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Safety Nets: A social prescribing intervention to support young people on CAMHS waiting lists

Abstract

High numbers of young people are facing mental health difficulties in the UK and numbers are increasing, particularly after the COVID-19 pandemic. Consequently, referrals to Child and Adolescent Mental Health Services (CAMHS) have increased, leading to reduced capacity and increased waiting times. Many reports state that young people's symptoms can be exacerbated whilst waiting for treatment.

Safety Nets is an 8-week group intervention involving one hour of psychoeducation and one hour of physical activity co-delivered by a CAMHS clinician and sports coach.
A mixed-methods feasibility study was conducted exploring the acceptability and usability of Safety Nets. Young people completed self-report measures pre and post receiving the intervention. Results from qualitative interviews are presented in a separate paper.

Safety Nets cohorts ran March - July 2022 with a total of 30 participants across four sites. Questionnaire completion rates varied, with highest completion rates for the Revised Child Anxiety and Depression Scale (RCADS) and the Strengths and Difficulties Questionnaire (SDQ) and lower rates for the Physical Activity Questionnaire (PAQ) and health resource use. Overall, scores between session 1 and session 8 were maintained for most outcome measures, demonstrating minimal deterioration in scores.

Results showed that there was no significant deterioration in symptoms for young people attending Safety Nets, and delivery was feasible with multiple NHS and community sites. Findings informed manualisation of the intervention and recommendations for delivery and future evaluations. This includes implications for youth mental health practice and highlighted the importance of trust between the delivery staff and young people, alongside peer support. There is now the need for a fully powered trial to test this intervention in terms of clinical and cost effectiveness and to support future implementation into services.

Key Words: Children and young people, mental health, social prescribing, community-based support, waiting list support, physical activity, psychoeducation

Introduction

Mental health difficulties

There are high rates of mental health difficulties such as anxiety and low mood/depression faced by children and young people in the UK (NHS Digital, 2023). Recent figures show that in 2023, 20.3% of 8 to 16 year olds were experiencing a probable mental health disorder (NHS Digital, 2023). This was a significant increase from previous rates in 2017 (12.5%) and remains high compared to rates in 2022 (19%) for both boys and girls (NHS Digital, 2023). The COVID-19 pandemic has had a huge impact on the lives of young people, with a survey of 2,111 young people with mental health needs finding that 83% felt their mental health had deteriorated as a result of the pandemic (Young Minds, 2020).

Waiting Lists

Given the increase in rates of mental health difficulties, there has been an increase in referrals to Child and Adolescent Mental Health Services (CAMHS), however capacity, in services has not increased alongside this, leading to longer waiting times for those needing support. Recent data from the NHS shows approximately 66,000 under 19 year olds were referred to CAMHS in April 2022, which reflects an increase of 109% in comparison to the same month before the COVID-19 pandemic (NHS 2019-22; NHS England, 2022). 76% of parents felt their child's mental health had become worse whilst waiting for treatment (Young Minds, 2018). With 50% of mental health problems emerging by age 14 years (Kessler et al., 2005), there are calls for more investment to fill the current gap in early interventions (Mental Health Network, 2021).

Increased waiting times for accessing treatment can impact on relationships, school attainment and can increase future service needs (Punton et al., 2022). It has been reported that 1 in 4 young people attempt suicide whilst on a waiting list (Young Minds, 2022). There have been calls for increased investment and provision of community based services which can be cost-effective, accessible and help to reduce stigma, particularly for underserved communities (PHE, 2018).

Social Prescribing

Social prescribing involves healthcare professionals referring patients to community groups to support their health and wellbeing (Social Prescribing Network, 2022). Systematic reviews have shown positive preliminary results for social prescribing programmes across all ages (Chatterjee et al, 2018; Pescheny et al, 2020) and specifically for children (Das et al, 2016; RCP, 2021). Whilst a systematic review in 2020 (Hayes et al, 2020) identified no eligible studies, social prescribing schemes have been increasingly implemented for children and young people, and an updated review in 2022 included four studies (Hayes et al., 2023). This review indicates high levels of acceptability to young people and preliminary effectiveness for improved wellbeing and reduced feelings of loneliness and anxiety. Social prescribing is noted to be an accessible form of non-stigmatising support for diverse groups of young people (OHID, 2022). Given these findings, social prescribing may be a useful way to support young people who are on waiting lists for specialist mental health treatment.

