

Feature

Adolescent consent and Generation Alpha: bridging policy, practice and empirical evidence in healthcare

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Adolescents, particularly today's Generation Alpha, face uncertainty about whether, when and how their autonomy will be respected, especially in mental health contexts. Existing consent and confidentiality practices may not reflect adolescents' preferences, potentially deterring help-seeking. This Feature examines the tension between adolescent autonomy and parental authority in mental healthcare. We synthesise interdisciplinary perspectives from the developmental sciences, medical ethics and law. We present data from 20 844 students (aged 11–18 years) in the 2023 OxWell Student Survey regarding barriers to accessing mental health support. Among those who wanted but had not accessed additional support ($n = 2792$), 72.3% reported privacy/confidentiality concerns, with half (50.3%) specifically citing that they did not want their parents to know. These concerns were particularly common among students reporting self-harm, gender-diverse adolescents and those in less stable home environments. We argue that respecting adolescent autonomy must be central to healthcare planning, not only as an ethical and legal imperative, but also to

enable timely support. A capacity-based, adolescent-centred approach – grounded in greater transparency, clearer explanations of when and how information may be shared (including the option to involve a trusted adult) and consistent, aligned policies across institutions, especially around parental involvement, could help address a key barrier to care.

Keywords

Adolescent health services; mental health services; consent; personal autonomy; health services accessibility.

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Adolescence is defined by change – moving from childhood to adulthood, dependence to independence and immaturity to more accountability. The ambiguities in healthcare that surround this time are manifest in numerous uncertainties: when adolescence starts and ends; which decisions an adolescent can be enabled and entrusted to take for themselves and others; the role their parents and primary caregivers play throughout this transition; and who has a right to know about concerns regarding their health, level of risk and healthcare decisions. This article will explore and confront the current healthcare approach, which commonly gives primacy to parental involvement and might be limiting adolescents' access to services as a result, in particular for mental healthcare. Drawing on insights from the developmental sciences on adolescent decision-making, medical ethics on autonomy and self-determination and legal perspectives on capacity and rights, alongside new empirical findings on adolescent barriers to care, we examine two key questions: (a) Are assumptions of parental authority limiting help-seeking? and (b) To what extent should adolescents be granted the right to consent and confidentiality regarding their information and decisions?

Adolescent access to healthcare, across many medical systems worldwide, often prioritises parental involvement at the expense of appropriately respecting autonomy.¹ Adolescent autonomy refers not only to making independent decisions ('autonomy-as-independence') but also to the extent these decisions are aligned with values, preferences and interests ('autonomy-as-volition'). Notably, volitional autonomy is a process that develops progressively across the life course.² Autonomy does not necessarily mean detachment from parental figures: parental involvement can both foster and hinder autonomy, depending on whether it is supportive or controlling in practice. Crucially, evidence indicates that adolescent thriving is more closely associated with being supported in volitional decision-making, and environments that foster it are

linked with well-being and psychosocial adjustment across diverse cultural contexts.² In healthcare, consent constitutes a central practice of adolescent autonomy with associated assumptions of confidentiality and respect for their privacy. Yet the ways these principles are operationalised in many healthcare systems are, we argue, no longer fit for the modern era.

Generation Alpha, or Gen Alpha, are children of millennials, born from 2010 until 2025.³ Gen Alpha number almost 2 billion; they are the largest generation in history and comprise a quarter of the global population.³ The rising proportion of adolescents is largely driven by increasing numbers in the Global South, reflecting both improved infant survival rates and a relatively higher proportion of individuals of child-bearing age in these regions. In contrast, higher-resource settings are characterised by smaller household sizes, leaving the majority of the world's adolescents residing in lower-resource settings – often (and more appropriately) referred to as the 'majority world'.⁴ This next generation of adolescents have, as a whole, greater access to information, and have been raised at a time where the relevance of the adolescent voice is being magnified in public discourse. These adolescents can potentially make more informed decisions, as they are better placed to question the veracity of information presented to them and have more opportunity to (rightly) challenge established assumptions of cooperation with hierarchical structures given the reality of childhood exposures to abuse from individual, institutional, community and societal actors.⁵ However, these same experiences may expose them to misinformation, manipulation and other negative influences which could potentially shape their perceptions, decision-making and trust in authority in complex ways.

