The Pathways Project

Examining and Improving Pathways into Mental Health Support for Tasmanian Young People

June 2026 | Prepared by:
Dr Megan Wells
Dr Antonio Mendoza Diaz
Dr Brett McDermott, OAM

UNIVERSITY of TASMANIA

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Acknowledgements

Acknowledgement of Country

We acknowledge the Pakana and Palawa people of Lutruwita, the traditional owners of the land upon which we live and work.

We pay respects to Elders past and present as the knowledge holders and sharers. We honour their strong culture and knowledge as vital to the self–determination, wellbeing and resilience of their communities.

We stand for a future that profoundly respects and acknowledges Aboriginal perspectives, culture, language and history.

Acknowledgements

The authors wish to acknowledge and thank the Mental Health Council of Tasmania, who funded the project and contributed to the development of the research protocol and data collection. The Mental Health Council of Tasmania is supported by the Tasmanian Government through the Tasmanian Department of Health. We gratefully acknowledge the contribution of the steering committee and youth advisory group who consulted throughout the project and contributed to the research design and interpretation of findings. We also acknowledge the schools, students, and parents who participated in the program and whose data is contained in this report. We acknowledge the Tasmanian Department of Health for their stewardship and strategic guidance on the project. The authors wish to thank the research team at the Tasmanian Centre for Mental Health Service Innovation (TCMHSI) for their guidance and consultation throughout the course of the research and for their contributions to reviewing and editing the resulting report. Finally, we wish to acknowledge the Tasmanian Department for Education, Children, and Young People (DECYP) for facilitating the conducting of this research in Tasmanian public schools.

Disclaimer

Researcher Reflexivity Statement

The research team take a constructivist epistemological position, acknowledging that knowledge and understanding is influenced by the interacting subjectivity of both participants and researchers. It is therefore important that the positionality of the research team and potential impacts on the methodological and analytic decision-making are acknowledged.

Megan Wells and Antonio Mendoza Diaz, members of the research team who conducted data collection and analysis, are registered/clinical psychologists practising in Australia, and work primarily with young people in need of moderate to high intensity services. Their understanding of and involvement in the mental health system in Tasmania shapes their understanding of the perspectives shared by participants, as do the experiences shared with them by clients within the Tasmanian mental health system. Megan and Antonio are also both adults, neither of whom are originally from Tasmania, aiming to accurately understand and convey the perspectives of Tasmanian young people. Antonio is a heterosexual man of Latino background. He endorses liberal and humanist social and economic values and tends to take an intersectional lens in his clinical and research work. Megan is a white, queer woman, and endorses similar values and clinical perspectives. Their value-systems and personal experiences, shaped by positions of privilege, influence their understanding of the Tasmanian mental health system, the social context in which the study was conducted, and the experiences shared by participants in the study.

Executive Summary

The report outlines the results of a study commissioned by the Mental Health Council of Tasmania and conducted by the Tasmanian Centre for Mental Health Service Innovation. The study examined the perspectives of Tasmanian young people and parents on pathways into mental health care, including the accessibility, appropriateness, and acceptability of these pathways.

>1 in 5 young Australians experience high psychological distress

~ 14% of children and young people experienced mental illness in the last 12 months

Approximately 47% of young people in need of professional support do not access services

Effective, acceptable, and youth-appropriate pathways into mental health care are essential

A primarily qualitative research design was used, supported by limited quantitative data collection to characterise the sample. Focus groups were conducted with n=27 young people and n=7 parents recruited from three schools in Southern Tasmania, including schools located in regional and rural areas. Data were analysed using an interpretive description methodology, with the ecological framework used to support analysis of individual, interpersonal, institutional, community, and policy-level influences on access to care.

Qualitative analysis of focus group transcripts resulted in seven key findings relating to young people's experiences and understandings of the pathways into mental health care in Tasmania:

1. Public awareness of the pathways into mental health care is limited, and strategies are needed to enhance awareness among young people, parents/carers, and their communities
2. Human connection and trust are priorities for young people, and services may enhance these elements of care by embracing trauma-informed principles
3. The nature of mental health stigma is changing, but fear continues to delay help-seeking. Community-wide interventions are needed to normalise help-seeking and dismantle emerging forms of stigma
4. The ability and value in early help-seeking is often overlooked, and efforts are needed to increase awareness and acceptability of early access to low-intensity services
5. Young people hold varying values and priorities when accessing support, and should be empowered to make choices in how they engage with services

6. Stakeholders are generally supporting of the appropriate use of novel approaches and technologies, however these should be utilised in a manner that complements, rather than replaces, existing pathways and maximises trustworthiness and validity
7. Service navigation is complex for parents, and this burden may be attenuated through strong inter-service connectivity and explicit navigation support

These results were synthesised into seven recommendations for improving pathways into mental health support for Tasmanian young people (Figure 1).

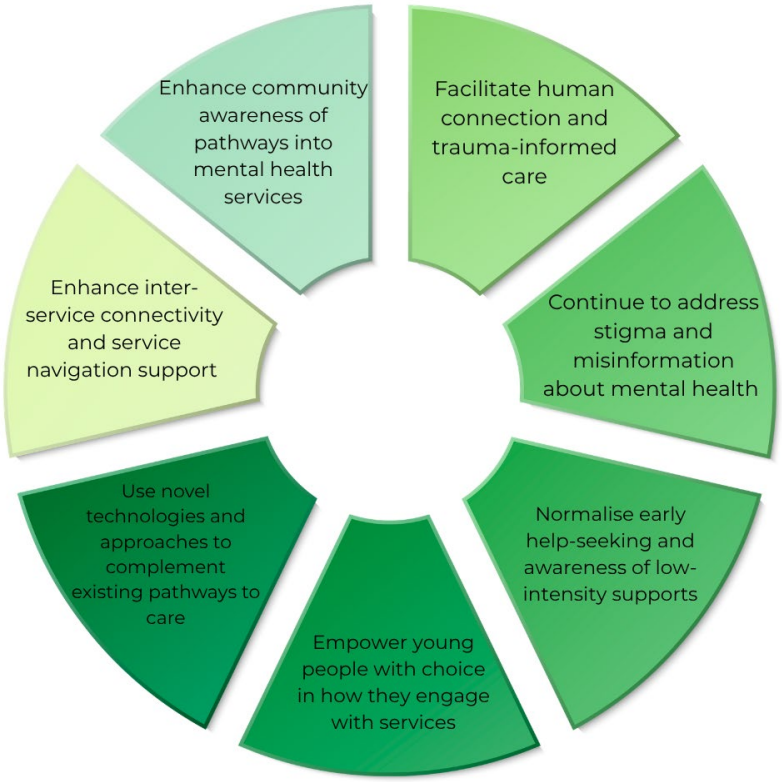


Figure 1: Overview of Key Recommendation

The results of the study highlight that improving pathways into youth mental health care require more than increasing service availability. Young people and families require clear information, practical navigation support, relational and trauma-informed service environments, and flexible access options. Strengthening pathways into mental health care for Tasmanian young people will require coordinated action across individual, family, service, community, and policy levels to ensure that support is accessible, appropriate, and safe when young people need it.

Contents

1. Purpose and scope of report

This report outlines a study conducted by researchers at the University of Tasmania, commissioned by the Mental Health Council of Tasmania. The study examines the perspectives of young people and parents on the pathways into mental health care for young people in Tasmania. The aim of the research is to identify the factors which influence young people's access to mental health care and ways in which the mental health sector can improve its responsivity to the needs of young people. The report begins with an overview of relevant literature, followed by a description of the research methodology and results. Finally, the results are discussed in the context of existing literature and implications of the findings for the Tasmanian mental health system are explored.

2. Background

The burden of mental ill-health among young people in Australia is high, with over one in five young people experiencing high levels of psychological distress [1] and an estimated 14% of children and adolescents experiencing mental illness in the last 12 months[2]. Of the young people who perceive a need for mental health support, an estimated 53% access services, leaving approximately 47% of Australian young people in need without professional support[3]. Compared to the national average, people living in Tasmania have higher rates of diagnosed mental illness[2], likely related to complex profiles of disadvantage, including geographical isolation, low literacy rates, and socioeconomic disadvantage[4-7]. Population-adjusted rates of ambulance attendances for suicidal behaviour or self-harm among Tasmanian young people are high compared to other eastern Australian states[8], pointing to high prevalence of psychological distress among this cohort. Rates of high psychological distress are higher among younger people in Tasmania, and have increased over the 10-year period between 2013 and 2022[9]. While the exact prevalence of mental illness among Tasmanian children and young people is not known, it is likely that the systemic influences contributing to high prevalence of mental illness among adults similarly impacts young people in the state, resulting in a high burden of mental ill-health among Tasmanian young people.

In the context of high prevalence of mental illness and psychological distress, effective and accessible pathways into mental health support and treatment are imperative[10,11]. However, young people's pathways to mental health care are complex, often involving confusing referral processes, prolonged wait times and capacity limitations, and attempts to access support from multiple services before reaching the appropriate support[12,13]. Marginalised populations of young people, including those living in rural/remote regions, Aboriginal and Torres Strait Islander youth, culturally and linguistically diverse youth, those experiencing housing or financial instability, or LGBTQIA+ young people may face even greater barriers to care[14]. In the Tasmanian context, service capacity limitations and a lack of available 'moderate intensity' services for young people have also been identified[15], further compounding the complexity of accessing appropriate services.

Although the Australian mental health system is typically separated into adult and youth services (sometimes with the addition of transitional services for emerging adults), referral pathways for young people are often the same as those for adults. In Australia, referrals into mental health treatment are usually initiated by a GP (with referral pathways similar to those described by Lynch et al. in the context of the Irish public mental health system[16]), but alternative pathways include self-referral or referral through other support services. Given the unique developmental stage of young people, including the key role of peers in influencing behaviour, the tension between individuation and continued reliance on parents, and cultural differences between young people and older adults, it cannot be assumed that the referral pathways that are appropriate for adults will meet the needs of young people. Rather, it is internationally recognised that health services, including mental health services, must adhere to specific principles of youth-appropriateness in order to provide adequate interventions for young people[17,18]. Characteristics of youth-

friendly health and mental health services include specific accessibility considerations (for example, low cost, accessible locations, and out-of-hours appointment availability, and limited wait-times), involvement of young people in shared-decision making, adapted service environments which appeal to young people, employed staff who hold a high level of competence in working with young people, and use of developmentally appropriate communication[19,20].

