Research Report

The experience of young people seeking emotional support in regional NSW

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ABBREVIATIONS

CAMHS	Child and Adolescent Mental Health Service
LHD	Local Health District
MH	mental health
NSW	New South Wales
PSH	Parkes Safe Haven
SH	Safe Haven
WNSW	Western New South Wales

DEFINITIONS

The terms ‘young people’ and ‘youth’ have been used interchangeably in this report, which reflects strategies used elsewhere. The period from adolescence into young adulthood is defined by differing age ranges, depending on the context, with ages 16 to 25 commonly in use. This range has been chosen for the study as age 16 aligns with the legal age for providing consent for health procedures (as a mature minor) and age 25 is frequently used as the upper age for health services focused on young people.

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ABSTRACT

Objective

The objective of this study is to examine and describe the experiences of young people, aged 16-24 years, who have used the Safe Haven mental health service in Parkes, regional NSW.

Methods

This study employed a descriptive qualitative design involving individual interviews with four participants recruited via purposeful sampling. Interviews were audio recorded and transcribed by a professional transcribing service. Data were coded manually and themes verified by two experienced research supervisors (KD and RM).

Findings

Six themes were identified: Needing help to seek help; Acceptance; Time and space; Feeling safe; New understandings; and Sharing. Participants described moving from their experience of distress, to feeling accepted, growing and learning, with the ability to better help themselves and the desire to help other young people, based on their own individual experiences.

Implications for practice

This study has demonstrated the acceptability for young people of a drop-in café-style Safe Haven mental health (MH) support service staffed by skilled and experienced peer workers. An 'all-ages' service enabled youth to access help when they may not have sought more formal MH support services. Improvements to the model could be achieved by extended opening hours and providing a greater visible presence in the local schools. Increased community awareness of the service would ensure more adults were able to facilitate young people's initial access to the service.

Conclusion

All participants in this study identified the positive experience of support for their mental distress provided by the Safe Haven model in Parkes. The skilled peer workforce, and the 'drop-in' model of care allowed them to have control over when and how they accessed support which was of primary importance. However, reaching appropriate help initially required the active engagement of a supportive and motivated adult, someone who knew about the SH model and was able to physically accompany them on that first visit. Once introduced to the setting, the Parkes Safe Haven (PSH) model, with its philosophy of unconditional positive regard and recovery focus enabled young people to feel empowered concerning their own mental health, and gave them the opportunity to develop emotionally and gain increasing knowledge about their own strengths and abilities to manage their own healthcare.

INTRODUCTION

What is already known

Youth mental health

Globally, rates of youth impacted by mental illness and psychological distress have been increasing over recent decades (World Health Organisation, 2024), with developed countries more significantly impacted. Additionally, the recent experience of COVID 19 increased the numbers of presentations to emergency departments for mental health related problems (Sara et al., 2023). Nationally, 38.8% of young people aged 16-24 years old experienced a 12-month mental disorder during the period 2020-2022 (Australian Bureau of Statistics, 2023), and data from the national Mission Australia survey of young people identified almost half of those surveyed cited mental health as being a major concern for them (McHale et al., 2024).

People in regional Australia face challenges accessing timely and effective healthcare due to distance and the reduced availability of sufficient healthcare professionals. In addition, those living further from metropolitan centres also suffer higher levels of ill-health and increased social disadvantage (Carey T & Gullifer J, 2021). Across Australia, young people are increasingly concerned about their mental health problems, with one in five recognised as having high levels of psychological distress (McHale et al., 2024). Yet despite clear evidence of the level of distress and mental health needs being experienced by youth globally and across Australia, approximately 50% never seek help for their distress (MacDonald et al., 2018; MacKinnon & Colman, 2016).

This global and national data confirms what is often expressed at the local regional level, that significant numbers of adolescents and young adults are experiencing mental health challenges, with long term impact on their life trajectory. Further, suicide is a significant health problem in regional Australia, with all age groups impacted. It is the most frequent cause of death amongst young people (Australian Institute of Health and Welfare, 2023). A death by suicide has a significant and long-lasting impact on extended families and whole communities, particularly in regional settings and small communities.

Barriers to young people seeking help

There are several barriers influencing a young person's decision to access mental health care when impacted by emotional distress, including difficulty recognising the problem, lack of service availability and access challenges, fear of stigma, cost and a desire to solve the problem themselves (Biddle, Gunnell, Sharp, Donovan, et al., 2004; Gulliver et al., 2010; Radez et al., 2021; Salaheddin & Mason, 2016). A lack of trust in the available health services poses a significant barrier to seeking care (McGorry et al., 2022). Specific rural and regional barriers to youth help-seeking for mental health concerns include distance and fear of stigma (Aisbett et al., 2007) as well as the potential silencing of mental health difficulties in small communities.

The mental health needs of young people are recognised to be different to adults, with many mental health challenges emerging in adolescence and early adulthood. Young people generally have less experience of accessing health services, are reluctant to seek help for mental health problems, and are

often reliant on seeking help from informal sources (Gulliver et al., 2010; MacKinnon & Colman, 2016; M. Roberts et al., 2022; Salaheddin & Mason, 2016).

Enablers of young people seeking help

Existing literature concentrates on barriers for young people seeking help for their emotional distress, however fewer papers identify enabling factors, which are often context dependant (MacDonald et al., 2018). Seeking information online, reaching out to family and friends and obtaining information from school have all been mentioned as helpful strategies (Kauer et al., 2014; Pohl et al., 2024; Rickwood et al., 2015). However, in most cases the mental health services being discussed are provided by professionals such as general practitioners, psychologists, psychiatrists, and emergency department. Young people's desire for autonomy in solving their own problems is recognised as developmentally appropriate but can hinder effective help-seeking. The vital role of parents and friends as front-line support for impacted youth has been recognised (Australian Institute of Family Studies, 2018; Rickwood et al., 2015) however the availability of appropriate mental health services remains a challenge in regional settings.

Safe Haven model

The Safe Haven model was initiated in the United Kingdom (UK) in 2014 and has been gradually implemented in NSW since 2021. Safe Havens are an initiative of the NSW Government Towards Zero Suicides effort to reduce suicide rates across the state by providing an alternative to hospital emergency departments. This service is aligned with the NSW Strategic Framework for Suicide Prevention (Mental Health Commission of New South Wales, 2022). The Safe Haven in NSW is a café-style drop-in support centre, funded by New South Wales (NSW) Health and overseen locally by Western NSW Mental Health Drug and Alcohol. Staffed by peer workers in a community setting for people seeking emotional crisis support, it provides an alternative pathway to mental health care than other formal services such as emergency department, GP or psychological services. Access to Safe Havens in Western NSW requires no referral and has no age limitations. There are two Safe Havens in Western NSW, in Parkes and Dubbo, with the Parkes service opening in November of 2021.

Parkes is a regional town in the Central West of NSW with a population of approximately 14,000, with agriculture and mining forming significant employment industries. MH services for young people are provided by Community Mental Health (Child and Adolescent mental health services (CAMHS) up to 17 years old and adult MH- 18-64 years old) and non-government providers such as Rural Youth Mental Health Service (RYMH,12-24-year-olds).

The Safe Haven in Parkes is staffed by peer workers with their own lived or living experiences of mental health or drug or alcohol distress and recovery. Peer workers are mental health workers who form part of a multidisciplinary team with clinicians. They have comprehensive training in engaging and providing support to persons who may be in emotional distress, including those who may be suicidal (Byrne et al., 2021). Safe Havens promote wellness, foster hope and trust, and facilitate individual recovery using non-clinical methods, for people experiencing emotional distress, their families and carers. The Parkes Safe Haven (PSH) is supported by the Community Mental Health Service in Parkes.

Research topic

This study focussed on people with mental health issues who access public mental health services in regional New South Wales. The purpose of the study was to increase knowledge concerning the experiences and help-seeking choices of people who access mental health care, specifically those who sought assistance from the Parkes Safe Haven (PSH) alternative to emergency department at a time of emotional distress. The study explored the experiences of visitors to a rural Safe Haven seeking mental health care when in a crisis. Participants from 2 cohorts were included in the larger study; cohort A includes people aged 16-24 years who had accessed the Safe Haven, and cohort B is focused on adults aged 25 and over. This report considers the findings from cohort A, to understand their experience of the Parkes Safe Haven and their broader experience of seeking help for their mental health and emotional challenges as a young person in regional NSW. The age group 16-24 years was chosen to reflect the recognised distinct period of emerging adulthood where youth are progressively attaining adult skills (Arnett, 2000).