We believe that these shifting landscapes give us an opportune moment to rethink how adolescents can exercise more autonomy and question paternalistic assumptions prominent in their healthcare. We will discuss access to healthcare in general but focus on

mental healthcare in England as an exemplar. We note the proliferation in mental health provision taking place beyond the bounds of traditional healthcare (such as in schools, community hubs and online), and assert that the principles discussed here are relevant across all settings where adolescents can seek support. For the purposes of this article, we will focus on early adolescence, defined as those aged 12–18 years, fully cognisant that adolescence is now more broadly defined as covering ages 12–24. We will focus, however, on the end-point of 18 years as this aligns with most international legal frameworks and many healthcare services, marking the end of ‘childhood’ and the beginning of ‘adulthood’ or ‘age of majority’ with its associated privileges and responsibilities as individuals gain legal rights and take on formal societal roles.

In this Feature we argue that the current practices in consent for mental healthcare limit adolescent autonomy in a way that might be preventing adolescents from accessing therapeutic interventions, especially for the most vulnerable. We propose that when adolescents actively seek healthcare, the extent of parental involvement should be decided by the adolescent themselves and may, in some cases, need to be minimal to ensure that adolescent rights are upheld.

Adolescent decision-making: evidence from developmental science

There is growing research highlighting the many significant brain changes that occur during adolescence, likening it to a second period of rapid development after infancy. Adolescence is a dynamic maturational period during which young lives can pivot rapidly – in both positive and negative directions.⁴ These changes not only have an impact on physical development but also on emotional, behavioural, moral and cognitive functions. Of relevance to cognitive development is the maturation of executive functions, which develop significantly throughout adolescence including into the early 20s.⁶ Executive functions include the processes that help us regulate our thoughts and behaviours to make plans, solve problems and attain goals.⁷ Major subcomponents of executive functioning have been described as attention, inhibition, self-regulation, working memory, cognitive flexibility, planning, organisation, problem-solving and performance-monitoring,⁷ all highly relevant in considerations of capacity for any healthcare consenting process. Although these executive functions ‘mature’ substantially during adolescence, they are unlikely to have fully reached their potential until later in adolescence or in adulthood.

Adolescents have a heightened susceptibility to peer influence and often prioritise short-term rewards over long-term consequences, with some variation by gender and cultural background.⁸ Experimental neuroscience points to developmental changes during adolescence that influence decision-making, marking a shift from parental to peer influence. Studies show that risk-taking increases in the presence of peers, and is associated with heightened sensitivity to immediate reward and a stronger drive for social acceptance. While this can support exploration and identity formation, it can also lead to the commencement of potentially harmful behaviours such as substance use and gambling, which can be ominous prequels for later problematic use (typically peaking around 22–25 years).^{9,10}

While much of the existing research pre-dates the rise of social media, it is likely that alongside in-person relationships, virtual peers, including social media ‘influencers’ and celebrities, now play a significant role in shaping adolescent attitudes, behaviours and decision-making.¹¹ This shift from parental to peer and virtual influence, reflects the evolving – and algorithmically influenced – social landscape that adolescents navigate today.¹¹

Consent and confidentiality: legal considerations in healthcare

Navigating the balance between decisions shaped by limited executive functioning or potentially uninformed social influence, versus those in which adolescents demonstrate reflective and autonomous decision-making, remains a key consideration in providing care.

In healthcare, consent is a key mechanism for respecting individual autonomy and refers to the permission given before any medical intervention. For consent to be valid, the individual must have the capacity to decide, meaning they are able to reach a considered judgement about their care. It relies on having, and understanding, sufficient information about the nature, risks and alternatives of the intervention, as well as acting voluntarily, free from coercion or undue pressure. The importance of collaborative, developmentally appropriate decision-making between clinicians and adolescents cannot be overstated.¹² In most healthcare systems, treating someone with capacity without their consent may result in legal liability under tort law – the branch of law dealing with civil wrongs and harms – and might include claims of negligence or, in some cases, assault.

Consent must be obtained with awareness of the potential power dynamics, particularly the influences of those in perceived positions of authority, such as medical professionals. Additionally, consideration should be given to how a patient’s sense of agency may be affected when unwell. If a patient lacks capacity (no matter what age) then treatment can be provided if it is in their best interests. This principle thus requires that the wishes of autonomous individuals be respected, and that individuals with diminished autonomy be protected.¹³

Legal thinking on adolescent consent and confidentiality has progressed significantly over the past few decades, and while frameworks vary across jurisdictions, a growing number recognise that competent adolescents – particularly those over 16, or younger individuals deemed *Gillick competent* – can make autonomous decisions about their care, including the right to confidentiality. A summary of relevant English case law is provided in Supplementary Material 1 available at <https://doi.org/10.1192/bjp.2025.10488> (Legal Frameworks and Case Law on Adolescent Consent and Confidentiality). These developments have laid the foundation for a more rights-based, capacity-focused approach to adolescent healthcare.

