Experiences of young people, parents and delivery staff of the social prescribing intervention 'Safety Nets': a qualitative investigation

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Abstract

High numbers of young people in the United Kingdom (UK) experience mental health difficulties. Referrals to Child and Adolescent Mental Health Services (CAMHS) have increased and young people often face lengthy waits before accessing treatment, during which time young people's mental health can deteriorate further. *Safety Nets* was developed to support young people on CAMHS waiting lists. It is a social prescribing intervention that runs for two hours a week for 8-weeks at local professional sports clubs. Sessions include one hour of psychoeducation and one hour of physical activity co-delivered by a CAMHS clinician and sports club coach. The aim of this qualitative work was to explore the experiences of young people who attended, and staff who delivered Safety Nets, to inform future delivery and research. Qualitative semi-structured interviews were conducted with 25 participants, including young people who attended Safety Nets (n=6), their parents/carers (n=6), and delivery staff (n=14). Interviews explored the acceptability and suitability of the intervention and recommendations for future delivery. A thematic analysis identified four themes and one sub theme from the data: 1. Motivations to attend or deliver Safety Nets, 2. Positive experiences of Safety Nets, 3. Perceived positive impact of Safety Nets (subtheme 'Staff development opportunity') and 4. Application of skills learned. Overall, qualitative data indicated the Safety Nets programme was well received and highlighted important aspects of delivery for implementation. Future research, such as large-scale evaluation of the efficacy and cost-effectiveness of Safety Nets is warranted.

Keywords: Children and Young People, Mental Health, Social Prescribing, Psychoeducation, Physical Activity, Waiting Lists

Introduction

Increasing rates of children and young people suffer with mental health difficulties such as anxiety and depression both globally and in the United Kingdom (UK) (NHS Digital, 2023; UNICEF, 2021). It is estimated that more than 13% of adolescents aged 10–19 years live with a diagnosed mental disorder (UNICEF, 2021). In 2023, 20.3% of 8–16-year-olds were experiencing a probable mental health problem (NHS Digital, 2023).

In recent years there has been a significant increase in referrals to National Health Service (NHS) Child and Adolescent Mental Health Services (CAMHS) (Children's Commissioner, 2024). Service capacity has not increased to meet this need, which has led to increased waiting times for young people, with an estimated 40,000 children waiting up to 2 years for services (Children's Commissioner, 2024). In 2018, Young Minds reported that 76% of parents felt their child's mental health had worsened whilst waiting for treatment. Delays in treatment negatively impacts on young people's wellbeing, relationships, school attendance, and increases the need for future services (Punton et al., 2022).

There have been calls for increased investment and provision of community-based services to support mental health treatment options, which can be cost-effective, accessible and help to reduce stigma, particularly for underserved communities (PHE, 2018). This is particularly important given persistent inequalities in access to mental health services among socioeconomically disadvantaged and minoritised groups. Social prescribing involves helping individuals to connect to non-clinical, community services to provide additional support with their health and wellbeing (Muhl et al., 2023). Social prescribing has been explored in over 30 different countries (Morse et al., 2022) and in the UK, is included in the NHS Long Term Plan (2019). Studies have found a positive impact for children's wellbeing, confidence and reduced

isolation (Bertotti et al, 2020; Hayes et al., 2023; RCP, 2021) however, there is limited understanding of how social prescribing can best be implemented in clinical services to support children and young people (Hayes et al, 2023; Gordon et al., 2024).

Psychoeducation involves teaching a person, or those involved in their support network(s) about what their condition is, what it may mean to them and how to manage it. Psychoeducation can be an integral component of interventions for children and young people with mental health conditions (Jones et al., 2018), with reported benefits including increased self-awareness and self-efficacy, increased condition knowledge, reduction of symptoms, increased abilities to overcome obstacles and improved social skills (Powell et al., 2021; Sahin et al., 2011).

Despite growing recognition of the potential benefits of social prescribing, evidence on its effective implementation for children and young people remains limited. In particular, there is little understanding of how structured psychoeducation can be combined with community-based activities to support those on CAMHS waiting lists. Addressing this gap is crucial to developing scalable, acceptable, and effective early interventions that align with NHS priorities.

