Government of **Western Australia**
Child and Adolescent Health Service

Personality Disorder in Young People:

Recognition and Management

Evidence-based Framework

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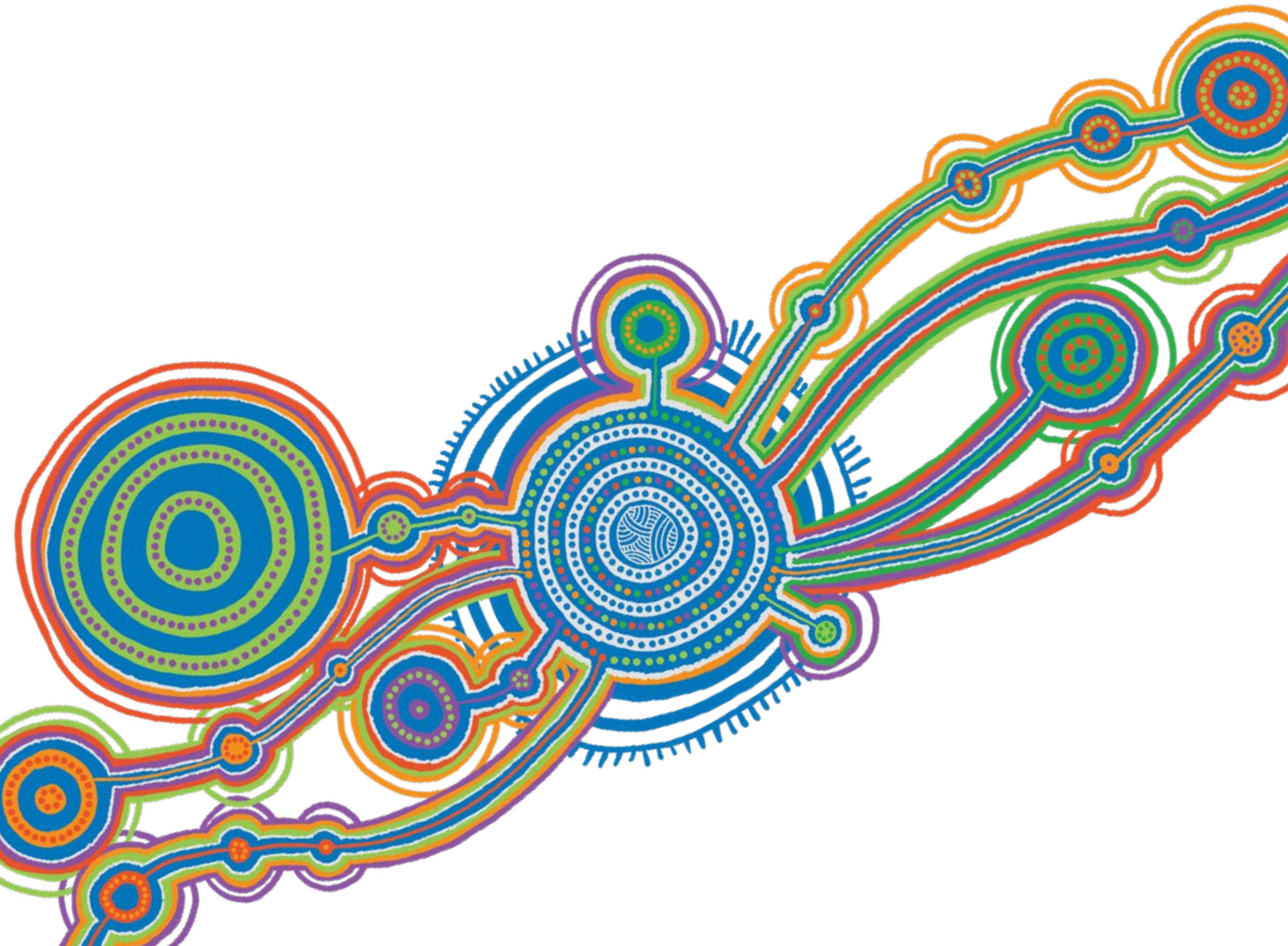

Acknowledgement of Country

The Child and Adolescent Health Service (CAHS) acknowledges the Whadjuk and Binjareb people of the Noongar Nation as the Traditional Custodians of the land, sea and waters on which we work and live. We pay our respects to the Elders past and present.