Whilst many studies have looked at barriers to help-seeking for young people with mental health needs, there is a gap in the literature regarding their experience accessing a community-level peer-run service such as the Safe Haven. In addition, much of the literature regarding youth help-seeking behaviours does not specifically describe the experience of those in rural settings, where healthcare resources are significantly reduced. The PSH had already demonstrated its acceptability to young people, with more than 30% of visitors being within the 16-to-24-year age range. This study adds to the literature around both young people and adults accessing mental health care in regional settings where service choices are limited.

A literature search was undertaken by accessing search engines, PubMed, Google Scholar, Elicit, using the key terms: help-seeking; Safe Haven; youth; adolescent; young people; young adult; mental health; emotional distress; peer worker; rural.

Relevance

The findings of this study have relevance for public mental health service directors, mental health professionals and non-government service providers in NSW and across the country. It contributes to what is already known about youth barriers and enablers to accessing timely and effective mental health care, specifically regarding the unique setting of regional Australia. This study also adds to what is known about the impact of the Safe Haven model for youth in a resource-depleted rural setting.

Recommendations

This study highlights specific actions that can be taken at government, Local Health District (LHD) and community levels to increase the scope and reliability of the SH model for young people, including increasing school presence; supporting key adults with information, role definition and health literacy, and developing a youth peer advocacy role to support the work of the SH with young people.

AIM

The aim of this study is to understand the experience of young people seeking help for their emotional distress at the Parkes Safe Haven.

METHOD

Study Design

This study utilised a qualitative descriptive method as described by Sandelowski (Sandelowski, 2000, 2010) where a comprehensive description of the phenomenon was sought through examining the real-life experiences of people closest to it (Sandelowski, 2000). In this research, the phenomena of interest were related to young people's experience of the Parkes Safe Haven.

Ethics approval was provided by the Greater Western Human Research Ethics Committee (2024/ETH00388). (Appendix 1)

Recruitment and participants

Participants were recruited by purposeful sampling through the Parkes Safe Haven itself, as only people with that experience were suitable for this study. Safe Haven staff were briefed about the project and were willing to contact potential participants who were known to the service, and who had previously given consent to be contacted regarding service development opportunities. Eligible participants were: 16-24 years of age at time of interview; English speaking; had at least one experience of accessing the PSH for mental health support and were able to participate in a face to face or online interview. Six people aged 16-to-24 years old were approached. One declined to participate, and one was greater than 24 years old at the time of contact. A total of four participants agreed to be contacted for more information about the study. (Demographic data Appendix 2)

Four Safe Haven clients provided verbal consent to the SH staff member and were followed up by phone contact from the researcher, (VL), who provided further information about the project and clarified and concerns or questions. A time and date for a face-to-face interview was then organised. Interview times were made based on participant availability. Written Ethics approval was obtained prior to interviews being undertaken.

Data collection

Participants were interviewed at the Safe Haven, to provide a familiar environment. Interviews were conducted by VL, with no SH staff present. The possibility of an online interview was offered to all participants, but all chose the face-to-face option. Demographic variables were collected at commencement of the interview: age, town of residence, usual living arrangement, preferred gender, and work or school participation. Interviews were audio recorded on the Zoom video conferencing platform, with the camera disabled and only the voice recording active. Recordings were uploaded securely for professional transcription. Interview duration was between 35 and 50 minutes. No follow up interviews occurred, and results were not provided to participants for comment.

Interview questions were developed by the research team and reviewed by the headspace Orange Youth Reference Group, as well as a male and a female peer support workers based at the Bloomfield Mental Health campus. In addition, the sample questions were presented to the Consumer and Carer committee as part of the study preparation. No question changes were proposed by any of these reviews. Practice interviews were not undertaken.
Sample questions (Appendix 3) were provided to the participants with the participant information sheet (PIS) in advance of the interviews. Semi-structured interviews allowed for the questions to be presented flexibly with all the participants, enabling exploration of participant responses in more depth. It also allowed participants to spontaneously offer information they perceived to be relevant.
The researcher had no prior relationship with participants; initial conversations were held via phone call to confirm interview date. At interview the researcher explained her professional background and reasons for undertaking the study, to know more about the effectiveness of the SH model for young people.

Data analysis

Data were collected and analysed concurrently. Data saturation was not considered due to the small number of participants. Data collection continued until no new participants could be identified, with data collected from a total of four participants. Only initial interview data was used, with no feedback obtained from participants on the findings.
Transcribed data were coded and analysed by the primary researcher (VL), the study supervisor (KD) and the study mentor (RM) who comprised the coding team. KD and RM provided their long experience as clinicians and academic researchers to the project, providing oversight and guidance to VL in her role as researcher-in-training. Coding and analysis followed the principles of Braun and Clarke's reflexive thematic analysis (Braun & Clarke, 2006, 2021). Recordings and transcripts were read and listened to multiple times, secondly, initial coding took place with labelling of codes and concepts checked by KD and RM. Thirdly, the codes were reviewed and refined by the coding team to identify and organise themes. And finally, the themes were reviewed multiple times by all members of the team to check for alignment and clarity, and consensus was reached.

Rigour

Rigour in this study was ensured by following the four criteria described by Lincoln and Guba (Guba & Lincoln, 1985): credibility, dependability, confirmability and transferability. Credibility was achieved by a long engagement with the interview design and implementation process, including triangulation with the research team and youth/ peer advisory groups. At the time of the study the occupation of (VL) was District Coordinator of Infant, Child, Youth and Family Mental Health services in WNSW, with KD and RM being experienced health researchers and study supervisors. All researchers were female. Dependability was supported by consultation with youth and peer groups for interview design, and with the research team for data analysis. Researcher bias and assumptions included recognition of the limitations of MH service provision for youth at time of study. Confirmability was met through reflective memo-ing and checking with the research team, and transferability supported by the level of detail in describing the site and participants. Field notes were used to check researcher impressions of interviews.

FINDINGS

The findings of this study describe the participants' experiences of the Parkes Safe Haven and comprise six themes with their associated subthemes. Together, the themes can be read as a progression, an evolution of awareness and understanding of the participants' own needs initially, to a broader understanding of what constitutes mental health care, their capacity to take charge of their situation, and finally their ability to share their learnings with others. Table 1 lists the themes with a definition of each. (Further detail of themes and subthemes with sample text is at Appendix 4). Demographic data of each participant is seen in Appendix 2.

Table 1: Description of the overarching themes from participant interviews

Theme	Description
Need help to seek help	Relates to participant's distress, not knowing what to do and the involvement of a trusted adult who facilitated effective help-seeking
Acceptance	Impressions of the physical and emotional experience of accessing the PSH, specific ways participants felt cared for, and how it feels and what it means to be completely accepted.
Space and time	The importance of time and physical and emotional space in creating the participants' own experience. The importance of not feeling rushed into talking and being able to talk as long as they wanted when they were ready. Comparative descriptions of negative experiences from formal health settings.
Feeling safe	Features of participants' experiences which helped them to feel safe, including staff approach, realising they can take the help they need when they need it. The absence of expectations from staff and presence of unconditional support
New understandings	Participants describe ways they began making sense of their experience at the PSH, reflecting on previous understandings of healthcare, including the purpose of the PSH. They recognised their new capacity to take charge of their own needs to more effectively manage any future mental health challenges.
Sharing	Descriptions of ways participants endeavoured to help friends with mental health challenges, often expressing a sense of responsibility to 'pay it forward'. Also includes guidance for the PSH about opportunities to increase access for young people.

Theme 1 Need help to seek help

Participants described a period of uncertainty or hesitation prior to engaging, frequently overwhelmed by their emotional state to a point where they were unable to take any action toward help-seeking. This theme incorporates the necessity of a trusted adult who activates the help-seeking, acknowledgement of lacking courage to take the first step alone, difficulty identifying and validating the problem, and the challenges young people and families face seeking information to direct their help-seeking.

Subtheme i: Role of a trusted adult

Initial help-seeking is described, facilitated by a trusted adult to identify the Safe Haven as an option for help as well as physically taking the participant for their initial visit. Participants recalled the intervention of an adult known to them who facilitated their initial entry to the PSH. For two young people this was a parent (mother), for another it was their sister, and for the fourth participant their initial visit was facilitated by a friend. It was clear from the data that none of these participants would have self-initiated that first visit. P2 describes being very distressed:

> *"… and Mum said, 'you need to come in here', and I did".*

Or P4 whose mother assisted with online searching for suitable help:

> *"Mum looked up places for me to go"* and then they went together on the first occasion.

Similarly, P3 reported: *"I went down with my sister",*

and P1 was: *"invited by my friend, my neighbour".*

Subtheme ii: Needing courage

Some participants described being aware of the PSH but lacking courage or requiring encouragement of others. This subtheme recognises a sense of bravery was required taking first steps toward receiving help. P3 knew of the PSH from family and friends:

> *"... but didn't have the courage to go in"*.