While the importance of youth-friendly health systems and effective pathways into care are recognised, the extent to which current pathways into mental health care meet the needs of young people in Tasmania is not known, and it is likely that there are many intersecting factors which influence young people's access to the mental health system. This report draws on the ecological framework, originally developed by Bronfenbrenner[21] and later applied by McLeroy and colleagues to the context of health promotion[22], to capture these various influences and develop tangible recommendations to improve access. The ecological framework posits that behaviours, including behaviours relating to help-seeking and treatment access, are determined by characteristics of the individual (intrapersonal factors); interpersonal influences and norms (interpersonal factors); characteristics of relevant institutions and organisations (institutional factors); cultural and community-related characteristics (community factors); and relevant laws and policies (public policy)[22]. To develop comprehensive approaches to improving treatment access, ranging from large-scale policy changes to enacting chance at the individual- or interpersonal-level, it is essential to consider factors at all levels of influence across the ecological framework.

The current study explored the perspectives of Tasmanian young people and their parents on the pathways into mental health care for young people, including the ways in which the Tasmanian mental health sector may more effectively meet the needs of this population. We also explored feedback and suggestions around specific contemporary approaches to mental health referral and access to examine their acceptability for young people, including centralised telephone-based referral services, structured decision-tools for mental health referrals, and the use of novel technological solutions.

3. Methods

This section outlines the research methods employed by the research team, including the research design, recruitment methods, data collection procedures, and data analysis procedures.

3.1 Ethics approvals

The project received approval from the University of Tasmania's Human Research Ethics Committee (project number 32243) and the Department for Education, Children and Young People (project number 2025-26).

3.2 Research design

A primarily qualitative research design was selected for the project, with some limited quantitative data collection to facilitate characterisation of the sample. The research utilised an interpretive description methodology, which aims to produce practical, clinically meaningful outcomes using qualitative research methods [23,24]. Interpretive description was originally developed in the context of nursing research, which aims to increase knowledge of clinical phenomena in a way that gives rise to practical improvements in clinical practice. Given the applied nature of the current project and the goal of producing interpretations which can tangibly inform policy, service development, and clinical practice in the Tasmanian mental health system, this practical and pragmatic qualitative methodology was deemed appropriate to the research aims.

Consistent with the epistemological assumptions underlying interpretive description[23], the researchers acknowledge the inherent subjectivity of the research topic and the unique perspectives of individual young people and families. The research, therefore, does not aim to capture all possible experiences and perspectives on the mental health referral system in Tasmania, but rather aims to use the perspectives of a diverse group of young people and parents to improve the responsivity of these systems to the various needs of young people.

3.3 Participants and recruitment

Participants included young people (aged 12-18) and parents of young people living in Tasmania. Participants were recruited through both independent and public (DECYP) schools. A purposive sampling approach was used, with schools at different levels of rurality targeted for participation and participants across grades 7-12 recruited. Rurality was classified according to the Modified Monash Model (MMM)[25], which classifies areas as metropolitan (MM1), regional (MM2), rural (MM3-5), and remote (MM6-7). As no areas in

Tasmania are classified as metropolitan and no schools in remote areas agreed to participate in the study, only participants living in regional (MM2) and rural (MM3-5) areas are included in the sample.

School leadership were contacted directly to enquire about participation in the project. Interested schools disseminated consent forms directly to students and parents, and those who returned consent forms were included in the focus groups. While both students and parents were recruited for the study, parental participation was not a requirement for a young person's participation, and vice versa.

3.4 Procedures

A total of nine focus groups were conducted (seven with young people and two with parents), with a total of 27 young people and seven parents. Student focus groups comprised young people from similar grade levels (for example, one focus group may comprise students from years 7 and 8) to ensure representation from across the target age range and increase young people's comfortability within the groups.

Focus groups were conducted either on-site at participants' school (k=6) or online via Microsoft Teams (k=1). Focus groups were facilitated by a clinically trained member of the research team and followed a semi-structured focus group guide developed by the research team for the purpose of the project. Focus groups lasted an average of 82 minutes (range 49-116 minutes; range was higher than anticipated due to scheduling constraints at some participating schools resulting in shorter focus groups) and comprised three stages: 1) group discussion around existing knowledge and beliefs about the pathways to mental health treatment for young people in Tasmania, 2) information about select pathways and services provided to participants by the research team, and 3) group discussion focused on obtaining feedback about the services and pathways presented, pertaining primarily to their accessibility and appropriateness for young people. Focus group guides may be provided by the research team upon request.

Focus groups were video-recorded and manually transcribed by a member of the research team. All data were de-identified during the transcription stage. Following transcription, all original video recordings were destroyed, with only de-identified transcripts retained, in accordance with HREC-approved data management procedures.

Participants were asked to complete brief demographic questionnaires either prior to or following participation in the focus group. All participants were asked about suburb of residence (used to classify rurality using the MMM classification system[25]), gender, age, lifetime history of accessing mental health treatment, and lifetime history of mental health disorder diagnosis. Young people were also asked to indicate their current school grade. Parents were asked to indicate their highest level of education, whether their child has ever been diagnosed with a mental health disorder, and whether they have ever sought mental health treatment for their child.

3.5 Data analysis

Qualitative data were analysed using an interpretive description methodology[23,24]. Data analysis was conducted concurrently with data collection and analysis occurred iteratively, with comparative coding conducted continuously throughout the analytic process and previously analysed focus groups revisited as the coding framework developed. Interpretive description seeks to create meaningful interpretations of meanings and connections within the data. Analysis therefore focuses on understanding broad patterns and notions within the data, rather than conducting line-by-line or word-by-word data coding[26]. Preliminary coding was conducted by one member of the research team (MW). Initial codes and preliminary themes were reviewed with another member of the research team (AMD) to facilitate reflection on the interpretation of the data, alternative meanings, and coherence of the findings. This process was repeated throughout the course of data analysis.

The ecological framework[22] was used as an analytic framework to structure the qualitative analysis. Using this model as the foundation of analysis allows for a comprehensive analysis of the ways that variables at varying level of influence might impact young people's ability and willingness to engage with the mental health system, without the rigid application of a priori assumptions about what will be important to young people at each level. The use of this framework also facilitates the identification of practical targets of change at each level of influence to improve the youth-friendliness of mental health access pathways, from strategies to develop skills and knowledge within individuals, through to broad policy and practice changes that may be required.

The coding framework developed using the ecological model is presented in Appendix 1. This framework was reviewed by two members of the research team (MW, AMD), and related concepts occurring across domains of the ecological framework were identified. These interrelated findings were consolidated into seven key findings, which are presented below (see Key Results section). Concepts were identified as key findings based on recurrence across the theory-driven coding framework, the researchers' existing knowledge of the Tasmanian mental health system, and potential for practical application.

4. Key Results

This section outlines the key findings of the research. In Section 4.1, the characteristics of the sample are presented to contextualise the results. Section 4.2 presents seven key findings, developed through the qualitative analysis of focus group transcripts, alongside practical recommendations drawn from each key finding.

4.1 Sample characteristics

The total sample consisted of 27 young people and seven parents, recruited from three schools in Southern Tasmania. Two schools were based in regional areas and one in a rural area, based on the MMM classification system[25].

Twenty-two young people and six parents completed demographic questionnaires, representing 82% of the total sample. See Table 1 for an overview of the sample characteristics.

Table 1 – Sample Characteristics

	Young people (n_{Total} = 27, n_{Survey} =22) n(%)	Parents (n_{Total} =7, n_{Survey}=6) n(%)
Age (mean, SD)	14.7 (1.8)	49.5 (3.4)
Grade		
Year 7-8	6 (27)	N/A
Year 9-10	11 (50)	N/A
Year 11-12	5 (23)	N/A
Highest level of education		
High school not completed	N/A	0
High school completed	N/A	1 (17)
TAFE/trade	N/A	0
Undergraduate degree	N/A	1 (17)
Postgraduate degree	N/A	4 (67)
Gender		
Man/boy	7 (32)	2 (33)
Woman/girl	11 (50)	4 (67)
Non-binary/another term	4 (18)	0
Prefer not to say	0	0
Rurality of suburb of residence		
Regional (MM2)	12 (55)	5 (83)
Rural (MM3-5)	10 (46)	1 (17)
Lifetime mental health disorder diagnosis		
Yes	4 (18)	4 (67)
No	18 (82)	2 (33)
Lifetime access to mental health treatment		
Yes	9 (41)	3 (50)
No	13 (59)	3 (50)
Mental health disorder diagnosis of child		
Yes	N/A	2 (33)
No	N/A	4 (67)
Sought mental health treatment for child		
Yes	N/A	3 (50)
No	N/A	3 (50)

Note. Table 1 presents characteristics of n=28 participants who completed demographic surveys. No demographic data is available for n=6 participants who did not complete demographic surveys. Among participants who commenced the survey, there was no missing data on any of the above variables.

4.2 Key findings

The key findings presented below reflect central themes raised by young people and parents across domains within the ecological framework, including practical implications for service delivery and public policy. The full analytic framework from which key findings were derived is presented in Appendix 1. The alignment of key findings with the analytic framework is presented in Appendix 2.

1. Public awareness of the pathways into mental health care is limited, and strategies are needed to enhance awareness among young people, parents/carers, and their communities

The importance of community awareness of mental health and the pathways into care was highlighted by both young people and parents/carers, with friends, family, and community representing important resources in young people's journey into care. Despite young people turning to those around them for guidance, often due to limited capacity to recognise or acknowledge early signs of distress in themselves, entry into support services was complicated by the recognition that friends and carers may themselves have limited knowledge of mental health systems.

> "I think the first place we go, as we all said, is with parents or friends... It goes from the young person to [parents, friends, teachers], and then it never goes the next step because either they don't know how to, or they ask the person and the person doesn't want to go that next step even if they need to"
>
> (Student, group 1)

Parents often understood their children's mental health experiences and needs through the lens of intergenerational experiences with mental health help-seeking. For some parents, these intergenerational experiences led them to anticipate the onset of mental health difficulties for their children and take pre-emptive steps toward accessing support. Similarly, family histories of mental ill-health were perceived to normalise help-seeking in times of distress, reducing the barriers to support when symptoms arose for their children. However, despite drawing on personal- and family-experiences to understand mental health and the need for help-seeking, parents often felt ill-equipped to navigate the system and described a high burden associated with service navigation.

> "So similar to [parent], there's really big mental health stuff in my mum's family and so when I've seen stuff come up with my girls, there's kind of a print there for me to understand it."
>
> (Parent, group 1)

Limited pre-existing knowledge of the mental health system was further compounded by the complexity system once help-seeking was initiated. Participants recognised that services targeted toward young people may need to provide more structure around service navigation and employ active approaches to disseminating information compared to adult services, given young people's limited prior experience access health services.

