermore, patients with mental health disorders had an increased risk of accommodation and convergence anomalies which decrease quality of life.[4] There are also studies which show substance and alcohol use can exacerbate myasthenia gravis and decompensate heterophorias which leads to diplopia.[5] These risk factors can be identified via the questionnaire and

additional information, via the business card model, can be given to the patient to enable education and access to support services.

Promoting MECC and supporting public health education is a key aim of this service improvement and aligns with the NHS Long Term Plan.[6] However, a secondary aim is to use the standardised data collected from the questionnaires to improve the department's understanding of the patient demographic within the outpatient clinics. This allows resources, clinic support services and staff training to be tailored to the patient demographic. Once the service improvement is implemented, a follow up report will be published where the responses will be audited and any further service improvements proposed as a result of the questionnaire will be presented.

Method

The questionnaire is proposed as a service improvement at Stepping Hill Hospital. The questionnaire was used for patients aged 18 and over attending for an Orthoptic-only appointment. Nine Orthoptists agreed to take part in the service improvement. The questionnaire included 9 closed questions with Likert scale or multiple-choice, as seen in Figure 1. The final comment on the questionnaire is for staff to document if any MECC information was given and if so, for what area of public health. This will be audited to explore if the questionnaire resulted in an uptake of MECC information. Informal verbal consent was required before completing the questionnaire and identifiable patient information was anonymised. The questionnaire did not form part of the patient record once complete. The questionnaire was designed to be completed prior to the Orthoptic assessment and should take no more than 5 minutes to complete. The questionnaire responses were reviewed in conjunction with a full Orthoptic assessment. At the end of the consultation, the patient was offered information signposting wider support networks, depending on the question responses. The MECC information was gathered from a range of validated websites and charities. Figure 2 shows an example of the patient information leaflet. The leaflets are available for 21 areas of public health support, ranging from stop smoking services to dementia groups. The questionnaire is available in accessible formats. Visually impaired patients were offered the choice of having the questionnaire in larger font or having the questionnaire read aloud to them. At the end of the 3-month trial the questionnaire responses will be audited and results included in the retrospective case study.

Outcomes

As this is a prospective case study no results have been collected. A retrospective, follow-up case study will be presented to gauge the number of participants who were able to access further support or information as a result of the public health questionnaire being used as part of the Orthoptic case history. The questionnaire has been developed specifically for this project and therefore it has not been peer reviewed. As a result, a focus group style verbal discussion including administrative staff, Orthoptists and patients allowed for some initial feedback before the questionnaire was rolled out:

1. "I feel the questionnaire gives patients opportunity to raise wider health issues without the anxiety which can be inflicted with face-to-face conversation." Orthoptist

2. "It may add to patient stress before their consultation, particularly if the patient arrives late." Clinical administrator

3. “Due to the nature of our patient demographic some patients may not be able to access the questionnaire in text/written format due to visual impairment.” Specialist Orthoptist

4. “I feel like I didn’t have a chance to tell anybody how I was feeling after my stroke, any opportunity to access wider support or information is great.” Stroke patient

Comment 1 identifies a good point which was a driver for implementing the public health questionnaire. The questionnaire reduces both patient and clinician anxiety which surrounds starting healthy conversations around sensitive topics. Furthermore, having structured information to hand ensures a proactive approach to public health. The patient can choose what they wish to disclose via the questionnaire rather than being questioned directly which may discourage attendance at future appointments.

In response to comment 2, it is important the questionnaire is not viewed as a ‘compulsory’ part of the patient assessment: healthy conversations are a patient choice.

Comment 3 raises a valid argument; if the implementation of the questionnaire is successful, the aim is to make the questionnaire accessible in different formats for all patients such as online or braille format. This relates to the wider effort required to ensure that MECCs and public health initiatives are accessible to all patients within the healthcare setting.

Key learning points

1. Case history taking offers a good ‘ice breaking’ environment where you can start healthy conversations from the outset. Providing a short questionnaire focused on general physical, mental and social health empowers the patient to guide the conversation.

2. Our role is not to counsel but to listen and signpost appropriately. It is important that we respect when patients do not want to take part.

3. The questionnaire is not intended for new patients only and therefore could be offered at a follow up appointment. The questionnaire can also be repeated.

4. The service could be improved significantly if a pre-consultation questionnaire could be sent out via online links and other accessibility formats prior to the patient attending the hospital. The aim is for the questionnaire to take less than 5 minutes to complete.

5. The literature and NHS Long Term Plan supports early signposting and prevention. This can improve recovery period of ischemic palsies, lower risk of recurrent palsies, better mobility due to cardiovascular health and lower risk of falls. Supporting public health and MECC reduces the likelihood of inpatient admissions beyond the eye clinic.

6. Case history is often overlooked and condition-specific, further standardisation allows us to understand the needs of our patient demographic on a public health scale.

7. As a department we are working to improve the scope of the ‘business card’ style services offered. Currently there are contact details for public health concerns such as smoking, financial support and gambling addictions. Having contacts to hand means you can act on the concerns raised via the questionnaire proactively and patients feel supported.

8. A follow up case-study will be released following implementation of the questionnaire after a 3 month period. Auditing the responses will allow us to understand outpatient cohort and further support their needs.

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Figure 1: **Well-Being Questionnaire (Please circle your answer)**

1. How are you feeling today?

   1 2 3 4 5

   (1 being low- 5 being very happy)

2. Do you have interests/hobbies that you enjoy and support your wellbeing?

   Yes No

   (This could be walking, coffee mornings, reading or anything you enjoy!)