Safety Nets

Safety Nets was developed by a child psychiatrist (RD) and co-produced with young people and families with lived experience and staff. Safety Nets is targeted at young people aged 11-16 years who are on a waiting list for treatment for anxiety, low mood and/or depression from Child and Adolescent Mental Health Services (CAMHS) in the UK. It aims to prevent the deterioration in symptoms of anxiety and depression young people face whilst on mental health service waiting lists. Safety Nets is a novel social prescribing intervention, developed based on the evidence for community support, physical activity and psychoeducation in supporting young people's mental health (Jones et al., 2018; Muhl et al., 2025; Smith et al., 2024).

Safety Nets involves a weekly 2-hour group session (with 8-12 young people) run for eight weeks during school term time. Sessions are run at local professional sports club stadiums (usually football or rugby Community Foundations) and include one hour of age-appropriate psychoeducation, led by CAMHS clinicians, and one hour of mild-moderate physical activity led by a community sports coach. Both staff members participate in both elements (physical activity and psychoeducation) to help build trusting relationships and to highlight the importance of both psychoeducation and physical activity in managing mental health.

The psychoeducation sessions covered a range of topics which were selected based on current evidence alongside feedback from clinical staff and young people. Topics included social networking, peer support (Foster et al., 2016; Long et al., 2020), social media use (Best et al., 2014), diet, sleep (Hosker et al., 2019; Khalid et al., 2016) and mental health literacy (Coles et al., 2016). Where possible, the psychoeducation session is linked to the physical activity, for example, the benefits of good sleep for both wellbeing and physical activity.

The physical activity includes a range of multisport opportunities which are chosen collectively by the young people attending the sessions. This means activities can be adapted to the mental, physical and cultural needs of each group. Previous examples of activities include netball, badminton, dodgeball, yoga, fun relays and exercises that encourage competition to improve on your own performance. The aim of the physical activity is to facilitate the development of trusting relationships between the young people and staff, which enriches the psychoeducation conversations.

Aims

Safety Nets has been tested in a service evaluation (Dias et al., 2023), and a feasibility study. The quantitative results of the feasibility study have been published elsewhere (Garside et al., 2024) and this paper presents the qualitative results of this study. The study took place between

September 2021 and September 2022, with qualitative interviews conducted between July 2022 and September 2022.

The study aimed to explore the experiences of young people, their parents/carers, and delivery staff in participating in and delivering Safety Nets. This will inform future implementation and testing of Safety Nets and provide insights for delivery of social prescribing within clinical services for children and young people.

Methods

Design

A relativist ontological approach and a subjectivist epistemological approach was adopted for this work as these approaches assume that individual realities are influenced by individual previous experiences (O'Grady, 2014). Semi-structured interviews were chosen to allow for in-depth explorations of individual participants' experiences and to place the voices of young people, their families and Safety Nets delivery staff at the centre of this work.

Participant identification and recruitment

Young people were eligible to attend Safety Nets sessions if they were aged 11-16 years and on an NHS CAMHS waiting list for treatment of depression/low mood or anxiety. Clinical professionals referred young people to the Safety Nets programme. If their clinical judgement suggested that the young person had a history of aggression, or if they did not have the physical capacity to take part in the physical element of the intervention (with no adaptations that could be made to support participation), then they were not invited to undertake the programme. Autistic young people were also not invited in case their needs could not be fully met and supported in a group environment. The exclusion criteria were discussed with clinical delivery staff as part of the qualitative work. Whilst there were no other exclusion criteria specified

from the research team, given that clinicians had first point of contact for referring young people it may be that they did not refer those with more complex additional needs such as learning disabilities and other neurodevelopmental conditions.

Eligibility criteria to take part in the current qualitative study were: 1) young people who have attended the Safety Nets programme, 2) their parents/carers, and 3) all clinical and sports club delivery staff. These participants were invited from five sites across Yorkshire and Humber where the programme was running.

Following the eight weekly Safety Nets sessions, all delivery staff, children and young people and their parents/carers were contacted by a research assistant through a follow up phone call or email to invite them to participate in a qualitative interview, and an age-appropriate study information sheet was provided. The researcher then arranged a convenient time for the interview with those who expressed interest in participating. All participants aged over 16 years provided informed consent. Young people under 16 years of age provided informed assent with informed consent from their parent/carer.

Study Procedures

NHS ethical and HRA approval was obtained in January 2022 (REC 21/YH/0277).

