Cambridge Acorn Project

Every child and young person should be able to aim for the stars

“You should be really liberated when you’re doing it”: Voices of children accessing therapy

CAMBRIDGE ACORN PROJECT

We would like to thank all the children who shared their experieces as part of this project as well as all the children and families who engaged therapeutic services through Cambridge Acorn Project's *Empathetic Communities* project.

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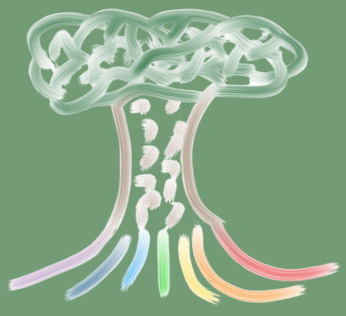


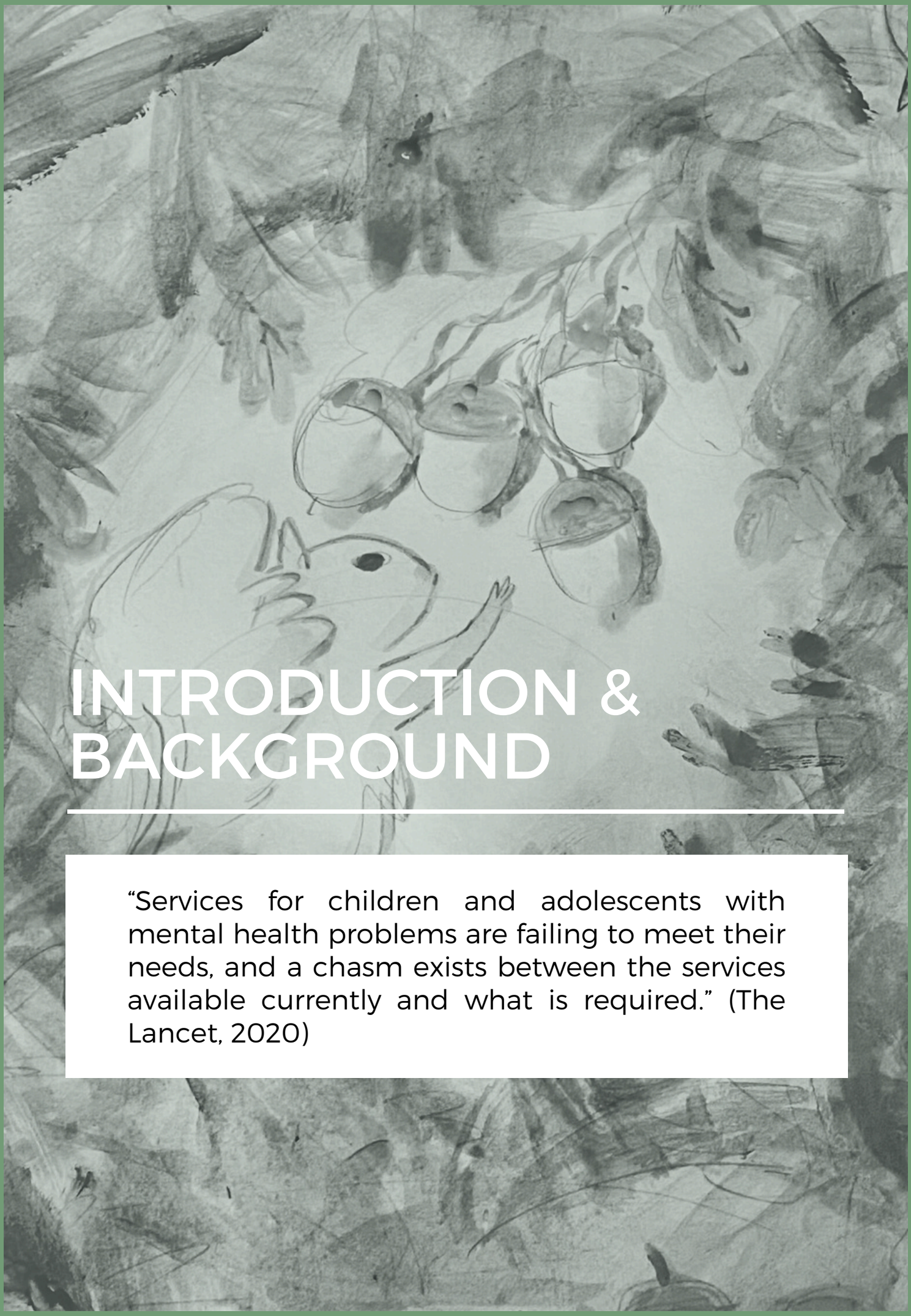
EXECUTIVE SUMMARY

In England, the prevalence of mental health conditions among children is rising rapidly and the child mental health system is in a critical condition. The voluntary sector is providing services to increasing numbers of children whose needs cannot be met by the statutory and commissioned services. *Empathetic Communities* was designed as a community-based project in response to the growing children's mental health crisis in Cambridgeshire. The project, funded by the National Lottery Community Fund, was designed to provide therapeutic, structural, and community support to children and families through schools and communities in three Cambridgeshire districts.

This research project was designed to listen to the voices of children who accessed services through the project to understand their experience accessing therapy as well as exploring children's perceptions of what good therapeutic services should look like in order to embed children's voices into future service development.

The children reported positive experiences of engaging in *Empathetic Communities* and the impact it had on their lives. Importantly, the children conceptualised the therapists as trusted adults in their lives who listened and responded to their needs and promoted freedom and agency within sessions. In conceptualising what good therapeutic services should look like, children were able to describe key components including the importance of needs-led services where children have agency, the ingredients for a good therapeutic alliance, and the potential of therapy to promote emotional recovery.

As an output of this research, the findings have been incorporated into a Children's Theory of Change and a Children's Charter for Therapy. It is hoped that moving forwards both documents can be used to highlight the children's voices within the work of Cambridge Acorn Project and shed more light on children's experiences and views within the local mental health sector.



INTRODUCTION & BACKGROUND

"Services for children and adolescents with mental health problems are failing to meet their needs, and a chasm exists between the services available currently and what is required." (The Lancet, 2020)

INTRODUCTION

In England, children's mental health is in crisis (The Lancet, 2020). The National Health Service (NHS) currently estimates 1 in 5 children aged eight to sixteen years has a probable mental health condition (NHS Digital, 2023). Even higher rates are estimated for children considered vulnerable, such as those living in low socio-economic households (NHS Confederation, 2021). Concerningly in 2020 intentional self-harm and/or suicide was found to be the leading cause of death for both males and females aged 5 to 34 (ONS, 2021). The pressure on children's mental health services is consistently increasing and in 2021 the Children's Commissioner estimated that more than a quarter of children were turned away from statutory Child and Adolescent Mental Health Services without being offered support (Gilhooley & Clark, 2021). Where support was offered 64% of children were not seen within a year (ibid.). Increasingly children are having cases closed by statutory services either before or after an initial assessment, and so it is falling to the third sector to pick up the burden of a failing mental health system - this fragmented system is exacerbating existing stress and has the potential to perpetuate inequality.

In Cambridgeshire, where the present study is based, NHS data shows a 62% increase for referrals into the statutory Child and Adolescent Mental Health Services (CAMHS) across the year 2019-20 compared with the previous year, and 38% of these children had their referrals closed before any treatment was offered (NHS Digital Data, 2020). To respond to the growing need within Cambridgeshire the *Empathetic Communities* project was developed by Cambridge Acorn Project and funded by The National Lottery Community Fund.

The project began in June 2019 eight months before the Covid-19 Pandemic began to affect the UK in February 2020. *Empathetic Communities* was designed to provide therapeutic, structural, and community support across East Cambridgeshire, Huntingdon and Cambridge City. The project worked with school partners in each location

as well as with third-sector partner organisations to provide street-level drop-in community-based support for families in each locality. To date, *Empathetic Communities* has delivered services to 295 children and families. The current research worked with children who accessed services at school-level during the academic years 2021-2023. The aim of this research was to explore children's experiences of the therapeutic service, whether they found those services to be helpful and their feedback which could be incorporated into Cambridge Acorn Project's organisational development going forward. Namely, the study aimed to answer the following research questions:

1. **What do children who participated in the Therapeutic Work element of *Empathetic Communities* think about their individual experiences of accessing Cambridge Acorn Project's therapeutic services delivered through the *Empathetic Communities* project?**
2. **What do children who participated in the Therapeutic Work element of *Empathetic Communities* think good therapeutic services should look like?**

Within literature on child patient feedback in mental health services, a sense of scepticism has been reported as to the extent of which children's views are actually used to meaningfully shape service development (Crosier & Knightsmith, 2020). Therefore, a vital aim of this project was to actively combat this issue and generate rigorous service users experience research where the findings would be used transparently to shape service development for the charity. In addition, it is hoped this work can support the charity on its organisational journey to louder advocacy and activism within the children's mental health sector. Therefore, as well as identifying research questions three guiding outputs for the research were also identified:

1. **Create a Children's Theory of Therapeutic Change**
2. **Create a Children's Charter for Therapeutic Working**
3. **Inclusion of Children's Voices into all staff training resources by September 2024**

BACKGROUND

Cambridge Acorn Project is a registered charity (Charity No: 1175019) aiming "to relieve the suffering of children and families in Cambridgeshire and surrounding localities facing trauma or emotional distress by the provision of a therapeutic model of social work". To date, Cambridge Acorn Project has supported over 700 children and families, to date, using their long-term approach to promote emotional recovery. Referrals for support can be the result of complex trauma such as domestic abuse, and/or experiencing sexual, emotional, or physical abuse as well as single-incident trauma such as house fires/floods, medical trauma, or traumatic loss. Cambridge Acorn Project works with some of the most complex cases in Cambridgeshire, including children who have witnessed murder and similarly horrific crimes. In addition, many families who are supported experience intergenerational trauma.

Cambridge Acorn Project's work is about breaking cycles of trauma and poverty, tackling inequality stemming from adverse childhood experiences and promoting emotional recovery. The charity works at the intersection of poverty and childhood trauma, a link well documented in research (for example, Nurius et al., 2016). Linked to this, services are predominantly based in areas of Cambridgeshire that fall into the most 20-30% deprived areas of the UK (UK Gov, 2019). Moreover, currently 69% of Cambridge Acorn Project's child caseload access Free School Meals and 70% are registered for Pupil Premium (Cambridge Acorn Project, 2023).