3. How many days per week do you consume alcohol on average?

   1 2 3 4 5 6 7

   (1 being 1 day per week - 7 being 7 days per week)

4. Do you smoke?

   Yes Never I used to smoke but have stopped

   (Even 1 cigarette rarely would be 'yes')

5. Are you a carer?

   Yes No

   (This can be looking after a parent/partner, does not have to be full time)

6. How do you cope with daily stresses?

   1 2 3 4 5

   (1 being unable to cope - 5 being stressed doesn't impact me)

7. How many minutes exercises do you perform weekly?

   I do not exercise Less than 150 minutes More than 150 minutes

   (Exercise counts as intended walking, skipping, resistance training etc)

8. On how many days per week do you eat 5 portions of fruit or vegetables?

   1 2 3 4 5 6 7

   (1 being 1 day per week - 7 being 7 days per week)

9. Do you feel you need support with any other aspects of your wellbeing?

   Please write any further suggestions below:

Patient information given:

Figure 2: Making Every Contact Count 'business card' style for dementia patients:

Dementia drop-in support sessions Stockport:

1. The kitchen at Chestergate
   Monday 11am-1pm 0161 804 4400 hello@pureinnovations.co.uk
2. Tea Dance Offerton Community centre 2pm-4pm 07794810032
3. Woodbank walking group
   Tuesdays 1.30pm at Vernon Park Café
4. Singing for the Brain Hazel Grove Civic Hall 0161 477 6999
   stockport@alzheimers.org.uk
5. Reddish dementia friendly café Wednesdays 12pm-3pm St Agnes Church North Reddish 07498996634
6. Activity memory group
   Tuesdays 12.30-2.30pm Bramhall United Reformed Church
   0161 969 4151

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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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.

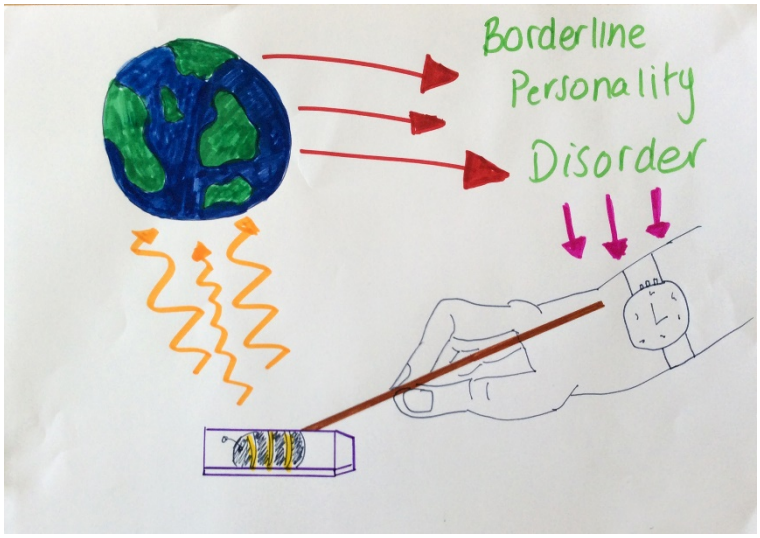

Image 3 represents Ezrah's experience of living with EUPD (also referred to as borderline personality disorder, e.g. BPD): she is the bee in a box, feeling trapped and easily agitated. When things go wrong, she experiences this as being poked with a stick which leads to further agitation and tension. 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.

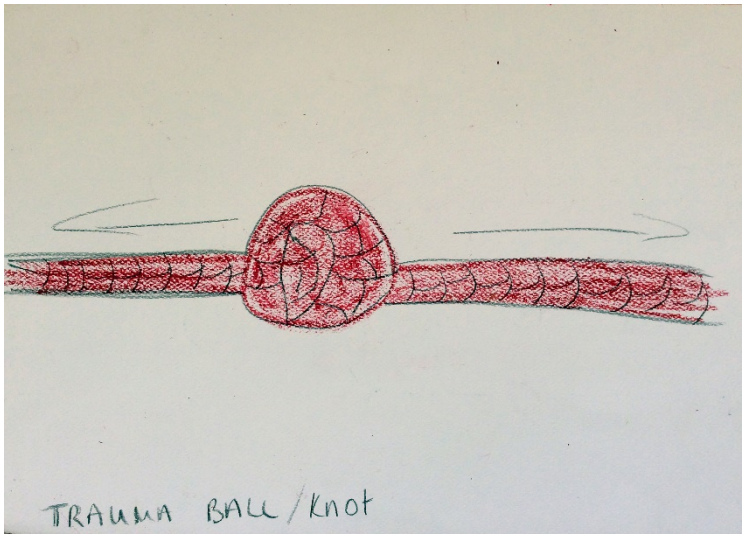

Image 4 is titled *The trauma knot/ ball.* This is an example of 'interoceptive imagery' (Sigal, 2021) – a visual depiction of an internal mental state which Ezrah experienced as a tight, pulling, painful and raw knot in her intestine. This is where the physical sensations related to the trauma and the 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.