Despite growing legal recognition of adolescents’ decision-making capacity, healthcare systems have not kept pace in practice. Confidentiality, a legal right and ethical imperative, protects adolescents’ privacy by ensuring information shared with professionals is not disclosed without consent, except in situations of significant risk of harm. These tensions can be most tricky in child protection and safeguarding, central issues in adolescent mental healthcare. In such contexts, frameworks are needed that both enable adolescents to exert autonomy where appropriate, and crucially, establish trusted support systems – for example involving a trusted adult – so that young people do not delay or avoid needed care.

Balancing adolescent autonomy and parental authority in healthcare services

Adolescents increasingly exercise autonomy in the decisions they take, including what subjects they want to study, which careers they might pursue and how they want to express themselves in their intimate, social or virtual relationships. Notwithstanding, in healthcare, strong ethical arguments remain for involving a trusted adult, usually a parent. Such involvement often enhances

autonomous decision-making by helping adolescents make choices within their own historical, interpersonal and environmental context. The bioethical principle of beneficence – an obligation of healthcare professionals to act in the patient’s best interests – has also been extended in practice to parental figures. Yet beneficence can come into tension with autonomy. For many adolescents, the desire for privacy and control over personal health decisions reflects emerging independence, not family dysfunction. Some value adult support, while others prefer independence, especially in mental health contexts where issues such as stigma, shame or a wish to protect their parents may discourage disclosure.

Healthcare systems therefore need to embed two essential components in practice.⁶ First, they must ensure that adolescents are supported to make as autonomous a decision as possible, with appropriate information and relational scaffolding. Second, they must determine how best to respond to those decisions. In light of these two conditions, decisions may not always need to be respected – for example if it is assessed that they lacked sufficient capacity, volitional autonomy or if the decision places the adolescent at risk of significant harm (as reflected in the principles underpinning Section 31 of the Children Act 1989, which outlines the circumstances under which a child can be removed from parental care¹⁴).

There are, however, circumstances where caregiver involvement may be inappropriate or even harmful, such as strained family relationships, coercion or safeguarding/child protection concerns. In these cases, prioritising adolescent decision-making is ethically justifiable to ensure adolescents seek timely medical care and the adolescent should be encouraged to involve an appropriate trusted adult.^{15–17} Indeed, across domains such as obstetric care,¹⁵ vaccination, sexual health, substance use treatment and, more recently, in healthcare for trans and gender-diverse adolescents, the requirement for parental consent has been challenged as an undue barrier.^{18–20} This aligns with the American Medical Association’s ‘Opinion on Confidential Care for Minors’ which recognises the importance of autonomy, noting that mandatory parental involvement can, in some cases, be ‘counterproductive’ to health.²¹

Privacy and confidentiality as barriers to mental healthcare: empirical findings

Recent data from the OxWell Student Survey can help elucidate the extent to which adolescent concerns about confidentiality and parental involvement might influence their willingness to seek mental healthcare.

Methodological overview

The full methods of the survey are available in our protocol,²² but in brief, the OxWell Student Survey (University of Oxford Research Ethics Committee reference R62366/RE014) is a self-report repeated cross-sectional survey examining the health and well-being of students in school years 5–13 (aged 9–18 years). Schools and Further Education Colleges in England are recruited directly by local authorities, and students are enrolled using (a) a parental opt-out model with student assent (student age <16 years) or (b) students’ informed consent only (student age ≥16 years). The survey is administered during the school day and does not collect identifiable information.