REVIEWING *EMPATHETIC COMMUNITIES*

Empathetic Communities was a project initiated in response to the growing number of traumatised children in need of support locally and recognition that the intersectional nature of trauma and poverty requires a flexible person centred approach to support. Specifically, the project is based on an ecological model of practice that recognises, in order to address well-being, a child cannot be viewed in isolation from their

parents/carers, wider family, school and community (Bronfenbrenner, 1994). In sum, the project had 4 key elements:

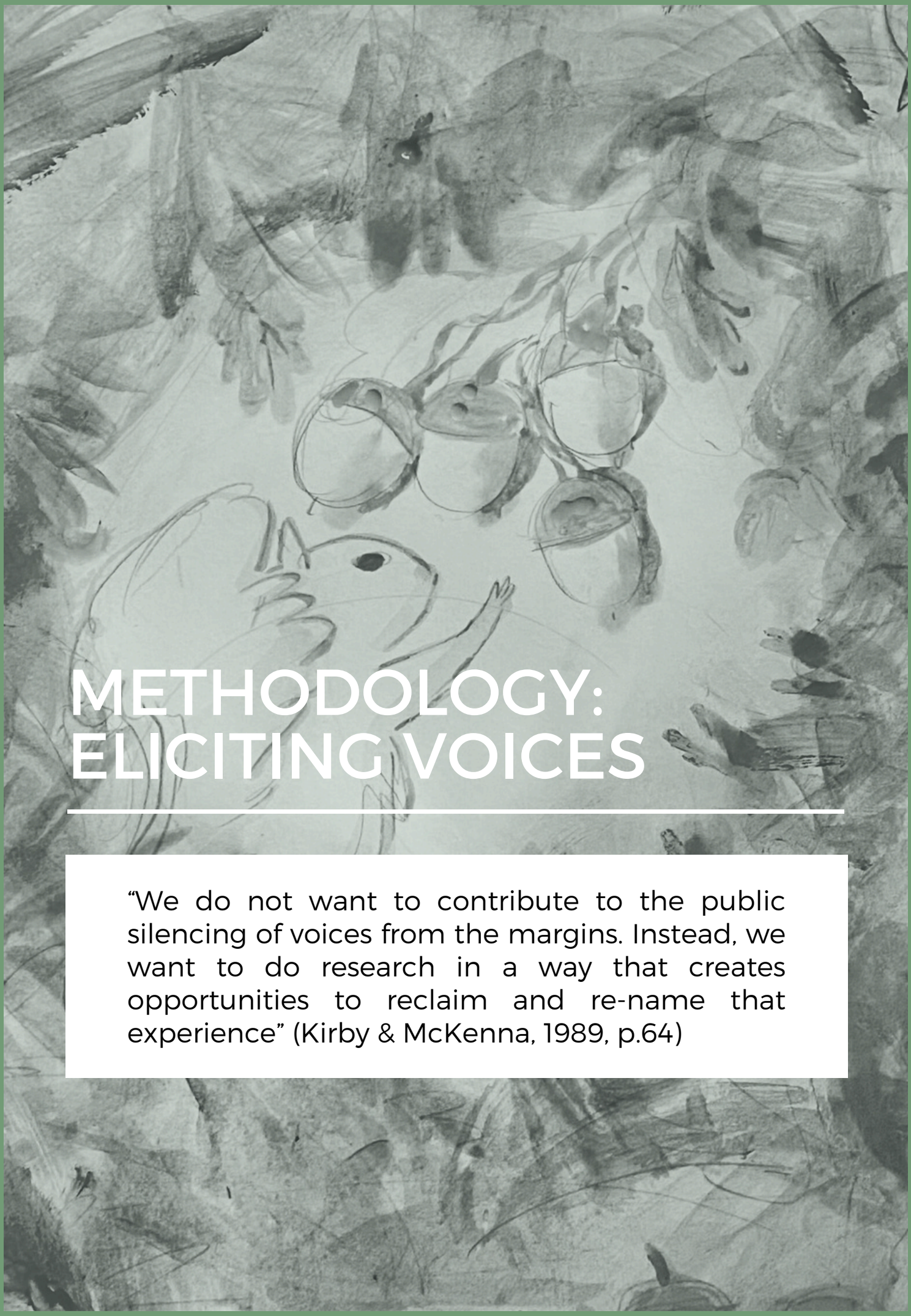
Therapeutic work: such as using evidence-based programmes (e.g. dramatherapy, art therapy, Video Interaction Guidance) to provide 1:1 support for children and parents/carers and focussed on creating positive attachments between people.

Structural Work: emotional and practical support for parents/carers including advocacy, access to benefits and other services.

Preventative work in schools: to develop 'Happy Minds' plans led by children (see Appendix I: What Makes a Happy Mind).

Empathetic Community Development Work: responding to local community identified needs to improve emotional health and wellbeing including the development of a network of community 'listeners' (supported as volunteers), peer support and working with partners to facilitate community led groups.

Empathetic Communities was focussed on three places in Cambridgeshire – Cambridge City, Huntingdonshire, and East Cambridgeshire where referral pathways had already been established by Cambridge Acorn Project and where the need was identified and demand for Early Help (Targeted Support) was growing. The present study focusses on the element of *Empathetic Communities* that were delivered in schools – namely, the therapeutic work. Through this project, therapists were situated in 14 schools for one day per week, enabling a swift referral process between schools and Cambridge Acorn Project to ensure that children would be able to be given quick access to therapy.



METHODOLOGY: ELICITING VOICES

"We do not want to contribute to the public silencing of voices from the margins. Instead, we want to do research in a way that creates opportunities to reclaim and re-name that experience" (Kirby & McKenna, 1989, p.64)

METHOLDOGY

Ensuring that children's voices and experiences are heard is a key facet of ensuring that children are supported to fully embody their rights. The United Nations Convention of the Rights of the Child (UNCRC, 1989), of which the UK is a signatory, enshrines the right of children to express their views in Article 12. Consequently, this right is enshrined within UK Law through the 2004 Children Act. This right is further reflected within best practice healthcare recommendations in the UK where the National Institute of Health and Care Excellence states that "health care professionals should involve children and young people in decisions about their healthcare in ways that are appropriate to their maturity and understanding" (NICE, 2021). Similarly, within research, there has been a paradigm shift to a new sociology of childhood and children are being seen as having valuable voices that should be listened to (Darbyshire et al., 2005) Consequently, much research is now 'alongside children' rather than 'on children'. Nevertheless, within psychological research, children's voices often remain on the margins.

Given the primary work of Cambridge Acorn Project, and a key purpose of the *Empathetic Communities* project, is delivering long-term therapy to children, it was vital to undertake research that prioritised children's voices. As the research followed the ending of therapeutic work it was important to ensure the research was child-centred and provided opportunities for 'good relationships' (Benthall, 2009, p.172). Therefore research instruments were selected on the basis of being able to hold a therapeutic space and enable a relational exchange between the child and researcher despite there not being a pre-existing inter-personal relationship. The research took a qualitative multi-case study approach (Cresswell and Poth, 2017), the following sections explicate the research processes undertaken.

LISTENING TO CHILDREN'S EXPERIENCES OF THERAPY

The research took place with children aged between seven and 12 years old who had accessed therapeutic provision whilst they were in primary school. As children develop language progressively (Lomax, 2012) and the subject matter being researched was exploring personal experiences of accessing therapeutic services, a key concern in selecting the research instrument was to ensure the children were able to participate fully and on their own terms. Whilst there is relatively little guidance on the practicalities of undertaking research with younger children (under 12) and particularly scant literature in the field of psychology a review of the literature was undertaken to identify appropriate existing tools. When reviewing the literature it was kept in mind that life is generally experienced through multiple senses and that "not all knowledge is reducible to language" (Bagnoli, 2009, p.547). Caldairou-Bessette et al.'s (2020) "Talk-Play-Draw" protocol was identified as an approach that would enable "children to have a multidimensional voice in qualitative interview settings" (P2). The protocol included the following elements and the complete protocol used for the present study can be seen in Appendix iii).

> 1. A "talk moment" based on simple questions about how the services were experienced.
> 2. A play situation in which the materials included figurines of different ages and cultural origins and three colour sheets to represent spaces...The guideline was "Let's pretend it's the story of a child who goes to the clinic to see someone like [the clinician's name]." The creation of the story was encouraged by asking simple questions.
> 3. A drawing for which the materials included one sheet of paper and a set of coloured pencils. The guideline was: "If we were to draw a a child who goes to the clinic to see [name of clinician], what would it look like?" In a few open-ended follow-up questions the child was asked to talk about how the characters might feel.
>
> (Caldairou-Bessette et al., 2020, p.5)

FINDING THE CHILDREN

The participants in this study were identified from the population of children who had engaged in the *Empathetic Communities* project between 2021 and 2023. The therapists working in *Empathetic Communities* were provided with a summary of the research project and asked to identify children who they had worked with for whom they thought the research would be safe. Safety was ascertained by only considering children who were far enough through, or had finished, their therapeutic journey so as to be able to be at a point where they could reflect on their journey. As well as this, the therapists assessed whether the child was ready to engage in conversations about their experience of the project without any adverse effects. Finally, the therapists reviewed the research in order to be able to identify children for whom it would be cognitively appropriate. Where the therapists identified suitable children, schools were then approached as gatekeepers. Following gatekeeper consent, parents and children were approached to ascertain interest and to seek parental consent as well as assent (ongoing) from the children. A further reflection on the research ethics is subsequently presented at the end of this chapter.

In total 15 children were approached, 12 children and parents/carers consented to the research however, three children dropped out of the research prior to the interviews taking place including one child who chose on the day not to participate. In total, nine children participated in the research. Four of the children were boys and five were girls. All the children had accessed the *Empathetic Communities* project whilst they had been in primary school. Eight were still in primary school at the time of the research and one had recently started year seven. The youngest participant was 8 years old at the time of the research and the oldest was 12 (one child was 8, two children were 9, three were 10, two were 11 and one was 12). The children had attended six different primary schools in Cambridgeshire that had received services through Cambridge Acorn Project's *Empathetic Communities* project. The 12-year-old had been at primary school when she accessed services but had moved to secondary when the research had took place. All of the children were White British, this is a limiting factor of the research especially in considering that children with a range of ethnicities accessed services through *Empathetic Communities*.

All of the children had been referred to access *Empathetic Communities* by their school. Referral reasons were wide ranging and included abuse, all of the children were referred for more than one reason including: Anxiety (n=4), Attachment (n=1), Behaviour (n=3), Bullying (n=2), Disruptive Attachment (n=2), Domestic Abuse (n=1), Emotional Abuse (n=2), Inappropriate Sexual Behaviours (n=1), Learning Disability (n=1), Low confidence (n=1), Low Mood (n=6), Neglect (n=2), Parental Mental Health (n=1), Parental Separation (n=2), Parent in Prison (n=1), Physical Abuse (n=1), Relationship difficulties (n=1), Sexual Abuse (n=1), Sibling Mental Health (n=2).

