Australian Government

IAR-DST Domains - Adolescent Adaptation (12-17 yrs)

Domain 1 - Symptom severity and distress (Primary Domain)

Overview

This domain considers symptoms to include both internalised (emotional) problems experienced by the adolescent (e.g., anxiety and depressive symptoms) as well as externalised behaviours observable by or impacting on others (e.g., impulsive behaviours, perceived concerning or aggressive behaviours, appearing to ignore instructions from adults, seeming distracted or unable to concentrate).

Symptoms may be associated with distress, but this is not always the case and (for example) may present as somatic symptoms like headaches and stomach pain. Symptoms may indicate a particular diagnostic condition, but a diagnosis is not required for rating an individual on this domain, determining an appropriate level of care, or referring the person for mental health services.

Assessment of an adolescent on this domain should consider:

- Current and past symptoms and duration.
- Level of distress associated with the mental health issues.
- Previous experience of a mental health condition.
- Are symptoms improving/worsening, is distress improving/worsening, and are new symptoms emerging?

PRACTICE POINT – eating disorders

Eating disorders are mental illnesses accompanied by physical and mental health complications which may be severe and life-threatening. A person with an eating disorder can experience disturbances in behaviours, thoughts, and feelings towards body weight/shape or food and eating. A person with symptoms suggestive of an eating disorder requires a comprehensive eating disorders assessment and referral to appropriate services according to a person's needs.

IAR-DST users should be familiar with their local eating disorder screening and assessment pathway. Contact the GP or state/territory mental health services for care instructions in the absence of a defined local pathway. For more information about eating disorders, visit the National Eating Disorder Collaboration - https://nedc.com.au/eating-disorders/.

D1 Scoring

0 = No problem in this domain

1 = Mild Symptoms are likely to be sub-diagnostic and have been experienced for less than three months (but this may vary)

a. Mild anxiety-related symptoms (e.g., occasional fears, worry, difficulty concentrating, body image issues, occasional unexplained somatic symptoms like headache and stomach pain) without significant avoidant behaviour.

b. Mild mood-related symptoms (e.g., sadness, fatigue, apathy, some reluctance to participate in previously enjoyed activities, irritability, occasional disrupted sleep).

c. Mild behavioural symptoms (e.g., distractibility, overactivity, occasional difficulty completing tasks, quick to anger, occasional concerning or aggressive behaviours, occasionally appearing oppositional, minor interpersonal difficulties).

d. Currently experiencing a mental health condition associated with mild distress or mild reduction in quality of life.

2 = Moderate Symptoms are at a level that would likely meet diagnostic criteria and have been experienced for more than three months (but this may vary)

a. Moderate anxiety-related symptoms (e.g., excessive worry, agitation, panic, difficulty concentrating, significant self-consciousness or significant concerns about body image, appearance or weight, frequent unexplained somatic complaints) with significant avoidance of anxiety provoking situations.

b. Moderate mood-related symptoms (e.g., excessive sadness, apathy, exhaustion, frequent irritability, loss of interest and pleasure and/or frequent reluctance to participate in previously enjoyed activities, frequent sleep disturbance).

c. Moderate behavioural symptoms (e.g., frequent impulsivity, hyperactivity, non-adherence to age-appropriate rules or social norms, frequent concerning or aggressive behaviours, significant interpersonal difficulties).

d. Currently experiencing a mental health condition associated with moderate levels of distress and/or moderate reduction in quality of life.

e. History of a diagnosed mental health condition earlier in childhood that has not responded to treatment, with continuing symptoms but only associated with mild to moderate levels of distress.

3 = Severe

a. Severe anxiety-related symptoms are present most of the time, the adolescent has difficulty controlling or managing the symptoms and seeks to avoid anxiety provoking situations and/or experiences severe distress if asked to engage in anxiety provoking situations such that there is severe distress and/or significant disruption to the adolescent's (and/or parent/family's) life.

b. Severe mood-related symptoms are present most of the time, the adolescent has difficulty controlling or managing the symptoms and the symptoms are associated with severe distress and/or significant disruption to the adolescent's (and/or parent/family's) life.

c. Significant behavioural symptoms are present most of the time the adolescent has difficulty controlling or managing the symptoms and the symptoms are associated with severe disruption and/or distress for the adolescent, and/or their parent/family and interpersonal relationships.

d. Currently experiencing other severe mental health symptoms or severe psychological distress (e.g., complex trauma responses, obsessions, compulsions, severely disordered eating). Symptoms may be ongoing or of more recent or sudden onset.

e. Symptoms suggestive of an early form of a severe mental health condition (e.g., odd thinking/ behaviour/speech, abnormal perceptions, suspicious thinking, rapid mood swings, a substantial decrease in the need for sleep) or symptoms suggestive of an eating disorder.

f. Has been treated by a specialist community mental health service or admitted to hospital for a mental health condition in the previous 12-months.