Convenience sampling maximised participation within feasibility constraints; recruitment ceased when interviews yielded no new novel codes. Interviews were virtual (Microsoft Teams/phone). Young people were offered independent interviews but all preferred parent/carer presence; questions avoided sensitive disclosure. Questions focused on what participants liked and disliked about attending or delivering Safety Nets, what they felt the benefits were (if any) and how they felt the intervention and research delivery could be

improved. Interviews with staff explored their experiences of delivering the intervention, what they thought went well, and what improvements could be made.

Interviews were audio recorded using an encrypted Dictaphone (for both those conducted by Microsoft Teams and via phone) and transcribed verbatim by the researcher. Interviews took approximately 30 minutes.

Data analysis

Reflexive Thematic Analysis (RTA) identifies patterns across the data. Reflexivity is central and relates to how codes are based on the researchers' own interpretive lens on the data (Braun and Clarke, 2021). An inductive RTA was conducted by author AT. Reflexivity involved keeping analytic memos documenting evolving interpretations and regular team discussions to deepen understanding of the data. No software was used. This involved Braun and Clarke's (2021) six phases of RTA:

1. **Data familiarisation:** All transcripts were read and re-read to immerse the coder in the content.
2. **Initial Coding:** Short phrases (codes) were assigned to data relevant to the research question.
3. **Initial Theme Development:** Related codes were grouped manually, beginning to develop broader pattern of meaning across the data.
4. **Theme review:** Themes were checked to ensure a coherent story of participants was represented.
5. **Define and name themes:** Each theme was assigned a clear descriptive name.

6. **Final report:** Results were written up, and quotations were identified to evidence themes.

Results

A total of 25 semi-structured interviews were conducted with six parents/carers, six young people, nine clinicians and five sports leaders (two sports leaders from the same club took part in one joint-interview) (see Table 1). Clinicians included clinical psychologists, social workers and CAMHS support workers. Through RTA, four themes were developed (see Figure 1).

Table 1. Participant Demographic Information

Participant ID	Age (years; YP only)	Gender
YP1	14	Female
YP2	12	Male
YP3	13	Male
YP4	12	Male
YP5	12	Trans male
YP6	14	Female
P1	N/A	Female
P2	N/A	Female
P3	N/A	Female
P4	N/A	Female
P5	N/A	Female
P6	N/A	Female
C1	N/A	
C2	N/A	
C3	N/A	
C4	N/A	
C5	N/A	
C6	N/A	
C7	N/A	
C8	N/A	
C9	N/A	
SL1	N/A	
SL2	N/A	
SL3	N/A	
SL4	N/A	
SL5	N/A	

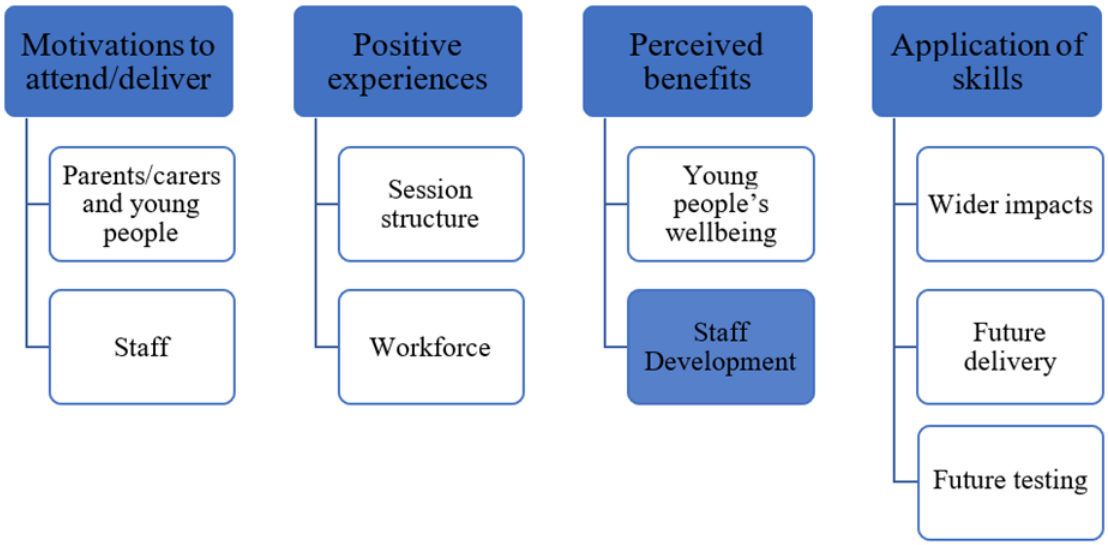

Figure 1. Developed themes and subthemes.