> "I guess when you're younger, like when you're really little, you won't have a phone and you won't have a way to search it up. Or you won't have the mindset to think "oh I should search this up". Whereas maybe when you're an adult you can think to do that"
>
> (Student, group 3)

In order to improve ease of entry into the mental health system, participants suggested that strategies to improve awareness of mental health systems for young people, parents/carers, and the broader community were needed. Improvements in knowledge were needed in areas such as the types of services available, access/eligibility criteria, where and how to initiate the help-seeking process, indicators of need for professional support, and how to navigate between services once access is achieved. A whole-of-community approach may be best placed to address knowledge gaps, as young people may approach community members such as teachers, sport coaches, and mentors for guidance, as alternatives to their parents or professional supports. Participants also recognised that embedding age-appropriate knowledge of mental health early in young people's lives may have lasting effects on their ability to access supports throughout their adolescence, and school was identified as an accessible place where this knowledge may be gained.

> "And sporting groups, coaches. [Name of child] plays hockey, year 9 hockey, and is there actually four nights a week... So, if adults in the community can be generally more educated on the process..."
>
> (Parent, group 2)

> "I guess a lot of the support that's accessible now probably wouldn't have been accessible when [parents] were younger, so it's kind of like "oh that's just something that you can deal with, you don't need to get help for that"...There could be ads that are targeted more toward parents that say like "this is how your child could be feeling and this is common""
>
> (Student, group 3)

Recommendations

Efforts are needed to improve community awareness of mental health access pathways. Given the role that informal supports such as friends, parents, and community members often play in facilitating help-seeking, strategies are needed to improve awareness not only among young people themselves, but also among parents and broader communities. Ensuring that age-appropriate and up-to-date information about services and access pathways is embedded into educational curricula is one mechanism through which this may be achieved, alongside community-level awareness campaigns and the promotion of centralised sources of reliable information. Interventions to improve public awareness should focus not only on the nature of mental health concerns, but also on the types of services available, access criteria, where to initiate the help-seeking process, indicators of need for professional support, and how to navigate between services once access is achieved.

Although improving community awareness of the pathways into mental health support was identified as an important priority for improving treatment access, it is important that

practical barriers to treatment access are not overlooked. Participants identified distance to services (particularly for young people living in rural areas) and service costs as hindering access to treatment. Additionally, complex administrative processes for entering services may also reduce access for those with limited functional capacity or literacy. Thus, in conjunction with addressing awareness-related barriers to mental health support, it is important that institutional- and policy-level strategies are used overcome practical access barriers, particularly for vulnerable or marginalised populations.

2. Human connection and trust are priorities for young people, and services may enhance these elements of care by embracing trauma-informed principles

Connection with referrers and service providers was a key factor influencing young people's experiences of care and likelihood of continued help-seeking. The importance of connection was identified both within individual interactions with service providers and in the context of continuity of care. Within individual interactions, young people highlighted the importance of feeling understood, validated, and cared for, and expressed a preference for more casual and straightforward communication styles and non-clinical service environments. Young people also expressed the role of genuine connection with their provider, including a desire for appropriate use of self-disclosure to build trust.

> Student 1: "Connect with me and be human"
>
> Student 2: "Share something about themselves, like just have a normal conversation."
>
> Student 3: "You want them... I don't actually care if they are genuine, and if they genuinely care, but if they can at least act like they do. Like just make eye contact and stuff like that to make sure it's more personable"
>
> (Students, group 2)

Beyond the need to build connection within individual interactions with service providers, participants highlighted the role that continuity of care and ongoing relationships with service providers play in improving access to care. Trust was identified as a key factor determining whether and where young people will seek support, but may be difficult to develop in single instances of contact with no pre-existing rapport. For parents, the presence of pre-existing relationships with a trusted service provider or referrer was also key, easing service navigation and reducing barriers to accessing support when the need arose.

> "For myself, with my daughter, it was going and seeing my GP. I think I sort of lucked-out in the GP I got. He's really good and I'd seen him before... So I think when I found out about my daughter, I felt that I knew I could take her there and that he could probably help. I didn't even think about calling any of the numbers or anything like that, I think it was just purely 'Okay, I need to get help. Where do I go? Okay, the GP I've had a good experience with, so go there'"
>
> (Parent, group 2)

Adherence to trauma-informed care principles was perceived to facilitate the development of personal connection with service providers and improve experiences of help-seeking. Broadly, trauma-informed care involves the provision of care in a manner that is responsive to the impacts of trauma, recognising the possibility that all people seeking support may have experienced trauma throughout their lives. Principles of trauma-informed care include ensuring physical and psychological safety; demonstrating trustworthiness and transparency; empowering people with choice in how services are delivered; prioritising collaboration and shared decision-making; and respecting and valuing diversity[27,28]. Participants in the current study noted the importance of catering to individual needs and preferences regarding communication style, including for neurodivergent young people, and providing young people with choice around the provider they speak with to optimise feelings of personal connection. The option of changing providers to find the right fit and facilitate connection and trust was frequently identified as important for participants, and provides young people with a level of age-appropriate autonomy over their healthcare.

Participants reflected on the importance of working collaboratively with young people to facilitate connection and trust, including through shared decision-making around referrals into care, particularly as young people progress further into adolescence. These practices, which align with the principles of trauma-informed care, enabled young people to seek support when needed and informed decisions about which services they would engage with. When identifying a provider perceived to be trustworthy and acceptable, important considerations for young people included the extent to which the provider/service was perceived to be sufficiently qualified, knowledgeable, and holding specific expertise in working with young people. Both parents and young people also suggested that facilitating safety and connection by meeting young people where they are at, with activities they are comfortable with, may improve willingness to engage with referral or support services where formal conversations around mental health may be overwhelming.

> "You're doing something, and you're talking while you're doing it. That makes it so much easier to share, and it means it doesn't all have to revolve around you in your mind... I'm not sure that every place needs to offer that, but I think it would be useful because it's accessible"
>
> (Student, group 3)

Recommendations

Services should embrace the principles of trauma-informed care, including providing choice in service provider, developing trust, and ensuring physically and psychologically safe service environments. When working with young people, facilitating human connection is a particularly important mechanism through which the acceptability and appropriateness of a service may be enhanced. Facilitating human connection may be effectively achieved through the use of non-clinical and person-centred communication, and demonstrations of compassion and care. Service providers must also be afforded sufficient time within interactions with young people to establish trust and rapport, and where possible, young people should be provided the opportunity to work with a consistent provider across multiple interactions with a service. Providing age-appropriate

autonomy and choice in service provider may further enhance feelings of safety, connection, and trust.

3. The nature of mental health stigma is changing, but fear continues to delay help-seeking. Community-wide interventions are needed to normalise help-seeking and dismantle emerging forms of stigma

Some participants noted reduced shame around disclosing mental health concerns and increased normalisation of help-seeking among young people compared to older generations, indicating a shift in stigma among younger people. However, perceived or actual judgement remained a concern for participants and was reported to delay or prevent help-seeking, with young people describing a hesitance to seek support at sub-clinical levels of distress. Importantly, stigma was not always overt and for some young people internalised stigma led to a difficulty "admitting" to experiences of distress or the need for supports. Fears around negative reactions or concerns about being treated differently made young people hesitate before seeking support from informal support networks, despite informal supports being identified as the first preference for support by the majority of participants. This tension highlights the difficulty faced by young people when choosing when and how to seek support, with family and friends being both an important pathway into support and a barrier to help-seeking due to fears about how they will respond.

> "It's not like my parents wouldn't want me to get that support, but I don't want my relationship with them to change... And I feel that goes for everyone in my close world, and that's such a hard barrier to break through"
>
> (Student, group 3)

The perceptions of others, including both peers and parents, were salient concerns for young people and had the potential to delay or prevent help-seeking. Belonging and social standing among peers was important, and fears about interpersonal judgement made it difficult for young people to acknowledge when mental health support may be needed. Similarly, participants noted that although mental health literacy may be higher among their generation, limited understanding of mental health among parents may reduce access to supports, particularly in instances where parents are relied upon to facilitate access to services. Both negative and dismissive reactions from parents were identified as barriers to help-seeking, and participants highlighted the role that friends or professional supports may play in facilitating conversations with parents to mitigate unhelpful responses.

> "I guess if it's something that your parents... that you wouldn't want your parents to know because they wouldn't take it well, you could find someone to help you find out how to share that to them in a way that they would be able to understand and respectfully acknowledge. That could also be quite helpful."
>
> (Student, group 2)

Perceived, anticipated, or actual judgement from professional supports represented an additional barrier to help-seeking for participants. Both young people and parents expressed the importance of a non-judgemental stance among service providers, and for young people this required active demonstration of non-judgement in practice, rather than statements about spaces being safe or non-judgemental. While specific actions or approaches that would evidence this non-judgemental stance were not identified, participants highlighted that statements about non-judgement were insufficient, suggesting that feelings of trust and safety are likely to be developed over time through continued engagement with a provider. For some participants, there was also a concern that young people's distress may be dismissed or not taken seriously by service providers, with the use of structured assessment tools in place of clinicians' judgement endorsed as a potential solution.

> "Especially when you're a younger age they might not think you have as bigger problems as someone who is older, or they're not going through as much"
>
> (Student, group 7)

Recommendations

Although stigma around mental health may be reduced in young people compared to older generations, concerns around the judgement and negative reactions to disclosures of mental health continue to dissuade young people from seeking help. Efforts to normalise help-seeking, including at sub-clinical levels, within the Tasmanian community are needed to address stigmatising attitudes and judgement from peers. Additionally, support for parents to respond effectively to disclosures of mental ill-health may increase willingness to seek support, particularly in light of the key role that parents play in enabling treatment access. Support people such as school staff or mental health professionals may facilitate conversations about mental health with parents, and supporting parents to initiate conversations about mental health may further reduce shame among young people. For service providers, providing clear and explicit evidence of non-judgemental attitudes may support young people's willingness to engage with their service. Among others, one strategy that may support this aim is helping young people know what to expect when accessing a service, which may attenuate fears about judgement or dismissive responses by providers.

4. The ability or value in early help-seeking is often overlooked, and efforts are needed to increase awareness and acceptability of early access to low-intensity services

Help-seeking was characterised by many young people as something that occurs when symptoms or distress reach a high level of severity, with few students identifying early-stage symptoms as indicators that support may be needed. Instead, help-seeking was discussed as something that may occur *"if I was breaking down every time I came home from school" (Student, group 4), "When life feels like it's not going to get better anytime in the*

foreseeable future" (Student, group 5), or "if they can't cope anymore (Student, group 7). The perception that difficulties may not be significant enough to warrant support was consistently identified as a barrier to seeking support, further evidencing the perception that supports are sought only at high levels of distress.

For some young people, mental health support was similarly perceived to be "all or nothing", with limited awareness of low-level supports. For many participants, awareness of supports outside friends and family was limited to crisis phone lines (e.g. Lifeline, Beyond Blue), specialist mental health services, or emergency services. School-based supports were a notable exception to this pattern, with many young people well informed about the availability supports within their school. It may be that the relationship between limited awareness of low-level supports and the belief that support-seeking occurs only at high-levels of distress is bidirectional, suggesting that both increasing knowledge of the spectrum of services available and normalising early-intervention are important for this population. Increasing knowledge of what constitutes low-intensity support, including when it is indicated and how it differs from higher-intensity support options, may also reduce the barriers to accessing these types of supports.