The children drew pictures of children each drew an avatar of an imaginary child that was used as part of a role play discussion. These have been used as avatars for each child and along with a pseudonym and age of the child (see Table 1. Participant Overview).

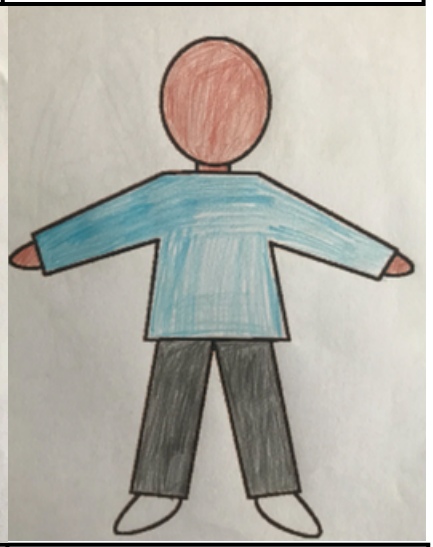
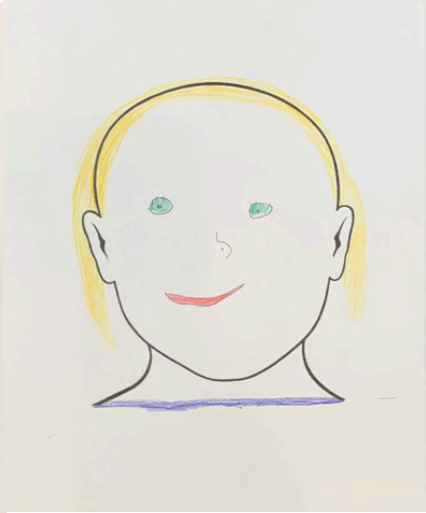
ANALYSIS

All of the "talk-play-draw" interviews were automatically transcribed in real-time using Otter.ai. The transcripts were checked on the same day to ensure they were transcribed verbatim, and the automatic transcription audio file was deleted. The transcripts and corresponding quotes have been kept verbatim to ensure the integrity of the child's voice. To efficiently manage the data, Computer Assisted Qualitative Data Analysis (CAQDAS) was used. However, one challenge was finding software that was fit for purpose and free, as commonly used software such as NVivo were out of our price range. Instead, Taguette was used which is a free open-source programme enabling the electronic coding of qualitative data.

Thematic analysis was undertaken drawing on the inductive guidelines set out by Braun and Clarke (2006) who offer a clear approach for "identifying, analysing and reporting patterns (themes) within data" (p.79). To begin, I familiarised myself with the data by reading and re-reading transcripts, and noting down initial thematic ideas in a mind-map formation whilst being careful not to "gloss over relevant data" (Colley, 2010, p.187). The mind-maps were refined into a coding schedule with logical groups of thematic ideas (Braun and Clarke, 2006).

Throughout the analysis the coding schedule was adjusted treating it as a

TABLE 1. PARTICIPANT OVERVIEW

Lyra aged 10	Sophie aged 11	Tom aged 9
		
Harry aged 10	**Rose aged 11**	**Elena aged 12**
		
George aged 9	**Abbey aged 8**	**James aged 10**
		

live and iterative process (Creswell, 2014). Data was then recoded to ensure that the final coding schedule was systematically applied across all the data. Efforts were made to reduce my own bias within the process and ensure that I was open to "new interpretations and phenomena" (Strauss et al, 1987), and whilst it was difficult to completely remove my own self, the coding schedule provided a clear structure to work from. In order to do this, the advice of Marshall and Rossman (1999) was followed "reading, reading and reading once more through the data forces the researcher to become familiar with those data in intimate ways. People, events, and quotations sift constantly through the researcher's mind" (p.153). Hence, this familiarity with the data aids the trustworthiness of the data (Creswell, 2014; Lincoln and Guba, 1985).

ETHICAL REFLECTIONS

Undertaking research has the potential to create unequal relationships between the researcher and the participants, this can be exacerbated when working with children (Groundwater-Smith et al, 2014). In order to reduce the potential for inequity to be reproduced through the research opportunity was created for the children to be deeply listened to with communication being based on respect for the children's autonomy and dignity, as well as ensuring informed assent and space for silence and dissent (Lewis, 2010).

The research was designed in line with the Ethical Guidelines for Educational Research (BERA, 2018) as the research was undertaken in schools. The research was scrutinised by peers who sat on an internal ethics panel, this included senior members of Cambridge Acorn Project staff including the Designated Safeguarding Lead and Health and Safety Officer and a colleague who was a university lecturer. The ethics panel was invited to give feedback and question the research to ensure ethical rigour. Once approval was obtained, the researcher developed a gatekeeper and participant information sheet to obtain informed consent. Consent for participation was then obtained in three stages as outlined below.

1. Schools where *Empathetic Communities* operated were approached and gatekeeper consent was obtained.
2. Therapists then approached the parents/carers of children for whom the research was appropriate.Where parents indicated they were happy for their child to participate and had spoken to their child, the researcher then made contact to obtain formal parental consent.
3. Informed assent was sought by the researcher from the child before the research started and during the research itself. Each child was shown a document outlining the research and a demonstration was given showing how the automatic transcription software Otter.ai worked. Once the child had asked any questions assent was sought from the child to confirm they wished to participate. They were reminded that they did not have to take part, they could say no at any point, and that there would be no consequences for choosing not to take part, or for stopping at any point. Further, the children were reminded that they should only share things that they felt comfortable sharing as a way to try to support them to keep themselves safe. During the course of the research the children were reminded regularly that they didn't have to answer any question they didn't want to and that they could stop at any point.

Importantly, three children dropped out of the research including one child who chose on the day not to participate in the research. This underlines the agency of the children within the research and highlights the importance of transparent child assent protocols and the importance of ensuring children understand their right to say no without consequence. Anonymity was provided through the process of pseudonymising. All children were given a pseudonym and any information that made a child identifiable such as school name, parent name, references to siblings and family members were changed to protect the identity of the child. Any particularly unique experiences that the children shared were also changed to make it hard to identify children through these details. The opinions and experiences of the programme that the children shared were left unchanged to ensure the trustworthiness of the research.

CHILDREN'S INDIVIDUAL EXPERIENCES OF ACCESSING EMPATHETIC COMMUNITIES: FINDINGS

I've been having bad thoughts a lot less now. So, I think it has helped because I also now believe that I don't think I need to continue therapy at secondary school. So I think it has helped a lot" (James, aged 10)

FINDINGS

In this section, data is presented relating to the first research question what do children think about their individual experiences of accessing Cambridge Acorn Project's therapeutic services delivered through the *Empathetic Communities* project? This data is predominantly derived from the "talk" section of the "talk-play-draw" tool where the children were asked to think about their experiences receiving therapy from the *Empathetic Communities* project. Themes emerging from the analysis are discussed highlighting any similarities and differences in the children's experiences and views. Whilst this is a small sample size, their shared experience of the project *Empathetic Communities* ties their experiences together offering reflection on the experience and impact of the project. When reflecting on their therapeutic experiences within the programme, the children focussed on three key areas – their practical experiences, the benefits obtained and the more challenging elements of engaging in therapeutic work.

PRACTICAL EXPERIENCES: FUN AND PLAY

All of the children spoke positively about their experiences with therapy, with one child describing how they would **"always look forward to going there" (Elena, aged 12)**. Similarly, all of the children praised the therapists they met, highlighted their caring qualities, and described them using positive language such as: really nice, friendly, kind, caring and funny. When asked about what happened in therapy sessions, the majority of the children initially focussed on the practical physical aspects of the sessions. This element of the sessions was characterised by all the children as being "play". However, when describing "play" a range of different activities were described including gymnastics, games (such as Uno, Bananagrams, and puzzles), imaginary play (such as using toy animals and teddies), sensory activities (such as stress balls, water play, and play-doh), crafts and drawing. Across all the children's experiences there was a general sense of having enjoyed being able to do activities within the sessions:

“I like how we get to do stuff, like draw”
(Tom, aged 9)

These activities were seen as inherently important by the children because they were **“really fun” (Elena, aged 12)** and made them feel **“really happy” (Sophie, aged 11)**. Most of the children initially identified the **“selection of things to do” (Harry, aged 11)** as their favourite part:

“Researcher: What did you like the most about when you’d meet with (therapist)?

Lyra (aged 10): When we play

Researcher: Why was that the best?

Lyra: It’s just really fun”

For one child, the play-based activities were considered particularly significant because they connected to important familial memories:

“Researcher: Is there a special moment you remember?

Abbey (aged 8): I remember playing games

Researcher: Playing games - and why were the games important to you?

Abbey: ‘Cos they made me thing out [sibling name]”

Importantly, some of the children were able to identify the therapeutic value of the objects and how they were able to be incorporated into the emotional work that was happening in the sessions:

“I think it’s just like, well I kind of preferred to have the teddies with it

because you could usually like play with them. And you could also like incorporate them into what you're doing [in the therapy session]" (James, aged 10)

PRACTICAL EXPERIENCES: A SAFE SPACE TO TALK

Initially, when reflecting on the talking side of the sessions talking was mentioned in passing alongisde the play-based activities:

"We talk, I like doing crafts – that's fun. We like to play with playdoh and it's really fun and it makes me feel happy. And we talk about lots of fun things. We like making the bracelets, I like making...I've made like this one (shows bracelet) has like two blue, white and like greens – really nice. She's made lots too and they're really cool" (Sophie, aged 11)

However, as conversations developed, the children often became more specific about the types of talking that happened within the sessions. 6 children spoke about the therapy room being a safe space where they could **"talk about anything" (Child F).** Specifically, some of the children explained that they shared their previous experienced with the therapists and worked through their feelings:

"We, when I first met her, we were talking about all the things I had gone through and what it felt like...I liked it that I could be able to like talk to someone because when I talked to Mummy and Daddy I didn't really like to do it because I'd really like talking to someone about my feelings. But [therapist], I actually trust it with." (Abbey, aged 8)

Importantly, three of the children noted the importance of the therapeutic alliance and the relationship built between child and therapist. These children identified how there was a trusting relationship which cultivated a safe space where the child was able to have agency over what they shared.

"It feels, it feels very safe because I know (therapist) quite well now...If I go to her, I say like, I say like, I like of like had, I say I had, for example, I say I had a bad dream. And then she says 'would you like to talk about it or not?' So, I think she also knows more now that I wouldn't want to talk about it. So, she says like "would you like to talk about it or not because she knows I might not want to." (James, aged 10)

Notably, two of the children also reflected on how the therapist gave them feedback and/or suggested strategies which was identified as being useful by both children.