The survey contains a suite of questions pertaining to preferences for and experiences of accessing mental healthcare. Students were asked *whether they had accessed* mental health support in the last year, *what* they had accessed and whether they had found it *helpful*. Regardless of whether they self-reported having previously sought support, they were then asked about

preferences for additional support (‘Is there any support you would have liked to have accessed or people you wish you could have talked to?’) as well as *barriers* to accessing support (‘Is there anything that prevented you from accessing support?’). The barriers were grouped into the following broad categories: privacy and confidentiality; perceptions of care provision; and practical and logistical concerns. The survey also allowed us to explore groups with higher mental health risk, including those with elevated symptoms of anxiety and/or depression (11-item Revised Children’s Anxiety and Depression Scale (RCADS)),²³ those who reported that they had ‘ever’ self-harmed and those displaying signs of disordered eating (Development and Well-Being Assessment (DAWBA) eating disorder screening questions²⁴). The survey also provided insight into whether some groups were more likely than others to have concerns about parental involvement according to the following sociodemographic characteristics and potential vulnerability indicators: gender, year group, ethnicity, whether the student or parent was born abroad, self-identified neurodivergence, experience of food poverty, relationships with household members, feelings of safety at home, experience of child maltreatment and (student-reported) parental mental illness or substance misuse (Supplementary Material 2 presents the full list of questions used in this analysis.).

To explore the scope and potential barrier of accessing services because of parent-related concerns, we descriptively report the proportions of students who (a) had accessed support from school, community, health or social care sources in the last year; (b) reported wanting additional support; and (c) whether they then endorsed one or more barriers to help-seeking. We report these statistics for the total sample and for those with higher mental health risk. We then examined the group who were concerned about parental knowledge of help-seeking and compared adolescents who did and did not endorse this concern using univariate logistic regression with a false discovery rate control to adjust for multiple testing.

Key findings

We considered a subsample of 20 844 secondary school students (school years 7–13, approximate ages 11–18 years) who reached the section of the survey that covered mental health support. Of these, 17.6% (3665/20 844) reported having accessed mental health support at school, in the community or through health and social care provision. The equivalent proportion for students with elevated symptoms of anxiety and/or depression was 31.1% (2459/7903), for those reporting self-harm it was 40.7% (1522/3741) and for those showing signs of disordered eating it was 26.8% (2450/9158). Of note, 13.4% (2792/20 844) reported a desire to access at least one additional form of support, including among those with higher mental health risk: 26.3% (2076/7903) of students with elevated symptoms of anxiety and/or depression, 32.4% (1212/7903) of those reporting self-harm and 22.1% (2021/9158) of those showing signs of disordered eating.

Table 1 shows the numbers who had a desire to access support and which barriers to seeking this support they then endorsed. Of these, 72.3% (2020/2792) endorsed at least one barrier related to *privacy and confidentiality*, making it the most commonly reported category of the three options. Among students identified as having higher mental health risk, the proportion reporting at least one barrier in this category was even higher, ranging from 79.0% (1596/2021; students with symptoms of disordered eating) to 82.5% (1000/1212; students who reported self-harm). Among adolescents who wanted additional support, one of the foremost concerns was not wanting parents to know, reported by half (50.3%, 1405/2792). This figure rose, for those with higher mental health

Table 1 Barriers reported by secondary school students wishing to access mental health support in the OxWell Student Survey

| Barrier | Full sample (n = 2792), n (%) | Students with possible anxiety and/or depression (n = 2076), n (%) | Students reporting self-harm (n = 1212), n (%) | Students with disordered eating (n = 2021), n (%) |
|--|----------------------------------|---|--|---|
| Privacy and confidentiality | 2020 (72.3) | 1672 (80.5) | 1000 (82.5) | 1596 (79.0) |
| Privacy and confidentiality 1: Wider networks | 1698 (60.8) | 1430 (68.9) | 869 (71.7) | 1368 (67.7) |
| Didn't want parents to know | 1405 (50.3) | 1191 (57.4) | 752 (62.0) | 1148 (56.8) |
| Didn't want other young people to know | 792 (28.4) | 671 (32.3) | 403 (33.3) | 638 (31.6) |
| Didn't want teachers or staff in school to know | 1018 (36.5) | 885 (42.6) | 551 (45.5) | 850 (42.1) |
| Privacy and confidentiality 2: Response to disclosures | 1753 (62.8) | 1481 (71.3) | 875 (72.2) | 1405 (69.5) |
| Didn't feel safe to share | 1115 (39.9) | 951 (45.8) | 594 (49.0) | 905 (44.8) |
| Didn't want the stigma | 521 (18.7) | 458 (22.1) | 310 (25.6) | 428 (21.2) |
| Scared/worried about what people might say | 1412 (50.6) | 1211 (58.3) | 705 (58.2) | 1152 (57.0) |
| Perceptions of care provision | 1902 (68.1) | 1586 (76.4) | 932 (76.9) | 1499 (74.2) |
| Didn't like the person providing support | 425 (15.2) | 362 (17.4) | 218 (18.0) | 342 (16.9) |
| Worried I might not get taken seriously | 1403 (50.3) | 1200 (57.8) | 724 (59.7) | 1135 (56.2) |
| Didn't like to talk to strangers | 847 (30.3) | 711 (34.2) | 411 (33.9) | 658 (32.6) |
| Didn't want to burden anyone | 1345 (48.2) | 1162 (56.0) | 704 (58.1) | 1101 (54.5) |
| Process: Practical and logistical concerns | 1916 (68.6) | 1573 (75.8) | 919 (75.8) | 1488 (73.6) |
| Didn't know who to ask | 1003 (35.9) | 803 (38.7) | 436 (36.0) | 760 (37.6) |
| Worried I would not be seen as a priority by the service | 915 (32.8) | 812 (39.1) | 508 (41.9) | 761 (37.7) |
| Might have to wait too long to get help | 824 (29.5) | 722 (34.8) | 467 (38.5) | 665 (32.9) |
| Too much hassle to get the help | 1223 (43.8) | 1032 (49.7) | 616 (50.8) | 974 (48.2) |