> **"People who are around my age, they hear the word "mental health" and they think like 'insane, in a psychiatric ward all the time, and just can't be... aren't human' basically, which is a complete lie"**
>
> (Student, group 4)

In contrast to the perspectives shared by youth participants, parents described low-level supports and early intervention as key components of an effective mental health system, with some describing a preference for seeking lower-intensity services for their children before accessing specialist services. Consistent with the salience of belonging and social standing described by young people (discussed above), normalising these kinds of supports was identified as an important means of improving young people's willingness to access early-intervention services.

Many participants described a mental health system which is unable to provide prompt supports for young people due to long wait times, a lack of services, and limited capacity within existing services. Limited service capacity, particularly within moderate-intensity services, has been identified previously in the Tasmanian context and results in limited support for young people who do not meet eligibility criteria for either early-intervention or tertiary-level services [15,29]. The experiences of participants in the current study suggest that knowledge of and/or willingness to engage with early-intervention services may be limited among young people, which may contribute to the "bottlenecking" at the moderate-intensity level of support. The results suggest that both increasing availability of moderate-level supports within the community and improving knowledge and acceptability of early-intervention supports are important targets within the Tasmanian mental health system.

> **"It took a couple of weeks to get into the GP... So before that I already started, I started cold-calling psychologists as well, just to see if I could get her in anywhere. All of them, obviously, pretty much have waiting lists and everything is like that."**
>
> (Parent, group 2)

Recommendations

Mental health support was often viewed as "all or nothing" and young people expressed limited awareness of early intervention approaches, which likely prevents help-seeking during the early stages of distress or mental ill-health. Young people should be supported to understand the full spectrum of available mental health services, and strategies to increase the acceptability of early help-seeking are needed. This requires supporting young people to understand what constitutes low-intensity support, including when it may be indicated and how it differs from higher-intensity treatment options. Access issues may be further attenuated by system-level changes to increase capacity of low- and moderate-intensity services to reduce bottle-necking and promote access to early intervention.

5. Young people hold varying values and priorities when accessing support, and should be empowered to make choices in how they engage with services

Young people described varying values and priorities when choosing how to engage with services, which often competed with one another. As described above, participants valued connection in interactions with service providers, and this was perceived to be afforded by more personal modalities of engagement (e.g. face-to-face, phone calls) compared to chat- or web-based engagement. For this reason, many young people described a preference for these more personal engagement modalities, describing increased trust, connection, and ability to interpret non-verbal communication.

> "Sometimes the face-to-face stuff, compared to the online stuff, is more real. The online stuff can feel pretty... like it's not real and it's not really helping, and you're still alone even if there's people there"
>
> (Student, group 3)

Conversely, more personal modalities of communication felt more daunting or vulnerable for some participants, which made accessing these services more challenging. This group of participants described concerns about anonymity when accessing services face-to-face, and valued the privacy associated with online or text-based communication and the ability to provide thought-out responses.

> Student 1: "Well I find phone calls less... well, not less confronting, but confronting. I don't know the word. Just because there's... less contact to start with. I think for most people generally, the less contact the better. So we started with texts because there's no voice, no continuous live conversation. And then next would be phone calls with no facial recognition or anything"
>
> Student 2: "I think with a video call it might feel more like you're talking to a human because you can see their face and you know what they look like and understand them. But I do agree with what [student 1] is saying that it would be more daunting,

> definitely, because you might again feel like you're getting judged for how you look or something like that."
>
> (Students, group 1)

The acceptability of telephone-based services was mixed, with some participants describing an avoidance of phone calls among their generation relating to feelings of awkwardness and anxiety. For some young people, it felt easier to trust a website compared to a person on the phone, while others reported negative perceptions of call-services due to expected wait-times. Call-services were, however, perceived to be appropriate for more serious concerns, for people with limited social supports, or in rural areas with greater distance to services. Access to reliable phone reception was important in determining the appropriateness of telephone-based services, particularly for those in rural regions where phone-services may be most needed.

Despite the importance of providing choice and age-appropriate autonomy for young people, the tensions and complexities associated with the adolescent stage of development may complicate the provision of autonomy-supportive care. Participants reflected on a desire for increasing autonomy in healthcare throughout adolescence, and wanted access pathways that prioritised shared decision-making and recognised their expertise and right to make informed choices about their care. However, tensions emerged between this desire for autonomy and the desire (or sometimes, requirement) for parental involvement in care. For some young people, this tension was navigated by characterising parents as playing a supportive, rather than a decision-making, role in treatment, for example providing advocacy for their young person and facilitating practical aspects of access to care. For other young people, however, the requirement for any parental involvement served as a barrier to help-seeking, while for some parents the lack of such a requirement was also a barrier. The complex and nuanced ways in which young people understand and navigate help-seeking, dependence, and autonomy highlight the importance of providing flexible and individualised approaches to care, balancing the competing priorities, needs, and preferences of individual young people while maintaining fidelity to a model that ensures safety and recognises the key role of parents in supporting youth mental health.

Recommendations

Modality of engagement is an important consideration for young people when determining whether to seek support, and there are many intersecting considerations that guide young people's preferences around engagement. To optimise willingness to engage, young people should be empowered to access services in a way that meets their needs and reduces access barriers. This requires a treatment system which can be accessed through various services and modalities, in which young people are provided age-appropriate autonomy and choice, and which embraces the principles of a "no wrong door" approach.

6. Stakeholders are generally supportive of the appropriate use of novel approaches and technologies, however these should be utilised in a manner that complements, rather than replaces, existing pathways and maximises trustworthiness and validity

Novel approaches and technologies discussed in focus groups included the application of structured assessment tools, such as the Initial Assessment and Referral Decision Support Tool (IAR-DST)[30], and the use of artificial intelligence to optimise mental health treatment access. With regard to structured assessment tools, both young people and parents/carers were generally supportive of the use of resources like the IAR-DST by referrers to determine the appropriate level of care. Young people highlighted the inclusion of contextual domains (such as social support, environmental stressors, history of service use) as an important element of these tools, increasing the likelihood that important information is captured within the assessment. The tool was also perceived to standardise referrals to care and reduce the impact of clinician bias. For some young people, the outcomes of structured tools like the IAR-DST were perceived to be more trustworthy than people's personal assessment of their own needs, although the importance of allowing for re-assessment and stepping-up or stepping-down in care was acknowledged.

> "I think most people aren't very good at gauging exactly where they're at in terms of severity. I think as [student] said before, including a bit of other context would probably make that a more efficient system. Whether that context is an easy thing to collect, though, is another thing"
>
> (Student, group 1)

Where hesitations around structured assessment and referral tools were expressed, for young people these often related to limited trust in the outcomes of one-off assessments, while parents' hesitations often centred on limited trust in general practitioners (GPs) as the source of the assessment and the importance of continuous needs assessments. Parents reflected that GPs are overburdened and have limited capacity to conduct comprehensive mental health assessments, may not identify the need for mental health assessment, and may not have knowledge of the range of services available. Thus, parents expressed a preference for and increased trust in the outcome of structured referral tools when they are administered by specialist mental health professionals, regardless of their specific qualifications.

> "I thought the tool you showed us was really good and I think the dimensions that it was across were excellent. But again, it hits up against the system of GP medical care... And that's not to dismiss GPs in any way, they do an amazing job. But it's the system that they're working in that, structurally, makes then really hard to access and get care from"
>
> (Parent, group 1)

Having a clinician-administered tool was important for participants. Reliance on a clinician was perceived to reduce bias compared to self-administration of assessment tools, and the use of clinical judgement was described as important in the context of fallible tools. Moreover, participants described the need for clear guidance around the practical

implications of the assessment outcome. A tension arose between young people's trust of their own understanding of their needs and trust in the outcome of a structured assessment tool, such that the outcome of the tool was viewed as a starting point from which to explore appropriate treatment options and conduct regular re-assessments. Support may also be important for managing the range of emotional responses that may arise in the context of assessment and referral, particularly if the recommended level of care diverges from young people's expectations. Future research examining trajectories in care over time may provide insights regarding how care is elicited (by whom, and at what points in time), and whether patterns in service access are themselves informative of the young person's mental health.

> "Maybe you check in with yourself and look at where you're at, and maybe recalibrate yourself, or at least try to. Like, see if maybe you're overthinking... but also then be ready to go back and say 'I'm sorry, you're wrong and I need more'"
>
> (Student, group 3)

When discussing the potential role that artificial intelligence may play in facilitating mental health referrals, both parents and young people expressed caution and hesitation. The strength of artificial intelligence was identified as the breadth of information contained within these systems, and some participants suggested that this would make them appropriate for preliminary information-seeking around mental health treatment options. However, many participants voiced concerns around the trustworthiness of information contained within open artificial intelligence systems, and some suggested that closed, purpose-developed artificial intelligence tools would be a more safe and appropriate solution.

> "I feel like the fact that it's been trained with so many resources though... it doesn't know more than a person, but it understands more. It has a very broad sense of knowing."
>
> (Student, group 3)

The most commonly raised issue regarding the use of artificial intelligence was the reliability of information provided, while some participants also expressed concerns around the privacy personal information provided to artificial intelligence systems and the ethics of artificial intelligence (for example, its environmental impacts). A high level of technology-literacy among participants was evident in these discussions, with participants also aware of the potential for artificial intelligence systems to "hallucinate" material, provide misinformation, or be used to access personal information.

> "Its information can be quite off sometimes because it starts taking from itself and then it gets, like, mutilated. And then it's not factual anymore"
>
> (Student, group 7)

The central role that human connection plays in facilitating mental health help-seeking was reiterated in discussions about the role of artificial intelligence, with young people concerned that seeking support via artificial intelligence would not allow for much-needed experiences of connection, support, and empathy. Thus, where artificial intelligence was described as a feasible addition to the mental health referral system, it was primarily described as a preliminary, information-seeking step in the help-seeking

process, rather than as a substitute for traditional professional assessment and referral processes.

Recommendations

Integrating novel approaches and new technologies into existing treatment pathways may improve accessibility and reduce some barriers and inequities in treatment access. However, human connection and clinical judgement remain important priorities for both parents and young people and new approaches should complement, rather than substitute, the human and professional elements of the referral system. Structured tools like the IAR-DST were broadly acceptable, if delivered holistically and by an appropriately qualified professional, and when used in conjunction with clinical judgement and respect for the preferences and expertise of young people seeking help. Young people were more cautious about the use of artificial intelligence systems in light of concerns about their trustworthiness and ethical considerations, and suggested that if these are implemented, they should be used for information-seeking rather than for referrals or the provision of advice around service access. As with all innovations, integration into referral and treatment systems requires ongoing evaluation of efficacy, risk, and acceptability to their target populations, embedded across all stages of implementation.