Theme 1: Motivations to attend or deliver Safety Nets

Four parents/carers and three young people taking part in this study explained that they joined the programme in the hope of receiving some practical support which was not currently available whilst on the CAMHS waiting list.

> *'Honestly, at the time, I just wanted any help I could get so we went along with an open mind really' (Parent 4)*

Four parents/carers stated the long waiting lists for services was a key motivation for taking part in the programme as they felt they lacked support in the interim:

> *'We had waited so long to get anything to see somebody from CAMHS. The long waiting lists… we desperately needed some support. I didn't get any at the time.' (Parent 1)*

Five parents/carers and all six young people were enticed by the physical activity element of the intervention. Parents/carers felt their child would engage well if they had a fun activity to look forward to.

> *'Especially the sport bit. That was a huge incentive for doing it. I think for the children as well, it allows them to think… like they won't be like oh my god I've got this session I don't know what to talk about and get worked up, it allows them to look forward to what they will do afterwards as well.' (Parent 6)*

Young people particularly liked the physical activity element, and felt it helped them to build relationships and share experiences through the psychoeducation:

> *'For me personally, after I did the sport, I felt a lot calmer around people and would be easier to talk if that makes sense' (Young Person 5)*

Two parents spoke about the benefits they believed physical activity can have on mental health which influenced them in encouraging their child to attend the Safety Nets groups:

> *'You know, people always say don't they, that exercise is good for your body and your mind so I thought it would be a good thing for him to do.' (Parent 3)*

> *'Yeah, and at the time things like that he wasn't going out as much or physically doing as much especially when he was struggling to attend school and when he's not at school, he not moving around, just sat at home and it's no good for anybody. So yeah, I did encourage him to do it.' (Parent 3)*

Clinical CAMHS staff were keen to be a part of facilitating the Safety Nets intervention as part of their professional development and they felt seeing potential benefits of Safety Nets for the young people provided them with job satisfaction. Two clinicians also commented on the importance of group work being their motivation to take part.

'For me it gets me out the office, changes my day up a little bit and I get to do group work. Group work I think should be the way forward. I think there is a lot of benefits to group work. It shows kids that they are not on their own' (Clinician 9)

Three sports leaders spoke of how they wanted to emphasise the positive impact sport and exercise can have on mental health and how this was a motivational factor for them agreeing to support the programme:

'I think it is right that sport can have such a huge impact and that we do underestimate it and all too often we maybe say the right things but don't do the right things' (Sports leader 4)

Theme 2: Positive experiences of Safety Nets

Participants commented on the positive experiences they had when attending or delivering the programme. These included the structure of the sessions, the relaxed and friendly atmosphere and where the sessions were held.

All participants commented that they enjoyed the structure of Safety Nets, with one hour of psychoeducation and one hour of physical activity:

'He does really like sports so I think that is a good balance, [name] actually really likes sports, but for anyone that didn't it's not like the whole session is sports, you've got that balance of not too much of one thing, something for everybody really.' (Parent 1)

'I did enjoy taking part. It helped me a lot with my anxiety and confidence' (Young Person 1)

Two clinicians and two sports leaders said they enjoyed how all staff were involved in all aspects of the intervention:

'I think for us as clinicians it's been quite fun to like actually do some sports with the kids and actually having the same anxieties you know, it's been quite nice to you know, have that less power kind of, and actually a more equal group' (Clinician 2)

All participants also stated that they enjoyed the informal nature of Safety Nets and reported that sessions had a relaxed and friendly atmosphere:

'The sports leaders were really supportive. They tried to get you to play the games and do something fun. They were nice and I had fun with them.' (Young Person 4)

This atmosphere was appreciated by participants and was encouraged to be included in future delivery of the programme:

'Erm I think because it is very relaxed, erm it's a space for young people to just come and talk about whatever is on their mind. It's quite informal, it's not too structured I think that helps because they talk to each other, make friends and that helps them grow in confidence and yeah. It's a nice group to be part of every week. (Clinician 3)'

One clinician also explained that they thought the experience of the staff delivering the intervention was important and helped create the positive experiences young people gained from attending Safety Nets:

'I think you need quite experienced people working to engage young people in that sort of way but also erm, to consider how to manage any potential challenges that might come from that sort of group process which is why you need at least 2 and probably 3 clinicians, and certainly is a pool of staff from your CAMHS team and then you need 2 people from the sports side of things' (Clinician 6)

One young person and two clinicians commented that they liked that the sessions were held at a local professional sports club as it felt exciting and special. This 'pull of the badge' may

support young people in wanting to take part by reducing stigma and encouraging engagement with the intervention more than if it were based in a clinical setting.