And P2, who had no previous experience of seeking help for emotional distress:

> *"didn't want to talk to anyone"*, but was encouraged by their mother.

Subtheme iii: Identifying and validating the issue

This theme describes participant's initial struggles to acknowledge the need for help:

> *"I thought if I just kept ruminating, it would go away"* (P3)

often feeling anxious about seeking help, or else believing that their problem would resolve on its own. P4 suggested young people are unaware of where to go to seek help and added:

> *"When I was upset I just kind of dealt with it"*.

A level of inability to recognise their own level of distress, or accepting their situation was evident. P2 stating:

> *"I wasn't having a very good day"* and suggesting boys *"don't really like to talk to anyone"*.

Subtheme iv: What to do, where to go

The participants expressed difficulty help-seeking for mental health concerns, and how help from others was required for this step in the process. P1 noted the difficulty for young people, including friends, noting:

> *"they just don't know where to start".*

Knowledge about the Safe Haven locally was mixed, with P4 describing an assignment at school which facilitated finding helpful information but noted that otherwise they:

> *"wouldn't have known where to go"* or what actions to take.

This sentiment was supported by P2 who stated:

> *"Probably wouldn't have"* regarding seeking other help if had not found the PSH.

On a practical level, once the Safe Haven was known to be a site for help, the sign on the front of the building served as a useful locator. Referring to knowing where to go to get help, P4 stated the Safe Haven is:

> *"... the only one that really has a sign that says it".*

Theme 2 Acceptance

Participants described the physical and emotional experience of being at the SH, their initial response to entering the space, and positive way they were greeted by staff and other SH visitors.

Subtheme i: Welcoming reception

The initial sense of being welcomed was described by participants, this reflected not only their first visit, but also the repeated feeling on subsequent visits. P3 summed up their first experience at the PSH saying:

> *"it was a really welcoming environment".*

And when referencing the welcoming environment, P4 reflected:

> "*yes, that's my favourite. I love that one",* adding that a friend had also enjoyed *"the people and the atmosphere"*.

Availability was described as part of the overall welcoming nature of the service, noting:

> *"the doors are always open"* (P2), or "*you can just instantly be welcomed in"* (P3).

Being welcomed was noticed by staff gestures which led to participants feeling welcome.

"*there's always a smile", "always offering*" (P3).

The experience was compared to that of entering the hospital by P2:

"...*whereas you walk in here and everyone's got a smile on their face"*.

Subtheme ii: Comforting, homely

Once they had been received into the centre, the sense of comfort and homeliness added to the sense of being accepted, and provided participants with reassurance as they became familiar with the setting:

"it feels very comforting… more homely I guess" (P1)

"*it was just really relaxing"* (P3).

Elements of the physical environment contributed to this subtheme, with the quiet and the quality of the furniture noted by P3:

"*the furniture really stood out"* and *"it was really quiet"*, as well as describing:

"the home, the main lounge room is really big".

The openness of the space, the quality of the furnishings, the level of the lighting and the availability of activities such as fidget toys and massage chairs all played a role in their experience of feeling comforted and reassured.

Subtheme iii: Feeling nurtured

Each participant described the importance of feeling heard, being cared for and an interpersonal quality like that between friends. The combination of these qualities engendered a feeling of being nurtured.

"when you come here, they just listen to you, and you're not pressured to do anything" (P2), "*They're more here to listen and help"*. (P4)

The quality of staff reception also contributed significantly to their overall positive experience.

"When I chat to them, they're really caring about me" (P1); "*they really take care of you"* (P3).

The level of follow-up was also experienced by P4 as being part of being cared for:

"*When you don't think about it for a while and you haven't been here, you kind of forget. But then they call you and say, "how are you going?". That's always good"*.

The sense of being cared for was often a relief after the anxiety and worry that preceded the initial visit:

"*the staff were lovely, very, very kind*" (P3).

Some participants compared the engagement with staff as being a bit like being with a caring friend. When comparing the experience to more formal health settings, P2 noted staff:

"*feel a lot more like friends rather than people you're forced to come and talk to*".

When describing the sense of ease of access to the PSH, P1 described being able to:

"*come in and chat like almost with a friend"*.

These descriptions identified a level of ease of communication and related to the quality of the listening by staff, the combination of which provided a sense of being nurtured.

Subtheme iv: Face-to-face

Most participants (3) noted their strong preference for face-to-face service. Commenting on other options that were recommended, P2 noted the PSH to be:

"... *real people and someone I knew",* and "*it's probably the only reason I came in here"*.

During the help-seeking process P3 described losing hope when trying other online services:

"... *it just wasn't that face-to-face experience*".

And P4 provided a strong preference for face-to-face experience:

"*I just like face-to-face instead of over the phone*".

Theme 3 Time and space

The unique combined qualities of physical space and staff approach created an environment where participants felt free to progress at their own pace. Not feeling rushed and being able to talk about their difficulties at a time and pace of their own choosing was significant. This experience provided them all with a sense of control over their situation. Participants conveyed the way time and space were *offered* by the PSH and concurrently, they progressively felt empowered to *take* their own time and space within that setting.

Subtheme i: No rush

The experience described contrasted with previous experience of accessing formal healthcare providers such as GP's or psychologists. P4 noted the GP experience to be:

"...rushed, very rushed" and felt pressured to talk.

Likewise, P3 appreciated being:

"... *able to speak more freely and for longer*" at the PSH.

Taking time, and being offered the time and space, were two sides to this subtheme.

"*When you come in here, they just listen to you, and you don't feel pressured to do anything*" (P2).

P1 described it as: "*having space to have a break"*.

And P3 summarised the duality of the SH experience as:

> "*This is like always somebody with you if you need someone. There is always someone not with you if you don't need someone*".

This comment not only summarised the flexibility of time and space to suit the participant's needs on any occasion but also highlights P3's capacity to direct the experience to meet their needs on any day.

Subtheme ii: Come when ready

The drop-in nature of the PSH was appreciated by all participants. Several expressed the relief at being able to come at a time that suited them:

> "… *making an appointment puts pressure on as well*" (P1),

Compared to other medical appointments where:

> "*I had to be prepared*", whereas at the SH, "*I can just walk in when I feel prepared to have a chat or whenever I need to have a chat"*.

Preparedness for this participant related to being emotionally prepared to discuss mental health challenges with a professional, it was a situation described as very stressful. The contrast with the experience at PSH was a benefit for her and others, and being able to choose their own time to access the service was important.

Subtheme iii: No waiting

Several participants talked about the absence of waiting at the PSH, often in the context of negative experiences of waiting in formal health settings such as at the GP, or in the emergency department (ED). For P3, the experience at the hospital ED:

> "…*the waiting is the worst thing"*, and "*just waiting to get the simplest yes or no answer"*

had left a negative impression. Another participant also noted the length of waiting to get appointments with formal health providers, whereas for P2:

> "*it's just a lot easier knowing that you can walk in the doors anytime and there's someone here*".

Subtheme iv: Staff patience

The quality of staff patience added to participant's experience of being able to take their time:

> *"… very, very kind, very patient."* And, "*It's a relief for me because I have trouble talking and not good on the spot, so they were really patient with me while I was really distressed*" (P3).
>
> The sense of relief at not feeling rushed formed part of being able to take the time needed to express themselves.

Theme 4 Feeling safe

Participants expressed ways they felt safe at the PSH. For each, the feeling of safety was provided by slightly different qualities but the interplay between physical and emotional safety in a non-judgemental environment was key. The multiple ways participants expressed feeling safe translated into their experience of being able to present 'as they are'. This feeling of acceptance extended to other visitors

using the centre, and participants expressed a sense of confidentiality and an unspoken understanding between participants using the centre at the same time.

Subtheme i: Talk freely

Safety was also expressed through the ability to speak without restraint, and for one participant it formed a definition of a 'safe space':

> "*A safe space for me is somewhere I can express myself freely, talk freely*" (P3).

More specifically, P4 noted the absence of bullying:

> "*This is a safe sort of place that's not… no-one bullying"*.

Another participant expressed the freedom to speak freely in the context of being able to open-up emotionally, having not expressed his emotions previously:

> "*And once I came in here, I think I cried for an hour*" (P2).

Subtheme ii: Staff qualities

Participants described positive staff qualities in terms of ordinariness:

> "*like other people but they are just there to listen*"

and by the lack of negative qualities:

> "*They're not here to judge you*" (P4).

For others it was experienced as reliability:

> "*you can rely on people in here as well*" (P3).

Staff qualities that increased a sense of safety were described in broader terms:

> "*It's a bit more relaxed and not as official*" as compared to more formal health services (P1).