7. Service navigation is complex for parents, and this burden may be attenuated through strong inter-service connectivity and explicit navigation support

For parents, supporting their young people to access mental health support was a complex process, requiring active advocacy, service navigation, follow-up, and care co-ordination. Parents described navigating a large number of services with their children, and expressed a desire for clear, accessible information about how to navigate services and specific service processes.

> "So that was very challenging, especially when you're across a number of different services. So I guess for her, there was the psychiatrist, there was the testing, there was school, there was the government stuff that came into my life sometimes, and then there was the anorexia clinic at the hospital ultimately, as well as the GP, and various things. So yeah, that was enormous."
>
> (Parent, group 1)

Parents described services as acting as gateways to other services, although their perception of this process differed according to their individual experiences. For some parents, they felt unable to gain entry to much-needed services due to the need for referral through another service which acted as a "gatekeeper" to more specialist treatment pathways. For other parents, where inter-service communication and collaboration was strong, the ability to gain access to services was facilitated by their referral or treating team, who supported parents through effective liaison and communication with other services and providers. Regardless of their specific experiences,

many parents felt that access to services was dependent on gaining initial access to the treatment system, after which doors to additional supports and treatment options could be opened.

> "My perception is there are issues with GPs in the public health system being the gateway to specialists… they more often than not keep that gate closed and deal with things and keep the public away from specialists… From my experience, both personal and with children, you had to push pretty hard to bey beyond just the GP."
>
> (Parent, group 2)

> Parent 1: "It sounds so fragmented – this service, that service. Who did hold it together… who made it whole?"
>
> Parent 2: "In the beginning it was us, as the parents. But then when we got into the psychologist, she has been brilliant and has been liaising with the clinic… I think if we didn't have someone like that psychologist we could be, I think, floundering a bit."
>
> (Parents, group 2)

In addition to strong interservice connectivity, explicit support to navigate the mental health system was an important, but missing, element of treatment access for many parents. Parents described navigating a large number of services and felt that complex entry criteria and processes made this particularly challenging. They described a need for tailored and explicit guidance around accessing services, particularly where their children's needs were complex or required input from multiple providers, and described the need for a single, accessible point of contact to facilitate this.

> "So for all the people who don't necessarily know what's available in Australia, or in Tasmania, rather, wherever their community is, if there's someone that understand the pathways available and understands the options… it could be in schools, community groups, I guess even in workplaces."
>
> (Parent, group 2)

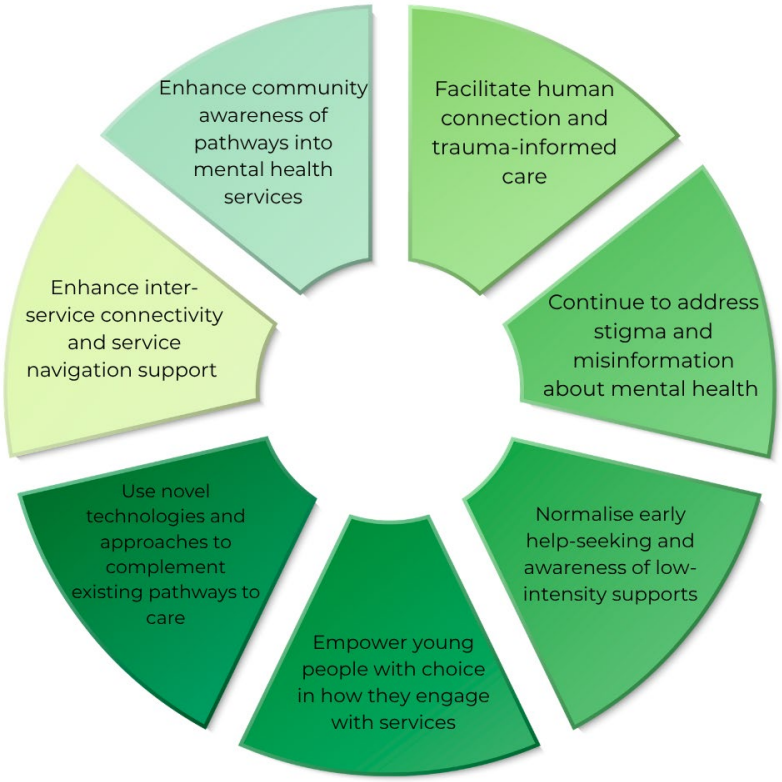
Recommendations

Services increasingly recognise the importance of interconnectivity and communication, especially when working with vulnerable people and families who may have limited capacity to navigate services independently or advocate for their needs. Given the key role that services play in coordinating access to the broader treatment system, effective communication and collaboration mechanisms between services are needed to ensure access to comprehensive and appropriate care. This requires clear understandings of the range of services available and their access pathways, in addition to appropriate information-sharing pathways to reduce the need for young people and families to repeatedly share their stories. The burden of service navigation for parents may also be mitigated through clear and centralised guidance and support, provided by an identified, accessible member of the treatment team.

5. Discussion

The current study examined the perspectives on Tasmanian young people and parents on the pathways into mental health care, with a focus on the accessibility and acceptability of current and emerging access pathways. Results were consolidated into seven key findings and recommendations (Figure 1), with implications ranging from those relating to the individual and intrapersonal elements of help-seeking behaviour to the broad policy community contexts of the Tasmanian mental health system.

Figure 1 – Overview of key recommendations



The results are largely consistent with international recommendations about the nature of youth-friendly mental health services, suggesting that many of the principles of youth-friendly services also apply to the pathways into care. Consistent with the findings of our research, facilitating connection through communication style has been previously identified as central tenet of youth-appropriate services, as has the provision of autonomy, flexibility, and choice [19,20]. Despite their importance, system structures may not always facilitate the provision of flexible engagement approaches and the development of relationships with a consistent service provider. Referral services may, due to organisational policy, funding requirements, or capacity, provide limited opportunities for choice around young people's engagement or be structured around single-instances of contact. Despite these constraints, the current results underscore the relevance of established youth-friendly service principles to Tasmanian young people and to the

pathways into care, and reinforce the need to prioritise these elements of care throughout service design and delivery. The application of audit tools and checklists, such as those developed by the Western Australia Department of Health [31] and the New South Wales Department of Health [32], may facilitate this through the application of clearly operationalised criteria and benchmarking around the extent to which current procedures align with youth-friendly care.

Capacity for facilitating human connection informed young people's preferences for modalities of engagement with referral services and service providers. For many young people, face-to-face communication was perceived to allow for greater connection and rapport-building compared to telephone or message-based engagement, although this benefit was often offset by increased feelings of vulnerability and reduced anonymity. Previous literature has examined the use of telephone-based mental health triage services in the adult population, with studies reporting broad satisfaction with services, but limitations identified around shared decision-making [33,34]. Despite being applied in practice to young people, research examining the efficacy, acceptability, and experiences of young people accessing these services is limited. An examination of youth mental health reform strategies in England identified that the development of a single point of access referral system streamlined referral processes and was accessed by parents, young people, and other relevant stakeholders [35]. Although, the authors noted that online referrals were increasingly used over telephone-based contacts [35]. The results of the aforementioned study have promising implications for the feasibility and utilise of centralised referral services in similar jurisdictions, such as Australia. The results of the current study suggest that remotely delivered referral services may be acceptable for some young people in Tasmania, including those who desire increased privacy and those in rural areas. However, the importance of choice is also evident, and aligns with best-practice principles for youth mental health services [10,19], with sub-groups of young people holding different values and priorities regarding modalities of engagement. In order to ensure services are accessible and acceptable to all young people, it is important that services are flexible and responsive, allowing young people to engage through multiple modalities, thereby meeting their personal needs. Additionally, future research examining the outcomes and experiences of young people and families accessing centralised referral services is warranted.

For young people in Australia, the catalyst for mental health help-seeking may be personal distress and a desire for help, often assisted through interventions by concerned friends, parents/carers, or other supports (e.g. school staff) [36]. Consistent with these diverse entry points, the results of the current study indicate that broad, population-level awareness of mental health systems and access pathways are needed to mitigate barriers to care, rather than interventions to increase awareness solely among young people themselves. Flexibility regarding who can access support, and whether support can be accessed on behalf of others, is likely to lower barriers to care. Once help-seeking is initiated, the process of navigating services can continue to complicate the process of accessing appropriate support. Consistent with previous Australian research, parents in the current study noted limitations around inter-service communication [12], complex access and

referral pathways [12], and identified the central role that parents are carers play in coordinating support and advocating for their young person [29]. The complexity of mental health service navigation is well established, and best-practice guidelines recommend the allocation of care-coordinators to reduce the navigation burden for parents and carers [11]. Embedding service navigation support into routine service provision may be an important mechanism to reduce unnecessary system complexity and parental burden of service navigation.

Parents described the key role that primary care services play in either enabling or hindering access into the mental health treatment system, and services can have different expectations regarding what the role of a parent/carer involves. This may be further complicated by the differing needs, expectations, and capacities of individual young people, which preclude the application of concrete decision rules about parental involvement in care. For example, a 15 year-old young person with limited capacity to understand the health system or make informed health-care decisions may require parental involvement in all elements of care, while parental involvement may be contraindicated for another independent young person with high personal capacity and limited parental capacity. Thus, flexibility and clinical judgement are needed to ensure adherence to ethical standards and duty of care without inadvertently excluding young people for whom parental involvement may be complex or infeasible.

The centrality of primary care providers in facilitating access to public services has been identified in previous research in the Irish health system, which is structured similarly to the Australian system, with a portion of mental health services provided within the public health system alongside a portion of private and community providers[16]. In this context, pathways into the public mental health system were described as disempowering for young people given the limited opportunity for involvement in decision-making, with decision-making power held primarily by primary care referrers[16]. Reforms in the similarly structured English mental health system have been undertaken to increase self-referral pathways to mental health care for young people in order to remove unnecessary system complexity reduce the barriers to care [35]. Internationally, the importance of the pathways into mental health care is increasingly recognised [10,11], with parsimonious, streamlined, and accessible entry points essential to an equitable and effective mental health system. The results of the current study highlight the need to ensure that the youth-friendliness of innovations and reforms in the mental health access system is considered, and that collaborative, participatory methods of service development are prioritised. Evidence from health system reforms in jurisdictions which have a similar structure to the Australian health system may be used to inform local reform efforts.

