Theory of Change

Our Theory of Change is written in trust and realism. Trusting that we make a difference, borne out by our outcome scores for our clients and realistic to know that as a small charity we cannot solve our area's mental health crises and nor do we. Outcome measures are difficult to measure and if we used the NHS ones we're not sure how much you could attribute to Wellspring. Theories of Change often assume a fixed environment rather than a fragmented, ever evolving landscape making baselining almost redundant. What we do know is that if we weren't here, overall mental health would be worse as for people on low incomes, we are the only provider of our type in the area.

What problem are we trying to solve?

To relieve psychological distress in individuals.

What is the ultimate, long-term change we want to see?

A significant and sustained reduction in the preventable, systematic disparities in mental health outcomes and access to effective therapeutic support across all demographic groups in our area.75% of mental ill-health in adults starts in childhood. We want to prevent that. The baseline prevalence rate is 20% for childhood mental health issues in the Harrogate District (estimating roughly 7,362 young people out of a population of 36,809 by 2035). So by reaching more children we will have more impact.

Equitable Mental Wellbeing Across the Lifespan:

- **Expression:** We aim for a future where an individual's mental wellbeing and resilience are not determined by their socioeconomic status, geographic location, and other characteristics, from early childhood through to old age. This means reducing the gradient of mental ill-health that currently exists, where those in more deprived circumstances experience higher rates and severity of conditions.

  We take as our inspiration 1 Corinthians 12. 12-27

Universal Access to Timely, Appropriate, and Professional Therapies

- **Expression:** We desire a system where anyone experiencing mental health difficulties, regardless of their background, can access high-quality, evidence-based therapy at the earliest appropriate point.

Reduced Disparities in the Burden of Mental Ill-Health:

- **Expression:** We seek a future where the prevalence, incidence, and severity of common mental health conditions are more evenly distributed across the population. This means specifically targeting the disproportionately high rates of mental health problems observed in specific vulnerable groups in our community, especially younger children, older people in rural areas and parents in insecure accommodation.

What are the intermediate and short-term changes (outcomes) that need to happen to achieve that long-term goal?

I. Related to Universal Access to Timely, Appropriate, and Professional Therapies:

- **Short-Term Outcomes (1-2 years):**
    - **Improved Initial Contact & Navigation:** A decrease in the time taken for individuals to make initial contact with a mental health service, and an increase in the proportion of individuals successfully navigated to appropriate first-line support.
    - **Enhanced Referral Pathways:** Development and implementation of streamlined, cross-sectoral referral pathways between primary care, social services, community groups, and mental health providers, specifically targeting vulnerable children.
    - **Increased Capacity in Therapeutic Workforce:** A measurable increase in the amount of evidence-based practice available to reduce mental health distress. This will include an increase in the number of qualified therapists (e.g., counsellors, and creative therapists) available in underserved areas or specialising in specific vulnerable populations.
    - **Reduced Waiting Times:** A significant reduction in average waiting times for initial assessments and subsequent therapeutic interventions across all service types. No individual waits longer than 3 weeks for first therapeutic session.
    - **Improved Accessibility of Digital Mental Health Tools:** An increase in the uptake and effective utilisation of evidence-based digital mental health resources by target populations.
- **Intermediate Outcomes (3-5 years):**
    - **Equitable Access to Therapy:** Demonstrated reduction in disparities in access rates to appropriate therapeutic interventions for children.
    - **Increased Engagement in Therapy:** A higher proportion of individuals who begin therapy complete their recommended course of treatment.

II. Related to Reduced Disparities in the Burden of Mental Ill-Health:

- **Short-Term Outcomes (1-2 years):**
    - **Early Identification of Distress:** An increase in the proportion of children whose psychological distress is identified at an earlier stage.

    - **Targeted Prevention Programs Launched:** Implementation of tailored mental health promotion and prevention programmes specifically designed for identified vulnerable groups (e.g., perinatal mental health support for parents in insecure accommodation, therapy for primary-age children in rural areas, counselling for older people in rural areas).
    - **Community-Led Initiatives Strengthened:** Increased number and effectiveness of community-led initiatives focused on mental wellbeing and peer support within vulnerable communities.
- **Intermediate Outcomes (3-5 years):**
    - **Reduced Incidence of Mild-to-Moderate Conditions:** A measurable reduction in the incidence of common mental health conditions (e.g., anxiety, depression) within targeted vulnerable groups, especially children.
    - **Improved Early Intervention Outcomes:** Individuals receiving early interventions demonstrate improved symptom reduction and functional outcomes.
    - **Increased Social Support Networks:** Strengthened informal and formal social support networks for individuals within vulnerable communities.