Safety Nets

An example of a social prescribing intervention is 'Safety Nets'. Safety Nets is aimed at young people on CAMHS waiting lists for treatment for anxiety and/or low mood and depression. The aim of Safety Nets is to prevent the deterioration in symptoms faced by young people whilst waiting for treatment. Safety Nets was developed by a child psychiatrist (RD) who recognised through his clinical experience the benefits that sport and physical activity could offer to young people facing mental health challenges and the need for engaging, non-stigmatising support, that could be accessed in community-based locations.

Safety Nets creates groups of up to 12 young people, which run weekly for two hours, during school term time. The sessions are run at a local professional sports club ground, either football or rugby clubs. Sessions include approximately 1 hour of age appropriate psychoeducation and 1 hour of physical activity. The psychoeducation sessions are run by CAMHS clinicians and the physical activity sessions are run by sports coaches from the club, with clinicians and coaches participating in both sessions.

The psychoeducation sessions cover a range of topics, which were developed based on current evidence and with input from clinical staff. Psychoeducation has been shown to reduce symptoms of depression and psychological distress (Donker et al., 2009). They include topics such as social networking, peer support (Barrett et al., 2006; Cowie et al., 2008; Foster et al., 2016) and peer relationships (Long et al., 2020). Topics also contain practical lifestyle support around social media use (Best et al., 2014; Glazzard & Stones, 2019), diet and sleep (Hosker et al., 2019; Khalid et al., 2016; Robotham, 2011), mindfulness (Dunning et al., 2019) and mental health literacy (Coles et al., 2016). The topic of the psychoeducation session is linked to the physical activity, for example, discussion around how sleep is beneficial for physical health as well as mental health, or how good communication is essential between teammates.

The groups aim to prevent the deterioration in mental health faced by young people on mental health service waiting lists, by improving their understanding of anxiety and depression and providing practical ways of self-managing this. Sessions provide an opportunity for social networking with other young people with similar experiences, all facilitated by physical activity, which has been shown to encourage social interaction and improve wellbeing (Biddle et al., 2019). Although sessions are delivered at football and rugby clubs, the activities include a wide range of physical activity chosen by the young people attending, meaning activities can be adapted to be accessible to all members abilities, interests and cultures. Previous activities have included sports such as netball, badminton, dodgeball, yoga, as well as games that encourage self-competition to improve on your own performance. Young people receive rewards for attending, such as a branded water bottle in week 1, a hat or training shirt in week 5 and tickets to a game in week 8.

Safety Nets has previously been tested in a service evaluation (Dias et al., 2023). 24 young people took part in this earlier evaluation of Safety Nets, which delivered 5 groups across 4 sites. Young people completed the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) at the first and final session. At the final session they also participated in a short discussion about their experiences of the project. Results from this evaluation showed good levels of acceptability and engagement from young people, as well as their parents and the delivering clinicians and sports club staff. Paired WEMWBS scores in 24 young people showed an improvement of 11.6 (standard deviation 9.6) with a 95% confidence interval 7.5-15.6. The scores following the intervention were of clinical significance, with week 8 scores comparable to the national average for a similar age group, while week 1 scores were comparable to the lowest 15% of the UK population on a whole.

Safety Nets was then tested in this current feasibility study, with the aim of manualising the Safety Nets programme, and to test research processes in preparation for a large scale trial. Manualisation of Safety Nets is essential for the roll out of the intervention on a larger scale in the future to ensure delivery consistency across sites.