In interpreting the results of the study, it is important to note that opportunity and access to services is not ubiquitous in the Tasmanian population. Compared to the national average, a large portion of Tasmania is classified as regional and remote [5] and residents report lower median weekly income [6], which significantly impacts access to services. Participants in the current study identified distance to services as an important consideration in determining preferred engagement modalities (e.g. face-to-face versus

telephone), and some suggested that awareness of services may be particularly low in more remote areas. Cost of services was similarly described as a barrier to care, with many services in the private sector not accessible to those experiencing high socioeconomic disadvantage. Although potentially exacerbated in Tasmania by the high prevalence of disadvantage and rural living, these findings are not unique to the Tasmanian context. Research in other Australian states has identified unique barriers to health or mental health care for young people living rurally, including high distance to services, limited specialist youth service providers, greater stigma, limited awareness of services, and anonymity concerns [37,38], while Tasmanian research has highlighted attitudinal, social norm-related, and structural barriers to care for rural young people [15,39]. Australian research has similarly suggested that while barriers to mental health services exist across populations of young people, these may be exacerbated for families experiencing socioeconomic disadvantage [13]. It is important to note role of intersectionality here. Many rural areas in Tasmania also experience high socioeconomic disadvantage, and individuals living in these regions may hold multiple additional marginalised identities, such as cultural and linguistic diversity or gender and sexual diversity. Thus, ensuring access to mental health services for vulnerable populations of young people requires an integrated approach, drawing on the strengths and preferences of individuals and communities while addressing the broader systemic and individual barriers to accessing care.

Our results highlight the potential for the integration of novel approaches to facilitate access to the mental health system, such as structured assessment protocols and centralised referral services. However, they also point to the need for caution in the ways that these systems are integrated to maintain (or ideally, enhance) equity of service access and prevent falling into “one-size-fits-all” approaches to access and referral. Participants in the current study appreciated the potential for structured assessment tools to reduce prejudice and facilitate comprehensive and holistic assessments, while emphasising the need for clinical judgement to ensure individualised recommendations are provided and facilitate ongoing monitoring and re-assessment. Similarly, centralised telephone- or chat-based services were described as being less confronting for some young people, improving access and information for rural communities, and as reducing the burden of service navigation for parents. However, these services were not acceptable for all participants and the important of providing choice was consistently highlighted. These findings suggest that the integration of novel approaches should be conducted in such a way as to *enhance accessibility, choice, and individualised care*, rather than being universally and undiscerningly applied to all Tasmanian young people.

5.1 Limitations and future research directions

The findings presented should be viewed with consideration to a number of limitations. Limited sociodemographic and clinical characteristics were collected from participants. This methodological decision was made to reduce the time burden of participation, as data collection occurred in schools and involved time away from class for participants.

Further, this decision protected the psychological safety and privacy of participants in the focus-group context. The decision to collect limited demographic and clinical data reduces our ability to assess for diversity in the sample and identify perspectives which may not be present in the data, which may limit the generalisability of the results to the broader population of Tasmanian young people.

The sample comprised young people who were engaged with school, were willing to participate in a group discussion about access to mental health services, and were able to obtain parental consent. Young people outside these groups may have different experiences of the mental health referral system that are not reflected in the findings. In particular, young people who are disengaged from education, experiencing acute mental health concerns, involved with the justice system, or unable to obtain parental consent may face additional barriers to accessing care. Appropriate and acceptable pathways into care may also differ for Aboriginal and Torres Strait Islander or culturally and linguistically diverse young people, and children and young people may require different access pathways across their developmental stages. Future research with young people attending mental health, youth, or community services, and with young people living in the North and North-West of Tasmania would strengthen the diversity of perspectives represented and support greater inclusion or marginalised or underrepresented groups.

6. Conclusion

This study examined the perspectives of young people and parents living in Tasmania on the pathways into mental health care for Tasmanian young people. Findings were largely consistent with previous literature in the Australian and international context, highlighting variables ranging from the personal beliefs, knowledge, and preferences of young people to the broader Tasmanian policy context that influence young people's access to mental health support. Key recommendations relate to the 1) need to enhance community awareness of the pathways into mental health services for young people; 2) the centrality of human connection and the need to prioritise this in service delivery; 3) the implementation of community-level interventions to address stigma and promote safe responses to disclosures of mental ill-health; 4) the importance of normalising and increasing the acceptability of early-intervention and early help-seeking; 5) the necessity of providing options and choice, and catering to the individual preferences of young people seeking support; 6) the potential for novel approaches and technologies, delivered in an autonomy-supportive and individualised manner, to improve service access and acceptability; and 7) the importance of cross-service communication and collaborative care to increase continuity of care and reduce the burden of health-service navigation. Consistent with recognised best-practice principles, results highlighted the importance of providing individualised services and empowering young people to make informed decisions about their care to ensure that services are accessible, appropriate, and safe for all young people.

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Appendix 1 – Complete Qualitative Coding Framework

The complete qualitative coding framework, developed based on the ecological model and the specific research questions, is presented below.

Level of Influence	Themes	Codes
Intrapersonal factors	1. Presence of both skills-based and attitudinal barriers to service access	Attitudinal and emotional barriers Ambivalence about discussing mental health concerns Being assessed or evaluated can feel overwhelming Difficulty acknowledging or admitting mental health concerns Family and friends hesitant to refer for support due to perceived betrayal Hesitance to seek help until difficulties reach high severity threshold Hesitation to seek support for friends for fear of damaging relationships Hesitation to seek support for friends until distress reaches high acuity or safety risk Lower intensity supports perceived as 'not enough' from services Parents experience guilt trying to seek support for young person Perception of supports as either all or nothing – limited knowledge of intermediate supports Perception that concerns may not be significant enough to warrant help-seeking Poor self-esteem may hinder help-seeking Tension between reluctance to share information and desire to be understood Young people not wanting to worry or burden people Young person's willingness to engage impacts ease of service navigation Skills-related barriers Difficulty differentiating mental from physical health Experience navigating the mental health system improves ability to navigate in the future Families in distress have limited capacity to advocate for their needs Family and friends have limited knowledge or ability to navigate referral pathways Parents express limited confidence to identify when mental health support is indicated Reliance of friends and family to identify need for mental health support Young people have limited knowledge of health system
	2. Unique characteristics of adolescent stage of development impact help-seeking and service access	Adolescence as a transitional and vulnerable stage, with tensions associated with the transition to independence Absence of requirement for parental involvement a barrier for parents supporting access Adolescence identified as a particularly fragile or difficult developmental stage Desire for limited parental involvement – information, not decision-making Desire for parental involvement Desire for privacy from parents Difficulty communicating about experiences that are changeable and dynamic Important that referral tools and services allow for ongoing re-assessment as needs often change Parent involvement accepted when symptoms reach high severity Parental involvement accepted where there is risk of harm Parental involvement necessary, but not always preferred Parents as facilitating practical aspects of access to system Parents as primary co-ordinators of health care Parents seeking involvement of care beyond what is desired by young people Requirement for parental involvement as a barrier to access

		Services or tools need to be responsive to dynamic and changeable needs Sudden onset of mental health concerns results in confusion about where to turn for support Tension between individuation from parents and need for parents to facilitate access to support Tension between parental value and young person's values Transition to independence is a challenging stage for parents Transitional nature of adolescence – parental support still needed, but autonomy and individualisation increasing Desire for increasing autonomy in healthcare throughout adolescence Desire for autonomy and choice over who they seek support with Desire for information and knowledge Value in shared-decision making or autonomy in healthcare decisions Young people have expertise over their experience Young people should have the right to seek help independently Young people viewed as having capacity to make decisions about when to seek help Despite increasing independence, young people have limited confidence, and they may defer to professionals Trust placed in 'objective' tools over self-assessment of needs Trust placed in professionals because they are professionals Trust placed in professionals over self-assessment of needs Trust placed in self over external assessments or tools Young people want explicit encouragement to share their perspectives
	3. Intergenerational experiences and understandings of mental health impact parental responses to young people	Family history of mental health concern can normalise help-seeking Parental preference for low-level supports before high-level supports Parents anticipate mental health concerns for their children Parents describe intergenerational mental health history impacting on response to mental health concerns for child Parents draw on personal experiences to understand their children's needs Parents express desire to provide adequate support for their children
Interpersonal factors	1. Concerns about judgement and unhelpful responses from others prevents help-seeking, while active encouragement and guidance can enhance help-seeking ability	Unsolicited advice from family members experienced by parents as unhelpful Belonging an important consideration for young people Concern that young people's difficulties may not be taken seriously Desire for different parts of young person's life to remain separate Experience of close others with support services impacts likelihood of engagement Fear of negative reactions to disclosure of mental health concerns Hesitation to disclose mental health concerns to people within social network Not wanting to be treated differently Importance of having a support-person to facilitate mental health conversations with parents Important to normalise low-intensity support-seeking Invalidating or minimising responses inhibit help-seeking Parents willing to accept information and advice from peers Perceived or actual judgement from parents inhibits help-seeking Perceived or actual judgement from peers inhibits help-seeking Perceived or actual judgement from service providers inhibits help-seeking Perception of self as abnormal may inhibit help-seeking Providers must demonstrate non-judgemental stance Stigma inhibits help-seeking Young people willing to accept advice about referral options from relatable and trusted people

	2. Connection and trust are key, informing both where young people seek support and the acceptability of services	Tendency to rely in informal supports before seeking formal or professional supports Adults as first point of contact – either professional or informal School-based supports sometimes described as first point of contact Informal supports as initial contacts Feelings of safety Feels like less of a 'big deal' Frequency of contact Knowledge of history and context Trust Reliance on self-help and informal supports before seeking support Informal supports particularly relied upon in rural areas Seeking support and comfort from non-traditional sources Connection with service providers and parents enables young people to discuss mental health Connection with parents facilitates sharing Connection with service provider important Desire for two-way communication and sharing from service provider Difficulty developing trust in single-instances of contact with a service or provider Existing relationships with mental health services facilitated access when needed Ongoing connection with service provider important Option for substituting a parent for a trusted adult Perceived trustworthiness of service or provider impacts likelihood of use Trust is key in determining where young people will go for support Young people more comfortable seeking support from a provider they know Young people wanting choice over who they speak with Communication style is an important predictor of connection, with young people preferring casual, empathetic, and straightforward communication Active encouragement can support young people to discuss mental health Blunt or straightforward communication style values Clear and developmentally appropriate communication style needed Communication style should be responsive to context Desire for more casual or relaxed communication style Difficulty expressing what makes discussing mental health more comfortable Importance of feeling understood Importance of feeling validated and heard Importance of person-centred communication from service provider Importance of reassuring communication Preference for less formal modalities of communication Service providers should not make assumptions about young people Want to feel cared for
Institutional factors	1. Mismatch between young people's need for prompt support and system structures and capacity	Greater access to low-intensity services needed Immediacy of support is important Mismatch between system structure and young people's desire for immediate support System not perceived to facilitate effective response in crisis System unable to provide prompt support
	2. Youth-acceptable service characteristics include specialisation in supporting young people, flexible engagement approaches, explicit guidance around service access, and considerations around confidentiality and anonymity	Confidentiality and anonymity important considerations for young people and may reduce willingness to access services Concerns about anonymity when accessing services Confidentiality an important consideration Desire for control over personal information Parental concerns about confidentiality may impact choice of services Perceived regulations of services or adults is a barrier to access Holistic support is important