4 = Very severe

a. Very severe and pervasive anxiety symptoms are present virtually all the time, the adolescent can rarely control or manage the symptoms and the adolescent refuses to engage in anxiety provoking situations or activities. The symptoms are associated with severe distress, significantly reduced quality of life and/or severe disruption to nearly all aspects of the adolescent's (and/or parent/family's) life.

b. Very severe and pervasive mood-related symptoms are present virtually all the time, and the adolescent can rarely control or manage the symptoms. The symptoms are associated with severe distress, significantly reduced quality of life and/or severe disruption to nearly all aspects of the adolescent's (and/or parent/family's) life.

c. Extreme behavioural symptoms are present virtually all the time, and the adolescent can rarely control or manage the symptoms. The symptoms are associated with severe distress, significantly reduced quality of life and/or severe disruption to nearly all aspects of the adolescent's (and/or parent/family's) life.

d. Currently experiencing very severe symptoms (e.g., disordered thinking, extreme mood variation, obsessions, compulsions, extreme avoidant behaviour, extreme interpersonal difficulties, extremely disordered eating with associated physical symptoms). Symptoms may be ongoing or of more recent or sudden onset.

e. Highly unusual and bizarre symptoms/behaviours indicating a severe mental illness (e.g., hallucinations, delusions). Symptoms may be ongoing or of more recent or sudden onset.

Domain 2 - Harm (Primary Domain)

Overview

This domain is focused on:

- Suicidality – current and past suicidal ideation, intent, planning, and attempts.
- Intentional, non-suicidal self-harm – current and past.
- Impulsive, dangerous, or risky behaviours with the potential for psychological or physical harm to self or others (consider and include risks associated with the use of alcohol and other drugs).
- The psychological or physical harm caused by abuse, exploitation, or neglect by others.
- Unintentional harm to self, arising from symptoms or self-neglect.

The IAR for adolescents includes the **harm from others** *in Domain 2 because there are direct implications for the intensity of mental health response an adolescent at risk of or experiencing harm from others is likely to require. Placing harm from others in another domain (e.g., Domain 6) does not carry the same weight within the logic that underpins the recommendations about a level of care. Note that the presence of external stressors (e.g., family violence) is rated at Domain 6, but the degree of harm arising from those stressors is rated separately at Domain 2.*

PRACTICE POINT - Evaluating harm associated with suicidal thoughts, impulses, or behaviours

This domain must be considered in the context of information gathered across the other seven domains. Information gathered across the other seven domains (e.g., severe symptoms, impulsivity, use of substances, environmental stressors, recent changes, degree of engagement with helping resources) is especially important when evaluating harm.

The IAR-DST is not a suicide risk assessment or risk formulation tool. If an individual expresses suicidal thoughts or impulses or displays suicidal behaviours, a risk formulation compatible with local or state-based protocols (e.g., Towards Zero, Connecting with People) is indicated.

A risk formulation generally involves:

Determining risk status by considering static factors such as a history of psychiatric illness, family history of suicide, history of abuse, and history of suicidal behaviour.

Exploring risk state by considering recent suicidal behaviours, current symptoms and stressors, and engagement with helping resources. Comparing the current risk state to the person's "baseline" and "worst-point" states. Exploring the risk state includes building an understanding of the:

- Nature of the suicidal thoughts (frequency, intensity, speed of onset, persistence, intrusiveness)
- Perception of the future (hope, alternatives to suicide)
- Degree of planning
- Degree of preparation
- Ability to resist thoughts of suicide

Considering the **resources available** to the person and **foreseeable changes** that might exacerbate risk, a **suicide risk formulation may need to happen urgently**. If this is the case, refer to localised urgent assessment and care pathways.