Aims

The main aim of the feasibility study was to assess the potential for a fully powered randomised controlled trial of Safety Nets to support young people waiting for mental health treatment from Child and Adolescent Mental Health Services (CAMHS).

This included meeting the following objectives:

1. Collect qualitative and quantitative data from children and young people attending Safety Nets as well as their families, and clinicians and sports club staff
2. Develop a manual for Safety Nets
3. Create recommendations for a fully powered randomised controlled trial

Methods

Design

This was a mixed-methods feasibility study. It presents pre and post quantitative data collected from young people participating in the Safety Nets intervention, and qualitative data from participating children, their parents/carers and clinicians and sports club staff delivering the intervention. Qualitative outcomes are presented in a separate paper. Ethical approval was obtained in January 2022 (REC 21/YH/0277).

Participants

Delivery of Safety Nets took place across four sites over four NHS Trusts between March and July 2022. Two of these sites delivered two cohorts and two delivered one cohort, meaning a total of six cohorts were delivered over the study duration.

Inclusion/Exclusion Criteria

Young people:

Young people were eligible to take part if they were 11-16 years old and on an NHS CAMHS waiting list for treatment for low mood/depression or anxiety.

Young people were excluded if; the young person had an existing diagnosis of Autism, due to this population having bespoke needs that may not be met in a group environment, if the young person posed a threat to others attending (e.g. had a relevant history of violence or aggression), if they did not have the physical capacity to be able to participate in the physical element of the intervention (and the physical element could not be adapted to meet their abilities) or if the participant was unable to complete the English language outcome measures or effectively participate in the psychoeducation sessions due to a language barrier which could not be overcome.

Clinicians:

Clinicians were clinically qualified staff at NHS CAMHS, with experience of working with children and young people in a CAMHS setting. At least two clinical staff members were present at each session.

Sports club staff:

Sports coaches working at the local partner sports club were eligible if they had experience working with young people in a group setting.

Procedure

A study steering group was established including those who had been involved in developing Safety Nets, staff from Yorkshire Sport Foundation, members of the research team, academics with expertise in physical activity and staff from involved NHS Trusts who were supporting delivery. These meetings were held monthly throughout the study to update on progress and were chaired by the study coordinator.

A study protocol was developed for the feasibility study and NHS ethics was confirmed in January 2022. Sites were then set up across NHS Trusts. This included establishing relationships between the CAMHS services and local professional sports clubs in each locality. The development of these relationships was led by Yorkshire Sport Foundation.

Clinicians at participating sites identified eligible young people from their waiting lists for treatment for anxiety and/or low mood/depression. They contacted the young person and their parents/carers to let them know Safety Nets was available and to check if they would be happy to be contacted by a researcher. If so, a research assistant contacted them to explain the study in more detail, and to send participant information sheets and consent forms. Participants had at least a week with the information sheets prior to the first session, this allowed them to decide if they wanted to take part and have the opportunity to contact the researcher with any questions. Informed consent was collected prior to the start of the first session. For young people aged 16 years, they were able to consent on behalf of themselves, and for those aged 11-15 years old assent was collected from the young person and consent was collected from their parent/carer.

Safety Nets sessions ran weekly for 8 weeks during term times. Sessions included one hour of psychoeducation led by the clinician, and one hour of physical activity led by the sports coach. Session topics followed a structure based on recommendations from clinicians, as well as experience from previous delivery (Dias et al., 2023) and were focused on low level self-care psychoeducation. As this was a feasibility study with the aim of manualising Safety Nets, some flexibility was allowed in delivery, based on clinical expertise and the input of the young people attending the groups.

Data Collection

A research assistant attended the first and final session to support the young people and to collect informed consent. They supported the young people to complete the quantitative measures. Participants' questionnaire booklets were assigned a unique code, to allow completed questionnaires to remain anonymous and confidential.