The fact of staff being peer workers was expressed directly by P3:

> "*they are here because of their own personal experiences as well. And I thought that was amazing*", adding,
>
> "*With how the environment looks and how they act and it just, it all feels very genuine"* (P3).

Subtheme iii: Create own experience

Participants appreciated a sense of freedom and agency to direct their own experience. The ability to:

> "*do what you really want to do*", and "*be in your own space*" (P3)

or in more practical terms by P4:

> "*if you want to sit there and read a book, you can. If you want to … just lie down, you can*".

The proximity of the experience to that of being at home was described by P1 as:

"*a space out of home to hang out*"

and described being able to "*just come and have some space for yourself*."

The experience of participant's home life was not investigated within the interviews, however comments such as those from P1 suggest the 'home-like' quality of PSH providing them with a supportive place away from their family situation was helpful.

Subtheme iv: Presence of others

The shared common space of the PSH was a setting where participants would encounter other service users. None expressed a negative response to these encounters. Regarding other service users, P3 clearly stated everyone:

"... *who comes here is really nice", "you always get a 'gidday' or a nice conversation"*.

The opportunity to engage with people they may not have encountered in their regular life was also of interest to the participants, with P1 appreciating the opportunity to:

"... *chat to people outside of my life, outside of home*".

Acceptability of the numbers of other service users was stated by P4 as:

"... *there are not too many people that it's crowded"*, and

"*it's alright because most people here are doing the same sort of stuff, So it's not really a bother*".

Subtheme v: Confidentiality

A sense of confidentiality from staff as well as from other service users was expressed here. Participants were asked about any concerns for privacy in the context of the service and more broadly from being in a small regional town. Referencing the small-town experience P2 stated:

"... not so much me, but I know a lot of people ... would rather keep it quiet"

and more specifically reflecting the PSH experience stated:

"I don't know, I couldn't tell you why it is, you know no-one is going to tell anyone anything".

The unspoken feeling of privacy and confidentiality was echoed by P1:

"I know it won't go any further" and "I can really trust them as well".

This was supported by P4 who had encountered young people he knew at the PSH:

"Yeah, no-one else says anything about it" (being seen at the SH).

Theme 5 New understandings

Participants all expressed having learned new things about themselves, about the function of the PSH, as well as what constitutes mental healthcare. They were able to talk about the experience as one that not only helped increase their ability to seek and obtain mental healthcare but also learning more about their own emotional development and skills as they move into their adult lives.

Subtheme i: Previous understandings.

Some participants had experiences of accessing ED, psychologists or other formal mental health services. Comparing her previous experience of receiving healthcare, P1 stated:

> "*I always thought that to really have support with mental health, I had to go to that extreme of seeing someone professionally*"

and reflected on the realisation,

> "... *how much a space like this can help with my mental health, just by having a space to chat to someone*".

Adding more detail of her insights stated:

"... *getting help always looked like going through the doctors*", but accessing PSH made her realise getting help:

> "*doesn't have to be a big hall with the label on it*".

P3 had previous experience of attending ED for emotional distress on multiple occasions and despite feeling the experience had no positive impact on their mental health, reported:

> "*I had to keep going back, but you just get sedated and then sent back home*".

The previous understanding of what constituted an emergency was described by P2, who had not understood an emotional situation could constitute an emergency:

> "... *at the time I wouldn't think it's an emergency, but I do now*".

Subtheme ii: Options

Building on the recognition that PSH had provided participants with an alternative for getting help was expressed as a relief for some. P4 described the experience of:

> "*just talking to people that wasn't my mum or dad… yeah, that was good*".

The realisation that there was an opportunity to talk about their challenges when previously they felt that keeping problems to themselves was the best option was expressed by P2:

> "*Well before I was just quiet, didn't want to talk to anyone*" … "*But I came in here and it made me feel 10 times better*".

For P1 the drop-in model was significant as an alternative option:

> "*It's just that whenever you need, you can just go in".*

Subtheme iii: New skills

Feeling more confident in their lives, and in managing mental health challenges, as well as noticing changes in themselves came through from participants.

> "*I feel more confident about everything really, not having to get upset at everything*" (P4).

Improved self-understanding was expressed by P3, noting being:

"*more in tune with own feelings*", "*I know what I'm feeling and what I can say*"

as well as noticing improved responses to others: "*I'm a lot more patient…. A lot more empathetic*".

Subtheme iv: Misunderstandings clarified

Uncertainty about the PSH and what it offered was common for all participants initially.

> "*While I knew we had a Safe Haven here I never knew what it really meant"*.

A confusion about what help for suicidal thoughts could look like, P1 stating:

> *"(I) thought it was, if you were suicidal, that's where you'd go. But (young people) don't realise it's more of a space to help yourself*".

This comment was echoed by other participants when describing the discrepancy between uncertainty over recognising their own or others level of emotional distress and need for help. It also signals their assumptions of mental healthcare needing to be complex, and the revelation that something simpler can promote self-help as a valid option. P3 described the opportunity:

> "*you can get educated here a little bit on mental health*".

Subtheme v: What makes a good service

Reframing their learning, participants described what service qualities are most helpful for young people. Presence in schools and in the community was noted, suggesting:

> "*somewhere that's very out there* (visible)".

And recognisable,

> "*like you've seen that face before and you know they're a good person*" (P2).

Further emphasising the point that Sydney-based services were not effective for young people in rural and regional settings, P2 went on to add:

> "*you don't want to talk to a stranger. You want to talk to someone you know*".

Trust is implicit in this statement. P1 noted the importance of staff qualities required to provide an effective service:

> "*that comforting and understanding perspective*" and, "*while being there professionally, being there as a friend*".

These comments highlighted the importance of the qualities of caring. Comparing PSH with formal health services, P3 summed up the benefit of a less formal service experience:

> "*It gives them* (young people) *more a sense of self and a bit more freedom*, (they) *are usually in an environment where they can't speak freely about those things* (MH concerns). *And going to a place where… you won't be judged, that's really…so powerful.*"

Theme 6: Sharing

This final theme demonstrated the participants making sense of their experience of involvement with the PSH. They were able to consolidate their learnings to provide advice for service improvement at the PSH, as well as to friends and young people more broadly.

Subtheme i: Advice to Parkes Safe Haven

Many practical suggestions were made for the staff and management of PSH to better reach young people and make to service more accessible to them, from extended hours of service:

> "*Open more until 5pm…and on the weekends, probably till 3pm*" (P4),

To another suggesting more groups, having enjoyed group sessions elsewhere:

> "...*they would get more people, and it* (the PSH) *would be more known*" (P3).

Greater visibility of the service was promoted, P2 suggesting:

> "... *go and talk to schools…make sure they know your face*"

and P1 reiterating the need for 16–24-year-olds to receive more information about the PSH, adding

> "... *maybe get(ing) the schools to tell them…explain to them what it really is*" and

> "... i*t would be really great if they (YP) could learn what the Safe Haven's here … so …. they have a place to come if they need it*".

These comments support the concept from Theme 1, that young people struggle to know how and where to find help. P2 suggested Parkes and the Central West of NSW:

> "... *probably needs a couple more places like this around here".*

The idea of youth mental health advocates in schools was supported by P4:

> "... *most younger people listen to people around the same age… it'd be great because more people (would) know about this place"*.

Subtheme ii: Helping friends and others

Participants shared their positive experience with friends and family, encouraging them to access the PSH for their own emotional distress and demonstrating their desire and capacity to help others. P2 had actively encouraged his friends:

> "*I did suggest it to my friends, but I don't think any of them came here"* however *"when I come in here, (it) help(s) me and everyone else"*,

explaining being able to take his new knowledge back to his friends is still helpful,

> "... *because I think that's the hardest part, is finding out how to ask someone if they're alright*".

This sentiment of wanting to share new understandings with friends was also expressed, P4 stating:

> "... *yeah, I …recommend it (to) them… I've talked to a few friends about it"*, adding a friend's response, "*when he came here, he said he actually really enjoyed it"* (P4).

P3 described bringing his partner on the second visit, and thinking more broadly stated:

> "*I remember what I went through…and I want to try and help as much as I can*".

These sentiments suggest not only a desire to share a positive experience, but indicate a recognition of the struggles of others, and a sense of responsibility to support their peers.

DISCUSSION

Young people shared their perspectives, learnings and reflections on the experience of accessing the Parkes Safe Haven in regional NSW. This study has highlighted the progression from emotional distress to finding appropriate support from a peer-run dop-in mental health service. It has outlined the factors required for successful help-seeking and the components of an effective peer-run model of support, enabling youth to develop skills and maturity to be more in control of their mental health journey. Practical implications for providing community-based, peer-run mental health support settings are discussed.

