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‘Safety Nets’: A community based social prescribing intervention involving combined physical activity and psychoeducation for young people on mental health service waiting lists: A pilot service evaluation.

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Abstract

Objective

Young people can face long waiting lists when accessing UK Child and Adolescent Mental Health Services (CAMHS) with limited support whilst waiting. “Safety Nets” was developed as a social prescribing intervention that includes physical activity and psychoeducation for young people with anxiety, depression and low mood on CAMHS waiting lists. This mixed methods service evaluation aims to show the acceptability and impact of ‘Safety Nets’ on the mental health and wellbeing of these young people.

Method

This study conducted a mixed-methods service evaluation of ‘Safety Nets’. 24 young people on CAMHS waiting lists for support for anxiety, depression and low mood were recruited to an 8-week group intervention, “Safety Nets”; delivered in five groups across four sites. Participants completed a Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) at the first and final session and completed a qualitative exit interview.

Results

Results showed good acceptability and engagement from all stakeholders and young people gave high satisfaction ratings. Paired WEMWBS scores in 24 young people showed an improvement of 11.6 with a 95% confidence interval 7.5-15.6.

Discussion

This service evaluation showed acceptability and positive impacts of ‘Safety Nets’. A large-scale trial is warranted to test the clinical and cost-effectiveness for social prescribing for children and young people on CAMHS waiting lists.

Keywords: Young people, psychoeducation, exercise, mental health services, waiting lists, social prescribing

Main Text

Introduction

Depression among adolescents is highly prevalent both in the UK and worldwide (Thapar et al., 2012; Wright et al., 2020) and rates may be rising (Collishaw et al., 2010). A recent study showed that 1 in 6 children in the UK have a probable mental health disorder (NHS Digital, 2021), an increase on figures from 2017 where 9% of 11-16-year olds in the UK were reported to face an emotional disorder using a multi-informant diagnostic process (Sadler et al., 2018). Studies suggest gender differences, with poorer emotional health among adolescent girls compared to boys (Brooks et al., 2017). Adolescent depression also carries increased risk of adult depression (independent of other comorbidities) (Fombonne et al., 2001). It has been suggested that approximately 50% of mental health problems start before 14 years of age (Kessler et al., 2005).

Current waiting lists for psychological treatments are long. NHS data suggests approximately 66,000 under 19s were referred to Child and Adolescent Mental Health Services (CAMHS) in April 2022. The numbers of young people accessing CAMHS have risen as a result of the pandemic, with this figure from April 2022 showing a 109% increase compared to April pre-pandemic in 2019 (NHS Digital, 2022). This increase in referrals then leads to longer waiting times for these young people. Data from 2017/2018 shows that some young people were waiting over a year for an initial assessment or to start treatment (Young Minds, 2021).

It is important that young people are supported to enhance positive mental health, where they can cope with daily life stressors and function well in their daily lives (Fusar-Poli et al., 2020). This can include improving understanding and knowledge of mental health and learning self-help tools to manage symptoms of anxiety and depression. Whilst it is important for adolescents to receive psychological services, National Institute of Clinical Excellence (NICE) guidance (Lawton & Moghraby, 2016) recommends that adolescents with depression should also be offered advice on the benefits of regular exercise. Physical activity may be beneficial in the management of depression (Lowe et al., 2018) with recognition that benefits also arise from associated social interaction, learning of new skills, and possible neurophysiological mechanisms (Mandolesi et al., 2018).

Current evidence supports the benefits of exercise for supporting mental health. A UK randomised controlled trial (RCT) with 87 adolescents found significant effects for aerobic activity on depressive symptoms at 6 months (Carter, T., et al., 2015) and qualitative outcomes reported the young people found the exercise motivating and enjoyable (Carter, T., Morres, I., Repper, J & Callaghan, P., 2016). There have been multiple systematic reviews examining the effects of exercise interventions in reducing depression and anxiety in children and adolescents (Larun et al., 2006; Bailey et al., 2018; Brown et al., 2013; Carter, T., Morres, I., Meade, O., J & Callaghan, P., 2016). These found small to moderate effect sizes in favour of exercise and support the acceptability and feasibility of exercise interventions, with low drop-out rates reported. However, the reviews highlighted low quality evidence, with small numbers of studies, small sample sizes, and a range of participants, interventions and outcome measures limiting the ability to draw conclusions. Larger, more robust research studies are therefore needed.