> *'*[NAME] *have been really amazing working with us and I think it is an exciting place for the kids to come as well…so yeah the fact that is was at* [NAME] *was amazing, the kids walked around the pitch and we played games in the dug out by the side of the pitch and stuff and that was really good.' (Clinician 8)*

> *'it just seemed special' (Young Person 2)*

Theme 3: Perceived benefits of Safety Nets

All facilitators commented that they felt Safety Nets had a positive impact, particularly around confidence building and forming peer relationships amongst the young people:

> *'I think the main benefits were the peer relationships that were formed and the confidence. I think they all improved in confidence through like engaging with others in the group. … they are getting something out of it just by being there' (Clinician 7)*

One sports leader noted that this may be due to young people feeling a sense of 'belonging' and in a safe space with other young people experiencing the same things they are:

> *'Really good for confidence. A lot of the kids when they first start, they just want to be with their parents, or they will sit in the corner quiet and this really helps them get them out their shell. I think it's a feeling of belonging for some of them as well. They may not fit into school, so… sense of belonging' (Sports leader 2)*

All facilitators also noted that they witnessed a positive impact on young people's self-esteem and that they overcame anxiety and mental health challenges:

'I think it's wonderful to see how some people can blossom in terms of managing their anxiety, overcoming their shyness and growing in self-belief around how they can be confident to enter situations which they perhaps had felt terrified by and felt that they had no chance of being able to successfully do and all of that having that wider positive impact on their self-esteem.' (Clinician 6)

Young people themselves reported seeing improvements to their mood and confidence, often related to improvements to their sleep:

'That just changed my mood instantly, like from being upset and things and moody after staying up late, it just changed how I was' (Young Person 2)

'The one I use most is erm, techniques to go to sleep with. So like stuff to do like stop electronics and certain times and stuff like that' (Young Person 3)

Theme 3, subtheme 1: Staff Development Opportunity

Staff who facilitated Safety Nets, especially the sports leaders, commented that taking part helped them with their professional development. All five sports leaders stated that it had helped them gain knowledge and skills in mental health:

'Yeah, I definitely have more knowledge on how to deal with certain aspects and the different behaviours they bring that you maybe wouldn't see in school I've worked in before and stuff' (Sports leader 2)

In particular they enjoyed working alongside CAMHS, and felt they learned by shadowing clinicians with more mental health expertise:

'It was brilliant. Not even just for the kids I got a lot out of it myself and I really enjoyed it' (Sports Leader 5)

'I really enjoyed it, it was refreshing and different erm something new, erm so it was a learning curve certainly for lots of reasons and to get the opportunity to work with different professionals obviously with a different background and different set of expertise' (Sports Leader 4)

It was suggested that this knowledge could then help improve wider sessions they ran at the sports site, and develop confidence of staff:

'I thought was really useful and intriguing and just added to the process and also just from a confidence point of view that when we do things independently as the (site) we are heading in the right direction and the things we're doing are no different to perhaps than what would be best practise' (Sports Leader 4)

Theme 4: Application of skills learned

All young people commented that what they learnt in the psychoeducation sessions was useful and that they continued to utilise the skills in their everyday lives. One parent stated that although their child had not understood the value of the healthy lifestyle session at the time, it had later been useful to them when planning a family holiday:

'One of the sessions you did was about healthy lifestyles… long story short we're all going on a family holiday and we're all trying to lose a bit of weight, and he said oh mum I really get it now, we talked about this when I was doing the counselling. So that was really good that he could make that link, even though it was a couple of weeks ago, it is something currently in his life now, so it has been really beneficial to him.' (Parent 1)

Four young people also stated that the sessions had helped them with managing their anxiety and to establish a healthy sleep pattern:

'Oh, I found them great. It was nice to learn something. Like me mum said, before I went there it was just all I didn't know about this and that and I didn't know what anxiety meant but ever since I've learnt about it I understand a bit more and I know how to handle it when it gets worse so it's been a really good subject to look at and all the other things I've learnt about have been really easy to understand.' (Young person 4)

Three young people and one parent also commented that since taking part in Safety Nets they have noticed a difference in other aspects of their life. In particular, they felt more comfortable in other social settings and attending school.