PRACTICE POINT - Safety Planning

If indicated, a safety plan can be an important resource to develop with a patient. There are templates and guidance for developing a safety plan available online from mental health service providers and systems.

PRACTICE POINT - assessment of adolescents with a suicide attempt history but no current suicidal indicators

While any history of a suicide attempt is a risk factor for a subsequent attempt, several factors elevate this risk. These factors include:

1. When the previous suicide attempt occurred: the risk of re-attempting suicide remains high throughout a person's life but is particularly high in the 12-months following an attempt.

2. The lethality of the previous attempt: the method, medical seriousness, rescuability, and physical consequences of the attempt all contribute to assessing potential lethality. A previous attempt with higher lethality is associated with an increased risk of a subsequent attempt.

3. Post-attempt aftercare services: a person's participation in high-quality post-attempt aftercare services is associated with a decreased risk of a subsequent suicide attempt.

The factors contributing to a person attempting or dying by suicide are complex and highly variable. A previous suicide attempt is considered a risk factor – however, some people who attempt suicide may never again experience suicidal thinking or behaviours.

An adolescent who has previously attempted suicide is rated at minimum as a 2 (moderate risk) on this domain - or higher if there are current suicidal behaviours. A rating of 2 on Domain 2 is aligned with Level 3 care and above. This rating will help to ensure a comprehensive mental health assessment is made available (a core feature of all Level 3 services). Following a comprehensive mental health assessment, the clinician can consider the suitability of lower-intensity interventions (Level 1/Level 2).

PRACTICE POINT - Mandatory reporting

Mandatory reporting laws aim to identify adolescents at risk, including abuse and neglect incidents, and protect the individual adolescents involved. The laws require selected groups of people to report suspected child abuse and neglect to government authorities. Laws exist in all Australian jurisdictions. However, the laws are not the same across all jurisdictions. Differences exist in who must report, the nature of risks and incidents that must be reported, and to whom the report is made.

It is important to note that any person is lawfully entitled to make a report if they are concerned for an adolescent's welfare, even if they are not required to do so as a mandatory reporter.

Users of the IAR-DST should be familiar with signs of abuse and neglect and their legal responsibilities regarding mandatory reporting. Visit: the Australian Institute for Family Studies for more information: https://aifs.gov.au/cfca/publications/mandatory-reporting-child-abuse-and-neglect or seek advice from your professional indemnity insurer or professional association.

D2 Scoring

0 = No concerns about harm

1 = Previous but no current concerns about harm

a. No current suicidal ideation, but the adolescent has experienced suicidal ideation, plans, or intent in the past. Demonstrates future-oriented thinking and has strong protective factors.

b. Occasional non-suicidal self-injurious acts in the recent past and not requiring any medical treatment.

c. May have engaged in past behaviours that posed a risk to self or others, but no current or recent instances.

d. Currently at low risk of harm from abuse, exploitation, or neglect by others.

2 = Some current concerns about harm

a. Current suicidal ideation, without plan or intent but may have had plans, intent, or suicide attempts in the past. Demonstrates future-orientated thinking and has strong protective factors or previous suicide attempt (longer than 12 months ago) but no current ideation, intent, or plan.

b. Frequent non-suicidal self-injurious acts in the recent past that did not require any medical treatment.

c. Current or recent behaviours that pose a non-life-threatening risk to self or others.

d. Currently at some risk of harm from abuse, exploitation, or neglect by others.

e. Intermittent lapses in self-care that may lead to harm.

3 = Significant current concerns about harm

a. Current suicidal ideation with a plan, but no current intent or a strong reluctance to carry out a plan. May have a history of suicide attempts. Strong protective factors and a commitment to engage in a safety plan, including the involvement of family, significant others, or services.

b. Recent suicide attempt (within past 12 months) but no current ideation, intent, or plan.

c. Frequent non-suicidal self-injurious acts in the recent past and requiring medical treatment.

d. Recent or current impulsive, dangerous, or risky behaviours that pose a risk of harm to self or others, or that have had or are likely to have a serious negative impact.

e. Serious medical risks and/or complications associated with a mental illness.

f. Significant risk of, or recent experience of, abuse, exploitation, or neglect by others.

g. Clearly compromised self-care ability that is ongoing to the extent that indirect or unintentional harm to self is likely.