The study findings can be contextualised within the concept of emerging adulthood (Arnett, 2000) to frame the developmental nature of participants' progress. Arnett describes the period of 18-to-24 years of age as a time of emerging adulthood, with increasing adult skills and confidence developing over time. This prolonged period of maturation has an impact on mental health literacy and help-seeking behaviours, (Rickwood et al., 2015; Rosina et al., 2024; Stunden et al., 2020) with young adults continued reliance on parental support. Youth often feel they should be able to solve their own problems, adding barriers to effective help-seeking (Ishikawa et al., 2023; Rosina et al., 2024). Additionally, we have looked to Bronfenbrenner's Ecological Systems Theory (Bronfenbrenner, 1994) to position the Safe Haven model within the microsystem field of influence within these young peoples' lives. This model aligns with the participants' experiences of the PSH as nurturing, identifying qualities of feeling welcomed and accepted, and the staff "like friends".

Help-seeking

Help-seeking and the need for the participants to be assisted by a trusted adult was evident in Theme 1. The crucial role of parents or other caring adults in facilitating appropriate mental health support has been noted elsewhere (Australian Institute of Family Studies, 2018; MacDonald et al., 2018; Platell et al., 2023; Rickwood et al., 2005). The reluctance of young adults, particularly young men, to seek help when experiencing emotional distress is also recognised (Biddle, Gunnell, Sharp, & Donovan, 2004). Participants in this study identified the difficulty young people face in knowing what to do or where to go when distressed, not only the challenge finding appropriate information, but also needing help to recognise the scale of their distress. Each young person was actively taken by an adult to the PSH on the first occasion after a period of trying to manage the situation themselves, even when they were already aware of the service. The intervention of a caring, motivated and capable adult overrode the young person's desire for autonomy (Ishikawa et al., 2023) and helped them make the connection with a supportive service.

Awareness as a key factor in successfully accessing mental health services has been highlighted in the literature (Saurman, 2016) and was demonstrated in this study, although awareness by the young

people themselves was not sufficient to contact the Safe Haven, or any other formal MH services. This study has shown the vital role of supportive adults to be not only aware of MH service options, but also to provide courage to the young person by taking the necessary steps for initial access to the service.

The Safe Haven experience

The Parkes Safe Haven offers a community-based, informal style of mental health service, accessible without referrals and no appointment is required, available on an as-needs basis for all ages. The skilled peer workforce provides a nurturing and non-judgemental model of care. These qualities share similarities with the most immediate and influential aspects of an individual's life such as family, school, church and other organisations with face-to-face familiarity, recognised as the microsystem (Bronfenbrenner, 1994). This positioning places the Parkes Safe Haven in a more influential and ongoing interpersonal relationship with young people seeking help than other formal mental health services.

Other experiences of the participants visiting PSH were expressed in the data as 'Acceptance', 'Time and Space', and 'Feeling Safe'. Participants described the physical and emotional qualities of the PSH that allowed them to overcome their distress and gradually take more control of their mental health needs. Understanding the effective elements of the PSH experience is helpful to health services and professionals for promoting early youth access to MH support. In this study young people emphasised feeling accepted, being allowed time and space to move at their own pace and feeling safe as fundamental to their progress from distress to self-management. The qualities described in this study go further than what are sometimes broadly called 'youth friendly' service elements (Roberts, 2012) and add context to descriptions of MH services for young people needing to be community-based and non-judgemental where young people can feel comfortable and build a sense of trust (McGorry et al., 2022). The effectiveness and importance of skilled peer workers for child, adolescent and family mental health support has been outlined in the literature (Robertson et al., 2023; Simmons et al., 2023) however the detailed perspective and impact of young people accessing peer support in a regional setting are less well described. This study highlights specific qualities of the site, and the peer workforce that allowed participants to feel comfortable, safe, and build a trusting relationship, contributing to their progress toward an improved mental state over time. The elements of PSH described in this study work together to create a nuanced combination of support, reliability, physical and emotional space for young people to gradually forge a more independent path to mental health.

Developmental impact

This study has highlighted the developmental impact on young people accessing the PSH over a prolonged period, aligning with the concept of the 'emerging adult' (Arnett, 2000). Young people described new understandings of what can constitute mental health care, as well as reflecting on their own skill development and were able to detail what makes a good service for young people, shown in the theme 'New Understandings', and 'Sharing'. Young people not only described features of the PSH they found helpful but also provided reflections on the impact on them over time; gaining a more nuanced understanding of what constitutes valid mental health care, recognising their increasing skills and growing capacity to manage their own MH challenges as they move into their adult lives (Byrne et al., 2021).

An increased ability to manage their own lives was also manifested in their capacity to think of the needs of others, seeking to share their newfound knowledge and skills with friends, as well as providing broader advice to young people. The participants' growth and evolution from distress to realisations of their capacity to help themselves and others evolved in parallel with their developing confidence as young adults.

Strengths and Limitations

Strengths of the study include the detailed and person-centred perspectives provided by young people and provide a rural focus to existing literature on youth help-seeking. The study adds new information on the impact for youth of a new drop-in mental health service in a regional town. The limitations of this study include the small number of participants and considering only one Safe Haven site. Future studies could expand the scope and size of participant numbers by including Safe Haven sites from other Local Health Districts across NSW. In addition, follow up interviews with the existing participants could have provided additional richness to the data, including exploring more in-depth demographics such as cultural connections and Aboriginality. Findings from Cohort A could be collated with those from Cohort B and ore detailed quantitative data from the PSH.

Conclusion

This study identified that an informal model of mental health care in a regional setting can improve the emotional wellbeing of young people and provide foundations for them to increase their skills in managing their mental health needs. The combination of factors needed for emotionally distressed young people to access a community-based peer-led mental health setting provide a more nuanced understanding of what is required to facilitate successful help-seeking initially, an effective peer support model, and the factors that provide time and space for young people to move from distress to greater self-management. These findings provide clarity and guidance to health services about young peoples' preferences around engaging with mental health care.

KEY RECOMMENDATIONS

This study has highlighted the challenges faced at a local level for young people and their families seeking accessible and acceptable mental health support. It has also confirmed the value of the drop-in Safe Haven model for young people who typically struggle to seek help for their emotional distress. Actions can be taken at multiple levels to promote and expand features of the Safe Haven model effective for young people.

At government level

- Ensure Safe Haven model includes no lower age limit, and a 'no-barrier' approach, including youth input into service design.
- Expand the Safe Haven program into other low resourced settings across the state.
- Develop a youth peer support and advocacy role that can work alongside local Safe Haven staff in schools and other youth settings.

At local health district (LHD) level

- Enhance Safe Haven resources to support extended hours of operation

- Support Safe Haven staff to have a regular presence in local schools
- Support government efforts to establish youth peer and advocacy roles

At community level

- Work with the Safe Haven to promote and explain its role, particularly to young people
- Promote the role of the supportive adult who can be the initial facilitator of help-seeking
- Support development of local youth peer advocacy roles.

REFERENCES

Aisbett, D. L., Boyd, C. P., Francis, K. J., Newnham, K., & Newnham, K. (2007). Understanding barriers to mental health service utilization for adolescents in rural Australia. *Rural and Remote Health*, *7*(1), 624. https://doi.org/10.22605/rrh624

Arnett, J. J. (2000). Emerging adulthood: A theory of development from the late teens through the twenties. *American Psychologist*, *55*(5), 469–480. https://doi.org/10.1037/0003-066X.55.5.469

Australian Bureau of Statistics. (2023, October 5). *National Study of Mental Health and Wellbeing 2020-2022*. www.abs.gov.Au/Statistics/Mental-Health/National-Study-Mental-Health-and-Wellbeing/Latest-Release.

Australian Institute of Family Studies. (2018). Most teenagers turn to parents and friends for help. In *Growing up in Australia: The longitudinal study of Australian children 2017*. aifs.gov.au. http://www3.aifs.gov.au/institute/media/docs/

Australian Institute of Health and Welfare. (2023). *Suicide and Self-harm Monitoring*. www.aihw.gov.au/Suicide-Self-Harm-Monitoring/Population-Groups/Young-People/Suicide-Self-Harm-Young-People.

Biddle, L., Gunnell, D., Sharp, D., & Donovan, J. L. (2004). Factors influencing help seeking in mentally distressed young adults: A cross-sectional survey. *British Journal of General Practice*, *54*(501), 248–253.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2021). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology*, *18*(3), 328–352. https://doi.org/10.1080/14780887.2020.1769238

Bronfenbrenner, U. (1994). Ecological Models of Human Development. In *International Encyclopedia of Education* (2nd ed.). Oxford: Elsevier.