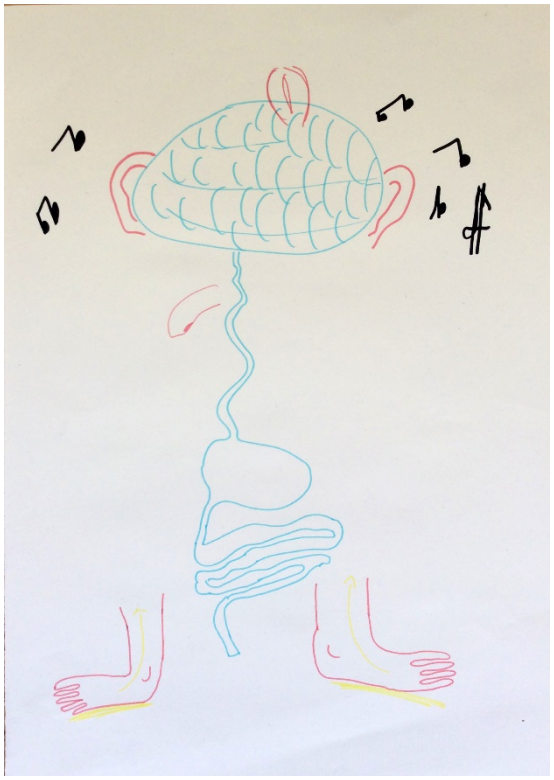

Image 6 is another interoceptive image, depicting Ezrah's fragmented sense of her own body. She drew the feet and the brain, the intestine, then the nose and ears for sensory perception; she added musical notes to represent earworms she would sometimes struggle with, and a vagina (drawn above the brain) 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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Arts therapy leadership activates creative resources which promote individual, team, and community growth in mental health settings

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Introduction

The arts therapies include art, dance-movement, drama and music therapy. These four creative professions use non-verbal psychological therapy to support people to make changes in their lives, which can improve both mental and physical wellbeing. The active ingredient in the arts therapies is the art form. Using play and experimentation, the person accessing arts therapies can: explore choices through artwork, trial a different version of themselves in role-play, find their voice with musical improvisation and learn to listen to their physical needs through movement.

While the arts therapies are a specialist and complex intervention[1] in clinical settings, as an allied health profession, arts therapists have a range of transferrable skills which can be activated in leadership roles to support the equally complex agenda of public health.

Alongside ensuring that the team deliver effective and timely clinical services in secondary mental health settings, my role as Head of Arts Therapies requires more to reduce local health inequalities in Bedfordshire and to focus on preventative rather than reactionary healthcare. As a leader, I modelled my creative values in action to empower the arts therapies team to do the same. Through collaborative working, we not only maximised our small arts-based resource but built capacity and confidence in other parts of the system with healthcare professionals, experts by experience and local cultural assets.

Context

Bedfordshire has a population of 670,000. As a county it is predominantly rural, with some of the most affluent communities living alongside some of the most deprived areas in the UK. For example, 43% of Luton Borough lies within the top 30% of the most multiply deprived areas in England[2]. Additionally, there is great cultural variety across Bedfordshire, with Luton being one of the most culturally diverse parts of the UK[3]. These geographic and socio-economic factors pose significant challenges for healthcare delivery, but also potential opportunities for celebrating cultural diversity.

The arts therapies team in Bedfordshire and Luton delivers a county-wide service across adult mental health, specialist learning disability and community health services provided by East London NHS Foundation Trust (ELFT). Each of the four arts modalities are represented in our team. However,

the arts therapies resource is limited, with the equivalent of four whole time posts serving the entire county.

Under ELFT's Trust-wide arts therapies strategy, clinical interventions are provided across a broad range of services, both inpatient and community, to a varied adult population (figure 1). Locally, we have also included support for NHS staff, both clinical and non-clinical, as an essential part of this arts-based strategy.

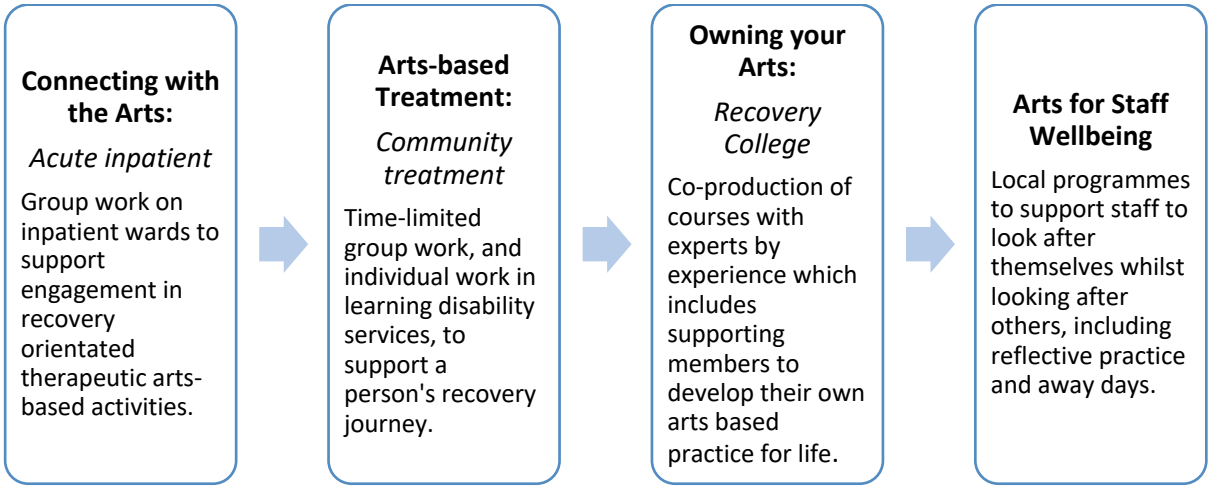

Figure 1: Arts Therapies Service provision in Bedfordshire & Luton, ELFT

This system-wide vision recognises "the benefits that the arts can bring to health and wellbeing"[4] as a recovery tool and in promoting psychological resilience beyond NHS service use. In parallel, our team has sought to provide continuity of care across mental health services so that people can access the arts at any stage of their recovery. To achieve this level of impact several factors drive our work, these are:

- Collaborative working maximises the use of our arts therapies resource which includes transdisciplinary inpatient working and coaching experts by experience to deliver their own recovery college courses.
- Building capacity and confidence in other parts of the system through using arts-based interventions with a strengths-focussed recovery approach for staff, service users and the public creates better outcomes for everyone.
- Clinical service delivery built on quality improvement principles enables a nimble response when providing county-wide services, increasing equity and accessibility, meeting demand in a timely and context sensitive manner. This includes piloting novel interventions in wider teams and introducing group-based delivery in learning disability services.