Other work suggests that the benefits achieved from exercise in group settings are considerably greater than the simple benefits of the physical activity (Eime et al., 2016; Lamblin et al., 2013) and include a sense of belonging, companionship and improvements to self-esteem. There is evidence highlighting the role of social connectedness in both prevention and treatment of depression and anxiety (Malaquias et al., 2015) and having good school and social connectedness at 12-13 years old is associated with better mental health outcomes in later years (Bond et al., 2007). These findings highlight the importance of group membership as a preventative measure for depression, which may translate to outcome benefit of group interventions for depression.

Social prescribing involves clinicians referring patients to community and voluntary agency groups to support their mental health. The intervention is adapted to the individual to suit their interest, including groups such as; drama, music, art, games and sport. Research suggests that UK social prescribing schemes for adults can reduce levels of anxiety and depression (Bickerdike et al., 2017; Chatterjee et al., 2018) with reduced need for GP services of 28% following referral (Kimberlee et al., 2017). There is limited literature on social prescribing for young people although NHS England recommends building a more robust evidence base for children and young people in the community (NHS England, 2019) and the Children and Young People's Mental Health UK Government Green Paper called for development of effective interventions outside specialist clinics (Department of Health & Social Care, 2017). Limited access to mental health services and long waiting times necessitates community interventions that facilitate earlier intervention and self-management. Given its promise it is surprising how little social prescribing research has been carried out with young people and robust research is urgently needed to examine the effectiveness and cost-effectiveness.

This paper describes a social prescribing intervention in Yorkshire and Derbyshire for young people to engage in fun physical activity alongside psychoeducation, called 'Safety Nets'.

Safety Nets

"Safety Nets" was designed to support young people on waiting lists for treatment for anxiety and depression in child and adolescent mental health services (CAMHS). It is a collaborative project involving seven CAMHS trusts from South Yorkshire (n=5), Derbyshire (n=1) and West Yorkshire (n=1). These Trusts developed working relationships with local professional football and rugby clubs in the Yorkshire and Derbyshire regions and have been running Safety Nets for 18 months.

Safety Nets creates groups for young people to support their mental and emotional wellbeing. Each group runs for eight weeks at a local professional sports club for two hours after school in term time. The sessions include 50 minutes of physical activity followed by 50 minutes of psychoeducation (after a 15-minute break). The physical activity session is led by non-clinical staff who are sports coaches from the local sports clubs, and the psychoeducation is led by the clinical staff. Both sports coaches and clinical staff participate and support delivery across both the physical activity and psychoeducation sessions. The physical activity was not restricted to just football and rugby but included multisport activities and team-building games and activities at a mix of both low and high intensity. During the physical activity, the non-clinical staff introduce the theme of the psychoeducation part of the session. Where possible, physical activity and the psychoeducation topic are linked to facilitate conversations. For

example, during the physical activity the young people may discuss how communication with teammates is important for the game. Following this, in the psychoeducation session there would be discussion around how communication with people around you is important for keeping safe and well. Table 1 shows the outline of Safety Nets sessions and their content but as a service evaluation, sites were able to have some flexibility in delivery based on clinician and staff expertise. This allowed the groups to be led by the young people and cover the themes that they wanted to discuss.

Table 1. Outline of Safety Nets sessions

Session Number	Aims	Content
1	Introduction	Setting ground rules for the group, introducing staff and each other
2	Promoting good health	Overview of what is needed for good mental health, discussion around anxiety
3	Social Media	Using social media safely
4	Peer Relationships	Helping develop good relationships, friendships and developing communication skills
5	Sleep	Sleep hygiene, setting good relationships
6	Mindfulness	Relaxation and mindfulness techniques
7	Diet	Healthy eating, how to reach a balanced diet
8	Making learning sustainable	Signposting to community groups they can continue to access, what learning will they take away from the groups

The psychoeducation session themes and content are based on current evidence contextualised by clinical experience. The content was chosen after review of the evidence base for universal interventions to improve social and emotional wellbeing in young people (Blank et al., 2009). It includes content to promote social networking (Barrett et al., 2006), development of prosocial skills (Shochet et al., 2001), life skills (Quayle et al., 2001) and peer support (Cowie et al., 2008) alongside general lifestyle advice including diet and sleep (Khalid et al., 2016; Robotham, 2011). Based on advice from clinicians and evidence that social media use is linked to experiences of social isolation, depression and cyberbullying (Best et al., 2014) and research which has shown positive links between mental health and good peer relationships (Long et al., 2020), mindfulness (Dunning et al., 2019) and mental health literacy (Coles et al., 2016), these topics were also incorporated into the content.