		Meet young people where they are at, with activities they are comfortable with Service environments should feel calm and non-clinical Services for young people should provide explicit guidance to navigate the systems Services must allow sufficient time to talk with young people Services must be perceived as specialised and able to meet intersecting and specific needs of young people Communication preferences and needs, including for neurodiverse young people, should be accommodated Difficulty identifying mental health concerns due to intersecting needs and co-occurring concerns Individual differences in capacity to understand mental health system should be accommodated Perceived trustworthiness of service or provider Service provider must be viewed as knowledgeable Service provider must be viewed as sufficiently qualified to help Services must cater to intersecting needs of young people Services should consider the specific concerns relevant to young people Young people wanting providers who specialise in working with youth Services should have flexible hours of operation to provide support when distress is highest Support and guidance is needed for parents to navigate the mental health system Burden of service navigation falls on parents Clear communication with parents about service processes is important Families must navigate large number of services Parents as advocates for young people in the mental health system Parents needing personal support while supporting young person Parents should be supported to understand the treatment system Parents want guidance on how to support their young person System challenging to understand due to complexity, number of services, unpredictability Time for mental preparation for appointments or contact is helpful, but excessive time may be overwhelming
Community Factors	1. Community awareness among young people, parents, and adults in the community, is important to facilitate access to supports	Embedding knowledge about mental health and support system early has lasting impacts Important that adults in the community are aware of referral processes Increase awareness of mental health services by reaching young people where they are Limited ability to find information in rural communities due to poor internet reception Low awareness of supports in rural areas Parent education about mental health and referral pathways needed
	2. Stigma continues to hinder help-seeking, but some forms may be less prevalent among younger generations	Less stigma about mental health and help-seeking among younger generations Parental stigma around mental health can hinder support-seeking Parents concerned about stigma and judgement in the community Self-diagnosis among young people perceived to be harmful Young people need less de-stigmatizing of mental health help-seeking than past generations
Public Policy	1. Cross-service and cross-provider communication reduced burden on consumers and improves outcomes	Better cross-service or cross-provider communication needed Limited continuity of care across services One-stop-shop services preferred Service navigation support is needed Absence of an accessible point of contact for service navigation Can be a long process to identify the right avenue for support Need for a specified person to help navigate or enter complex mental health systems Services act as a 'gateway' into other services Alternatively, services can prevent the progression to other needed services Services should reduce need for re-telling stories

		Turnover of staff members hindering access to supports
	2. Need for specific strategies to improve access for marginalised groups of young people	Complex entry requirements hinder access for vulnerable people Cost is a barrier to accessing support Distance to services is a barrier to accessing supports Practical barriers to accessing services must be overcome
Elements of the referral system	Themes	Theme summary and illustrative quotations
Modalities of engagement with the treatment system	1. Appropriateness of modality varies depending on purpose of engagement, access-related issues, and comfort with technology	Comfort with different forms of technology impact perceived appropriateness of different modalities Chat-based options viewed as less formal, increasing acceptability Convenience of text-based options Easier to remember website than phone number High technology literacy among young generation Negative perceptions of call-services due to wait times Phone calls feel awkward Phone services not acceptable Trust of websites over phone calls among younger generation Young people anxious about phone calls Young people comfortable using text and web-based platforms Younger generation avoidant of phone calls Modality of choice impacted by availability of good reception Modality of choice impacted by distances to services Need to speak to a person to fact-check information and find appropriate supports Online resources allow information gathering in a non-overwhelming way Online resources good for information-seeking Phone calls as an option for people with limited informal support networks Phone calls made more difficult when reception is poor Phone calls perceived as appropriate for more 'serious' concerns Phone referral services can support crisis navigation Self-report survey as an accessible source of information and advice Specialised referral services allow more time for assessment than GPs Telephone referral services must ensure active follow-up Video calls made more difficult when reception is poor
	2. More personal forms of communication increase connection, but may feel more daunting and compromise anonymity	Chat or text options allow considered responses Chat-based options remove ability to read emotions Chat-based services too impersonal Concerns about anonymity accessing face-to-face services Desire for more personal ways of communicating Face-to-face communication facilitates connection Limited ability to 'read' person on the phone More personal ways of communicating feel more daunting or vulnerable Phone calls allow more personal connection than text or web options Text-based options may provide safety and privacy Web-based options allow anonymity and confidentiality
Perspectives on structured assessment tools, including the IAR-DST	1. Generally positive responses to IAR-DST due to holistic nature of assessment and perception of reduced bias	Holistic assessment using the tool important Structured tool reduces prejudice Tiered level of care is a good system Tool ensures all key information is gathered Tool is perceived to be helpful Trust placed in objective assessments over self-assessments
	2. Hesitations relate to the use of one-off assessment procedures and	Limited trust in ability of tool to achieve desired outcomes Limited trust in GPs to administer tool or provide adequate support

	limited trust in GPs as the source of assessment,	Limited trust in the outcomes of one-off assessments Tool does not resolve issues around limited knowledge of services among referrers Tool may not cover all relevant considerations Use of IAR via GP and onward referral not appropriate for crises or complex needs Young people's experiences may not fit into tiered rating system
	3. Tool needs to be administered by a clinician to support management of emotional responses to outcomes, ensure clear guidance is provided, and reduce bias	Assessment by clinician reduces bias Clear guidance needed to understand practical outcomes of the assessment Emotional responses to misalignment between perceived need and the IAR-DST outcome include: clarity, demoralisation/invalidation, fear, frustration, motivation, overwhelm, stress Outcome of tool viewed as the start of the conversation, not the end Structured tools are fallible and clinical judgement is required Tension between trusting self-assessment versus trusting objective tools
Artificial Intelligence	1. Artificial intelligence may play a role in information-finding, but was not viewed as an acceptable substitute for human-delivered assessment and referral, largely due to concerns around trustworthiness, validity, and ethics	AI acceptable for information about referrals AI normalised among young people AI not viewed as a trustworthy source of information AI removes concerns about worrying people Concerns about privacy Ethical concerns Lack of empathy from AI Lack of personal connection from AI Low confidence in AI to conduct sufficient assessments Perception that people place too much trust in AI Purpose-developed AI acceptable Strengths of AI lie in breadth of information Wanting more evidence about AI effectiveness and trustworthiness

Appendix 2 – Development of Key Findings from Qualitative Coding Framework

The key findings of the research are outlined below. Alongside each is an overview of the themes, derived from the data and structured around the ecological framework, which informed the development of the key finding. Colour coding is used to differentiate themes and codes from each domain, drawn from the qualitative coding framework (see Appendix 1).

Key Findings	Associated themes, drawn from qualitative coding framework	Relevant codes from associated theme
Public awareness of the pathways into mental health care is limited, and strategies are needed to enhance awareness among young people, parents/carers, and their communities	Intergenerational experiences and understandings of mental health impact parental responses to young people	Family history of mental health concerns can normalise help-seeking Parents anticipate mental health concerns for their children Parents describe intergenerational mental health history impacting on response to mental health concerns for child Parents draw on personal experiences to understand their children's needs
	Presence of both skills-based and attitudinal barriers to service access	Skills-related barriers Family and friends have limited knowledge or ability to navigate referral pathways Parents express limited confidence to identify when mental health support is indicated Reliance on friends and family to identify need for mental health support Young people have limited knowledge of health system
	Concerns about judgement and unhelpful responses from others prevents help-seeking, while active encouragement and guidance can enhance help-seeking ability	Experience of close others with support services impacts likelihood of engagement Parents willing to accept information and advice from peers Young people willing to accept advice re support options from relatable and trusted people
	Connection and trust are key, informing both where young people seek support and the acceptability of services	Tendency to rely on informal supports before seeking formal or professional supports Adults as first point of contact - either professional or informal supports Informal support networks as initial contacts Reliance on self-help and informal supports before seeking support School-based supports also sometimes described as first-point-of-contact Seeking support and comfort from non-traditional sources
	Community awareness among young people, parents, and adults in the community, is important to facilitate access to supports	Embedding knowledge about mental health and support system early has lasting impacts Important that adults in the community are aware of referral processes Increase awareness of mental health services by reaching young people where they are Limited ability to find information in rural communities due to poor internet reception Low awareness of supports in rural areas Parent education about mental health and referral pathways needed
	Need for specific strategies to improve access for marginalised groups of young people	Complex entry requirements hinder access for vulnerable people Cost is a barrier to accessing supports Distance to services is a barrier to accessing supports Practical barriers to access must be addressed
Human connection and trust are priorities for young people, and services may enhance these elements of care by embracing trauma-informed principles	Unique characteristics of adolescent stage of development impact help-seeking and access	Desire for increasing autonomy in healthcare throughout adolescence Desire for autonomy and choice over who they seek support with
	Connection and trust are key, informing both where young people seek support and the acceptability of services	Communication style is an important predictor of connection, with young people preferring casual, empathetic, and straightforward communication Active encouragement can support young people to discuss mental health Blunt or straightforward communication style valued Clear and developmentally appropriate language needed Communication style should be responsive to context Desire for more casual or relaxed communication style Importance of feeling understood

		Importance of feeling validated and heard Importance of person-centred communication from service provider Importance of reassuring communication Preference for less formal modalities of communication Want to feel cared for Connection with service providers and parents enables young people to discuss mental health Connection with parents facilitates sharing Connection with service provider important Desire for two-way communication and sharing from service provider Difficulty developing trust in single-instances of contact with a service or provider Existing relationships with mental health services facilitated access when needed Ongoing connection with service provider important Option for substituting a parent for a trusted adult Perceived trustworthiness of service or provider impacts likelihood of use Trust is key in determining where young people will go for support Young people more comfortable seeking support from a provider they know Young people wanting choice over who they speak with
	Youth-acceptable service characteristics include specialisation in supporting young people, flexible engagement approaches, explicit guidance around service access, and considerations around confidentiality and anonymity	Holistic support important Service environment should feel calm and non-clinical Services must allow sufficient time to talk with young people Services must be perceived as specialised and able to meet intersecting and specific needs of young people Communication preferences and needs, including for neurodiverse young people, should be accommodated Individual differences in capacity to understand mental health system should be accommodated Service provider must be perceived as knowledgeable Service provider must be viewed as sufficiently qualified to help Services must cater to intersecting needs of young people Services should consider the specific concerns relevant to young people Young people wanting providers who specialise in working with youth Time for mental preparation for appointments or contact is helpful, but excess time may be overwhelming
The nature of mental health stigma is changing, but fear continues to delay help-seeking. Community-wide interventions are needed to normalise help-seeking and dismantle emerging forms of stigma	Presence of both skills-based and attitudinal barriers to service access	Attitudinal and emotional barriers Difficulty acknowledging or admitting mental health concerns Family and friends hesitant to refer for support due to perceived betrayal Hesitation to seek support for friends for fear of damaging relationships Parents experience guilt attempting to access support for young person
	Concerns about judgement and unhelpful responses from others prevents help-seeking, while active encouragement and guidance can enhance help-seeking ability	Belonging as an important consideration for young people Concern that young people's difficulties may not be taken seriously Desire for different parts of young person's life to remain separate Fear of negative reactions to disclosure of mental health concerns Hesitation to disclose MH concerns to people within social network Importance of having a support-person to facilitate mental health conversations with parents Invalidating or minimising responses inhibit help-seeking Perceived or actual judgement from parents inhibits help-seeking Perceived or actual judgement from peers inhibits help-seeking Perceived or actual judgement from service providers inhibits help-seeking Perception of self as abnormal may inhibit help-seeking Providers must demonstrate non-judgemental stance Stigma inhibits help-seeking