"Researcher: What do you guys talk about?

Sophie (aged 11): My worries – and when I've told her she gives back good feedback and I actually feel better and more happy"

PRACTICAL EXPERIENCES: FREEDOM AND AGENCY

In all of the children's reflections on how the sessions were conducted there was a keen sense that the therapists all worked in a child-centred way where the child was in the lead of what happened and had meaningful choice. Specifically, the children explicitly reported that they felt sessions were based around their needs and preferences, and that the therapists listened to their likes and dislikes:

“Researcher: Can you tell me about when you saw (therapist) and what you did together?

Elena (aged 12): …just like whatever I really felt like doing most of the time”

Some of the children reflected on their experiences within the therapy sessions highlighting the difference of the therapy session to other experiences within school-settings highlighting the freedom they experiences:

“Well, they were very free. You could kind of do whatever you wanted to do in them. So, you had a lot of free rein about what you wanted to do in them…She also like gives me complete free reign on what I want to do so, like, it’s not really like I’m really told what I need to do for it. I just get to do whatever I want… it’s very nice to be able to do whatever you want in it because, I guess, in school you’d kind of get a set assignment to do but there you can just do whatever you want. ”
(James, aged 10)

BENEFITS: IMPROVED WELLBEING

In discussing whether the sessions were of benefit, all of the children reported they were and reflected on their improved wellbeing in two distinct ways. Five of the children spoke in generalised terms about how the sessions supported them to feel **“better and more happy” (Sophie, aged 11)**. When the children spoke in these general terms, they focussed on the direct effect of the session and described a sense of immediacy in their improved wellbeing.

“We talk about stuff what was bothering me. And some Tuesdays I could be a bit upset and then we talked about [it] and then I would feel a lot more better” (Lyra, aged 10)

For the other children, however, they described the sessions helping on an ongoing basis to manage their feelings. Specifically, Harry (aged 10) explained:

“Researcher: Do you think seeing (therapist) helps?

Harry (aged 10): Yeah

Researcher: Could you tell me a bit about how it might help?

Harry: It helps me get through life”

Four children spoke about the longer term benefits they had felt from the sessions. These children were also able to specifically pinpoint the way in which the sessions had helped their mental health. Three of the children focussed on how the sessions helped with processing emotions whilst the other child focussed on how the sessions had reduced their symptoms. Of the three who spoke about processing emotions, one explained how working with the therapist helped her to process her experiences of her family’s structural breakdown explaining:

“It helped with my feelings about leaving (sibling name)” (Abbey, aged 8)

In connection with the sessions being identified as a place to process emotions, there was a sense that having access to a trusted adult who

was able to hear them that was a protective factor for their increased wellbeing.

"I like how it [the sessions] make me feel. It makes me feel really happy and I like, just, you know, having someone to talk to and playing with and it's really fun" (Sophie, aged 11)

For the young person who spoke about the sessions leading to a reduction in symptoms they also identified this change in their experience of intrusive thoughts as a sign that they were ready to end their therapy sessions.

"I've been getting...I've been having bad thoughts a lot less now. So, I think it has helped because I also now believe that I don't think I need to continue therapy at secondary school. So I think it has helped a lot" (James, aged 10)

BENEFITS: TIME OUT

When thinking about other ways the sessions had helped them, almost half of the children openly explained an additional benefit of engaging in the session was that they did not have to be in their normal lesson:

"Researcher: And what do you like the most about coming to the sessions?

Rose (aged 11): I don't have to be in class"

When expanding on the benefits of being out of class, three of the children spoke about being the therapy sessions being an opportunity for self-regulation. The children who reflected in this way described sessions s an opportunity for a brain-break, a place where you don't need to **"worry about anything" (Elena, aged 12)** and a time to relax out of lessons:

“Researcher: Do you think it helps coming to see (therapist)?

George (aged 9): Yeah

Researcher: Yeah? How do you think it helps?

George: So I can get away from learning?

Researcher: And does it help to have some time away from learning?

George: Yeah

Researcher: Can you tell me why?

George: Because I can have a break”

CHALLENGES: DIFFICULTY TALKING ABOUT TRAUMA

When asked about the possibility of what could be done to improve the service the majority of the children struggled to identify areas for improvement. When asked directly 7 of the children reported there was nothing that could be improved. Two of the children did identify areas for improvement: **“more sensory stuff” (Sophie, aged 11)** and being able to **“go outside” (Tom, aged 9).** However, in reflecting further on the sessions, 2 of the children spoke about the complexity of talking about trauma and emotional difficulties.

“Researcher: Is there anything you didn’t like about sessions?

Abbey (aged 8): Sometimes I used to go too far on it

Researcher: What do you mean?

Abbey: Like when I was, when we were

talking about like feelings, I...I...first I went too far on one and I got really upset.

Researcher: And what could have made it better or what could have helped?

Abbey: If I didn't say that much and I just did talk about it, but then [didn't] go too far on it"

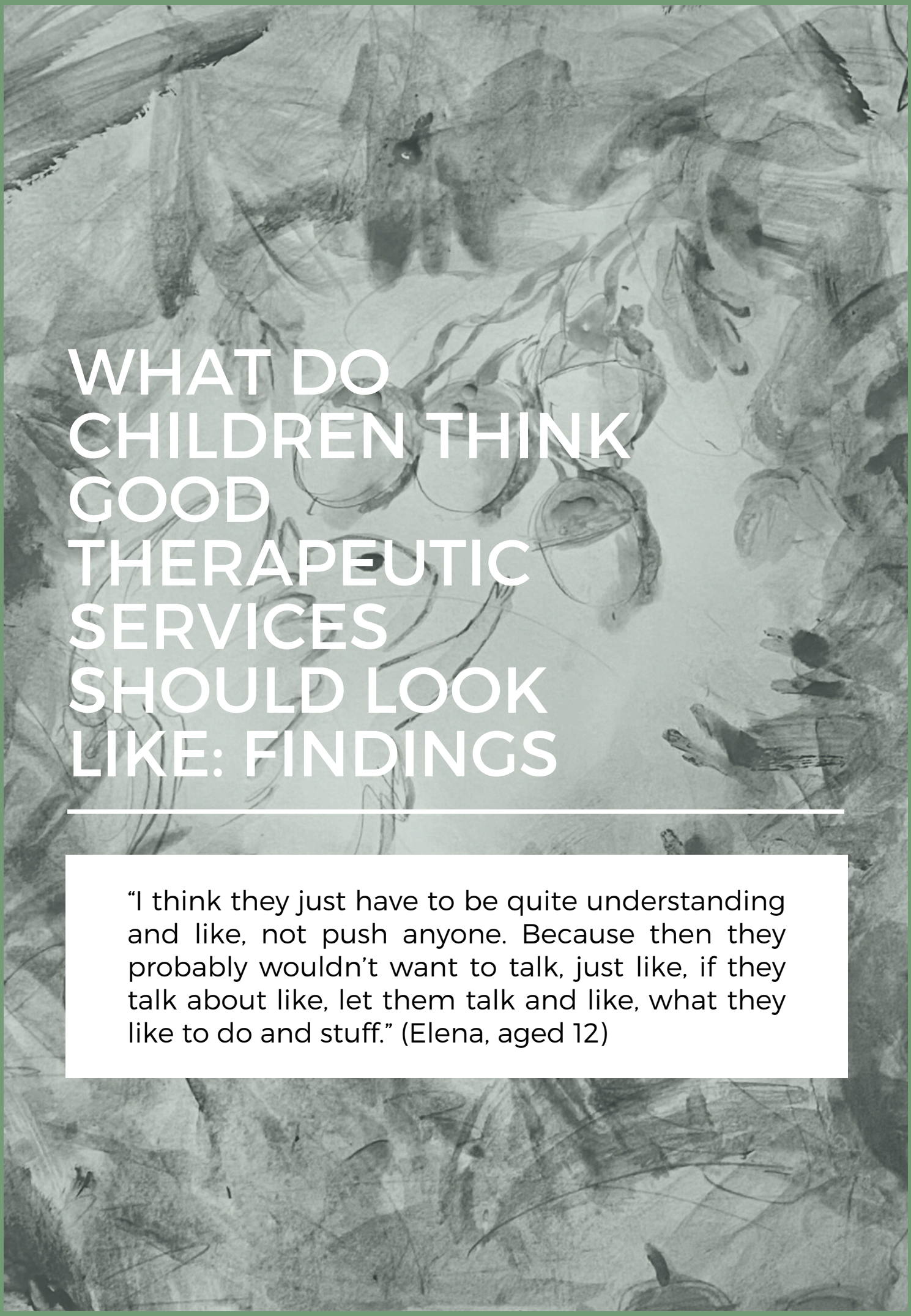
Interestingly, Abbey went on to explain how engaging in practical activities supports talking about difficult topics.

"Sometimes it makes me upset when they say "what's going on". And it makes me quite upset that we're talking about it. I do get some time to like think and we also play games as well what helps" (Abbey, aged 8)

Similarly, James also spoke about the difficulties of talking about trauma and highlighted the importance of having choice over what he shared.

"It's a safe space where you can say because like usually I don't really feel very comfortable with saying what actually happened but I do feel comfortable with saying that something bad or disturbing did happen"(James, aged 10)

Linked to the difficulties of talking about trauma both of the children who spoke about the challenges of talking about trauma also spoke about the importance of ensuring their privacy in the sessions. James spoke about the importance of having the doors closed whilst Abbey explained her worries about someone overhearing, highlighting the vital importance of having access to a safe and appropriate physical space for therapeutic work.



WHAT DO CHILDREN THINK GOOD THERAPEUTIC SERVICES SHOULD LOOK LIKE: FINDINGS

"I think they just have to be quite understanding and like, not push anyone. Because then they probably wouldn't want to talk, just like, if they talk about like, let them talk and like, what they like to do and stuff." (Elena, aged 12)

FINDINGS

This section addresses the second research question what do children, who have experienced therapy, think good therapeutic services should look like? Data in this section is predominantly derived from the "play" and "draw" section of the "talk-play-draw" tool where children were asked to use roleplay and drawing to reflect on how they thought therapy should happen and what therapists should be like. Resulting themes from the analysis are presented drawing together the children's similar and differing views of how good therapy should be delivered. Whilst only a small group of children's views are present in this study, their collective experience of adversity and therapy adequately positions them to comment on what a good service could look like and how they think therapy should be delivered – ensuring their voices are heard in Cambridge Acorn Project's future service development is vital as a way to safeguard services and make certain they remain child-led. When considering what good therapeutic services should look like the children focussed on services being needs-led, having the right ingredients for building a strong therapeutic alliances and having the potential to promote emotional recovery.