Measures were selected reflecting areas such as physical activity levels, anxiety, depression, and social connectedness where social prescribing is expected to impact (StreetGames, n.d.), with validated questionnaires and comparative data available where possible. As a feasibility study, these measures were explored to see which were most appropriate and acceptable for a full trial. Questionnaire booklets included the following measures:

Demographics

At baseline only, questions were included regarding age, gender, ethnicity, family make-up and parent/carer education level.

RCADS

The Revised Child Anxiety and Depression Scale self-report version (Spence, 1997; Chorpita et al., 2000) was used. This is a 47-item questionnaire with 6 subscales including: separation anxiety disorder, social phobia, generalised anxiety disorder, panic disorder, obsessive compulsive disorder, and low mood (major depressive disorder). By combining the 5 anxiety subscales, it

provides a Total Anxiety score and by combining all 6 subscale it provides a Total Internalising Scale (Total Anxiety and Depression scale). RCADS is used in the national CAMHS dataset, providing comparative data, and is a validated measure with good reliability on clinical samples (Chorpita et al., 2005).

SDQ

The self-report 11-17 year old Strengths and Difficulties questionnaire (Goodman, 1997, 1998) records responses to 25 questions which cover 4 difficulty subscales: emotional problems, conduct problems, hyperactivity, peer problems, and one strength subscale: prosocial behaviour. Scores are categorised for each subscale as 'close to average', 'slightly raised', 'high' or 'very high'. It is commonly used in services and has good consistency and validity (Yao et al., 2009).

SCS-R

The Social Connectedness Scale Revised version (Lee, Draper & Lee, 2001) is a 20-item scale to assess how connected to their social peers an individual feels with high reliability and validity reported. Respondents mark how much they agree with 20 statements on a Likert scale, where 1 is strongly disagree and 6 is strongly agree. 10 of the items are worded positively and 10 are worded negatively. The negatively worded items are reverse scored, and all items are summed to give a range 20-120. An overall item mean score can then be calculated, with a higher score reflecting stronger feelings of social connectedness.

PAQ

The Physical Activity Questionnaire for Adolescents (Kowalski et al., 2007) is a validated and reliable self-completed measure, which asks young people to recall their levels of physical activity from the previous 7 days. There are 8 items in total, each scored out of 5, with overall results providing a summary of general physical activity. A higher score reflects a higher level of physical activity.

EQ-5D-Y

The EQ-5D-Y is a quality of life measure with preliminary evidence of validity and reliability (Ravens-Sieberer et al., 2010; Wille et al., 2010), comprising 5 dimensions: mobility, looking after myself, doing usual activities, having pain or discomfort and feeling worried, sad or unhappy. Respondents rate their health relating to these on a three-point scale, where 1 is 'no problems', 2 is 'some problems' and 3 is 'a lot of problems'. It also includes a visual analogue scale where participants rate their health on a scale of 0 to 100.

Health Resource Use

A bespoke 'Health Resource Use' questionnaire was developed by the research team (Wright et al., 2014; Wright et al., 2020) and allows for recording of which health services the young person has accessed in the past 12 months across physical health, mental health and school-based services.

Goal based outcome measure

Commonly used in services, the young person is asked to set three goals they hope to achieve after receiving the intervention. They subsequently rate the achievement of these out of 10 at both baseline and post-intervention (Law & Jacob, 2013).

The research assistant attended sessions again in week 8, where young people were given follow up measures to complete. These questionnaire booklets contained the same measures as at pre-

intervention, except for the demographic measure. At the end of this session, participating young people and parents/carers were given information sheets containing details about taking part in a qualitative interview (qualitative methods and results are explored in detail in a separate paper, Taylor et al., *submitted*).

Analysis

Quantitative measures were inputted into an excel database by the researcher attending the session. After all cohorts were complete, all data were cross-checked by the study coordinator. Descriptive statistics were conducted (including frequencies, percentages, mean scores) and pre-post comparisons. These scores were calculated using all data collected from all sites, and then additional calculations were conducted using only those participants who completed measures at both session 1 and session 8. As the main aim was to explore feasibility and inform parameters for a full-scale trial, including recruitment rates and completion rates of outcome measures, powered inferential statistics were not used.