'It's definitely opened me up a bit more because you know if now, if a friend asked me to play with them, I wouldn't always say yes, but then when I go to Safety Nets I join in, I have a laugh with my friends and just have fun, so it has made me much happier.' (Young Person 4)

'Well actually I guess it has had a positive effect at school as well because it's stopped me from stressing about school at home. Like getting more sleep and I've been eating better so it all kind of works in its own little way.' (Young Person 1)

Whilst participants noted benefits of Safety Nets, it was suggested by nearly all that eight weeks may not be long enough. It may be important to clarify that the aim of Safety Nets is to prevent the deterioration in mental health symptoms experienced by young people while waiting, and not to fully replace the need for any CAMHS treatment:

'Yes, mental health is not something you fix overnight. At the very least I think it could be 12 weeks. Even that is really not long enough' (Parent 2)

'The first group said they only just started to feel like they got to know each other and that's why they wanted more because they felt more able to explore things. I guess for a lot of them as well, it's the only thing they've got in their calendar that they're looking forward to, something fun a bit different, seeing people outside of school. So yeah, you can't have it endless but maybe like 12?' (Clinician 7)

Future recommendations for implementation and testing

Participants were asked to provide any recommendations for how Safety Nets should be delivered in the future. Two young people found certain psychoeducation topics repetitive, and one parent felt travel distance reduced attendance. These minority views informed considerations for future delivery including flexible content and transport support. Other comments included continuing the positive experiences that were highlighted, such as encouraging an informal, relaxed, and friendly atmosphere. Two facilitators also stated that a key element of Safety Nets is having appropriate staff to deliver sessions, for example those with experience of working with children and young people who may have mental health difficulties and experience of facilitating group work:

'It has to be flexible; it can't be too formal and too structured. You absolutely need the right staff delivering it as well. If you get the wrong people delivering it could be awful' (Sports leader 1)

It was noted by a clinician that Safety Nets would be suitable for some autistic young people and that the criteria for young people to attend Safety Nets should reflect this in the future:

'I guess not including people from neurodiverse backgrounds made it a bit more tricky…, in both groups actually we had people there who were potentially on the spectrum but not diagnosed and they were probably the people who got the most out of

it. They engaged really well and actually probably you could see the most change. So, it is probably worth considering including more of a variety.' (Clinician 7)

Discussion

The aim of this study was to explore the experiences of those who took part in and delivered Safety Nets and to identify recommendations for future implementation and testing. High numbers of young people who need to access mental health services are placed on long waiting lists with limited support (Children's Commissioner, 2024). The results from this current study highlighted that a key motivator for engaging with the intervention for parents and carers was concern about long waiting times for mental health services and not knowing where to receive support from during this wait. This need has been recognised by other researchers, with evaluations of social prescribing on CAMHS waiting lists in progress (Fancourt et al., 2023).

Young people and staff both emphasised the importance of the informal and friendly atmosphere at groups. This is supported by the setting, with the local sports ground offering a non-clinical, non-stigmatising location to deliver sessions. The 'pull of the badge' meant that this was a more exciting place for young people to attend groups, encouraging attendance and engagement with the Safety Nets sessions. The informal and friendly atmosphere also developed from the inclusion of both clinicians and sports staff in all elements of each session, which helps to facilitate trusting relationships between staff and young people. This reflects findings from a recent scoping review of youth social prescribing (Muhl et al., 2025). However, all studies in this scoping review included a link worker model of social prescribing, where a young person is first referred to a connector role, who then supports them to access a community service. Safety Nets extends these findings to a direct referral model, where clinicians connect young people to, and are present in, community sessions.

Whilst an informal and flexible delivery approach was important to young people, if autistic young people are to be included in future delivery, as recommended by some of the clinical staff, this would need to be carefully considered as this population often report lack of routine and unpredictability can cause extreme anxiety (Lam et. al., 2008; Powell et. al., 2022). For example, it may be that where the flexibility in delivery remains, session overviews or plans could be shared with the young people at the beginning of each cohort to help mitigate this. Future research could explore adaptations needed to ensure Safety Nets is inclusive for autistic young people. There has been some work exploring social prescribing for autistic adults, but further work may be needed for youth populations (Featherstone et al., 2022).