Arts Therapies working across traditional healthcare barriers

My leadership style is participative, I know that I cannot implement large-scale transformation without my team being active change agents. As a quiet leader[5], listening is essential, in my silence I can hear opportunities for future collaborations and lean-in to difficult conversations, averting potential resistance. To successfully deliver the arts therapies strategy, in line with ELFT's public health priorities, I have prioritised the following:

1. Developing clinical leadership in the arts therapies team

Each member of the team has unique skills and valuable experience, together our creative voice can empower others. Building individual confidence and competence involves working across levels of capability through coaching and supervision, given as part of my leadership role. This included investment in talent through supporting autonomous professional practice and academic development which benefits the team and wider arts therapies. Creative experimentation through solution-focussed learning and working with uncertainty models authentic leadership for the team.

2. Strengthening the current clinical service provision through evidence-based practice

Communication, both verbal and non-verbal, lies at the heart of the arts therapies. Similarly, communication within an organisation is essential in understanding the multifaceted role of the allied health professions.

In our team, we began by holding our service accountable, through producing quarterly reports which included contact data with service users and staff, outcome measures and experience data. This enabled us to meet key targets and to celebrate successes. Additionally, we reduced barriers to accessing the arts therapies through strengthening referral pathways and widening participation across different client groups.

Each arts-based intervention is underpinned by quality improvement methodology, fostering a growth-orientated team culture. Increased visibility for the arts therapies has confirmed our role as valid contributors to multi-disciplinary mental healthcare.

3. Adopting a flexible approach to arts-based interventions to engage a range of stakeholders

Employing our therapeutic and arts-based skills flexibly enables the arts therapies to operate beyond the traditional confines of the clinical therapy room. The arts work across many levels. For example, we can facilitate challenging conversations through metaphor or role play. We can enable diverse groups of professionals and service users to each find a voice and feel heard through creative play. These skills not only provide psychological safety when exploring complex or controversial issues but foster more holistic solutions to issues of organisational change.

Some examples of specific work programmes that the arts therapies team have collaborated on are:

- Service Design

  A transdisciplinary steering group was set up, to develop a radical vision of barrier-free healthcare, for people with persistent physical symptoms and functional syndromes. This necessitated engagement across organisational levels, from borough director to service user. Additionally, we reached across geographic and traditional service barriers to include primary care and other provider organisations across the whole of Bedford Luton Milton Keynes (BLMK) Sustainability and Transformation Partnership (STP).

  An art therapist used a model of visual mapping (figure 2), which enabled all voices to be heard, to distil the strengths in the current system and identify areas for improvement. Through this process discussion of complex areas such as discriminatory language and the psychological impact on clinicians of this work were explored. Visual system mapping accelerated the journey towards personalised care for this client group, through recognition of the strengths in the system and collaboratively designing a better vision.