Results

Recruitment and retention

Overall, four NHS Trusts were recruited, covering four sites. Over the study's duration, six cohorts were run, with a mean number of 5 young people per group (range 2 – 8). The first period of delivery ran between March and April 2022, and the second period of delivery ran between May and July 2022. 30 young people were recruited into Safety Nets in total.

Some of the cohorts ran with smaller numbers of young people as recruitment was limited by time scales and capacity of CAMHS teams. Clinicians identified and contacted young people from their waiting list which meant there was a limited time frame before the start of each cohort in which to recruit for each group.

As one of the aims of this feasibility study was to manualise Safety Nets, some flexibility of delivery was allowed at sites where they had previously delivered cohorts outside of the research study, based on the clinician's expertise and experience. As a result, two cohorts (5 and 6) had larger sized groups but only some of these young people were included in the research. This may have been because there was not enough time before the group to complete the research recruitment processes (which required participants to have a minimum of one week with the information sheets to decide to participate) or because the existing group included an older age range than the research criteria. For cohort 6, where the two young people in the research withdrew, the Safety Nets group was still running with more young people, who were not part of the research study.

There were 8 withdrawals across all cohorts between week 1 and week 8. Two of these were due to the young person not feeling as though they needed additional support, and these young people subsequently came off the CAMHS waiting list. Two withdrawals were due to competing commitments, meaning the young people became unable to attend the sessions. Three were due to the young person being too anxious or needing alternative additional support, which they went on to receive. Only one young person dropped out because they did not feel it was right for them.

Most withdrawals occurred after attending one session, apart from two cases where the young people withdrew after session 3 and session 7.

Table 1. Number of participants attending each Safety Nets cohort

Safety Nets cohorts	Participants attending Session 1/how many expected	Participants attending Session 8/how many expected	Participants withdrawing before Session 8	Participants completing measures at both timepoints
1	3/4	3/3	0	3
2	6/10	3/6	3	2
3	6/7	5/7	2	4
4	8/8	7/8	1	7
5	4/7	4/4	0	4
6	2/2	0/2	2	0
Total	**29**	**22**	**8**	**20**

Table 2. Completion rates for each outcome measure at session 1 and session 8

Outcome measure	Session 1 (%)	Session 8 (%)
RCADS	29/29 (100)	19/22 (86)
SDQ	29/29 (100)	18/22 (82)
SCS	28/29 (97)	16/22 (73)
PAQ	24/29 (83)	14/22 (64)
EQ-5D-Y	22/29 (76)	14/22 (64)
Health Resource Use	12/29 (41)	5/22 (23)
Goal based outcome	27/29 (93)	21/22 (95)

Table 2 shows the completion rates for each of the outcome measures at both session 1 and session 8. Overall, the RCADS, SDQ and goal-based outcome measure had the highest completion rate at both sessions. There were lower completion rates for the PAQ and EQ-5D-Y, and particularly for the Health Resource Use questionnaire.

These results will be used to refine the outcome measures used for any future trial. The number and length of questionnaires used in this feasibility study may have been too high for young people to complete during sessions. This was explored through the qualitative interviews and options to reduce burden have been explored.

Demographics

Only 10 of the 30 young people chose to report their age. The mean age of participants was 12.7 years (range 12 -14 years old). 26 of the 30 young people reported their gender, with 54% (n=14) responding as female, 38% (n=10) responding as male, and 8% (n=2) choosing to self-define. 25 of the 30 young people reported their ethnicity, with 80% (n=20) responding as 'White English' and 20% (n=5) responding as African, Black British, Black Caribbean, Chinese and Asian.

RCADS

Most sites showed a lower mean score at session 8, with cohort 1 in particular showing a large change in mean scores. All cohorts, except for one, also showed reductions on the total anxiety scale scores, reflecting reduced feelings of anxiety from respondents. When considering data

from those participants who provided both session 1 and session 8 data (n=18), the mean scores for the total anxiety and depression scale were lower at session 8, reflecting fewer feelings of anxiety and depression from the young people (see Table 3).