The groups enable young people to learn about how and why anxiety and depression occur and to learn ways of managing them along with taking part in some multisport physical activity. The young people are also provided with rewards for attending Safety Nets such as a water

bottle in week 1, a sports team hat in week 5 and tickets (for the young person and adult) for a game at the sports club in week 8.

The aim of this service evaluation is to ascertain the acceptability and impact the Safety Nets service has had on young people and their families. Acceptability relates to how well the intervention meets the needs of the young people, and if it is an intervention they would want to participate in and find helpful (Ayala & Elder, 2011). Impact refers to the effect and potential change for both individuals and society as a result of the intervention (Chandler, 2014).

Materials and Methods

This is a mixed methods service evaluation. The service evaluation was approved by participating Trusts, and patient reported outcomes were assessed as part of a routine evaluation of services and not as part of research.

Population

Young People identification and recruitment

Participants were young people (age range 10-17 years) on the waiting list for Cognitive Behavioural Therapy (CBT) or brief psychological therapy for anxiety or depression, but not considered at high risk (such as a history of violence or experiencing suicidal thoughts) after CAMHS triage. Participants were contacted via letter, sent to them and their families detailing what the intervention involved and asking if they would be interested in taking part in Safety Nets. Young people then opted in. There is currently no formal parent/carer role in the intervention, although future evaluations of Safety Nets could explore the possibility of a parent group to further support the young person and their family.

Young People Eligibility Criteria:

- From 10 to under 18 years of age
- Currently under the CAMHS service and triage assessed by a CAMHS clinician
- Have an allocated case manager
- Have underlying difficulties with either anxiety or low mood, as assessed by a CAMHS clinician
- Be willing to engage with physical activity
- No history of violence or experiencing suicidal thoughts

Clinical Staff Eligibility Criteria:

- Clinically qualified (band 5 member of CAMHS staff or above, registered with a relevant professional body)
- Works with children and young people in a CAMHS setting
- Works for the NHS
- Not a support worker

Non-clinical Sports Club Staff Eligibility Criteria:

- Be willing to engage in physical activity with the young people
- Have prior experience with working with young people in a group setting
- Have safeguarding and mental health first aid training
- Works at the local sports club and has coaching experience

Procedures

This service evaluation was peer reviewed within the first author's organisation. Young people were recruited from CAMHS services and contacted via letter. The young people then opted in to participate in the 8-week Safety Nets programme. The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) was completed in-person at the beginning of session 1 and at the end of the final session. All young people and parents/carers provided verbal consent to attend the session and provide WEMWBS data for the service evaluation. Safety Nets cohorts grouped ages, for example one cohort ran with 12-14 year olds and others were run with 14-18 year olds.

After the final session, children, their parents, sports club staff and CAMHS staff were invited to provide qualitative feedback. CAMHS and sports club staff were invited to attend an interview lasting 15-25 minutes by phone and parents were invited to an in person interview. Parents could also submit feedback on the Safety Nets intervention via email. Young people were invited to attend a focus group (25 minutes) to take place after the final Safety Nets session of the first cohort at a South Yorkshire Rugby Club.

All individuals (parents, young people, staff) who took part in either interviews or focus groups provided verbal consent to do so, and parents provided additional verbal consent on behalf of their child. This was recorded by the Safety Nets team in the young person's medical records. Although institutional ethics approval was not required as this was designed as a service evaluation, ethical issues such as informed consent were considered, and the procedures were approved by clinical managers at each participating site. All participants provided verbal consent to participate and were fully informed of the service prior to joining. They were aware that they could withdraw at any time. All young people continued on the waiting list and continued to receive care as usual.