What specific activities will our charity undertake to bring about these outcomes?

1. Provide 165 hours per week of affordable counselling to those on low incomes
2. Increase the number of Creative Therapists working with children and young people aged 4-11 from 0 to 8 in two years.
3. Site therapists in two rural primary schools
4. Trial the therapeutic-led provision for children who are in alternative provision.

Why do we believe these activities will lead to these outcomes? What are our assumptions?

Provide 165 hours per week of affordable counselling to those on low incomes
People who experience mental distress struggle to access therapeutic support as they cannot afford it. Reducing the financial barrier to access support ensures more equitable access to care. As 75% of mental ill-health starts before the age of 18, reaching more children drives our activities.

Increase the number of Creative Therapists working with children and young people aged 4-11 from 0 to 8 in two years. This prevents mental-ill health developing. Early childhood is a peak period of *neuroplasticity* (the brain's ability to wire and adapt itself based on environmental inputs) followed by a massive phase of synaptic pruning. If a child's environment during this 4–10 window is saturated with chronic stress or digital over-stimulation, their neural architecture hardwires for heightened reactivity. Evidence from the *5Rights Foundation* and LSE warns that schools have inadvertently introduced significant digital anxiety. Gamified educational software—using public leaderboards, countdown timers, and behavioral point rankings—is replicating the worst excesses of social media inside the primary classroom. This drives toxic peer comparison, anxiety, and a feeling of being labelled bad in front of peers. Lifelong mental health relies on developing two things: *self-regulation capacity* (the ability to manage thoughts, distractions, and emotions) and *self-world capacity* (how a child forms their identity and

relates empathically to others). Creative Therapists are specifically trained in how to support children of this age to self-regulate and grow their self-world capacity.

Site therapists in two rural primary schools

Consultation with parents proved that the small window they have from finishing school to bedtime means there isn't enough time to travel from a rural area to Wellspring. Their local schools are trusted and school leaders are happy to create time for children to receive therapy in afternoons.

Trial the therapeutic-led provision for children who are in alternative provision.

Children who are neurodiverse are 75% likely to have mental health issues and become school avoidant. Reaching these children could be achieved through providing a therapeutic-led service which could help them return to mainstream education.

Measures

Phase 1: Output Tracking (Volume & Equity of Reach)

- **Demographic Data:** Capture age, postcode/rural classification, school environment, and socioeconomic background (e.g., eligibility for Pupil Premium). This directly proves our "Right Family" in the "Right Place." approach.
- **Scalability:** Baseline of 64 children a year completing therapy and Wellspring House.
- Workforce: Number of Creative Therapists working and volunteering expressed as hours of therapy provided per week.

Phase 2: Validated Clinical Outcomes (Soft & Hard Metrics)

- **Child Outcome Rating Scale (CORS)** for the 4–10 age category.
- **Qualitative & Relational Feedback:** therapist observations regarding clinical engagement, safe attachment markers, and the development of long-term coping mechanisms. Continue using child-led, creative feedback processes to allow the younger cohort to evaluate their own sense of safety, expression, and agency away from rigid, language-heavy assessment tools.

Phase 3: System and Educational Impact

Tracking Indicator	**Data Source**	**Population Health & Parliamentary Justification**
School Attendance Rates	School Registry / EBSA Trackers	Proves the intervention prevents school dropout and stabilises children suffering from digital or educational performance anxieties.

Behavioral Incident Reductions	School SIMS Data / SENCO Logs	Directly demonstrates a reduction in school distress escalations, acting as a buffer against exclusions.
Parental/Caregiver Resilience	Parental Wellbeing Scales (e.g., SWEMWBS)	Addresses the family dynamic, showing reduced parental helplessness and systemic fallout at home.
CAMHS/ND Pathway Deflection	Referral Triage Tracking	Proves that early Creative Therapy intervention stabilises the "missing middle," preventing secondary anxiety/depression developments and slowing the queue for statutory services.