NEEDS LED: EQUITY OF ACCESS

The children generally displayed the broad view that any child who wanted to access therapy should be enabled to do so:

"I think it can be anybody who feels that they need to go to therapy. So, if you suddenly feel that you need to go I think you should be able to go. I don't think there should be a certain thing that cites whether people can or cannot or like a certain thing that kind of unites, a stereotypical thing that sort of shows

that you should go to therapy or you shouldn't." (James, aged 10)

However, many of the children were also able to identify specific reasons that a child might need to access therapy including: because they were struggling, feeling sad, not having anyone to talk to or needing to have someone to talk to, feeling stressed including due to events happening at home, getting bullied, and bereavement. One child, who self-identified as Autistic felt that Autistic children would definitely benefit from accessing therapy:

"Researcher: What children should come to sessions like this?

George (aged 9): Autistic

Researcher: Okay, why do you think Autistic children should come to sessions like this?

George Cos they struggle to do stuff

Researcher: And do sessions like this help with that?

George: Yeah"

The children reported that access to therapy should usually be organised by a parent or by their school who they felt would know how to facilitate access. One child highlighted that sometimes it might be difficult for a child to ask for help and so schools and parents/carers should be aware of this so they can offer help:

"You don't always wanna ask for help, but like when it's given to you, that's nice" (Elena, aged 12)

As well as equitable access for all children, the majority of the children felt that frequency of contact was a key part of accessing therapy.

The children in the study had access to therapy through the *Empathetic Communities* project one per week during one lesson of the school day. However, when reflecting through the role play element of the research eight out of nine of the children thought children would benefit from accessing therapy more frequently. The most common suggestion was twice per week or a few times per week, however, twice per day was also suggested. Generally, there was agreement that sessions should last around 1 hour, however, Rose (aged 11), when participating in the role play element with an imaginary child Lila suggested that therapy should last for half the day to provide space for the child:

"Rose (aged 11): Half of the day

Researcher: Half of the day – wow. So they see each other quite a lot?

Rose: Yeah

Researcher: Do you think that would help Lila [imaginary child] more to see him quite a lot for quite a long time?

Rose: Mmmhmmm [in agreement]

Researcher: Do you think that's better than like a short session?

Rose: Yeah

Researcher: Can you help tell me why that might be?

Rose: So then she could have, like, enough time to do her own thing, and her own space"

NEEDS LED: THE RIGHT ENDING

In thinking about a child's journey accessing therapeutic services six of

the children were clear about the need for therapeutic services to be long term or to go on for **“as long as the child needs” (Abbey, aged 8)**. Moreover, George (aged 9) reported therapy should happen **“forever”** whilst Rose (aged 11) suggested therapy should continue until adulthood when **“she doesn’t have any stress anymore because she’s moved out”**.In addition, there was a general consensus that the long-term nature of the therapy was vital to ensure that the therapist **“could make sure that you’re doing a lot better”** (Lyra, aged 10).

Similarly, in thinking when a therapeutic journey would come to an end, there was an understanding from the children that a therapeutic service should primarily consider the child’s wishes. Importantly, the idea that child should have agency in the ending decision came across strongly in more than half of the children’s narratives:

“I think it should be up to the young person mainly…I think you should be able to stop whenever he says that he's ready.” (James, aged 10)

As well as being able to ask to stop when you’re ready, the idea of being able to ask for more was also highlighted:

“You could also ask when you finish art therapy, you could ask if it helped or if you think you need to do it a little bit more” (Lyra, aged 10)

The majority of the children felt that therapeutic endings were okay as long as the child was ready, they were able to identify what readiness looked like including **“the problem is solved and then they don’t like need it anymore” (Elena, aged 12)**, or **“when she’s doing a lot better and she’s not sad, and she can manage her emotions” (Lyra, aged 10)**. Similarly, whilst Abbey (aged 8) thought that a child would typically feel **“sad that they’re not getting as much as they used to before”** when therapeutic services ended, she was also able to articulate that a child would be able to know when they were ready for therapy to end:

“Because you know that you’ve, you’ve

done what you needed to and you've talked about it, and now it's time you don't need it anymore, because all your feelings have been helped with" (Abbey, aged 8)

BUILDING A THERAPEUTIC ALLIANCE: THERAPIST QUALITIES

In describing the qualities a therapist should have, the children were overwhelmingly clear that a good therapist would be kind, positive, happy, and friendly. The importance of friendliness was explained by two children who explained the importance of cultivating the right environment in the therapy room, Abbey (aged 8) explained this by reflecting on the importance of not having a **"stern voice"**, whilst James (aged 10) explained a friendly therapist would provide the right environment for a child to feel they were able to talk, whereas a more officious person would engender the opposite:

"I think they need to be very friendly, and like, I think they need to not be very serious and be quite playful. If there was somebody who was just like sitting there in a suit with a clipboard, asking you about how you felt in the past day, you'd probably feel less likely to talk about it. If there was somebody who was very okay with you, whether you wanted or didn't want to talk about it." (James, aged 10)

As well as being able to identify key soft-interpersonal skills that a therapist should have, three of the children conceptualised the therapist as fulfilling a role of trusted adult where the child would **"have a person to talk to" (Abbey, aged 8)**, who was **"there"** for them (Rose, aged 11). For James (aged 10), trust was something that was seen as developing over time:

"You learn to trust the person more and then eventually it's doesn't feel weird just going to them in saying this stuff." (James, aged 10)

In contrast, two of the children conceptualised trust as something that could be identified more quickly by directly questioning the adult:

“I would ask them if they would keep it and wouldn’t tell anyone” (Abbey, aged 8).

Similarly, Rose (aged 11) felt that they would be able to identify whether the adult was trusted or not by the way they acted:

Rose (aged 11): He [imaginary therapist in role-playing scenario] acts very kind to her. And she can tell what is suspicious.

Researcher: How can she tell that, how does she know how to tell?

Rose: By the voice and how they act

Researcher: So with Jason [imaginary therapist] what would his voice be and how would he act that is not suspicious?

Rose: He just always acts very kind and cheerful, and also the questions [that he asks]”

In reflecting further on the therapeutic alliance, six of the children also strongly spoke of the importance of the therapeutic alliance being relational. Specifically, they described the importance the child and therapist building a relationship through shared activity:

“They would play and talk, and they would like, they would bond with each other and they would just have fun” (Sophie, aged 11)

In addition, some of the children related the need for the therapist to explicitly show interest in them as an individual. These children explained the importance of building a relationship and getting to know each

other so that the therapist understood the child's sense of self:

"You would introduce each other if your parents haven't done, or just say your names to each other, and then get to know each other, like, what do you like? And what makes you happy?" (Abbey, aged 8)

Interestingly, Sophie (aged 11) was also able to identify how this strengthening of the therapeutic alliance would have a positive outcome:

"When she like, when she would respond to her, she'd make her feel better" (Sophie, aged 11)

BUILDING A THERAPEUTIC ALLIANCE: SELF-DETERMINGATION AND FREEDOM

As well as developing a strong relational therapeutic alliance, the children were also able to comment on the way the sessions should run. The theme of sessions being non-coercive was strongly evident across five of the children's narratives. Specifically, James explicitly articulated the importance of the sessions being based on principles of freedom and liberation:

"I would say that you [should] feel very free to do what you want with the session and that the people, the therapists, are okay if you do or don't want to say anything...It should be really free and you should be really liberated in what you want to do when you're doing it" (James, aged 10)

The five children who spoke about children's self-determination in the sessions reflected on the importance of the sessions being child-led which would provide an opportunity for the child to choose what they wanted to do.

"Researcher: How could the adult support them in the sessions?

Abbey (aged 8): Say what they wanted to do, and ask if they would like to do something"

In reflecting on the practicality of how a session would be child-led, all of the children were able to extensively list activities that might occur in a therapeutic session during the role play part of the research. This included a range of activities the children described as play such as: gymnastics, painting nails, playing a game, playing boardgames and puzzles, water play/sensory play, art and craft, computer games, playing with toys, being outside and playing catch. Notably, it was suggested that there should be plenty of choice:

"I just think like have plenty of things available, so you can like do what they want, change it up. Or like keep their like favourite thing to do just and they'll probably enjoy it like the most they can, and then talk more" (Elena, aged 12)

Importantly, when reflecting on the activities there was a strong sense across all of the children's role-plays that children should not have to do things in the sessions that they did not want to.

"Maybe if they don't like to do something or they don't want to do the therapy anymore you could just try and do what they want to make them more happier and know that, that you'll do kinda what they would like to make them happier" (Lyra, aged 10)

BUILDING A THERAPEUTIC ALLIANCE: PLAYING

As well as highlighting the importance of having the freedom to choose activities, Most of the children inferred a connection between engaging in activities alongside the therapist and talking.

“They could do gymnastics while talking, but mainly gymnastics” (Lyra, aged 10)

In considering what activities would be useful to have available in sessions, the children made a wide range of suggestions including: games and toys, art and craft resources, music, physical and sensory activities and imaginary play. Specifically, four of the children made a connection between engaging in activity based play and talking suggesting that this combination of activities was a useful way to support children to engage in conversation.

“You could draw a picture of what you liked and see if your adult drawed one and talk about stuff you do at school and what you do at home” (Abbey, aged 8)

Similarly, Elena (aged 12) explained that providing a child with their favourite activities would help a child to feel comfortable enough to share their feelings.

“I just think like have plenty of things available, so you can like do what they want, change it up. Or like keep their like favourite thing to do just and they’ll probably enjoy it like the most they can, and then talk more” (Girl 4 – Child F)

BUILDING A THERAPEUTIC ALLIANCE: TALKING

In addition to identifying how talking could be promoted within sessions there was a keen sense in the children’s discussions on how talking was the mechanism that helped with processing emotions.

“Researcher: How does the adult help them?

George (aged 9): Talking to them”

The children were able to functionally describe the way talking should be used within sessions idetifying common subjects to talk about

including: checking in with how they are doing, what is worrying the child, talking about feelings, what is happening at home, what is happening at school, and how their week has been. Whilst it was recognised that the therapist might take an active or lead role at times by asking some questions, but that it was important to balance this with working in a child led way:

"Rose (aged 11): They could ask them still some questions but also let them do their own thing

Researcher: Can you tell me a bit more about doing their own thing?"

Linked to this, it was highlighted as being important not to push a child too far when discussing certain topics, and let them lead on what they were comfortable talking about:

"I think they just have to be quite understanding and like, not push anyone. Because then they probably wouldn't want to talk, just like, if they talk about like, let them talk and like, what they like to do and stuff. And just like, yeah, and just like do that thing, and then they might like open up more" (Elena, aged 12)

However, Elena was also able to reflect on the fine balance of supporting a child to open up, but not being pushed too far.