Table 3. Mean RCADS scores at session 1 and session 8, with higher scores indicating higher levels of anxiety/depression symptoms

Cohort	Total Anxiety and Depression			Total Anxiety		
	Session 1	Session 8	Change	Session 1	Session 8	Change
1	65.0	46.7	18.3	54.7	39.7	15.0
2	56.3	58.0	-1.7	45.8	43.0	2.8
3	97.7	96.4	1.3	79.3	77.4	1.9
4	77.1	76.3	0.8	58.1	57.6	0.6
5	63.3	74.5	-11.2	49.3	63.5	-14.3
6	45.0	N/A	N/A	49.3	N/A	N/A
Only those participants providing data at both session 1 and session 8	74.4	72.8	1.6	59.0	57.7	1.3

SDQ

Mean scores on the total difficulties scale reduced for three sites reflecting young people reporting fewer overall difficulties across the emotional, conduct, hyperactivity, and peer problems subscales. When considering data from those participants who provided both session 1 and session 8 data (n=18), mean scores were maintained between session 1 and session 8 (see Table 4) showing no deterioration. These results are similar for each of the subscales individually, with mean scores for each site maintained between session 1 and session 8. It is important to note that for some cohorts, mean scores increased.

Table 4. Mean SDQ total difficulties score for session 1 and session 8, with higher values indicating more difficulties

Cohort	Session 1	Session 8	Change
1	18.3	13.7	4.7
2	19.3	23.0	-3.7
3	24.3	22.6	1.7
4	19.5	21	-1.5
5	23.8	23.5	0.3
6	18.5	N/A	N/A
Participants at session 1 and session 8	20.7	20.7	0.0

SCS-R

Overall, for the SCS, mean scores were maintained, or showed a minor reduction, reflecting fewer feelings of social connectedness (Table 5). It should be noted that there were poor completion rates for this questionnaire. This is also reflected when considering data from those participants who provided both session 1 and session 8 data (n=15).

Table 5. Mean SCS-R score for session 1 and session 8, with higher values indicating more feelings of social connectedness

Cohort	Session 1	Session 8	Change
1	4.4	4.2	0.2
2	4.0	3.3	0.7
3	3.2	3.1	0.1
4	3.0	3.0	0.0
5	3.5	2.9	0.6
6	3.6	N/A	N/A
Participants at session 1 and session 8	3.4	3.2	0.2

Table 6 below shows further results for the RCADS total anxiety and depression scale, the SDQ total difficulties scale, and the SCS-R mean item score. For participants with data collected at both time points (session 1 and session 8) the number of participants (n) is presented alongside the minimum (min), maximum (max) and median score, as well as the mean and standard deviation (SD). These results are to be interpreted with caution given the low numbers of participants.

Table 6. Table showing further results for the RCADS total anxiety and depression scale, the SDQ total difficulties scale, and the SCS-R mean item score at session 1 and session 8 for participants with data collected at both time points

Measure	Session 1					Session 8				
	n	**min**	**max**	**median**	**Mean (SD)**	***n***	**min**	**max**	**median**	**Mean (SD)**
RCADS AD	18	22	124	77	74.4 (28.1)	18	16	105	77	72.8 (24.7)
SDQ TD	18	12	33	21	20.7 (6.1)	18	7	29	22	20.7 (6.4)
SCS-R	15	1.7	4.7	3.0	3.4 (0.8)	15	1.9	4.9	3.2	3.2 (0.8)

PAQ

Overall, when combining all cohorts and when combining participants with data at both time points, there was no change in mean scores between session 1 and session 8. Although this questionnaire was helpful in providing a general summary of physical activity, it lacked detail about type or intensity of activity. The qualitative interviews provided more insight into changing attitudes around sport and physical activity in participants.