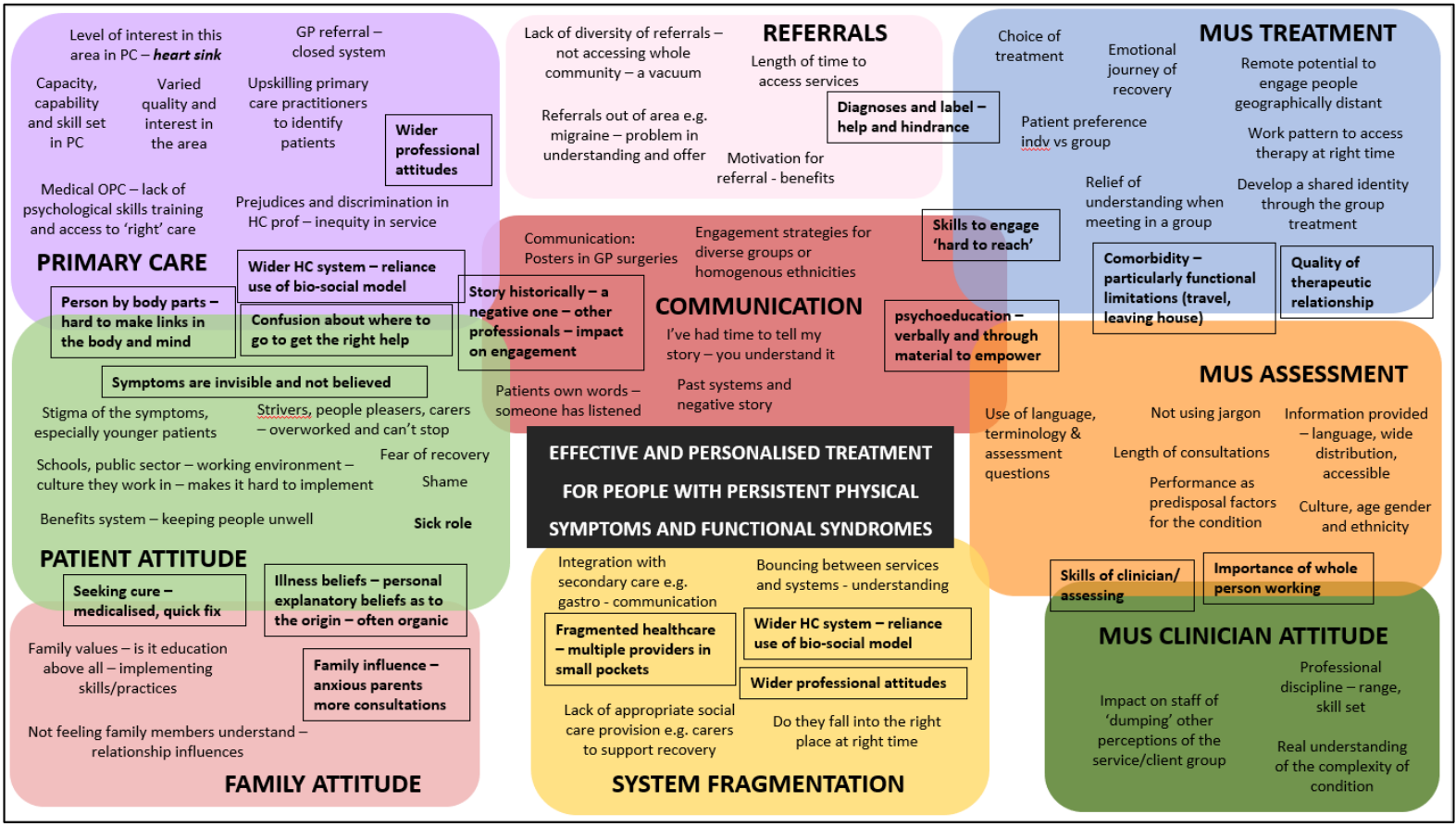

Figure 2: Thematic map of the barriers and facilitators in service access and use
(please note MUS stands for Medically Unexplained Symptoms, this is one term used to describe people who experience persistent physical symptoms and functional syndromes such as Fibromyalgia, Chronic Fatigue or some Musculoskeletal conditions)

- <u>Staff Support</u>

  It is widely known that staff experience is an antecedent to patient experience in healthcare. Teams which are well structured in organisations with a supportive culture, not only achieve higher staff retention and fewer sickness absences but demonstrate reduced patient mortality and readmission rates with increased patient satisfaction[6].

  The arts therapies draw on this evidence when caring for the person in the professional. We recognise the emotional impact of caring work in mental health services. We offer a multi-intervention approach which includes: structured debriefing after critical incidents; contracted arts-based team reflective practice; and during the pandemic tri-weekly creative breakout sessions. Using the arts enables difficult conversations to occur without blame and facilitates a team's own recovery resources through creative expression.

- <u>Strengths-focussed Psychological Support</u>

  People with a learning disability face a range of complexities when seeking support for their physical and mental health. There is a greater likelihood of comorbid diagnoses[7] and communication challenges, alongside referrals originating from support staff not the person themselves[8].

We developed a 4-session arts therapies assessment group[9] to activate service users' personal resources, support them to advocate for their needs and to make an informed choice about accessing psychological therapy. For some, this is all they needed, others enter non-verbal psychological therapy with a greater awareness and motivation to change. In parallel we engage the person's support team to maximise therapeutic success and understanding.

- Recovery College

  The arts therapies wing of the recovery college has seen co-production partnerships between experts by experience, that is, people with lived experience of mental health conditions and arts therapists, grow in unprecedented ways. Following a successful pilot programme with dramatherapy[10], psychoeducational courses are now part of our routine practice. Group members have produced a recovery-focussed book, delivered training within the Trust and presented at national conferences alongside arts therapists. In partnership, the arts therapies and experts by experience have supported local community resources to reduce stigma around mental health, widen access and foster inclusive public environments which promote life-long recovery.

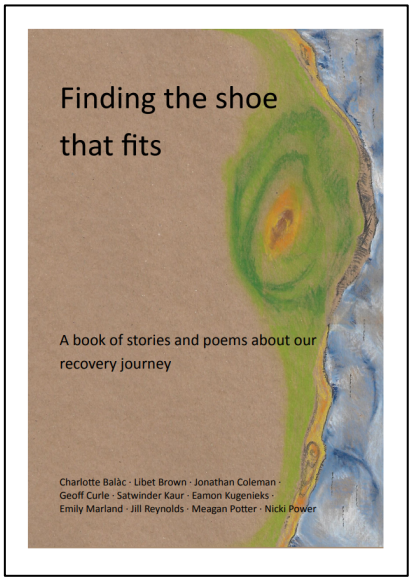

Figure 3: 'Finding the Shoe that Fits' a book about recovery made by experts with experience

Measuring success

There is no single measure of change which can accurately capture the range of interventions which we offer and continue to develop as a team. However, we use triangulation of data from a range of sources to help us build a picture of effectiveness, to identify where the arts therapies add value and to point towards future areas for development. We collect formal outcome measures, experience data and improvement suggestions from service users, staff and carers. Here are some selected outcomes from those who have accessed the arts therapies:

- Arts Therapies Team

  As well as providing direct clinical intervention, members of the team have been supported to write academic papers[11] building the evidence base for arts therapies and to develop leadership skills, for example, becoming a quality improvement coach.

- People who use mental health services

  One person who attended an inpatient group said:

  "Do you see how connected people seem now…before the group everyone seemed so isolated and tired…that was such a therapeutic experience".