"If you don't like to open up then it never really solves it, so when they begin to open up, you know, you might ask a couple of questions but not like push them into it" (Elena, aged 12)

In reflecting on how to ensure a child didn't feel they were pushed too far, Three of the children felt it was okay to check in about this using direct questions. In addition, one of the children felt that a visual tool

might be useful to help a child be more exact about how ready they were to talk about their feelings of experiences.

“But like with that [visual aid] it can be more exact about it, like whether you really don't want to talk about it, or you just don't feel like talking about it today, or whether you're close to feeling safe about talking about it.” (James, aged 10)

THE POTENTIAL OF THERAPY: EMOTIONAL RECOVERY

When reflecting on whether therapy might have an impact on a child, the children were able to consider both short and long-term effects. In reflecting on the short-term effects, there was a consensus that after sessions generally a child would feel happier. The children indicated that a child who attended therapy would likely be experiencing some level of distress, including being **“sad, lonely” (George, aged 9)** or **“upset” (Lyra, aged 10)**. After a therapy session, there was a shared the view that a child would likely feel an immediate increased sense of wellbeing and regulation. The children described how a child might feel **“calm” (Rose, aged 11)** or **“happy” (Harry, aged 10)**. In addition, four of the children explained that a therapy session would make a child feel more relaxed and less anxious. One child explained that the relaxation would support a child **“not to cry as much” (Rose, aged 11)**, whilst another suggested that increased relaxation following a session would mean they would be better able to focus on school-work and less likely to get told off suggesting that the boys also thought sessions had self-regulatory benefits:

“They’re relaxed, so they can do like their work, and they won’t get told off” (Tom, aged 9)

Similarly, when considering the longer term there was a consensus among the children’s narratives that the child would experience positive benefits. Specifically, the children made suggestions including that children who had engaged in therapy might live a **“more happy life” (Harry, aged 10)**, have wider social networks and **“get to know more people and make more friends” (George, aged 9)**. Another suggestion

was that therapy might lead to greater self-awareness with a child becoming more **"confident of how they are feeling" (George, aged 9)**. Interestingly, in reflecting further, Sophie (ages 11) was able to explain how therapy might have a long-lasting impact where the benefits gained from engaging in therapy might also mean that a child was better placed to support their peers. Notably, Sophie was able to be nuanced that whilst worrying thoughts might not completely disappear the child would still be okay, interestingly, she also noted how accessing therapy may enable a child to support other children:

"How the story ends is – she starts to feel better about her worries, but she knows she can still tell everyone and she feels better and now she knows not to stress so much. Maybe they're [therapist and child] are still like seeing each other, but she can go help her friends too with advice like that she [the therapist] gave her. Like if they still see each other she could still give her, her worries. Like she might not stop worrying completely because everyone worries, but hopefully she would feel better" (Sophie, aged 11)

THE POTENTIAL OF THERAPY: PROCESSING AND RESOLVING PROBLEMS

In addition to increased wellbeing, there was a sense that engaging in therapy would be an opportunity to process emotions and would lead to resolving problems. Three of the children spoke about the therapy room as being a space where children should be able to process their emotions. Notably, there was a sense that talking about feelings and experiences led to feelings **"relieved" (Rose, aged 11)**. In reflecting on why talking was useful, another child perceived talking as a way to process, or deal with, feelings:

"Researcher: What about after the sessions, how might Ivy [imaginary child from role play] feel?

Sophie (aged 11): Better, and very, like, I don't know how to explain it but she feels like a kind of weight's been lifted off her back"

Similarly, another child was able to reflect on the benefits of access to a trusted adult who a child could tell if something bad happened to them. Specifically, they spoke about the dangers of **"bottling up [feelings]" (James, aged 10)**, and how in the long run sharing feelings helps:

"I think they probably feel better, because they've been able to tell somebody so you probably feel..like...because if you didn't tell anybody you kept all bottled up inside you, it would probably grow to be worse than if you just told somebody to begin with. So then it's good that there's somebody who you know, you can tell if something bad happens" (James, aged 10)

In reflecting on the longer-term benefits of therapy, four of the children (three girls and one boy), suggested that engaging in therapy would help with sorting problems. There was an optimistic sense from these children that through engaging in therapy perceived problems would be resolved and this would be an indication that they were ready to stop therapy.

"Because you know that you've, you've done what you needed to and you've talked about it, and now it's time you don't need it anymore, because all your feelings have been helped with" (Abbey, aged 8)

THE POTENTIAL OF THERAPY: SAFETY

When reflecting on the propensity for therapy to improve children's lives, some of the children highlighted increased safety. This safety was

related in two different ways, one of the children spoke about the intervention of therapy improving their physical safety by the therapist working systemically with families to ensure that the child lives in a safer home. This seemed particularly important as the child was able to reflect on the different power dynamics and saw the therapist as having the agency to make positive change in the child's life:

"Researcher: What's Jason [imagined therapist] going to be like?

Rose (aged 11): Very kind and he speaks to the parents

Researcher: Okay – and is that a useful thing?

Rose: Yeah

Researcher: Why

Rose: Because no more horrible things would happen at home where she is"

In contrast, another child framed safety in terms of therapy having the potential to increase an individual's emotional security or resilience, ensuring they are better prepared to go into the world:

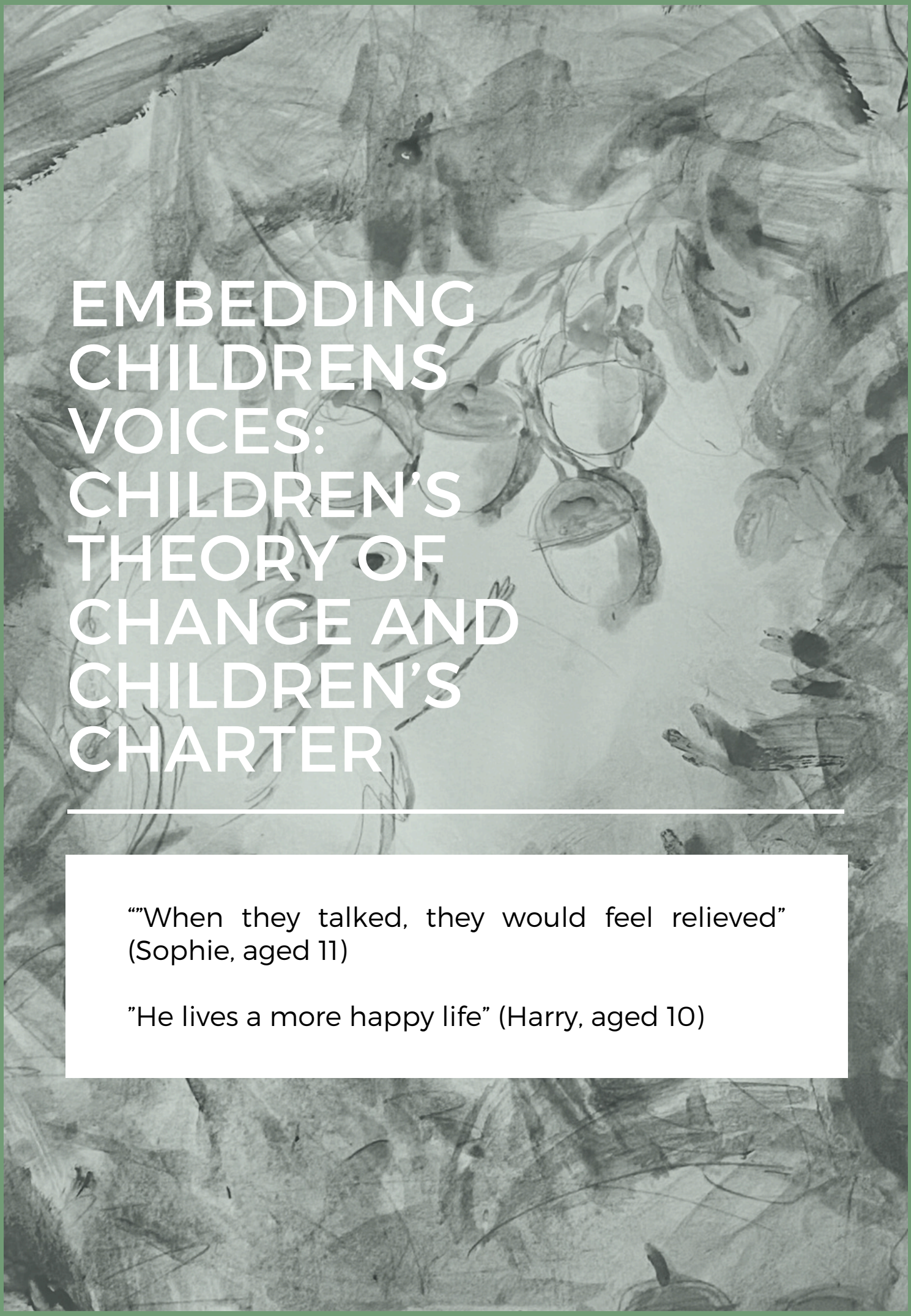
"So if he hadn't have had therapy, Roger [imaginary child] would probably feel much less safe going out into the world and he probably would have been much more worried about bad stuff happening. But now that he's been through therapy, and he's been through therapy until his dad is married again. He now feels much more safe going out into the world and he feels much more optimistic." (James, aged 10)

THE POTENTIAL OF THERAPY: DIRECTIVE STRATEGIES

As well as sessions being wholly child-led and child-centred, three of the children – notably all girls – felt there were opportunities for the therapist to be more directive by suggest strategies. One child viewed **"advice" (Sophie, aged 11)** as being a way to make a child **"feel better" (Sophie)**. Whereas for another child these strategies were seen as something the child could implement to help them manage their own wellbeing:

> **"They might ask me like about my family and what they're like. And then they could suggest like how I was doing or what like I could do" (Elena, aged 12)**

In one case, a child was clearly able to outline a strategy that the therapist had helped her family to implement where she had a worry box where she would be able to write down her worries before she went to bed and then screw them up and place them in the box. At night-time her parents could read them which she found helpful, and she thought this kind of strategy would be useful to be suggested to other children to help them too.



EMBEDDING CHILDRENS VOICES: CHILDREN'S THEORY OF CHANGE AND CHILDREN'S CHARTER

""When they talked, they would feel relieved" (Sophie, aged 11)

"He lives a more happy life" (Harry, aged 10)

THEORY OF CHANGE

The children's voices elucidated through the current research project have been used as the basis to develop a children's theory of change relating specifically to the therapeutic services delivered by Cambridge Acorn Project (see Figure 1. Children's Theory of Change). The children unanimously described how the services they accessed through *Empathetic Communities* made positive change to their mental health and wellbeing and through the analysis of their experiences it was possible to identify both short and long term positive change. The Children's Theory of Change sits alongside Cambridge Acorn Project's wider organisational theory of change which is in development and describes how the charity's bespoke panoramic services address the multiple levels of deprivation and inequality experienced by children and families referred to the service.