EQ-5D-Y

As with some of the other outcome measures, there were varying numbers of completion at session 1 and session 8 and so results should be noted with caution. When considering each of the 5 subscales at session 1, the scale relating to 'Feeling worried, sad or unhappy' had the highest percentage of respondents scoring '3 – I am very worried, sad or unhappy' (36%). This was maintained at session 8 (36%), showing no deterioration. Overall, the visual analogue scale showed an improvement, with ratings for 'how your health is TODAY' increasing from 52.8 at session 1, to 63.1 at session 8, showing the young people felt their health on that day was better than at session 1.

Health Resource Use

The Health Resource use outcome had a low completion rate from participants. From respondents that did complete this measure (n=17), the most commonly reported service uses were with a CAMHS therapist (n=12), GP (n=11), nurse (n=9), at either a surgery, at home or via telephone contact. In terms of school-based services, the most commonly reported contacts were with a school nurse (n=8), a school counsellor (n=7), or a school wellbeing worker (n=6). This questionnaire was included in this current study to explore feasibility of completion for future research. Based on completion rates and feedback from participants, for future trials this would be best completed by, or with support, from parents/carers.

Goal based outcome measure

Despite higher completion rates, the quality of completion for the goal based outcome measure was low. Often the questionnaires were either missing ratings out of 10 at baseline or new goals had been created at week 8, despite the baseline goals being added for the young person. 13 young people had goals matching between both session 1 and session 8. Of these, 85% (n=11) saw an improvement in at least one of their goals. Goals were typically related to reducing anxiety (Reduce stomach pain/feel less anxious), increasing self-confidence (Feeling more confident/comfortable around other people) and physical health goals (Feel healthier/be more active/learn new sports). Low completion rates suggest young people may need more individual support from the researcher in completing measures in a future trial.

Qualitative Results

Qualitative methods, analysis and results are presented in a separate paper (Taylor et al., *submitted).*

Discussion

High numbers of young people struggle with mental health difficulties like anxiety and depression, in the UK (NHS Digital, 2023). Many of these young people face long waiting times to access treatment, during which their mental health can deteriorate further. There is an identified need for improved provision for young people who are on waiting lists for specialist mental health treatment. Previous research has shown that social prescribing may be an accessible way to support young people with their mental wellbeing (Hayes et al., 2023).

This feasibility study aimed to assess the potential for a future trial of a social prescribing intervention known as 'Safety Nets' to support young people on CAMHS waiting lists. Feasibility of site set up, recruitment, Safety Nets session delivery and outcome measures were tested and quantitative and qualitative data were collected from participants, parents/carers and deliverers. Results have been used to inform manualisation of Safety Nets and to create recommendations for a future large scale trial.

Recruitment and Retention

Results showed a fully powered randomised controlled trial is feasible based on recruitment rates and uptake from services and Trusts. The study successfully recruited and set up four NHS Trusts and four sites to deliver Safety Nets, with 30 young people recruited to participate.

Findings also allowed potential attrition rates to be estimated. Across all six cohorts there were 8 withdrawals, although two of these were young people who subsequently came off the waiting list and did not require further support. Three young people withdrew as they were identified as needing a higher level of support. This may be viewed as a benefit of Safety Nets, whereby young people with more severe symptoms but who are placed on a waiting list can be identified quicker than if they did not receive waiting list provision, which is the case at many localities.

This study was limited due to a small sample size, which was a result of short time frames available for recruitment to groups and a narrow eligibility criteria. Clinicians reported that many young people on their waiting list, who were waiting for outcomes of Autism assessments were not approached to participate. Based on advice of clinicians, young people with an Autism diagnosis would benefit from participating in Safety Nets and so this may improve recruitment opportunities for future studies. Although the sample size was small, all groups were able to recruit and deliver sessions, and sufficient data was collected to allow study aims to be met, and for feasibility parameters to be measured to inform future testing. Planned future evaluations of Safety Nets will include additional timescales for recruiting to each cohort and eligibility criteria will be widened so that young people with (or waiting for) an Autism diagnosis would be eligible to participate.