4 = Very significant current concerns about harm*

a. Current suicidal ideation with intent, typically with a plan and means to carry out the plan or history of previous suicide attempt. Few or no protective factors. Limited or no future-orientated thinking.

b. History of life-threatening self-injurious acts that are prominent in the current presentation.

c. There is evidence of current severe symptoms (e.g., hallucinations, avoidant behaviour, paranoia, disordered thinking, delusions, impulsivity) with behaviour that is likely to present an imminent or unpredictable danger to self or others.

d. Extremely compromised self-care ability to the extent that there is a real and present danger of the adolescent experiencing harm related to these deficits.

e. Life-threatening medical risks and/or complications associated with a mental illness.

f. Other signs or indicators of imminent risk of serious harm to themselves or others.

Domain 3 - Functioning (Primary Domain)

Overview

This domain considers functional impairment caused by or exacerbated by mental health issues. While some types of disabilities being experienced by the adolescent may play a role in determining what types of support services may be required, they should generally not be considered in determining mental health service **intensity** within a stepped care continuum.

Assessment of an adolescent on this domain should consider the impact of the mental health issues on:

- The adolescents' ability to fulfil usual roles/responsibilities appropriate to their age, developmental level, and cultural background.
- The adolescent's functioning within the family or home environment, in educational or vocational settings, with friends and peers, and in the community.
- The adolescent's ability to undertake basic activities of daily living appropriate to their age and developmental level (e.g., self-care, mobility, toileting, feeding, and personal hygiene).

D3 Scoring

0 = No problem in this domain

1 = Mild impact

a. Mildly diminished ability to function in one or more of their usual roles (e.g., at home, in educational settings, with friends and peers, at play and in the community), but without significant or adverse consequences.

b. Mental health issues contribute to brief and transient disruptions in one or more areas of functioning.

2 = Moderate impact

a. Moderate functional impairment in more than one of their usual roles (e.g., at home, in educational settings, with friends and peers, at play and in the community) to the extent that they are frequently unable to meet the requirements of those roles, but without significant adverse consequences.

b. Mental health issues contribute to occasional difficulties with basic activities of daily living (e.g., eating, mobility, bathing, getting dressed, and toileting) or instrumental activities of daily living (e.g., preparing food, tidying up, completing tasks) but without threat to health.

3 = Severe impact

a. Significant difficulties with functioning, resulting in disruption to many areas of the adolescent's life most of the time (e.g., limited participation in educational or vocational activities, deterioration in or some withdrawal from the community or relationships with friends and peers), but the adolescent can function independently with adequate treatment, family, and community support.

b. Mental health issues frequently contribute to difficulties with basic activities of daily living (e.g., eating, mobility, bathing, getting dressed, and toileting) or instrumental activities of daily living (e.g., preparing food, tidying up, completing tasks) on a consistent basis but without threat to health.

4 = Very severe to extreme impact

a. Profound difficulties with functioning, resulting in significant disruption to virtually all areas of the adolescent's life (e.g., unable to participate in educational, social, or vocational activities, complete withdrawal from community, friends, and peers).

b. Mental health issues contribute to severe and persistent self-neglect that poses a threat to health.

Domain 4 - Impact of co-existing conditions (Primary Domain)

Overview

Increasingly, individuals are experiencing and managing multi-morbidity (coexistence of multiple conditions, including chronic disease).

This domain considers the extent to which other conditions contribute to (or have the potential to contribute to) increased severity of the mental health issue or compromise the adolescent's ability to participate in the recommended services and support.

Assessment of an adolescent on this domain should consider the presence, and impact of, three possible coexisting conditions:

- Physical health conditions.
- Cognitive impairment, intellectual disability, developmental delay, neurological conditions, or learning and communication disorders.
- Substance use.
- Where the adolescent has more than one of the coexisting conditions, consider the condition which has the most impact.

PRACTICE POINT – Definitions of cognitive impairment, intellectual disability, neurological condition, and learning and communication disorders

The terms cognitive impairment, intellectual disability, neurological condition, and learning and communication disorders have no universally agreed definitions. For this Guidance, the below definitions will apply:

Cognitive impairment – A description of a person's current functioning regarding learning, communication, attention, memory, thinking and problem-solving. Cognitive impairment can be temporary, permanent, mild, moderate, or severe. Cognitive impairment can affect the person's understanding and how they relate to others and interpret the environment.