Outcome measures

The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) (Tennant et al., 2007) was adopted to measure mental wellbeing outcomes. The WEMWBS has been validated for use with children aged 13 and over and has been used in the Health Survey for England since 2010 (Bryant et al., 2015). The outcome measure is comprised of 14 Likert-scale items describing the individual's thoughts and feelings over the past two weeks. A higher score indicates more positive wellbeing. Young people completed the WEMWBS in-person at the beginning of Session 1 and at the end of session 8. Following completion of the WEMWBS the scores were transcribed using an anonymised unique identifier into a spreadsheet.

Telephone interviews were conducted with children, their parents, sports club staff and CAMHS staff and young people participated in a focus group after their final session. The aim of the interviews was to find out the level of acceptability of Safety Nets and the perceived impact it had on individuals.

Data Analysis

Data on the WEMWBS were analysed using paired samples t-tests in SPSS. Interviews were not transcribed, but detailed in-depth notes were taken during all interviews and during the focus group. A Framework analysis (Yin, 2018) was used to identify data that fit within the identified a priori themes. These a priori themes were based upon the evaluation aims and were as follows: 1) Acceptability of Safety Nets and 2) Perceived impact Safety Nets has had on the mental health and wellbeing of young people accessing CAMHS. A priori themes were chosen to ensure that the data achieved the service evaluation aim: To show the acceptability and impact on mental health and wellbeing that results from Safety Nets. An inductive thematic analysis approach was not undertaken. Authors felt that these a priori themes were broad enough to ensure participants were able to freely express their views and focussed enough to respond to the questions posed by this service evaluation.

The framework analysis involved:

1. Identification of themes (see above)
2. Familiarisation with the data
3. Indexing, whereby relevant quotations were transferred into a Word document under the appropriate theme.
4. Charting, whereby the above process was iteratively reviewed.
5. Mapping and interpretation, where a summary description of the themes and relevant data was developed.

Discrepancies were resolved through group discussion in an iterative fashion between the authors.

Results

Quantitative results

24 young people engaged in the Safety Nets groups. The age range was 11-17 years old, mean age was 14.55 years old and there were 58% girls in the groups. Groups ranged in size from 4 participants to 7 participants.

Data were available for all 24 participants. Data were not collected on the number of young people who were invited to sessions and did not attend. Paired t-tests showed a mean increase of 11.6 on the WEMWBS following the intervention (standard deviation 9.6) with a 95% confidence interval of 7.5-15.6. This difference showed a significant improvement in mental health scores ($t(23) = -5.903, p<0.001$). Table 2 illustrates the mean and standard deviation of the WEMWBS scores before and after the participants undertook the Safety Nets service.

Table 2. Means, standard deviations, minimum and maximum WEMWBS scores pre and post receiving the Safety Nets service.

	N	**Minimum**	**Maximum**	**Mean**	**Standard Deviation**
WEMWBS pre scores	24	18.00	59.00	37.63	12.37
WEMWBS post scores	24	17.00	70.00	49.21	12.77

Qualitative results

The semi structured interviews were conducted separately with three young people, two CAMHS staff members and one staff member from a sports club. Additional email testimonials were provided by two parents and one child who were unable to attend an interview.

The focus group involved seven young people. Table 3 demonstrates demographic information for who took part in the focus group, interviews and email testimonials.

Examples of quotations that resulted from the Framework analysis are presented below.

Table 3. Demographic information of individuals who took part in this service evaluation.

ID	**Source data**	**Child age (years)**	**Gender**	**Location of Safety Nets group attended**
Parent 20	Email testimonials	15	F	Doncaster

[1]YP 20	Email testimonials	15	F	Doncaster
Parent 24	Email testimonials	15	F	Doncaster
YP 12	Focus Group	16	M	Doncaster
YP 13	Focus Group	13	F	Doncaster
YP 14	Focus Group	15	F	Doncaster
YP 15	Focus Group	16	F	Doncaster
YP 16	Focus Group	13	M	Doncaster
YP 17	Focus Group	17	F	Doncaster
YP 18	Focus Group	15	M	Doncaster
CAMHS Staff 1	Interview[4]	[2]NR	F	Barnsley
CAMHS Staff 2	Interview[4]	NR	F	Barnsley
[3]SCS 1	Interview[4]	NR	F	Barnsley
YP 3	Interview[4]	14	F	Barnsley
YP 4	Interview[4]	14	F	Barnsley
YP 5	Interview[4]	15	F	Barnsley

[1] Young Person; [2]Not Recorded; [3]Sports Club Staff; [4]Interviews were completed individually

Two a priori themes were identified for the framework analysis:

1. Acceptability of Safety Nets

All participants gave positive feedback. Parents reported an overall positive impact from the intervention for their child's mental health:

"This course has saved our daughter, we truly believe this" (Parent 20)

Young people highlighted the presence of clinicians as being a key component of the sessions, as well as the benefits to meeting other young people who were also facing mental health challenges.