Whilst the interviews focused on experiences of the Safety Nets programme, the findings align closely with and build on those from other studies of social prescribing with young people. Whilst these studies have more commonly focused on supporting young people with low level mental health needs (Muhl et al., 2025), Safety Nets explores social prescribing in a population with more complex levels of mental health needs. Interviews highlighted the importance of group delivery in providing peer support and a sense of belonging for young people, which helped to improve their confidence and self-esteem (Tierney et al., 2020). Safety Nets also helped young people to learn practical and achievable ways of self-managing their mental health. By empowering young people to develop self-efficacy, this can support improved mental wellbeing and quality of life (Bertotti et al., 2018). In Safety Nets, these outcomes are reflected in young people reporting feeling more confident to try new things, take up activities with friends and having less feelings of anxiety around attending school. These could then be protective factors in terms of preventing mental health decline (Henriksen et al., 2017).

Both clinicians and sports leaders reported that they enjoyed delivering Safety Nets. Sports leaders felt delivering the intervention supported their professional development by increasing their knowledge around mental health and the benefits of sport and exercise. This then had a

wider impact on improving other groups they delivered, such as school-based sessions. Clinical staff also reported job satisfaction when they observed young people improving in confidence and self-esteem. This is particularly relevant given current reports that challenges faced within these services can have significant impact on staff morale, leading to staff leaving services (NHS Providers, 2024).

There were few comments relating to negative experiences of Safety Nets, and these often focused on the length of the programme. Calls were made by some participants to lengthen Safety Nets from 8 weeks to incorporate more sessions over a longer period. This is something that should be driven by a balance between the voices of those with lived experience and the resources available i.e. time, funds and venue/staff availability. It must also be noted that Safety Nets aims to prevent mental health deterioration when a young person receives a CAMHS referral and are awaiting service access rather than to provide a solution to their mental health challenges. It may be that increased clarity around the role of social prescribing is needed, especially if offered to young people with more complex health needs.

Strengths and Limitations

The sample size for this study was small, however this was necessary due to the in-depth data collected to help understand the individual experiences of Safety Nets. Whilst this current study is limited to the specific programme of Safety Nets, findings are relevant to wider social prescribing programmes with children and young people, which are increasingly implemented both nationally and internationally (Khan & Guirca, 2024).

The geographical variability of the groups and participants is a key strength as it shows that Safety Nets has the potential to be rolled out across different locations and contexts. Despite this, social demographic data was not obtained therefore we were unable to report on social

deprivation index, something that we know can be associated with mental health challenges (Van der Linden et al., 2003).

Recommendations

Recommendations for future delivery include maintaining the welcoming, informal atmosphere and the balance between physical activity and psychoeducation elements. There could be further exploration around extending inclusion criteria for those with a diagnosis of Autism, and to consider further the specific experience of clinical staff delivering the programme to ensure the health, safety and wellbeing of the young people attending. Training around social prescribing, to provide clarity over its role and potential benefits may be useful within NHS teams to support implementation. Future research recommendations include evaluating Safety Nets in a large-scale trial, and further exploring the needs of young people attending Safety Nets from marginalised groups to identify any adaptations required.

Conclusion

This qualitative study explored the experiences of young people who attended a novel social prescribing intervention, Safety Nets, their parents/carers and delivery staff. Families felt the support provided through Safety Nets was beneficial, clinicians recognised the value of sessions and enjoyed delivering, and sports coaches reported that sessions supported their professional development. Participant views were favourable of Safety Nets with appreciation for the relaxed atmosphere, content of the sessions and the settings in which they were held. The findings enhance understanding of how social prescribing can be integrated within NHS CAMHS to support young people with significant mental health needs. Future work should examine how Safety Nets can be scaled and evaluated for effectiveness and sustainability.

Relevance for Clinical Practice

This study highlighted the value of providing support for young people whilst waiting for specialist mental health treatment and identified recommendations for future delivery of social prescribing with this group. Key aspects of Safety Nets delivery included co-delivery between clinicians and coaches to create an informal, non-stigmatising atmosphere and using a holistic approach, incorporating both physical activity and psychoeducation. To support implementation within services, further information and guidance could be provided to staff to clarify the role of social prescribing.

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