Intellectual disability – A disability characterised by significant intellectual functioning and adaptive behaviour limitations, covering many everyday social and practical skills. This disability originates before the age of 18. Genetic factors cause most intellectual disabilities. However, there are other causes of intellectual disabilities, such as brain injury or being born prematurely.

Neurological condition – Neurological conditions affect the brain, spinal cord, and the nerves that connect them. There are more than 600 nervous system diseases (e.g., epilepsy, motor neurone disease, traumatic brain injury, multiple sclerosis).

Learning and communication disorders – learning and communication disorders may affect how a person comprehends, recalls, understands, or expresses information. These disorders are often dynamic and can improve over time. The impairment caused by these disorders might be minimal or significant and vary from person to person.

D4 Scoring

0 = No problem in this domain

1 = Minor impact

a. Physical health condition(s) present but are stable and have no or a minimal impact on the adolescent's mental health.

b. Cognitive impairment, intellectual disability, developmental delay, neurological condition, or learning and communication disorder present but has no or minimal impact on the adolescent's mental health.

c. Recent episodes of substance use are limited, are not currently causing any concerns, and do not impact the adolescent's mental health.

2 = Moderate impact

a. Physical health condition(s) present and moderately impacts the adolescent's mental health.

b. Cognitive impairment, intellectual disability, developmental delay, neurological condition, or learning and communication disorder and moderately impacts, or has the potential to moderately impact the mental health of the adolescent.

c. Occasional substance use impacts on, or has the potential to impact on, the adolescent's mental health.

d. Non prescribed use of prescription medications impacts on, or has the potential to impact on, the adolescent's mental health.

3 = Severe impact

a. Physical health condition(s) present, which requires intensive medical monitoring and severely impacts the adolescent's mental health (e.g., worsened symptoms, heightened distress).

b. Cognitive impairment, intellectual disability, developmental delay, neurological condition, or learning and communication disorder present and severely impacts the adolescent's mental health.

c. Frequent substance use threatens health and wellbeing or represents a barrier to mental health-related recovery.

d. Non prescribed use of prescription medications significantly impacts the adolescent's mental health or presents a barrier to mental health-related recovery.

e. Occasional use of high or extreme risk substances. (e.g., substances with a high risk of adverse outcomes such as injury, loss of life, criminal charges and/or use of injection drugs which have a high risk of infection of blood-borne diseases).

4 = Very severe impact

a. One or more significant physical health conditions exist that are poorly managed or life-threatening and in the context of a concurrent mental health condition.

b. Cognitive impairment, intellectual disability, developmental delay, neurological condition, or learning and communication disorder present and very severely impacts the adolescent's mental health.

c. Regular and uncontrolled substance use.

d. Regular and uncontrolled non-prescribed use of prescribed medications that has the potential to threaten health and well-being.

e. Frequent use of high or extreme risk substances (i.e., substances with a high risk of adverse outcomes such as injury, loss of life, criminal charges and/or use of injection drugs which have a high risk of infection of blood-borne diseases).

Domain 5 - Service use and response history (Contextual Domain)

Overview

This domain considers the adolescent and their family's previous use of services and support focussed on mental health-related assistance. The initial assessment on this domain should consider:

- Whether the adolescent or their family has previously sought help from or required mental health services and related supports (including specialist or mental health inpatient services).
- Their progress or benefit from past services and support.

Definition of the term services and support - Relevant services and support refer to safe, developmentally, and culturally appropriate evidence-informed mental health, health or community services focussed on or relevant to the adolescent's mental health (such as a psychological service delivered by a GP or mental health professional or other behavioural services) rather than the personal supports provided by friends, family, or social networks.

Consider both the adolescent and their family's use of previous services and support but do not include those services and support relevant to, but not focused on, the adolescent's mental health.

D5 Scoring

0 = No previous service use

a. Has not previously sought help or required a referral for mental health issues.

1 = Excellent progress from previous service use

a. Previously accessed services for a mental health issue and experienced a significant benefit resulting in no need for additional services at that time.

2 = Moderate progress from previous service use

a. Previously accessed services and experienced a moderate benefit and required some additional services (either ongoing or periodically) to maintain the benefit.