"I don't think the conversations would have been the same if CAMHS weren't there, as CAMHS staff deal with it every day in their jobs" – (Young person 3)

"The best thing about being involved in this is the fact that the people there were going through similar things to me and it made me feel like I'm not alone and that's it's okay to feel like that sometimes." – (Young person 20)

"*I like that it is mixed gender, it's good to see that boys and girls do go through what we have.*" – (Focus group, Young person 18)

2. Impact of Safety Nets on CYP mental health and wellbeing

All participants stated that Safety Nets had a positive impact upon CYP's mental health and wellbeing including boosting their confidence and self-esteem. This is supported by the WEMWBS results. It is also deemed important that it was recognised that Safety Nets can increase young people's self-esteem and confidence as this is typically low in young people with mental health conditions. The consensus across participants was that Safety Nets was beneficial in terms of mental health and nobody noticed any detrimental effects.

Parents in particular commented on improvements in their child's wellbeing and self-esteem.

"Her self-esteem has been so low that I can't reiterate to you how much you have helped her" – (Parent 24)

(My daughter) *"...now speaks of her future and shares ideas and goals with us…she links my arm when we are out and she laughs!"* – (Parent 20)

This was supported by comments from young people themselves, who also felt they had improved in confidence.

(Safety Nets) *"Helped me with social skills and I have gained more confidence"* – Young (person 20)

In addition, the delivery staff also noticed improvements in self-confidence and development of peer relationships. This may have led to additional benefits including engagement with the FC community groups, which the young people may not have felt confident enough to access prior to participating in Safety Nets.

"I saw genuine enjoyment with getting together with others…building relationships and having a laugh" – (Sports club staff 1)

"The first thing that jumps into my head is confidence really. Participant X…has immediately gone and accessed the X FC group." – (CAMHS staff member 2).

Discussion

Significant numbers of children and young people in the UK are facing mental health difficulties such as anxiety and depression (NHS Digital, 2021). This has been increasing post-pandemic and has led to increases in referrals to specialist mental health services, meaning more young people are facing long waits to receive the support they need. This study aimed to conduct a

service evaluation of an intervention to support young people on waiting lists for treatment, to ascertain the acceptability and impact.

This service evaluation used mixed methods. Quantitative findings from SWEMWBS completed by young people participating in the Safety Nets intervention showed improvement in scores post intervention, reflecting more positive mental wellbeing. This was reflected in the qualitative results, with all participants reporting positive impacts on their wellbeing. This suggests that the Safety Nets intervention may have a positive impact on the wellbeing of young people with mental health difficulties, although given the low sample size results are to be interpreted with caution.

In the UK population in general, the lowest 15% of the population score 14-42 on the WEMWBS (the top 15% range from 60-70) (Warwick Medical School, 2021). This puts our current participant group in the same category as the lowest 15% of the population on a whole at the start of the intervention. The Health Survey for England Children's Well-Being (NHS Digital, 2015) reports the mean WEMWBS score among 13- to 15-year-olds at 51.4. This further contextualises the Safety Nets groups' improvement, as not only did the young people's scores improve compared to before participating in the group, but the scores following the intervention are of clinical significance, with week 8 scores comparable to the national average for a similar age group, when week 1 scores were comparable to the lowest 15% of the UK population on a whole. This improvement has potential implications for long term outcomes, considering the link between adolescent and adult depression, and the suggestion that approximately 50% of mental health problems start before 14 years of age (Kessler et al., 2005). It also carries the potential of alleviating pressure on CAMH services seen in recent years.

The improvement in WEMWBS scores is reflected in the positive qualitative feedback collected from interviews and the focus group. Young people, parents and staff reported that Safety Nets has helped improve the young people's confidence and self-esteem and allowed them to build these social skills while improving their mental well-being and having fun. Some feedback from young people suggested the sessions were helpful because of the presence of both the sports staff and CAMHS staff. Authors' felt it is particularly valuable to learn that participants valued Safety Nets and the inclusion of qualified CAMHS staff. The presence of clinical staff and their input into the groups may have added to the acceptability of Safety Nets as an intervention for those struggling with their mental health. Qualitative feedback was provided from young people of a range of ages, suggesting that it was an acceptable and positive intervention across age groups.