Aboriginal people, as the First Peoples, have cared for this land for at least 65,000 years. We recognise and value their continuing cultural and spiritual connections to this land. CAHS acknowledges the diversity of Aboriginal people from across Western Australia who access the health services provided within CAHS.

CAHS recognises that the colonisation of this Country has come at a great cost to Aboriginal peoples and communities and the continued effects of colonisation impact on health and wellbeing today. We pay tribute to the strength, resilience, and courage of Aboriginal people who have survived the devastation of the recent past, to stand strong and proud today.

CAHS is committed to working towards a better future, where all cultures are respected and valued, and Aboriginal people take their rightful place as the First Australians.

Using the term Aboriginal

Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander in recognition that Aboriginal people are the original inhabitants of Western Australia. Aboriginal and Torres Strait Islander may be referred to in the national context, and Indigenous may be referred to in the international context. No disrespect is intended to our Torres Strait Islander colleagues and community.



Foreword

It is my privilege, as Chair of the Child and Adolescent Mental Health Services (CAMHS) Framework for Personality Disorder (PD) Development Group, to introduce this framework, an important milestone in strengthening the care and support provided to young people with PD.

Over the past twelve months, this framework has been informed by extensive evidence review, expert consultation and collaborative refinement. It represents a significant step forward in how our health system understands, responds to and supports young people with PD, their families and carers.

This framework establishes a clear and contemporary foundation for practice, grounded in hope, recovery, compassion, family-centred care and shared responsibility. It reflects our collective commitment to ensuring that young people with PD are recognised, understood and supported with dignity and respect. It also acknowledges that high-quality care requires a coordinated whole-of-system response, underpinned by evidence, clinical expertise and a commitment to continuous improvement.

Personality disorder is everybody's business.

This principle sits at the heart of this framework and reinforces the shared responsibility of services and clinicians to provide compassionate, evidence-informed and responsive care for young people with PD, their families and carers.

I extend my sincere thanks to the members of the Expert Panel, whose collective expertise brought together perspectives from across Australia, including those of clinicians and people with lived and living experience. Their generosity in sharing their knowledge and experience has strengthened this framework and ensured its relevance to contemporary clinical practice.

I also acknowledge the invaluable contributions of people with lived and living experience. Their insights have helped ensure that this framework remains person-centred, clinically meaningful and grounded in the realities of young people, their families and carers.

I would like to acknowledge Laura Dondzilo, Simarleen Kaur, Monique Du Toit and Elizabeth Swann, whose contributions were instrumental to the completion of this framework. Laura coordinated the project, overseeing the drafting process and ensuring the work progressed through consultation, review and refinement. Simarleen, Monique and Elizabeth made substantial contributions to drafting, developing and refining the content. Together, their diligence, organisation and commitment were central to this framework's successful completion.

Finally, I extend my appreciation to all stakeholders who contributed through the consultation process, including colleagues across CAMHS and external agencies. The breadth and quality of this engagement reflect a collective commitment to improving the care and support provided to young people with PD. This framework is the result of the expertise, generosity and dedication of many individuals and organisations. I hope that this framework provides an enduring foundation for a consistent, compassionate and recovery-oriented approach to the care of young people with PD, their families and carers.