3 = Minor progress from previous service use

a. Previously accessed services with only minor benefits resulting in a need for additional services or longer duration of services.

4 = Negligible or no progress from previous service use

a. Previously accessed services with little or no benefit.

Domain 6 - Social and environmental stressors (Contextual Domain)

Overview

This domain considers the extent and severity of a range of factors in the adolescent's environment that might contribute to the onset or continuation of the mental health issue. Significant environmental stressors and adversity can lead to increased symptom severity and compromise the capacity of the adolescent and their family to participate in or benefit from the recommended resources or services. Furthermore, understanding the complexities the adolescent is experiencing (or has experienced) may alter the type of service offered or indicate that additional service referrals are required (e.g., a referral to a social support service).

Assessment on this domain should consider the degree to which any or all of the following factors are relevant to the adolescent's current circumstances and the referral decision:

- Significant losses (e.g., loss of friends or social connections, death of a loved one).
- Significant transitions (e.g., disruption to educational activities, parental separation/divorce, death of a loved one, transitions relating to gender identity or sexual orientation).
- Peer group stress (e.g., bullying, conflict with or isolation from the peer group, loss of friendships).
- Trauma (e.g., emotional, physical, psychological, or sexual abuse, exploitation, witnessing or being a victim of violence, family and domestic violence, natural disaster, exposure to suicide in family/community/school or peer group, loss, conflict).
- Victimisation (e.g., human rights abuses, discrimination, racial abuse, victim of crime, refugee, or asylum-seeking experiences).
- Family or household stress (e.g., household drug or alcohol abuse, the parent or family member with an illness or disability, carer stress or stress associated with a caregiver role).
- Performance-related pressure (e.g., unrealistic role expectations or responsibilities, schooling demands, caregiving responsibilities) and stressors related to high-performance demands in school, dance, sport, and other relevant extra-curricular activities.
- Socioeconomic disadvantage (e.g., poverty, parental unemployment, unstable or insecure housing).
- Legal issues (e.g., the juvenile justice system or family court involvement, enforced separation from family)

Evidence points to the contribution made by historical childhood adverse events to longer-term mental health development. Assessment on this domain should consider the adolescent's history but only record higher ratings where earlier experiences impact the current situation and require additional specific resources and services.

PRACTICE POINT - childhood experiences of trauma

Adverse Childhood Experiences (ACEs) are stressful events or circumstances that people may experience throughout their childhood. They may relate to childhood physical, sexual, or emotional abuse, physical or emotional neglect, exposure to family violence, parental substance use, parental mental illness, parental separation or divorce, or parental incarceration.

A summary of the evidence and impacts by Emerging Minds reiterates that:

"Exposure to ACEs does not mean poor outcomes are inevitable. If present and reinforced in a child's life, there are known protective factors that can build the child's resilience and reduce the impacts of adversity. Nurturing relationships form the basis of healthy brain development, effective early learning, and a child's capacity to positively respond and adapt to life challenges. Many adults who experienced significant adversity in their childhood have had successful lives and happy relationships" – (*Marie-Mitchell & Kostolansky, 2019; Traub & Boynton-Jarrett, 2017*).

How a person responds to trauma is highly variable, and many individuals who have been exposed to ACEs will not require a mental health service. Immediate assignment of a level of care based on the experience of trauma alone is problematic and should be avoided. The ACEs study demonstrated a strong relationship between a person's exposure to ACEs and their physical and mental health throughout their lives. Researchers have established a dose-response association for ACEs – for instance, four or more ACEs are associated with an increased risk of adverse impacts

PRACTICE POINT - bullying (online and in-person)

Bullying can impact the mental health of adolescents. Adolescents who experience bullying can experience feelings like shame, fear, embarrassment, anger, and worry. There is a marked increase in the risk of poor mental health outcomes, self-harm and suicidal ideation and behaviours among people who experience bullying, particularly if the experience of bullying is severe or prolonged.

Bullying, whilst common, is not a normal part of growing up, and an initial assessment with an adolescent should explore the adolescent's experience of bullying and the impacts of these experiences.

Bullying should be considered in the context of social and environmental stressors (domain 6). The impacts of bullying on the adolescent (if present) will be captured in symptom severity and distress (domain 1), harm (domain 2), and functioning (domain 3).