Intervention Delivery

Safety Nets aims to reduce this deterioration of symptoms for young people whilst on a waiting list which can be significant when left without support. In general, mean scores on most of the quantitative outcomes (SDQ, SCS, PAQ, EQ-5D-Y) were maintained between session 1 and session 8, demonstrating no significant deterioration. For the RCADS, minor improvements were shown between session 1 and session 8 with mean scores on the Total Anxiety and Depression Scale reducing from 74.4 to 72.8 for those participants completing measures at both time points. This reflects fewer feelings of anxiety and depression for the young people and aligns with previous studies of social prescribing for children, which found improvements to mental health and wellbeing (Hayes et al., 2023; Brettell et al., 2022). Results are to be interpreted with caution given the small sample size but provide indication that a further full scale trial may be warranted to explore this further.

It is important to note that some cohorts demonstrated a slight deterioration in scores. As the young people are awaiting treatment from CAMHS, some small levels of deterioration despite the intervention can occur. This may also be due to less standardised delivery models across sites, although this should be explored through further testing. As a feasibility study, this allowed for some flexibility in delivery, with outcomes informing manualisation of the intervention. Key recommendations for intervention delivery have therefore been highlighted such as consistent staff each week, and both clinicians and sports club staff participating in psychoeducation and physical activity sessions to build trusting relationships with the young people. Additionally, limiting group sizes to 6-12 young people, and each cohort running as a closed group so that the young people can develop strong peer relationships.

Additionally, a key limitation of the current study was the lack of a control group, and so future studies would need to consider this to help better determine the impact of Safety Nets. It is expected that the control group would receive treatment as usual; remaining on the waiting list and receiving reviews as stipulated by CAMHS protocols. Inclusion of a control group was not feasible within funding limits and timescales for the current study. Acceptability of study processes for a full scale trial was explored through qualitative interviews (see *Taylor et al., submitted* for qualitative results). Appropriate timescales for recruiting sufficient participants for a control group would need to be considered, as well as ethical issues relating to reimbursement or access to support for the control group.

Outcome Measures

Completion rates for each of the outcome measures varied. Completion rate tended to drop in the order that the young person worked through the questionnaire booklet, suggesting that there may have been too many outcome measures included. The RCADS would be a potential primary outcome for future testing given good completion rates. It is also widely used within CAMHS, providing comparative data. The SCS-R and the PAQ were longer questionnaires and took more time and thought to complete, which may have caused burden for the young people. The goal

based outcome measure is brief and more personal to the young person, this may have resulted in the higher completion rate despite being the final measure. Despite the higher completion rate for the goal based outcome measure, quality in completion was low. Future testing should limit the number of measures used, and more individual support should be provided to each young person when completing outcomes. Parent/carer completion of some measures could also be explored, such as the Health Resource Use questionnaire to reduce burden on the young people.

Conclusion

There is significant gap in support for young people on waiting lists for mental health treatment, and social prescribing interventions such as Safety Nets have the potential to benefit the NHS by offering accessible, non-stigmatising, sustainable help based in community-settings to those waiting for specialist services. Results from this study show that there was no significant deterioration in symptoms for young people attending Safety Nets, and delivery was feasible with multiple NHS and community sites.

Findings informed manualisation of the intervention and recommendations for delivery and future evaluations. This includes implications for youth mental health practice, highlighting the importance of trust between the delivery staff and young people. This was supported through having consistent staff delivering sessions, who were involved in both psychoeducation and physical activity elements and providing the opportunity for staff to engage with the young people in a non-stigmatising, non-clinical environment. Peer support was also identified as a key element of the intervention for the young people, which can be supported by delivering closed groups of 6-12 young people to allow these relationships to develop. A fully powered trial is now warranted to provide more robust testing of the clinical and cost-effectiveness of Safety Nets and support implementation into services.

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