  Another person, who attended a recovery college course said:

  "Gives you self-confidence to just sing and…
  to go and speak to people with similar health issues".

  A person with a learning disability who attended individual therapy said:

  "I was quite poorly with anxiety and depression… as my therapy progressed,
  I started to feel better in myself, and…I've really enjoyed …my [arts] therapy sessions.
  They've really helped me a lot….I have the tools to help me keep the work up".

- Staff in ELFT Services across Bedfordshire & Luton

  During the first national lockdown in 2020 the arts therapies team provided arts-based break spaces for 108 staff per month (March to July inclusive). This was a 200% increase in staff support provision. One staff member said they appreciated:

  "Having time away from direct clinical responsibility to share …and reconnect".

- Wider Community in Bedfordshire

  We have created sustainable partnerships with cultural organisations such as the Higgins Museum, The Place Theatre in Bedford and The Hat Factory in Luton. This has enabled people who face stigma to access these cultural settings as equal citizens, and staff beyond mental health care have benefited from mental health first aid workshops.

  Following a film showcase, which was co-produced with young people from CAMHS services (another pilot project we supported), a member of the public who had been in the audience said:

  "It was a very unique and special experience …exceedingly informative and deeply moving...immensely powerful voices, speaking and singing of strength and redemption, of emergence and new beginnings. Thank you …for convincing us that a better day is always possible".

Key learning points

- Creativity is an essential tool in service transformation. The creative process familiar to arts therapists, combined with therapeutic skills of engagement and group facilitation, make us ideal collaborators in complex change programmes.
- Just as arts therapies provide a space apart from everyday life for service users to make changes possible in their lives, this capacity can be harnessed to support staff wellbeing and team building.
- The value of systems approaches in the design and delivery of mental healthcare cannot be underestimated. Interdisciplinary work enables professions with limited resources to reach

further and maximise impact. Inclusive mental health services place the lived experience of the people accessing services firmly at the core of practice. Together, we can draw on a range of expertise and build a board skill base to strengthen our whole community's mental health approach.

- True co-production requires professionals to be led by our experts by experience. This takes time and involves learning for all. In any developing therapeutic programme, allied health professionals need to be mindful of the time and energy involved in genuinely collaborative and inclusive working.

- The arts are a vehicle to access the creative potential in the everyday. There is some need for caution when implementing arts-based interventions as part of change programmes. The potential uses of creativity are boundless, this poses a risk that we may over-stretch. Pacing and good project planning can mitigate this risk.

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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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‘Virtual Cuppa’

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Description

‘Virtual Cuppa’ (VC) was a daily online peer led virtual support group for Art Psychotherapists during the Covid pandemic. Evolving as a safe virtual space for connectivity to meet the needs of therapists and clients alike, following radical changes to work practices in response to Public Health Guidelines at the onset of lockdown.

Image by Sue Ellis

The UK Allied Health Professions Public Health Strategic Framework has 5 goals one of which is “Health and well-being of the workforce: The expertise of AHPs will be used to protect and improve the health and well-being of the health and care workforce” (Hindle and Charlesworth, 2019). This project demonstrates a response that meets this goal. ‘Virtual Cuppa’ evolved as a safe virtual space of connectivity, learning and emotional holding for Art Psychotherapists’ response to the COVID-19 pandemic.

Context

The pandemic created a unique dual experience affecting both the client and therapist alike, with isolation at an unprecedented level, directly impacting on their mental health, “Nearly a third of healthcare workers reported moderate to severe levels of anxiety and depression, and the number reporting very high symptoms was more than quadruple that pre-COVID-19” (Gulleen J, 2021).

The aim of VC was to support Art Therapists on two levels; first by creating a safe environment to support their mental health, secondly to create an environment for shared learning and professional development. Capturing the learning to create a new framework of online art therapy as a credible alternative to face-to-face interventions and enhance its capabilities by widening the scope of clients who find face-to-face models of therapy problematic.

By expanding our professional knowledge and skill base, Art Therapists are meeting the objective of the Royal Society of Public Health Strategic Plan 2022-2027 “*A skilled and well-trained workforce is essential for better Public Health”.*

Method

VC was available free of charge, accessed through an invite from Zoom video conferencing platform:

- Every weekday morning from 7.30-9.30 am
- Once a month evening sessions were offered
- Cyber Open Studio on Sundays, 4 hours of restorative creativity

VC delivered over 400 hours of support with an average of 3 people attending per session and a maximum of 12, and only a small quantity of sessions with no attendance. 12 evening session ran for 2 hours, average attendance 6 maximum 9. The Cyber Open Studio Sessions on Sundays delivered 100 hours with an average of 8 people in sessions and a maximum of 15.