Byrne, L., Wang, L., Roennfeldt, H., Chapman, M., Darwin, L., Castles, C., Craze, L., & Saunders, M. (2021). *National Lived Experience Workforce Guidelines*. www.mentalhealthcommission.gov.au

Carey T, & Gullifer J (Eds.). (2021). Rural, Remote, and very Remote Mental Health. In *Handbook of Rural, Remote and very Remote Mental Health* (pp. 1–16). Springer Nature. https://doi.org/10.1007/978-981-15-6631-8_1

Guba, E., & Lincoln, Y. (1985). Establishing Trustworthiness Naturalistic inquiry. In *Purpose Meets Execution*. SAGE.

Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: A systematic review. *BMC Psychiatry*, *10*. https://doi.org/10.1186/1471-244X-10-113

Ishikawa, A., Rickwood, D., Bariola, E., & Bhullar, N. (2023). Autonomy versus support: self-reliance and help-seeking for mental health problems in young people. *Social Psychiatry and Psychiatric Epidemiology*, *58*(3), 489–499. https://doi.org/10.1007/s00127-022-02361-4

Kauer, S. D., Mangan, C., & Sanci, L. (2014). Do online mental health services improve help-seeking for young people? a systematic review. *Journal of Medical Internet Research*, *16*(3). https://doi.org/10.2196/jmir.3103

MacDonald, K., Fainman-Adelman, N., Anderson, K. K., & Iyer, S. N. (2018). Pathways to mental health services for young people: a systematic review. In *Social Psychiatry and Psychiatric Epidemiology* (Vol. 53, Issue 10, pp. 1005–1038). Dr. Dietrich Steinkopff Verlag GmbH and Co. KG. https://doi.org/10.1007/s00127-018-1578-y

MacKinnon, N., & Colman, I. (2016). Factors Associated with Suicidal Thought and Help-Seeking Behaviour in Transition-Aged Youth versus Adults. *Canadian Journal of Psychiatry*, *61*(12), 789–796. https://doi.org/10.1177/0706743716667417

McGorry, P. D., Mei, C., Chanen, A., Hodges, C., Alvarez-Jimenez, M., & Killackey, E. (2022). Designing and scaling up integrated youth mental health care. *World Psychiatry*, *21*(1), 61–76. https://doi.org/10.1002/wps.20938

McHale, R., Brennan, N., Boon, B., Richardson, E., Rosetto, A. , & Christie, R. (2024). *Youth Survey Report 2024*.

Mental Health Commission of New South Wales. (2022). *Strategic Framework for Suicide Prevention in NSW 2022-2027*. www.nswmentalhealthcommission.com.au

Platell, M., Cook, A., & Martin, K. (2023). How parents can help or hinder access to mental health services for young people. *Children and Youth Services Review*, *145*, 106760. https://doi.org/10.1016/j.childyouth.2022.106760

Pohl, M., Elliott, S. A., Sidhu, H., Lappin, S., Liu, R., Scott, S. D., Newton, A., & Hartling, L. (2024). Understanding How Youth Search for Mental Health Information Online: A Qualitative Descriptive Study. *Journal of Health Communication*, *29*(3), 211–219. https://doi.org/10.1080/10810730.2024.2313990

Radez, J., Reardon, T., Creswell, C., Lawrence, P. J., Evdoka-Burton, G., & Waite, P. (2021). Why do children and adolescents (not) seek and access professional help for their mental health problems? A systematic review of quantitative and qualitative studies. In *European Child and Adolescent Psychiatry* (Vol. 30, Issue 2, pp. 183–211). Springer Science and Business Media Deutschland GmbH. https://doi.org/10.1007/s00787-019-01469-4

Rickwood, D., Deane, F. P., Wilson, C. J., & Ciarrochi, J. V. (2005). Young people's help-seeking for mental health problems. *Australian E-Journal for the Advancement of Mental Health*, *4*(3), 1–34. https://ro.uow.edu.au/hbspapers/2106

Rickwood, D. J., Mazzer, K. R., & Telford, N. R. (2015). Social influences on seeking help from mental health services, in-person and online, during adolescence and young adulthood. *BMC Psychiatry*, *15*(1). https://doi.org/10.1186/s12888-015-0429-6

Roberts, J. H. (2012). Improving primary health care services for young people experiencing psychological distress and mental health problems: a personal reflection on lessons learnt from Australia and England. *Primary Health Care Research & Development*, *13*(4). https://doi.org/10.1017/S1463423611000582

Roberts, M., Jones, J., Garcia, L., & Techau, A. (2022). Adolescents' perceptions of barriers and facilitators to engaging in mental health treatment: A qualitative meta-synthesis. *Journal of Child and Adolescent Psychiatric Nursing*, *35*(2), 113–125. https://doi.org/10.1111/jcap.12354

Robertson, H. A., Biel, M. G., Hayes, K. R., Snowden, S., Curtis, L., Charlot-Swilley, D., Clauson, E. S., Gavins, A., Sisk, C. M., Bravo, N., Coates, E. E., & Domitrovich, C. E. (2023). Leveraging the Expertise of the Community: A Case for Expansion of a Peer Workforce in Child, Adolescent, and Family Mental Health. *International Journal of Environmental Research and Public Health*, *20*(11). https://doi.org/10.3390/ijerph20115921

Rosina, R., McMaster, R., Lovecchio, V., & Wu, C. J. (2024). Young People Transitioning from Child and Adolescent to Adult Mental Health Services: A Qualitative Systematic Review. *International Journal of Mental Health Nursing*, 1–14. https://doi.org/10.1111/inm.13439

Salaheddin, K., & Mason, B. (2016). Identifying barriers to mental health help-seeking among young adults in the UK:a cross-sectional survey. *British Journal of General Practice*, *66*(651), e686–e692. https://doi.org/10.3399/bjgp16X687313

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing and Health*, *23*(4), 334–340. https://doi.org/10.1002/1098-240x(200008)23:4<334::aid-nur9>3.0.co;2-g

Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in Nursing and Health*, *33*(1), 77–84. https://doi.org/10.1002/nur.20362

Sara, G., Wu, J., Uesi, J., Jong, N., Perkes, I., Knight, K., O'Leary, F., Trudgett, C., & Bowden, M. (2023). Growth in emergency department self-harm or suicidal ideation presentations in young people: Comparing trends before and since the COVID-19 first wave in New South Wales, Australia. *Australian and New Zealand Journal of Psychiatry*, *57*(1), 58–68. https://doi.org/10.1177/00048674221082518

Saurman, E. (2016). Improving access: Modifying Penchansky and Thomas's theory of access. *Journal of Health Services Research and Policy*, *21*(1), 36–39. https://doi.org/10.1177/1355819615600001

Simmons, M. B., Cartner, S., MacDonald, R., Whitson, S., Bailey, A., & Brown, E. (2023). The effectiveness of peer support from a person with lived experience of mental health challenges for young people with anxiety and depression: a systematic review. *BMC Psychiatry*, *23*(1). https://doi.org/10.1186/s12888-023-04578-2

Stunden, C., Zasada, J., VanHeerwaarden, N., Hollenberg, E., Abi-Jaoudé, A., Chaim, G., Cleverley, K., Henderson, J., Johnson, A., Levinson, A., Lo, B., Robb, J., Shi, J., Voineskos, A., & Wiljer, D. (2020). Help-seeking behaviors of transition-aged youth for mental health concerns: Qualitative study. *Journal of Medical Internet Research*, *22*(10). https://doi.org/10.2196/18514

World Health Organisation. (2024, October 10). *Mental Health of Adolescents*. Who.Int/News-Room/Fact-Sheets/Detail/Adolescent-Mental-Health.

APPENDICES

Appendix 1

ETHICS APPROVAL

- Date of Decision Notification: **26 Mar 2024**

Dear Victoria,
Thank you for submitting the following Human Research Ethics Application (HREA) for HREC review:

2024/ETH00388: The experiences of people seeking help for emotional distress in regional NSW - HREA

This Application was reviewed as a **Greater than low risk review pathway** and was initially considered by the **Greater Western Human Research Ethics Committee** at its meeting held on **6 March 2024**.
The project has now been determined to meet the requirements of the National Statement on Ethical Conduct in Human Research (2023) and is **APPROVED**.

This email constitutes ethical and scientific approval only.
This project cannot proceed at any site until separate research governance authorisation has been obtained from the Institution at which the research will take place.