Cambridge Acorn Project's new Children's Theory of Change draws together evidence from children's voices in the present study, along with extant data describing the child population that Cambridge Acorn Project serves. The theory of change recognises the current context that the charity work in; the high prevalence of mental health difficulties amongst children, and the current crisis within the children's mental health system (The Lancet, 2020). It describes the long term therapeutic approach provided including a typical offer which includes a minimum of 32 sessions of therapy. The short term changes identified through the theory of change are based on the children's voices describing the therapeutic potential from having a safe space to talk with a trusted adult which leads to short-term improved wellbeing and regulation. The longer term outcomes are based on children making measurable change through intensive long-term work which provides opportunity for children to process their experiences. As well as the children's views outlining the long-term changes, measurable evidence of this is seen in the *Empathetic Communities* school survey (see Appexdix ii) and through SDQ data available in the charity's latest Impact Report (Cambridge Acorn Project, 2023).

FIGURE 1. CHILDREN'S THEORY OF CHANGE

Children's Theory of Change: Therapy

01 WHAT?

Children's mental health services are in crisis (The Lancet, 2020). The prevalence of probable mental health conditions is rapidly increasing and it is thought 1 in 5 children are affected (NHS, 2023) and statutory services are unable to meet the need. Children who experience trauma and abuse as well as living in households facing financial harship face multiple intersecting levels of deprivation.

02 WHO?

Children are referred due to complex trauma such as domestic abuse, and/or experiencing sexual, emotional, or physical abuse as well as single-incident trauma such as house fires/floods, medical trauma, or traumatic loss. Children referred predominantly live or attend schools in the 20-30% most deprived areas of the UK (Index of Multiple Deprivation, 2019).

03 HOW?

Children access long term, needs-led, evidence-based therapeutic support including long-term therapy as part of a larger bespoke panoramic therapeutic package supporting the child and family (see panoramic theory of change). Children are offered at least 32 therapeutic sessions.

04 WHAT CHANGES?

SHORT TERM

Having a safe space to talk about on going difficulties lead"s with a therapist who is a trusted adult leads to short-term improved regulation and wellbeing

"We talked about [it] and then I would feel a lot more better"

LONG TERM

Measurable change in wellbeing, increased school attendance and engagement and reduction in risk.

"You know that you've, you've done what you needed to and you've talked about it, and now it's time you don't need it anymore, because all your feelings have been helped with"

"IT HELPS ME GET THROUGH LIFE" - CHILD

THERAPEUTIC CHARTER

Through speaking with the children and analysing their discussions, key themes were identified that have been incorporated into a primary aged Children's Charter for Therapy (see Figure 2.) along with anonymised quotes from the children within this project. The themes identified for the therapeutic charter also link to evidence within literature highlighting important qualities of therapeutic work.

Equal access to therapy: The children highlighted the importance of equitable access to therapy for any child who feels that they need to access this type of support. Easy access to services is essential as early intervention for children at risk is vital to prevent difficulties from escalating to crisis points. However, the current state of children's mental health services means that high levels of children referred into statutory services are not seen. National data suggests that 60% of children referred into statutory services were not seen within a whole year (The Children's Society, 2019), whilst local Cambridgeshire NHS Digital Data (2020) shows 38% of children had their referrals closed by statutory services before any treatment was offered. Similarly, the Department for Education (2018) report that 70% of children and young people experiencing mental health difficulties have not received appropriate support at an early enough age. Further investment is needed in children's mental health care including in the third sector which is increasingly meeting the needs of children who are unable to access statutory or commissioned services.

Therapists should be trusted adults: Through the present research the children reflected on the importance of the therapists being trusted adults whom they could safely confide in. The notion of a trusted adult is also found in literature showing that access to a trusted adult that might be defined as an adult who "children and young people may turn to for help and will take them seriously" (Whitehead et al., 2019, p.5), can lead to a number of positive effects including mitigating the effects of Adverse Childhood Experiences (ACEs) (Bellis et al., 2017) and reducing harmful

FIGURE 1. CHILDREN'S CHARTER FOR THERAPY

Children's Charter for Therapy

Equal access to therapy

"I think it can be anybody who feels that they need to go to therapy. So, if you suddenly feel that you need to go I think you should be able to go."

therapists should be trusted Adults

"I think they need to be very friendly, and like, I think they need to not be very serious and be quite playful."

"When she like, when she would respond to her, she'd make her feel better"

talking and Playing

"I just think like have plenty of things available, so you can like do what they want, change it up. Or like keep their like favourite thing to do just and they'll probably enjoy it like the most they can, and then talk more"

therapy should be a place of freedom

"it's really important for therapy that it should be really free and you should be really liberated in what you want to do when you're doing it."

there should be no forcing

"I think they just have to be quite understanding and like, not push anyone."

"The therapists, are okay if you do or don't want to say anything."

therapy should be long term

"As long as the child needs"

outcomes (Frederick et al., 2023). The children's conceptualisation of a trusted adult also speaks to the importance of a strong therapeutic alliance which is evidenced in literature as having the potential to lead to symptom improvement (Hawley & Weisz, 2005) as well as higher levels of treatment adherence (Liber et al, 2010). This highlights the protective factor of a therapist promoting a child's recovery and expanding the child's network of trusted adults. Keen thought should be given to the ending of therapy and how children's networks can be expanded to ensure access to trusted adults both in and out of school.

Talking and playing: A clear theme in the children's discussions was the link between engaging in practical playful activities and the act of talking. Some children also explicitly described the act of engaging in play as a lever for deeper discussion. Whilst incorporating playful or creative activities into therapeutic sessions is different from explicitly defined arts therapies (e.g. Art therapy) there is an extant body of literature examining efficacy. For example, Moula et al. (2022) who undertook a Randomised Control Trial in primary schools which highlighted that "engagement with the arts as a coping mechanism under difficult circumstances…particularly in terms of expressing emotions and feelings which are complex and cannot be easily verbalised" (p.13). Further rigorous research listening to children's voices around the importance of playful activities within therapy is vital to ensure these approaches are accepted as part of an evidence-based toolkit for working therapeutically with children who have experienced trauma.

Freedom: The theme of freedom was strongly present in the children's own experiences of therapy and their descriptions of what therapeutic services should look like. Freedom was described as the opportunity for personal liberty, agency, choice and occupying a therapeutic space that was different where there was no fixed outcome/assignments. Respect for children's autonomy and their right to be heard is enshrined in the 1989 Children Act and the United Nation's Convention on the Rights of the Child (ratified by the UK in 1991) as well as through the process of shared decision making for decisions around care as recommended by the National Institute for Health and Care Excellence (NICE). Within the UK Government's (2022) recent publication on trauma-informed-practice, choice is highlighted as a key tenet, specifically the importance of "listening to the needs and wishes of service users and staff". Children's

views and experiences should be central to the development and deployment of children's mental health services if they are to be truly child-led and trauma-informed.

No forcing: In reflecting on the challenges of talking about trauma and difficult feelings, the importance of non-coercion and agency over how and when to talk were highlighted. Similarly, the children spoke about a general sense of not doing something if a child didn't like it. This speaks to theoretical underpinnings of therapy where to work therapeutically should be the antithesis of abuse and therefore premised on absence of coercion. This approach is highlighted in the UK government's (2022) working definition on trauma-informed practice where it notes the importance of "acknowledging that people who have experienced or are experiencing trauma may feel powerless to control what happens to them, isolated by their experiences and have feelings of low self-worth" thereby highlighting the importance of empowering or even re-powering children by redressing and returning the power within a therapeutic space. Ensuring children have meaningful power and control over when and how they share their thoughts, feelings and experiences is critical for trauma-informed-practice and an area for further research. As well as working in a trauma informed way, the Just Therapy movement highlights how people accessing therapy may be part of "a culture that is marginalised by the dominant culture" (Campbell et al., 2001, p.198) and thus highlights the other ways in which consideration should be taken in respect of promoting agency and rejecting any kind of oppression. When working therapeutically with children it remains central to consider positionality, priviledge, and intersectionality within the therapeutic relationship (Bergkamp et al., 2023; Pettyjohn et al., 2019) and especially how this interacts with the child-adult/therapist-client power dynamic, ensuring un/intended oppression (systemic or individual) and inequality has no place in the trauma-informed therapy room.

Long term: In discussing the length of services, the majority of children were very clear on three fronts: therapy should be long-term, it should end only when the child is ready, and the child should have agency in any decision to stop therapy. De Geest and Meganck (2019) suggest that in psychotherapy time limits are typically implemented due "pragmatic and economic reasons" (p.206). Extant research does not report a consensus and instead suggests that time limits can have both a

negative and positive effects. Notably, there is a lack of evidence on the temporal nature of therapy and significantly there is a significant lack of research taking into account the perspectives of clients, especially children. The present study elucidates the voices of children who argue for the long-term nature of therapy and thus this should be considered when developing therapeutic services which respond to children's needs. Innovative long-term services are needed to ensure that economic barriers do not prevent children's voices from being heard and acted upon.

To conclude, whilst this study is limited by sample size, the children's experiences shared within this research highlight the vital importance of children's agency being centrally located within the design and delivery of children's therapeutic services. Rather than focussing on whether services are directive or non-directive, it may be beneficial to consider the ways in which children have power and control returned to them through accessing trauma-informed therapeutic services. A beneficial dichotomy moving forward, may be to consider the ways in which trauma-informed services facilitate children to experience control or a lack of control through their design and delivery.

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APPENDIX i: HAPPY MINDS

For the preventative element of the *Empathetic Communities* project, workshops were undertaken in 10 primary schools with 1469 children between June 2019 - December 2022 to explore what makes a happy mind. During these sessions the children reflected upon and explored what makes a happy mind to feed into a preventative picture of what children say they need to thrive.

The children generated anonymous mind maps which made up the existing dataset. Consent for the dataset was given by schools who acted as gatekeepers and assent was sought from children for their work to go into the anonymous dataset, any data where consent was not given was removed from the final dataset. In total 290 pieces of children's work were collected. The work was then split into two data sets. The first data set (n = 241) consisted of children generally listing protective factors for positive mental well-being. For the second data set (n=48) children listed protective factors for positive mental wellbeing across three domains: school, home, community. Frequency analysis was undertaken to establish the frequency of each suggestion for what constitutes a happy mind. The data is presented through word cloud figures to highlight the most important protective factors the children identified.