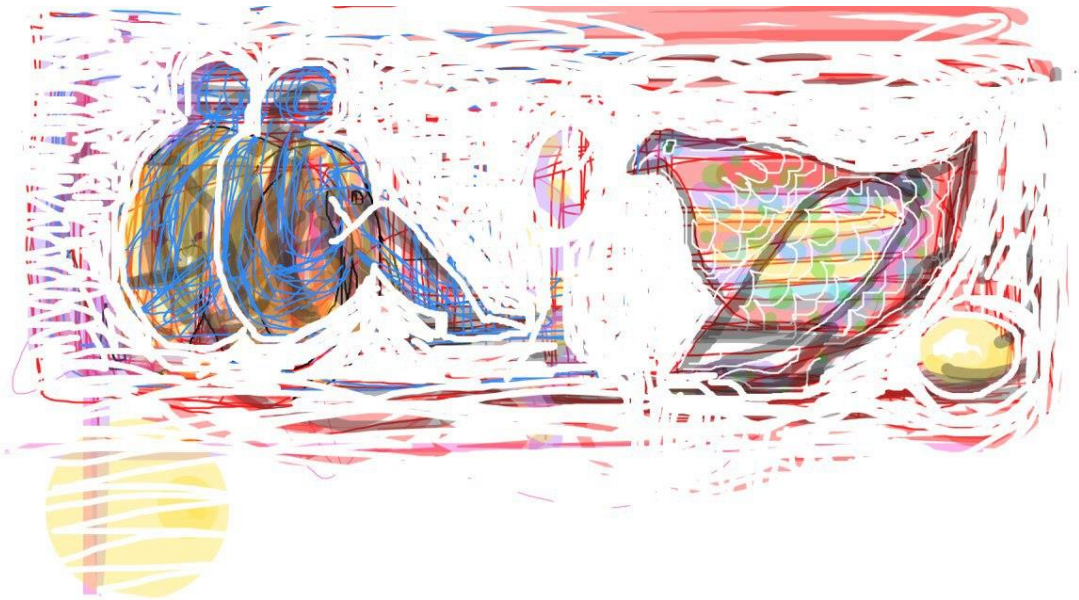

Image: by Sue Ellis in collaboration with another Art Therapist on the Zoom whiteboard

As time progressed, themes started to emerge and focused themed sessions were created to explore these further, inviting other professions/AHPs:

- Setting up our online studio space to look familiar to the art therapy space.
- Organising the technology, internet, camera, thinking about height to eye levels so the client did not feel you were looking down or up at them. Using one or two cameras, exploring lighting to create an authentic experience.
- Discussion around Arts for Health and art therapy online.
- Using Music, Drama, Movement and Poetry in therapy to support a less static and more sensory response to being in front of the screen.
- Using technology, photography, videography, VR, Minecraft and virtual games.
- Co-created Art in therapy – using the Whiteboard in Zoom creatively.
- Using a 'transitional object' to support connectivity with the client – sending letters and art projects out to clients with their name on the envelope, reinforcing their sense of self as a positive experience.
- Confidence – Imposter Syndrome.

- Going back to face-to-face working, taking forward our learning and experience of online working.

VC was Initially to support Art Therapists in the British Association of Art Therapists (BAAT) region 11 Yorkshire and Humber region. It expanded to include other BAAT regions and other Creative Therapists wanting to share their learning and experiences.

Although mainly attendees originated from Yorkshire, this grew over time to cover the length and breadth of the UK from Devon and Cornwall right up to the Orkney Islands and expanding across the globe with international colleagues from Europe, Canada, America, Australia, South Africa, South America and Israel.

Outcomes

VC showed we could successfully take art therapy online, following the early examples the USA Telehealth research, highlighted a credible option, 'a plausible best method of therapy for some clients' (Collie & Čubranić, 1999) cited in (Malchiodi, 2018). "A growing body of literature now suggests that use of telepsychiatry to provide mental health services has the potential to solve the workforce shortage problem that directly affects access to care, especially in remote and underserved areas." (Antonacci DJ, 2008) (Rees & Haythornwaite, 2004). In their study Day and Schneider compared "psychotherapy: face-to-face, real-time video conference, and 2-way audio (analogous to telephone)" and suggested that "differences in process and outcome among the 3 treatments were small" (Day & Schneider, 2020).

To support the most commonly ask questions and pull together our learning we produced E-Booklets:

- Art therapist working online
- Clients introduction to online art therapy with safety plans
- Student Art Therapist E-Booklet

Feedback:

"I so wish that I had come across the 'Virtual Cuppa' sooner I have found it invaluable and am very grateful for the new connections I have made, practice discussions and shared learning resources. Through one of our discussions around appropriate adolescent referrals to therapy Sue kindly shared her 'Venn Detective', a creative assessment tool that can help practitioners identify areas of difficulty at home and school as well as hopes and aspirations. I have been able to use this already online. My interest in working creatively, ongoing personal learning and future development of my practice has been rekindled by meeting with so many like-minded, experienced, passionate and enthusiastic professionals. Thank you so much". (Play Therapist and Creative Arts Counsellor for Children and Young People).

"How curious would Donald Winnicott be to see the use of his theory of the 'potential space' introduced to the world in 1953 being used 67 years later within cyber based therapies in 2020", (Art Therapist, 2020 in discussion in VC session).

"I've found the group to be the invaluable support I need as an early-career AT. Very inspiring conversations, with wise souls encouraging me to do my best out there! Hugely grateful" (message taken from VC Telegram page 2020).

“I like how Virtual Cuppa helps people, to work together and relate to one another using art and technology. Whilst at the same time supports learning and wider discussions, enabling people to know more about their process so partnerships can begin.” (Media Psychologist)

“Virtual Cuppa was my lifeline during the pandemic. In March 2020, I was naturally preparing to end work with several adolescents in alternative provisions. I had just been informed that my mother, who lived in a distant county, was terminally ill. Lock-down happened. Everything came to an abrupt stop. No proper endings. Wherever I was, Virtual Cuppa held me each morning before I started my day” (Art Therapist).

“I wasn't always able to make sessions but knowing you where there holding the space helped me feel held during my days especially when I have times of feeling overwhelmed” (Comment made in VC discussion).

Key learning points

The key learning points were the importance of holding the professionals and looking after their health and mental health in order that clients where safely held. The COVID-19 pandemic, fast forward the learning essential to place art therapy online in doing so, showed that distance need not be an exclusion for therapy.