When considering the level of care, consideration should be given to the informal supports that an adolescent might require outside the formal mental health system- social, school, family and community supports are generally important for adolescents experiencing bullying.

D6 Scoring

0 = No problem in this domain

1 = Mildly stressful environment

a. The adolescent is experiencing (or has experienced) one or more stressors that are currently having or are likely to have only a minor impact on the adolescent's mental health.

2 = Moderately stressful environment

a. The adolescent is experiencing (or has experienced) one or more stressors that are currently having or are likely to have a moderate impact on the adolescent's mental health.

3 = Highly stressful environment

a. The adolescent is experiencing (or has experienced) one or more stressors that are currently having or are likely to have a significant impact on the adolescent's mental health.

4 = Extremely stressful environment

a. The adolescent is experiencing (or has experienced) one or more stressors that are extreme, enduring, or recurring and are currently having, or are likely to have, a severe impact on the adolescent's mental health.

Domain 7 - Family and other supports (Contextual Domain)

Overview

This domain considers whether personal supports, including emotionally nurturing relationships, practical support, and social support are present in the child's environment and their potential to contribute to improved mental health.

This domain does not include or consider professional support. Personal supports include:

- Family/primary caregivers.
- Friends and peers.
- Supports within the school environment.
- Supports within the community (e.g., cultural connections, elders, spiritual leaders, sporting groups, neighbours etc.).

Personal supports may be present, but unable to provide the needed support at the time. There are a range of factors that may impact on whether personal supports are able to be provided, such as competing caring responsibilities, a lack of access to respite or other supports, financial or practical constraints, additional skill development requirements, or illness or distress in family or primary caregivers. It is important to avoid blame or judgement of personal supports when exploring this domain.

Where appropriate, a mental health assessment and intervention for the support person (or family as a whole) should be considered.

D7 Scoring

0 = Highly supported

a. There are family/primary caregivers and other personal supports available that are highly supportive, willing, and capable to meet the child's developmental, emotional, practical, and social needs.

1 = Well supported

a. There are a few family/primary caregivers and other personal supports available that are supportive, willing, and capable of meeting the child's developmental, emotional, practical, and social needs.

2 = Limited supports

a. There are a few family/primary caregivers available to provide support, but their willingness to provide support is variable or difficult to access, or the sources of support have insufficient resources or capabilities to meet the child's developmental, emotional, practical, and social needs whenever it is needed, or the child is reluctant to utilise the available supports.

b. Other personal supports are available for the child but only partially compensate for needs not met within the family.

3 = Minimal supports

a. Very few actual or potential useful sources of support are available, willing, and capable of meeting the adolescent's developmental, emotional, practical, and social needs.

b. There are serious limitations in the capacity or availability of supports outside the family, so that developmental, emotional, practical, or social needs are mostly unmet.

4 = No supports

a. No useful sources of support are available, and developmental, emotional, practical, and/or social needs are mostly unmet.

b. The adolescent has no access to other supports that could compensate for needs not met within the family.

Domain 8 - Engagement and motivation (Contextual Domain)

Overview

This domain considers the adolescent or their parent/caregiver's awareness of the mental health issue and their motivation to engage in or accept assistance.

Many adolescents do not have the agency or resources required to seek and access services and support independently. Therefore, the engagement and motivation of the parent/caregiver is the primary determinant of access and uptake, and the parent/caregiver sub-scale is used. Whilst the parent/caregiver sub-scale rates the engagement and motivation of the parent/caregivers, the adolescent should be included in discussions, using language they understand, and supported to express their choices, preferences, fears, and goals about referral next steps.

The parent/caregiver sub-scale is used when the adolescent cannot exercise decision-making control of their healthcare decisions. The parent/caregiver sub-scale considers:

- Ability and capacity to support the adolescent to manage the condition.
- The parent/caregiver's motivation to assist the adolescent to access necessary support (critical if considering self-management options).

Conversely, where the adolescent can exercise decision-making control of their healthcare decisions, the adolescent's engagement and motivation take precedence (adolescent sub-scale). The adolescent sub-scale considers:

- The adolescent's motivation to participate in the recommended services and support.

PRACTICE POINT - Checking in when engagement or motivation is low

A follow-up check-in helps determine if the recommended information, resources, or services are being utilised and perceived as helpful. Proactively "checking in" or encouraging the adolescent and parent/caregiver to "check back" is essential when engagement or motivation is low. A plan for check-in should be made at the point of referral and documented.