risk for example, to 62.0% (752/1212) among adolescents reporting self-harm.

We then compared those who reported concern about their parent knowing with those who did not report this barrier (Supplementary Table 3), which helps to identify potential subgroups of adolescents who might be more likely than others to be deterred from seeking mental healthcare due to concerns about parental involvement. The strongest associations found were among gender diverse and gender non-disclosing students, who were nearly four times as likely as boys to endorse this concern (odds ratio 3.83, 95% CI 2.55, 5.83 and odds ratio 3.91, 95% CI 2.66, 5.81, respectively). Unsurprisingly, students who reported poor relationships with members of their household (odds ratio 3.46, 95% CI 2.70, 4.45), those who did not feel safe at home (odds ratio 1.94, 95% CI 1.44, 2.64) and those who reported any form of child maltreatment (odds ratio 2.25, 95% CI 1.93, 2.63) were more likely to endorse a concern about parental knowledge of access to mental healthcare. Other groups more likely to endorse this concern included Asian/Asian British students, students who either self-identified as neurodivergent or who were uncertain whether they were neurodivergent and students whose parents had a history of mental health problems or substance misuse.

Discussion: Generation Alpha and the future of adolescent consent

The current generation of adolescents live in a world where their rights to privacy often remain constrained by paternalistic models of care that may no longer be appropriate. Without clear, consistent information and processes regarding confidentiality practices, many adolescents – especially those most in need of support – are deterred from accessing care, fearing their disclosures will be shared with parents or other authority figures.

Despite legal and ethical protections for adolescent rights to confidentiality, findings from the OxWell Student Survey, although cross-sectional, highlight a stark reality: a substantial proportion of young people, particularly those who report self-harm or are experiencing mental illness, do not access the support they feel they need, and over half of these report not wanting their parents to

know as the reason. Although adolescent individuation – the transition from dependence to independence – is a key developmental task, this does not diminish the important role that parents play. Many adolescents identify their parents as a central source of mental health support and may wish for them to have some involvement in their care.²⁵

However, there are cases where parental involvement is not appropriate. Maltreatment, including physical, sexual or emotional abuse, neglect or exposure to domestic abuse, is a clear example where parental involvement should not be the default, as disclosure may increase risk. Maltreatment is not uncommon in clinical caseloads, and policy should be designed for this reality rather than expecting it to be the exception. Beyond maltreatment, some adolescents simply prefer privacy, and for other vulnerable groups, parental involvement may introduce or exacerbate barriers to care. There may also be situations where a parent is not best placed or as competent (sufficiently informed) as their child to make a decision, for instance when unaware of experiences the adolescent has not disclosed, whether by choice or for fear of real or perceived family, interpersonal, social, legal or institutional repercussions.