This project has been Approved to be conducted at the following sites:

- Western NSW LHD - Mental Health Drug and Alcohol

The following documentation was reviewed and is included in this approval:

- Participant Consent Form/s, Consent form Cohorts A & B
- Other, Please specify, Cover letter- responses to HREC requests
- Application Attachment, Experiences at PSH-HETI Research Protocol V1 with appendices
- Questionnaire, Interview questions cohort A
- Questionnaire, Interview questions Cohort B
- Letter of Invitation, Participant initial invite letter Cohorts A & B
- Participant Information Sheet, PIS-abridged- tracked changes
- Participant Information Sheet, PIS-full version-tracked changes
- Study Protocol, Protocol-Experiences at PSH-V2-without appendices-25.03.24.pdf
- Application Documents - (link will only be active for 14 days from the decision date. The approved documents are also available to download from forms section of this project in REGIS)

The Human Research Ethics Application reviewed by the HREC was:
Version: 1.03
Date: 26 Mar 2024

The approval is for a period of 5 years from the date of this e-mail **(26 Mar 2024)**

The Coordinating Principal Investigator will:
• provide the HREC with an annual report and the final report when the

project is completed at all sites. This will be through the submission of a milestone in REGIS.
• immediately report anything that might warrant review of ethical approval of the project.
• submit proposed amendments to the research protocol, including; the general conduct of the research, changes to CPI or site PI, an extension to HREC approval, or the addition of sites to the HREC before those changes can take effect. This will be through a notification of an amendment in REGIS
• will notify the HREC if the project is discontinued at a participating site before the expected completion date, with reasons provided.

Submission of annual progress/final reports (milestone), amendments and safety reports should be done through the forms provided in REGIS. Guidance on these processes can be found on the REGIS website.

It is noted that the **Greater Western Human Research Ethics Committee** is constituted in accordance with the National Statement on Ethical Conduct in Human Research, 2023 (NHMRC).

Please contact us if you would like to discuss any aspects of this process further, as per the contact details below. We look forward to managing this study with you throughout the project lifecycle.

Regards,

Phil Sanders

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Research Governance Officer
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Appendix 2

DEMOGRAPHIC DATA OF PARTICIPANTS

AGE	IDENTIFIED GENDER	USUAL ACTIVITY	USUAL LIVING	USUAL ADDRESS
16 years old	Male	Work and study	Living with family	Parkes
19 years old	Female	Study	Living away for study	Parkes
19 years old	Male	Working	Living with partner	Parkes
18 years old	Male	Job seeking	Living with family	Parkes

Appendix 3

SAMPLE QUESTIONS

Demographic questions:
1. How old are you?

2. What is the postcode of your usual home?

3. Can you tell me about your usual living arrangements? For example, do you live with family or carers, with friends, alone?

4. Can you tell me what gender you prefer to identify as?

5. And are you working or still at school?

The interview questions will follow:
6. Can you tell me a bit about your experience of the Safe Haven.

7. And what about the first time you came? What was that initial experience was like for you? What did you know about the service before you came?

8. What other options did you consider for getting help at that time? Did you have some help from friends or family to make that decision?

9. Was this the first time you had asked for help for your mental health? If not, can you tell me a bit about where that was, and what that experience was like?

10. The Safe Haven provides a different type of mental health care to most other options for young people. How easy or difficult was it for you to approach a service like this one?

11. Were there any challenges for you in deciding to come to the Safe Haven, as compared to other healthcare options? (such as ED or the GP for example)

12. Have you made any changes to how you approach getting mental health care because of your experience at the Safe Haven?

Appendix 4

THEMES/ SUBTHEMES/ SAMPLE TEXT/ MEMOING

CORE THEMES	SUB THEMES	SEEN IN	THEMATIC MEMOS
NEED HELP TO SEEK HELP	Role of a trusted adult	P2 I "started crying in the café and Mum said, "you need to come in here" (PSH). …"my mother took me" P1 "I was invited by my friend, my neighbour" P3 "I went down with my sister" P4 "Mum looked up places for me to go just to talk to someone" "We just came here because we saw the Safe Haven (sign) out the front. It was quite good"	This theme is defined by descriptions of the participants' initial distress, not knowing what to do and the involvement of a caring and trusted adult- usually a family member. P's describe the process of seeking more information, often aided by their trusted adult or friend. It describes the help-seeking process undertaken and the uncertainty some felt before finally accessing the SH for the first time.
	Needing courage	P3 knew of SH from family and friends "but didn't have courage to go in." P2 had not previously used other services "didn't want to talk to anyone". Then with encouragement of mother "I thought it might be a good idea to come in here" P3 "I felt like I had no options left, and I didn't know what else to do, so I went down with my sister and finally took that chance to come in and give it a go"	
	Identifying and validating the issue	P3 "I just thought if I just kept ruminating, it would go away eventually, but it doesn't." P4 before knowing about SH: "When I was upset I just kind of dealt with it. But now, it's better because I can talk to someone about how you feel". P2 "I wasn't having a very good day, …and my Mum knew M that worked here. She said I should come and pay a visit"; Regarding difficulty seeking help: "it's more just boys. They don't really like to talk to anyone". And "the boys are just known for not talking to anyone".	
	What to do, where to go	P4 knew about SH from school project. "wouldn't have known where else to go" "this was really the only one that really has a sign that says it" (knowing where to get help) P1 "I know a few friends…they just need help, but … they just don't know where to start"; Harder to find help in regional area "when I've moved away to Melbourne, I was very easily able to access help when I needed it" (compared to regional area); "I think I would go looking online…. But even then, it's knowing what to look for I guess"; "while I knew we had a SH here, I never knew what it really meant" Finding help as a YP: "I think it's quite hard to be honest, unless you're already in a medical situation". Without already being linked in with medical care "I wouldn't have been able to find the help I needed" P4 If SH didn't exist would "Just try to talk to someone, a friend or something. But yeah, I don't know."; noted school counsellor as an option however "she's not there all the time".	

		P2 regarding hearing about MH services: “I suppose you don’t think you’ll ever need them. Eventually everyone’s going to”; Probability of seeking help if SH didn’t exist: “Probably wouldn’t have”	
ACCEPTANCE	Welcoming reception	P3 They “bring you into a separate room, like the lights are all dim, there’s a lot of … fidget toys you can play with, and it was a really welcoming environment.” And “when you’re here you can just be instantly welcomed in. It’s beautiful”; There is “always a smile”, “always offering” P4 “it felt really scary the first time ….. I didn’t know what to expect. But it was actually quite good” P2 “a bit more comfortable knowing that (the) doors are always open. There’s someone here to talk to”. P4 referencing the welcoming environment “Yes that’s my favourite. I love that one”; After suggesting PSH to a friend: “he actually really enjoyed it because of the people and the atmosphere” P2 “when you walk into the hospital, it’s just somewhere you don’t want to be. It’s not a happy place. Whereas you walk in here and everyone’s got a smile on their face”. P1 “feels comforting’; “when I chat to them, they are really caring about me”	This theme is defined by the P’s first impressions and lasting impressions of the physical and emotional experience of coming to the SH. They describe not only specific ways they felt cared for by the staff but also gave examples of what it means to be completely accepted, whatever their level of need and capacity to communicate at any given time.
	Comforting, homely	P3 “ it was just really relaxing”. “it’s such a nice environment” P1 “It feels very comforting” “just feels comforting”. “It feels more homely I guess” P3 Regarding positive qualities: “the furniture really stood out” and “It was very quiet. All you could hear was just the ticking of the clock. It’s so quiet” P3 “there’s a lot of different rooms. Like one with a TV, the home, like the main lounge room is really big, really spacious”. And, “if you need that alone time, you have a lot more comfort and reassurance”.	
	Feeling nurtured	P2 “when you come here, they just listen to you, and you’re not pressured to do anything” P4 “They’re more here to listen and help” P1 “When I chat to them, they’re really caring about me” P4 PSH f/u with service users: “they always check up on you. ….I like that a lot. When you don’t think about it for a while and you haven’t been here, you kind of forget. But then they call you and say, “how are you going?” That’s always good.” P3 “so I came here in a lot of distress. And it was really good. They really take care of you.” P3 felt reassured. “the staff were lovely, very, very kind” P2 “They feel a lot more like friends rather than people you’re forced to come and talk to” P1 staff are “there as a friend” P1 Can “come in and just chat like almost with a friend”	