Young people themselves felt that being part of a group, particularly a group including others with similar lived experience to their own, helped them feel less lonely and having mixed gender groups was acceptable, further highlighting the importance of the social interaction, and the role of exercise in helping to facilitate this. This aligns well with previous research reporting benefits from group intervention, particularly the benefits of participating in group physical activity compared to individual activity (Eime et al., 2013; Lamblin et al., 2017).

Several parents and staff reported the impact of sessions taking place at the professional sports club. Qualitative feedback suggests that may have made it easier for some young people to access CAMHS services as they perceive it as less stigmatising than going to a

routine CAMHS appointment, and the “pull of the badge” of Safety Nets being run with the known local sports club may have made it more attractive to them.

The WEMWBS results and the positive qualitative results are in keeping with existing reviews (Larun et al., 2006; Bailey et al., 2018; Brown et al., 2013; Carter, T., Morres, I., Meade, O., J & Callaghan, P., 2016) which found small to moderate effect sizes for exercise-based interventions in improving depressive symptoms for young people. This study adds to the evidence base for the use of exercise-based interventions to support young people with their mental health.

Limitations and Recommendations

Currently, due to the limited resources available for this service evaluation, Safety Nets was confined to the South Yorkshire area, limiting sample size. Despite this, results show that it is a feasible programme to deliver and is acceptable and accessible to young people. These findings are important given the sparse literature on these kinds of mixed group interventions. It is important to consider that although the physical activity session included a broad range of sports and games, there may be the potential for self-selection, with those young people who feel more confident towards physical activity selecting to participate in the intervention.

Additionally, the study design used did not include a control group or a longitudinal element and data were not collected around the number of young people who were invited to sessions and who did not attend. These are limitations of the current study and future work should aim to include a comparison group such as treatment as usual, as well as a longer term follow up of the young people to further consider the effectiveness of Safety Nets. For example, future studies could record whether young people continued on the waiting list and what support they went on to access.

In terms of the qualitative analysis methods, a limitation is that all interviews were not transcribed. Despite this, detailed notes were taken and used which still allowed for feedback to be collected from participants. Quantitative data collection only included the WEMWBS, but additional measures should also be considered as part of further testing.

Due to sessions being at the sports club this may have restricted participants who had limited transport access, in the future alternative transport options could be explored to remove this potential barrier.

Future evaluations of this intervention should aim to include a higher number of CAMHS staff and sports club staff to gain a broader view of stakeholders for the intervention across a variety of sites. With a larger scale study, it would also be beneficial to collect further information regarding the impact of Safety Nets on the sports staff and CAMHS staff as well as feedback from young people, families and staff with regards to how the programme can be continually improved. It may be that participating in a physical activity-based intervention with the participants is energising and that staff also enjoy delivering it.

It must also be noted that the delivery of the intervention varied across sites therefore further development of this intervention should aim to be standardised to ensure comparability across sites. Additionally, future evaluations should incorporate fidelity into analysis, by checking if the intervention is delivered as intended. Some flexibility may be necessary in the design (e.g.

different activities) and this can be built into future research designs to evaluate important elements of the intervention and begin to investigate the underpinning mechanisms.

Further Research

These data show that such work is not only feasible but is also acceptable and a larger randomised controlled trial of an intervention of this nature is warranted. Future research could explore the implementation of the intervention of Safety Nets at different stages in a care pathway for CAMHS. Future studies should build in cost-effectiveness analysis, to see if there is any impact for NHS services. Additional outcome measures related to diet and sleep health would also be beneficial to further research to explore the relationship between increased exercise to both (Khalid et al., 2016; Robotham, 2011).

Conclusions

Our preliminary data shows that it is acceptable to deliver Safety Nets to CYP on the CAMHS waiting list, and that it shows improvement in wellbeing outcomes, with clinical significance. Safety Nets is welcomed by stakeholders and is acceptable for young people. Research is required to investigate this intervention in a fully powered randomised controlled trial, focused on both the clinical and cost-effectiveness of the intervention.

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