Modern adolescents, equipped with unprecedented access to information, are more able than ever to understand and weigh-up information, but are also more exposed to potentially malicious perspectives. Paternalistic safeguards, such as primary caregiver rights and the presumption of parental authority and beneficence, have persisted and are likely maintained for several reasons, at the fore being a belief that adolescents require protection due to their susceptibility to peer influence or short-term decision-making that may lead to adverse social and health outcomes. In addition, there are circumstances that can compromise an individual's ability to exercise their autonomy, including in situations of abuse where victims might blame themselves, might be living under threat of severe harm if they disclose maltreatment or are coercively controlled in a manner that can compromise opportunities to fully ascertain their wishes until they are outside the confines of that relationship. Furthermore, capacity is not static, it can fluctuate over time and may, in some cases, be strengthened when adolescents are granted greater autonomy to make decisions, fostering their ability to engage in independent and informed choices.²

Given the rapidly expanding landscape of mental health provision outside traditional healthcare settings²⁵ and the importance of early intervention to improve longer-term outcomes, improving access to care for adolescents, especially for vulnerable groups more likely to ‘slip through the cracks’,²⁶ must be a priority. Confidentiality and trust have been identified in some other studies as among the highest perceived barriers to accessing care for adolescents.¹⁶ To address this, many initiatives and myriad services are converging on schools to expand mental health support.^{27,28} However, policies and practices around adolescent confidentiality and requirements for parental involvement are applied in diverse ways. This variation can make it confusing for both adolescents and professionals to understand the boundaries of adolescent autonomy and rights to confidentiality in the school setting. Confidentiality has even been described as the cornerstone of school counselling,²⁹ yet its interpretation varies considerably – even among school counsellors.³⁰ The implications of these inconsistencies extend to wider public health provision increasingly delivered in school and other community settings, from sexual health to shape and weight programmes.^{31,32}

Adolescents seeking mental health support are currently caught in a ‘Catch-22’ situation. To access care, they are typically required to undergo an assessment of their capacity – yet paradoxically, the assessment process itself is not necessarily bound by confidentiality unless they are deemed to have capacity. Adolescents are typically assured that what they share will remain private; this is usually qualified by the caveat: ‘unless there are concerns about significant risk to yourself or others’. While this principle applies across the age range, in practice it is applied inconsistently and confidentiality might be more readily breached for adolescents with capacity than for adults. This lack of consistency introduces further uncertainty at a point where trust is essential, whereby the very safeguards intended to protect adolescents might discourage those most in need from seeking support.

In light of our findings and the broader legal context, a number of solutions could be considered to align healthcare policy with these developments, reduce barriers to care and support a more adolescent-centred model of service delivery:

- (a) clarify confidentiality policies (and any differences) across healthcare, education and social care to reduce ambiguity and build adolescent trust in the system;
- (b) ensure transparency in risk-assessment and escalation processes, so that adolescents clearly understand when and how their information may be shared and the extent of their role in decision-making;
- (c) develop adolescent-friendly access points for care, such as school-based, digital and community hubs, to provide independent, confidential and easily accessible support;
- (d) enhance training for all professionals working with adolescents, ensuring they can navigate adolescent confidentiality while balancing legal, ethical and child protection responsibilities;
- (e) enable adolescents to identify a trusted adult (not necessarily a parent) to be involved if disclosure is necessary, ensuring both autonomy and protection, particularly for those in vulnerable situations such as abuse or coercion – the practical and ethical implications of this trusted adult role will need careful consideration.

All the above would benefit from co-design with young people to ensure that practices align with their lived experiences in the ever-evolving landscape of needs, risks and cultural and digital influences that shape adolescent decision-making.

In conclusion, adolescents can no longer be regarded as passive recipients of care. Their autonomy must be central to healthcare planning, not only as an ethical and legal imperative, but to ensure timely access to support. Our findings suggest that many adolescents – especially those most in need – may avoid seeking help because of concerns about parental involvement. Ensuring adolescents have autonomy over how and when their information is shared will not only strengthen trust in the healthcare system, but also allow the most vulnerable adolescents to access support without fear of unnecessary (and unlawful) disclosure.

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Supplementary material

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Data availability

The data that support the findings are available upon reasonable request. Researchers may access the data by applying through the BrainWaves Data Portal (<https://brainwaveshub.org/for-research/>), where applications are reviewed to ensure appropriate use. Further details, including the full list of questions, study protocol and other supporting materials, are available via the OxWell project’s Open Science Framework page: <https://osf.io/sekhr/>. The analytic code supporting the findings are available to other researchers from E.S. via the corresponding author, M.F.

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Author contributions

Conceptualisation: M.F., J.H.; data curation: M.F., OxWell; formal analysis: E.S. with preliminary analysis and the initial study code developed by D.N.; funding acquisition: M.F.; investigation: M.F., OxWell; methodology: M.F., E.S., D.N.; project administration: M.F., OxWell; writing – original draft: M.F.; writing – review and editing: M.F., J.H., E.S., M.P.

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Declaration of interest

None.

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