	Face to face	P2 the school recommended online services but “It wasn’t in person, and I suppose it’s probably don’t feel comfortable talking to someone that I don’t really know”; Face to face service very important. “It’s probably the only reason I came in here” “it’s real people and someone I knew”. P4 “I just like face to face instead of over the phone” P3 “I was losing a lot of hope when I was trying other services. But it just wasn’t that face-to-face experience”	
TIME AND SPACE	No rush	P4 experience at GP- pressured to talk. “rushed, very rushed” P3. “I got to speak, I feel like I got to speak more freely and for longer. Like I really got to think about my answers and didn’t feel like I was put on the spot.” P2 “When you come in here, they just listen to you and you don’t feel pressured to do anything”. P1 “having the space to have a break” P3 comparing experience with ED: “This is like always somebody with you if you need someone. There’s always someone not with you if you don’t need someone”	The importance of having enough time and the physical and emotional space to create the experience that they need at that time; of not feeling rushed to start talking about their challenges and being able to take as long as they need when they do start talking; comparisons with previous experiences at other health services, especially regarding waiting for appointments/ information. Conversely being rushed to divulge information as defined by the health worker.
	Come when ready	P1 “I feel like making an appointment puts pressure on as well” Whereas at the SH, “I can just walk in whenever I feel prepared to have a chat or whenever I need to have a chat”. P4 “it’s good that you don’t have to say what you’re feeling straight away. You can take a bit of time to just sit and just talk about other things instead of what’s the problem straight away”.	
	No waiting	P3 Emergency department “was really intimidating” “the waiting is the worst thing” “like having my mental health in their hands was just awful, just waiting to get the simplest yes or no answer” P2 long waiting times for appointments with GP or other health providers compared with SH “its just a lot easier knowing that you can walk in the doors anytime and there’s be someone here”. P4 No waiting at SH “can come straight in”	
	Staff patience	P3 staff “very, very kind, very patient. Which was, it’s a relief for me because I have trouble talking and not good on the spot, so they were really patient with me while I was really distressed”.	
FEELING SAFE	Talk freely	P3 “ a safe space for me is somewhere I can express myself freely, talk freely” P4 “This is a safe sort of place that’s not… no one, no bullying” P2 “when I was out there, I didn’t really feel like expressing anything and just kept the hoodie on and didn’t talk to anyone and stuff like that. And once I came in here, I think I cried for an hour straight”	This theme is defined by the features of the SH experience that helped the P’s to feel safe.

	Staff qualities	P4 staff are “like other people but they are just there to listen”; “They’re not here to judge you” P1 “it’s a bit more relaxed and not as official” “without… having to talk through things I was experiencing at the time” P3 “you can rely on people in here as well”; “They are here because of their own personal experiences as well. And I thought that was amazing”; “I feel like the people here are very genuine. Very, very genuine about keeping the privacy safe. Like they make it clear that this is a safe space. With how the environment looks and how they act and it just, it all feels very genuine”	It includes the approach provided by the staff as well as the P’s realisation that they can direct their own experience, to take what they need, when they need it. The absence of prescribed expectations from the staff and their unconditional supportive approach was a defining part of P’s experience.
	Create own experience	P3 can “do what you really want to do”; “can be in your own space” P4 at SH: “you don’t have people trying to tell you what’s right, all that” P4 “ if you want to sit there and read a book, you can. If you want to sit here and just lie down, you can” P1 “a space out of home to hang out”; “chat to people outside of my life, outside of home”; “ have some space for yourself”	
	Presence of others	P4 “It’s alright because most people are here doing the same sort of stuff. So it’s not really a bother” P4 “not too many people that it’s crowded and enough things for people, like, you can do” P3 Everyone “Who comes here is really nice” “you always get a ‘gidday’ or a nice conversation”.	
	Confidentiality	P2 “and at the same time, anyone in these rooms, I don’t know, I couldn’t tell you why it is, you know no-one is going to tell anyone anything” P1 “I know it won’t go any further” “I can really trust them as well” P4 “yeah, no one else says anything about it. You don’t go around, no one goes around really saying, “this person was at this place because they were doing something”. ” P2 regarding any concerns about confidentiality at SH and in a small town: “Not so much me, but I know a lot of people that, I suppose would rather keep it quiet”	
NEW UNDER-STANDINGS	Previous understandings	P1 “I always thought that to really have support with mental health, I had to go to that extreme of seeing someone professionally. But I didn’t realise how much a space like this can help with my mental health”. P1” Growing up and getting help always looked like going through the doctors…..and coming here it’s made me realise that …. it doesn’t have to be a big hall with the label on it. Like, it’s just somewhere to go”. P2 previous understanding of emotional distress: “At the time I wouldn’t think it’s an emergency, but I do now”. P3 regarding experience with ED: “so I was going through a lot of confusing emotions, and I didn’t know how to deal with them. So, I had to keep going back, but you just get sedated and then sent back home”	This theme is different to other themes as it demonstrated P’s making sense of their experience. They are reflecting on previous understandings of healthcare, including the purpose of SH, with their newfound

	Options	P2 “I’ve always just thought about not talking to people and just going about my day I suppose. But I came in here and it made me feel 10 times better than before I came in here”; “well before I was just quiet, didn’t want to talk to anyone”. P4 “it felt really scary the first time I came here. I didn’t know what to expect. But it was actually quite good”; “just talking to people that wasn’t my mum or dad, that was like other people but they’re just there to listen. Which was yeah, that was good” P1 regarding drop-in centre: “It’s just that whenever you need, you can just go in”	knowledge and experience. They recognise their new capacity to take charge of their own needs and have more confidence to more effectively managing any future MH challenges.
	New skills	P4 “I feel more confident about everything really, not having to get upset at everything. I’m more relaxed when something happens, like I know if I need to go somewhere I can come here” P3 “I’m a lot more patient” and “a lot more empathetic”; “more in tune with own feelings” P3 help-seeking: “It’s a lot easier to navigate… And so I know what I’m feeling, and I know what I can say” P3 is better at recognising unhelpful behaviour in others P4 can manage own needs “I know I can always come here. There’s always someone you can talk to”.	
	Misunderstand-ings clarified	P1 “while I knew we had a Safe haven here, I never knew what it really meant” P1 misunderstood the purpose of SH “thought it was, if you were suicidal, that’s where you’d go But they (YP) don’t realise it’s more of a space to help yourself”. P3 “you can get educated here a little bit on mental health”	
	What makes a good service	P1 “comforting and understanding perspective.” “just understanding whatever experience they’re going through is really helpful.” “While being there professionally, being there as a friend”; providing help “not a clinical way” P2 “somewhere that’s very out there (visible). Somewhere that say went out to schools and stuff like that constantly and done talks just so you know, like you’ve seen that face before and you know they’re a good person”; “like I said, you don’t want to talk to a stranger. You want to talk to someone you know”. P3 comparing SH with formal health services: “I guess it (PSH) gives them (YP) more a sense of self and a bit more freedom” “young people are usually in an environment where they can’t speak freely about those things (MH concerns). And going to a place where you can and you won’t be judged, that’s really…so powerful”	

SHARING	Advice to PSH	P4 suggested extended hours “open more until 5pm”… “and on the weekends, probably till 3pm” P3 “I would love there to be more groups, because in Panorama the groups were a big thing for me” “if there were more groups, I feel like they would get more people and it would be more known, especially if they advertised a bit more”. P2 “go and talk to schools” “make sure they get to know your face” (Then it) “might be easier for them to know who you are (and) to come in here, like it was for me”. “so, it’s not just like you come in here to talk to some stranger. You know their name, you know their face”; Parkes and Central West “probably needs a couple more places like this around here” P1 YP “need to know more about it” (the SH). “maybe getting the schools to tell them (YP) that they have this resource available…explain to them what it really is”. P4 supporting idea of a youth MH advocate: “most younger people listen to people around the same age” “it’d be great because more people (would) know about this place” P1 “one thing I think would be really important is getting more information to that age of 16 to 24 about what Safe Haven really is. They’ve always thought it was, if you’re suicidal, that’s where you’d go. But they don’t realise it’s more of a space to help yourself”. “..It would be really great if they (other YP) could learn what the SH’s here for so that they also feel they have a place to come if they need it as well.”	In this theme P’s describe ways they have sought to help friends with MH challenges, and advice to the SH for improvements that could make it easier for young people to know about and access the SH. They also describe ways they have tried to use their new understandings to help friends who are currently suffering, often feeling a sense of responsibility.
	Helping friends and others	P2 “I did suggest it to my friends, but I don’t think any of them came here. They were all kind of the same as what I was before I came in here. They didn’t want to go and talk to anyone.” P2 “when I come in here, (it) help(s) me and everyone else. I can go back and ask the same questions that they asked me of all of my friends…. Because I think that’s the hardest part, is finding out how to ask someone if they’re alright”. After first experience at SH “and ever since I’ve just been telling people if they’re having a hard time to come in here” P3 “I brought my partner the next time I came back”; expressing desire to help others; “I remember what I went through … And I want to try and help as much as I can” P4 after telling a friend: “when he came here, he said he actually really enjoyed it because of the people and the atmosphere”, “Yeah, I …recommend it (to) them. Yeah. I’ve talked to a few friends about it”. P1 Advice to other YP: “just to give it a go” “It’s really changed how I can look after myself” P2 regarding encouraging friends to access SH: “I tried to tell them, but I just went along with them and said, “Ok I’m not going to force you to do it” and I just made sure they were alright”	