The check-in should explore the following questions:

1. Is the adolescent engaging with the recommended information, resources, and services? If the adolescent is not engaging, it is essential to re-examine motivation and explore reasons for the lack of engagement.
2. Does the adolescent think that the recommended information, resources, and services are/were helpful?
3. Is there evidence of deterioration or changing risk of suicide or harm to self or others?

4. Is the adolescent experiencing new or worsening social and environmental stressors?

5. Discuss and document the next steps in collaboration with the adolescent. The next steps might include:
    - Continue existing service arrangements
    - Build in additional supports
    - Initiate a referral to a different level of care

PRACTICE POINT - informed consent

Clinicians have legal and ethical obligations to obtain informed consent before performing any healthcare intervention. To give informed consent, a person (or the person making decisions for them if they cannot make decisions for themselves) should be sufficiently informed of the risks and benefits of any treatment (including, where relevant, the risk associated with no treatment).

The process of gaining consent for the treatment of children and adolescents (under the age of 18) differs significantly from that of adults and is more complex and varied. In some instances, consent must be given by the relevant parent or guardian, whereas in others, it may be possible for a person under 18 who is a 'mature minor' to give consent. A mature minor is a child or adolescent assessed as having the capacity to make specific decisions based on various factors, including the nature of the treatment, age, maturity, medical/social history, degree of independence, understanding, and intelligence. If a child or adolescent is a mature minor, consent for treatment is not required from a parent or guardian.

Depending on the circumstances, involvement of both the parent/guardian and a child/adolescent in providing consent for assessment, referral and intervention can be preferable.

Where, on balance, the risk of engagement of the parent will lead to a potential negative impact on the child or adolescent, consideration may need to be given to the involvement of an alternative guardian if the child or adolescent is not a mature minor and cannot make treatment decisions for themselves.

Some states or territories have specific legislation governing the informed consent of children and adolescents in healthcare. It is the responsibility of all healthcare providers to know and understand their legal obligations in whichever state or territory they are practising. For further information, consult your state/territory legislation and/or consult your professional indemnity insurer or professional association.

D8 Scoring

PARENT/CAREGIVER SUB-SCALE

Use the parent sub-scale where the adolescent cannot exercise decision-making control of their healthcare decisions.

0 = Optimal

a. The parent/caregiver is motivated and capable of participating fully in the recommended services and supports.

b. The parent/caregiver is capable of taking an active role in supporting the adolescent to manage the condition.

1 = Positive

a. The parent/caregiver is mostly willing to accept and participate in the recommended services and support.

b. The parent/caregiver can mostly take an active role in supporting the adolescent to manage the condition.

2 = Limited or mixed

a. The parent/caregiver is unsure whether they will accept or participate in the recommended services and supports or has limited capacity to do so.

b. There is significant divergence between the parents/caregivers in the level of engagement, motivation, or ability to participate in the recommended services and supports.

3 = Minimal

a. The parent/caregiver cannot participate in the recommended services and support without considerable practical or emotional assistance.

b. Despite the adolescent requiring them, the parent/caregiver has not facilitated access to services and supports in the past due to low engagement or motivation.

4 = Disengaged

a. The parent/caregiver cannot support participation in services and supports or avoids potentially useful and available supports.

ADOLESCENT SUB-SCALE

Use the adolescent sub-scale where the adolescent can exercise decision-making control of their healthcare decisions. In most instances, when working with a mature minor (see Informed Consent Practice Point), the use of the adolescent sub-scale will be appropriate.

0 = Optimal

a. The adolescent is motivated to participate in the recommended services and support.

b. The adolescent is capable of taking an active role in managing the condition.

1 = Positive

a. The adolescent is mostly willing to accept and participate in the recommended services and support.

b. The adolescent can mostly take an active role in managing the condition.

2 = Limited

a. The adolescent is hesitant to accept and participate in the recommended services and support.

3 = Minimal

a. The adolescent is very reluctant to accept or participate in services and support.

b. The adolescent has not participated in services and support in the past, despite requiring them, due to low levels of engagement or motivation.

4 = Disengaged

a. The adolescent refuses to accept or participate in the recommended services and support.