		Unsolicited advice from family members experienced by parents as unhelpful
	Connection and trust are key, informing both where young people seek support and the acceptability of services	Communication style is an important predictor of connection, with young people preferring casual, empathetic, and straightforward communication Service providers should not make assumptions about young people
	Stigma continues to hinder help-seeking, but some forms may be less prevalent among younger generations	Less stigma about mental health and help-seeking among younger generations Parental stigma around mental health can hinder support-seeking Parents concerned about stigma and judgement in the community Self-diagnosis among young people perceived to be harmful Young people needing less de-stigmatizing of mental health help-seeking than past generations
The ability or value in early help-seeking is often overlooked, and efforts are needed to increase awareness and acceptability of early access to low-intensity services	Intergenerational experiences and understandings of mental health impact parental responses to young people	Parental preference for low-level supports before high-level supports
	Presence of both skills-based and attitudinal barriers to service access	Attitudinal and emotional barriers Ambivalence about discussing mental health concerns or vulnerable topics Being assessed or evaluated can feel overwhelming Hesitance to seek help until difficulties reach high severity threshold Hesitation to seek support for friends until distress reaches high acuity or safety risk Lower-intensity support perceived as 'not enough' from services Perception of supports as either zero or 100 - limited knowledge of intermediate supports Perception that concerns may not be significant enough to warrant help-seeking Poor self-esteem may hinder help seeking Tension between reluctance to share information and desire to be understood Young people not wanting to worry or burden people Young person's willingness to engage impacts ease of service navigation
	Concerns about judgement and unhelpful responses from others prevents help-seeking, while active encouragement and guidance can enhance help-seeking ability	Important to normalise low-intensity support seeking
	Mismatch between young people's need for prompt support and system structures and capacity	Greater access to low-intensity services needed Immediacy of support is important Mismatch between system structure and young people's desire for immediate support System not perceived to facilitate effective response in crisis System unable to provide prompt support
Young people hold varying values and priorities when accessing support, and should be empowered to make choices in how they engage with services	Unique characteristics of adolescent stage of development impact help-seeking and access	Adolescence as a transitional and vulnerable stage, with tensions associated with the transition to independence Absence of requirement for parental involvement a barrier for parents supporting access Adolescence identified as a particularly fragile or difficult developmental stage Desire for limited parental involvement - information, not decision-making Desire for parental involvement Desire for privacy from parents Difficulty communicating about experiences that are changeable and dynamic Parent involvement accepted when symptoms reach high severity Parental involvement accepted where there is risk of harm Parental involvement necessary, but not always preferred Parents seeking involvement in care beyond what is desired by young people Requirement for parental involvement as a barrier to access Services or tools need to be responsive to dynamic and changeable needs Tension between individuation from parents and need for parents to facilitate access to support

		Tension between parental values and young person's values Transition to independence is a challenging stage for parents Transitional nature of adolescence - parental support still needed, but autonomy and individualisation increasing
		Desire for increasing autonomy in healthcare throughout adolescence Desire for information and knowledge Value in shared-decision making or autonomy in healthcare decisions Young people have expertise over their experience Young people should have right to seek help independently Young people viewed as having capacity to make decisions about when to seek help
		Despite increasing independence, young people have limited confidence and may defer to professionals Young people want explicit encouragement to share their perspectives
	Youth-acceptable service characteristics include specialisation in supporting young people, flexible engagement approaches, explicit guidance around service access, and considerations around confidentiality and anonymity	Confidentiality and anonymity important considerations for young people and may reduce willingness to access to services Meet young people where they are at, with activities they are comfortable with Services for young people should provide explicit guidance to navigate the systems Services should have flexible hours of operation to provide support when distress is highest
	Appropriateness of modality varies depending on purpose of engagement, access-related issues, and comfort with technology	Comfort with different forms of technology impact perceived appropriateness of different modalities Chat-based options viewed as less formal, increasing acceptability Convenience of text-based options Easier to remember website than phone line High technology literacy among young generation Negative perceptions of call-services due to wait times Phone calls feel awkward Phone services not acceptable Trust of websites over phone calls among younger generation Young people anxious about phone calls Young people comfortable using text and web-based platforms Younger generation avoidant of phone calls Modality of choice impacted by availability of good reception Modality of choice impacted by distance to services Online resources allow information gathering in a non-overwhelming way Online resources good for information-seeking Phone calls as an option for people with limited informal support networks Phone calls made more difficulty when reception is poor Phone calls perceived as appropriate for more 'serious' concerns Phone referral services can support crisis navigation Self-report survey as an accessible source of information and advice Specialised referral services allow more time for assessment than GPs Telephone referral services must ensure active follow-up Video calls made more difficult when reception is poor
	More personal forms of communication increase connection, but may feel more daunting and compromise anonymity	Chat or text options allow considered responses Chat-based options remove ability to read emotions Chat-based services too impersonal Concerns about anonymity accessing f2f services Desire for more personal ways of communicating F2f communication facilitates connection

		Limited ability to 'read' person on phone More personal ways of communicating feel more daunting or vulnerable Phone calls allow for more personal connection than text or web Text-based options may provide safety and privacy Web-based options allow anonymity and confidentiality
Stakeholders are generally supportive of the appropriate use of novel approaches and technologies, however these should be utilised in a manner that complements, rather than replaces, existing pathways and maximises trustworthiness and validity	Unique characteristics of adolescent stage of development impact help-seeking and access	Adolescence as a transitional and vulnerable stage, with tensions associated with the transition to independence Important that referral tools and services allow for ongoing re-assessment as needs often change
		Despite increasing independence, young people have limited confidence and may defer to professionals Trust placed in 'objective' tool over self-assessment of needs Trust placed in professionals because they are professionals Trust placed in professionals over self-assessment of needs Trust placed in self over external assessments or tools
	Appropriateness of modality varies depending on purpose of engagement, access-related issues, and comfort with technology	Need to speak to a person to fact-check information and find appropriate supports
	Generally positive responses to IAR-DST due to holistic nature of assessment and perception of reduced bias	Holistic assessment using the tool important Structured tool reduces prejudice Tiered levels of care is a good system Tool ensures that all key information is gathered Tool perceived to be helpful Trust placed in 'objective' assessment over self-assessment of needs
	Hesitations around IAR-DST relate to the use of one-off assessment procedures and limited trust in GPs as the source of assessment,	Limited trust in ability of tool to achieve desired outcome Limited trust in GPs to administer tool or provide adequate support Limited trust in the outcomes of one-off assessments Tool does not resolve issues around limited knowledge of services among referrers Tool may not cover all relevant considerations Use of IAR via GP and onward referral not appropriate for crises or complex needs Young people's experience may not fit into tiered rating system
	Tool needs to be administered by a clinician to support management of emotional responses to outcomes, ensure clear guidance is provided, and reduce bias IAR-DST needs to be administered by a clinician to support management of emotional responses to outcomes, ensure clear guidance is provided, and reduce bias	Assessment by clinician reduces bias Clear guidance needed to understand practical outcomes of the assessment Emotional responses to misalignment between perceived need and IAR outcome Clarity, invalidating or demoralising, fear, frustration, motivation, overwhelm/stress Outcome of tool viewed as the start of the conversation, not the end Structured tools are fallible and clinical judgement is required Tension between trusting self-assessment versus trusting objective tools
	AI may play a role in information-finding, but was not viewed as an acceptable substitute for human-delivered assessment and referral, largely due to concerns around trustworthiness, validity, and ethics	AI acceptable for information about referrals AI normalised among young people AI not viewed as a trustworthy source of information AI removes concern about worrying people Concerns about privacy Ethical concerns Lack of empathy from AI Lack of personal connection from AI Low confidence in AI to conduct sufficient assessments Perception that people place too much confidence in AI Purpose-developed AI acceptable

		Strengths of AI in breadth of information Wanting more evidence about AI effectiveness and trustworthiness
Service navigation is complex for parents, and this burden may be attenuated through strong inter-service connectivity and explicit navigation support	Intergenerational experiences and understandings of mental health impact parental responses to young people	Parents express desire to provide adequate support for their children
	Presence of both skills-based and attitudinal barriers to service access	Skills-related barriers Difficulty differentiating mental from physical health Experience navigating the mental health system improves ability to navigate in the future Families in distress have limited capacity to advocate for their needs
	Unique characteristics of adolescent stage of development impact help-seeking and access	Adolescence as a transitional and vulnerable stage, with tensions associated with the transition to independence Parents as facilitating practical aspects of access to system Parents as primary coordinators of health care Sudden onset of mental health concerns results in confusion about where to turn for support
	Youth-acceptable service characteristics include specialisation in supporting young people, flexible engagement approaches, explicit guidance around service access, and considerations around confidentiality and anonymity	Support and guidance is needed for parents to navigate the mental health system Burden of service navigation falls on parents Clear communication with parents about service processes is important Families must navigate large number of services Parents as advocates for young people in the referral system Parents needing personal support while supporting young person Parents should be supported to understand treatment system Parents want guidance on how to support their young person System challenging to understand for parents due to complexity, number of services, unpredictability Services must be perceived as specialised and able to meet intersecting and specific needs of young people Difficulty identifying mental health concerns due to intersecting needs, co-occurring concern
	Cross-service and cross-provider communication reduced burden on consumers and improves outcomes	Better cross-service or cross-provider communication needed Limited continuity of care across services One-stop-shop services preferred Service navigation support is needed Absence of accessible point of contact for service navigation Can be a long process to identify the right avenue for support Need for a specified person to help navigate or enter complex mental health systems Services act as a 'gateway' for access to other services Alternatively, services can prevent the progression to other needed services Services should reduce need for re-telling stories Turnover of staff members hindering access supports