We supported each other in dealing with the following:

- The extreme tiredness of online working
- Hitting the brick wall of Covid
- Emotional and practical complexities of online working with clients such as:
    - Regressive behaviors experienced by both client and therapist
    - Disinhibition effect on therapy and disclosures
    - When the clients turn off the screen - holding the empty space
    - Dealing with technical issues and backup plans
    - Determining the levels of appropriate space for talking and silence
    - Dissociation and emotional dysregulation

Members worked collaboratively to create a ‘heighten attuned response’ across this new dual therapeutic space, developing:

- Safety plans written with clients prior to the commencement of session.
- Maximising the creative potential of Zoom by using the Whiteboard for co-created artwork.
- Dyadic Art Therapy approaches designed to hold children safe with distance working.
- The change in power dynamics with parents, helping parents through psychoeducation to have the confidence to position themselves in their child’s healing, helping the parent be the hero.
- The powerful dynamic way of co-working with the clients and families became part of the new normal. That supported the transition from online working within their home back to their home as their lived environment.
- Learning to hold the chaos over distance.

Emerging themes over the course of lockdowns:

- Working in isolation, away from professional teams.

- The loss of professional voice and practiced narrative; the emerging domestic narrative taking precedence started to coincide with loss of professional confidence.
- VC reach has been wide and varied from embracing the challenges that this pandemic has brought on all levels of personal and professional identity. It has been integral in providing emotional support for therapists to sit with each other in times of darkness, despair, and sadness.
- VC became that safe space to be held, re-gather and regain perspective to gain strength and carry on. For some it was a lifeline.

The response for support needed to be swift at this most challenging of times, it is hard to see how this level of intense support would be needed as we regain our normal ways of working.

Doing things differently would be to take the essence of this learning into our new every day with a hope that it is not lost. Providing online art therapy as a credible option for our clients that was not thought possible pre-Covid.

This was a unique time in our history, the lessons we can take forward is art therapy can be done successfully online and can become part of the blended approaches to meet the needs of our clients in the future, distance is no longer an issue for clients to assess mental health support.

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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

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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.

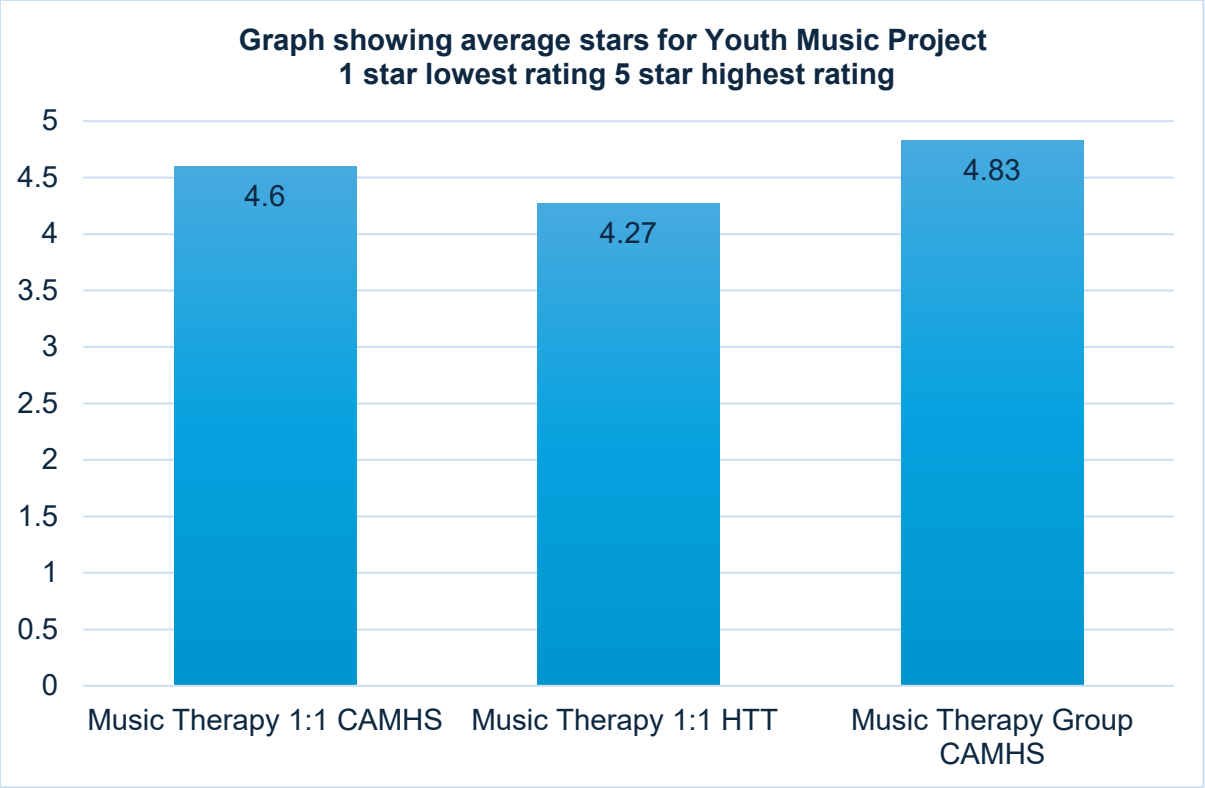
To assess impact, a Patient Reported Experience Measure (PREM) was used after each session. This was a card developed by CPFT Arts Therapists and used throughout the service. The team refer to the "star card". The star card was filled out by children or their carers. The star card had a star rating from 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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