HAPPY MINDS (DATA SET ONE)

As illustrated in Figure 1, when the children considered Happy Minds generally, the most suggested protective factors for promoting wellbeing were: friends (44% n=105), animals and pets (41% n=100), family (40% n=96) and food & drink (40% n=96)

FIGURE 1. HAPPY MINDS

HAPPY MINDS AT HOME (DATA SET TWO)

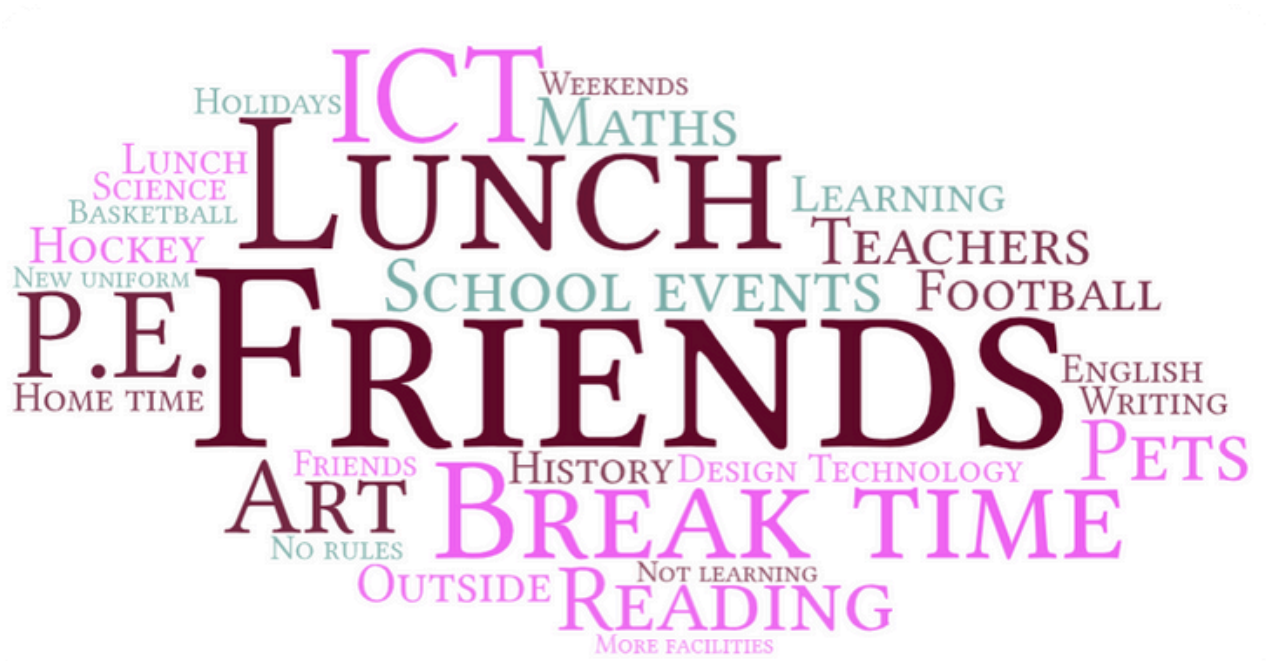
As illustrated in the word cloud in Figure 2 the most suggested protective factors for promoting wellbeing at home were: pets (46% n=22), eating (44% n=21), video games (44% n=21) and family (41% n=20).

FIGURE 2. HAPPY MINDS AT HOME

HAPPY MINDS AT SCHOOL (DATA SET TWO)

As illustrated in Figure 3 the word cloud in Figure 1 the most suggested protective factors for promoting wellbeing at school were: friends (63% n=30), lunch (58% n=28), break-time (46% n=22).

FIGURE 3. HAPPY MINDS AT SCHOOL



HAPPY MINDS IN THE COMMUNITY (DATA SET TWO)

As illustrated in Figure 4 the word cloud in Figure 1 the most suggested protective factors for promoting wellbeing in the community were access to: swimming and skate parks (both 35% n=17), football (29% n=14), parks (27% n=13), friends (25% n=12).

FIGURE 4. HAPPY MINDS IN THE COMMUNITY

UNDERSTANDING WHAT MAKES A HAPPY MIND

In looking at the individual domains of home, school, and community there was important variance in the factors identified as key to mental wellbeing. Factors identified for home were linked to family, food, pets and videogames. Key factors for school primarily focused on aspects outside of lessons including friends and breaktimes. The most important aspects of community life that contributed to positive mental wellbeing focused on access to enrichment and leisure facilities including access to swimming and skate parks.

Looking across both data sets, 'Friends' is a key protective factor identified by the children. For the general data set 1, 'Friends' was the most frequently cited element of a healthy mind with 105 children listing this (44%). Similarly, 'friends' appears across all three domains in data set 2. It is most prominent in the school domain occurring in 63% of the students' pieces of work. Friends also appears as a protective factor in community domain (25%), and home domain (27%). Another popular protective factor cited across both data sets was pets and/or animals. In the general data set 1 animals and/or pets were highlighted in 41% of the data. Similarly, in data set 2, pets appeared in 46% of data for the home domain. Pets and/or and animals also occurred in the other domains but appeared less frequently (School 15%, Community 4%).

Interestingly, whilst use of technology including using mobile phones, tablets, watching TV, and using social media was popular in the general data set 1 and the home category of data set 2, none of these factors were in the top five suggestions for protective factors for mental wellbeing. The only exception for this was video games which was the third most suggestive factor in the home domain (44%) in data set 2 and fifth most suggested factor in data set 1 (35%).

APPENDIX ii: SCHOOL EXPERIENCE OF SERVICE FEEDBACK

As part of the evaluation of this project, a satisfaction survey was undertaken with schools who had received E*mpathetic Communities* services in the year 2021-2022. The survey consisted of an adapted Experience of Service Questionnaire used within the NHS (confirm details and reference). Fourteen schools were contacted, and seven schools responded. Schools reported exceptionally high levels of satisfaction from the project with two schools describing the project as "invaluable". The survey consisted of 14 questions with a 3-point likert scale (certainly true - partly true - not true) with an extra "don't know" response (the same scale as used in the existing NHS questionnaire) as well as three free text boxes responding to the questions what was good about the service, what needs imporving and any other information. The respondents data is displayed below.

I FEEL THAT THE PEOPLE WHO HAVE SEEN OUR PUPILS LISTENED TO THE SCHOOL

100% "CERTAINLY TRUE"

14.3% "PARTLY TRUE"

IT WAS EASY TO TALK TO THE PRACTITIONERS AT CAMBRIDGE ACORN PROJECT

85.7% "CERTAINLY TRUE"

THE PUPILS WERE TREATED WELL BY PRACTITIONERS AT CAMBRIDGE ACORN PROJECT

100% "CERTAINLY TRUE"

TEACHERS' VIEWS AND WORRIES WERE TAKEN SERIOUSLY

100% "CERTAINLY TRUE"

I FEEL THE PRACTITIONERS AT CAMBRIDGE ACORN PROJECT KNOW HOW TO HELP WITH THE PROBLEMS PUPILS WERE REFERRED FOR

100% "CERTAINLY TRUE"

OUR SCHOOL WAS GIVEN ENOUGH EXPLANATION ABOUT THE HELP AVAILABLE FROM CAMBRIDGE ACORN PROJECT

100% "CERTAINLY TRUE"

OUR SCHOOL WAS ABLE TO WORK TOGETHER WITH PRACTITIONERS FROM CAMBRIDGE ACORN PROJECT

100% "CERTAINLY TRUE"

OUR SCHOOL WAS ABLE TO EASILY PROVIDE ROOMS FOR CAMBRIDGE ACORN PROJECT TO CONDUCT SESSIONS IN

CAMBRIDGE ACORN PROJECT WAS FLEXIBLE ABOUT SESSION TIMINGS

OUR SCHOOL WOULD USE THE SERVICES OF CAMBRIDGE ACORN PROJECT AGAIN

100% “CERTAINLY TRUE”

CAMBRIDGE ACORN PROJECT SERVICES HELPED PUPILS WITH THEIR MENTAL HEALTH

85.7% “CERTAINLY TRUE” | 14.3% “PARTLY TRUE”

CAMBRIDGE ACORN PROJECT SERVICES HELPED PUPILS TO INCREASE ATTENDANCE

85.7% “CERTAINLY TRUE” | 14.3% “PARTLY TRUE”

-CAMBRIDGE ACORN PROJECT SERVICES HELPED PUPILS TO INCREASE THEIR ENGAGEMENT IN SCHOOL

71.4% “CERTAINLY TRUE” | 28.6% “PARTLY TRUE”

OVERALL, THE SERVICES OUR SCHOOL RECEIVED FROM CAMBRIDGE ACORN PROJECT IS GOOD

100% “CERTAINLY TRUE”

WHAT WAS REALLY GOOD ABOUT CAMBRIDGE ACORN PROJECT’S SERVICES?

“Consistency was very good”

“The way that you took parent and school concerns seriously. Your flexible approach as the child being supported has had frequent periods of travelling this term. You have responded to emails. You have worked to ensure that the child's support continues into secondary school”

“The family that was supported faced some difficult times and the Acorn practitioner worked with them as a family to help them manage the situations they were in. The children responded extremely well to the practitioner and welcomed her each week. The practitioner also invited Mum and Dad to her weekly sessions which helped to transfer the learning to the family dynamic”

“I really valued the support we received from the Acorn Project, they supported the school with a mixture of pupils”

“[Therapist] was very good at listening and supporting our children. She liaised with parents and carers and kept them fully informed. Feedback to school staff was also good”

“How they engaged children”

“Fantastic communication and positive outcomes. We wish [therapist] could have continued with us!”

WAS THERE ANYTHING YOU DIDN'T LIKE OR ANYTHING THAT NEEDS IMPROVING?

Four schools responded “no” or “nothing to comment on” to this question.

“Sometimes the room was difficult to guarantee - so adaptability would be appreciated”

“Email issues”

“Such a shame it had to stop!”

IS THERE ANYTHING ELSE YOU WANT TO TELL US ABOUT THE SERVICE YOUR SCHOOL RECEIVED?

“It was difficult to end the sessions - some parents found this too abrupt”

“It has been invaluable to the children and families involved”

“It is an invaluable service”

“There was an amazing service and would love it to continue, it really filled a gap for us as a school regard the support we need”

“We are very grateful for all the support that our children and staff received from Rachael and we would really welcome any further support that Cambridge Acorn Project can offer our school in the future if it is possible for available please”

“Parents were positive about the provision. Their children talked about it at home”

Contact Us

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