A/Prof Vineet Padmanabhan

Chair, CAMHS Framework for Personality Disorder Development Group
Director Clinical Services, CAHS CAMHS

Authors

A/Prof Vineet Padmanabhan

BSc, MBBS, MRCPsych, FRANZCP, CCT (Child and Adolescent Psychiatry)
Consultant Child and Adolescent Psychiatrist and Director Clinical Services, CAMHS-CAHS; Adjunct Associate Professor, UWA Medical School, University of Western Australia.

Dr Laura Dondzilo

BSc (Hons), PhD
Research Manager, CAMHS; Adjunct Research Fellow, School of Psychological Science, University of Western Australia.

Simarleen Kaur

BSc (Hons), M Psych (Clinical)
Senior Research Psychologist, CAMHS; Clinical Psychologist Registrar.

Monique Du Toit

BSc (Psychology and Neuroscience), BSc (Hons) Psychology, PhD Candidate
Research Officer, CAMHS.

Dr Elizabeth Swann

BSc BA (Hons), MPsych (Clin), MHA, PhD
Consultant Clinical Psychologist, CAMHS.

Expert panel

Prof Andrew Chanen

MBBS (Hons), BMedSci (Hons), MPM, PhD, FRANZCP

Chief of Clinical Practice and Head of Personality Disorder Research, Orygen; Chief of Clinical Practice, PYMHWS.

A/Prof Sathya Rao

OAM, MBBS, DPM, Dip NB (Psychiatry), MD (Psych Medicine), FRANZCP

Executive Clinical Director of Spectrum; Consultant Psychiatrist.

Dr Julian Nesci

BA (Psychology), PGDip (Psychology), DPsych (Clinical)

Clinical Specialist, Spectrum; Adjunct Senior Lecturer, Monash University; Clinical Psychologist.

Dr Michael Daubney

MBBS, FRANZCP, Cert Child & Adolescent Psychiatry

Child and Adolescent Psychiatrist; Medical Director, Statewide Community AET Programs; Child and Youth Mental Health Service, Children's Health Queensland.

Adj A/Prof Michael Bowden

BMed, PhD, FRANZCP, Cert Child and Adol Psych, GAICD

Senior Clinical Adviser, Child and Youth Mental Health at NSW Health; Senior Child and Adolescent Psychiatrist.

Alison Parkinson

Lived Experience Coordinator, CAMHS; Carer Peer Lived Experience Representative.

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Introduction



Context

Research into PD in young people has grown substantially over the past decade, with mounting evidence now supporting both the validity and reliability of diagnosis during adolescence (Hutsebaut et al., 2023). This shift in the evidence base has important implications for service delivery. PD is not a rare presentation, with prevalence estimated at 7.8% globally (Winsper et al., 2020). Severe PD occurs in around 3% of young people in the community and around one fifth of those attending tertiary youth mental health services (Chanen, 2023).

PD is associated with elevated mortality rates, including significant risk of self-harm and suicide (Guilé et al., 2018). Among adolescents presenting to emergency departments following a suicide attempt, Greenfield et al. (2008) found that 68% met criteria for PD. Active suicidal ideation is reported in 59% of adolescents with PD, and non-suicidal self-injury (NSSI) in 58% (Knafo et al., 2015). Clinical studies also consistently report a higher frequency of suicide attempts among adolescents with PD than among those without (Knafo et al., 2015; Sharp et al., 2012; Yen et al., 2013).

Beyond this, PD affects functioning across many areas of a young person's life. Compared with both their peers and young people with other mental health conditions, young people with PD experience greater impairment in interpersonal, educational and occupational functioning (Barkauskienė et al., 2026). These difficulties frequently extend well beyond adolescence. PD in adolescence predicts poorer educational, vocational, interpersonal and financial outcomes in later life, even where symptoms have remitted (Hastrup et al., 2020; Winsper et al., 2016). Young people with PD also report the lowest quality of life of any similar-aged health condition, including psychosis and cancer, and their families experience significantly high levels of distress (Chanen, 2023).

PD is also associated with a substantial economic burden. By age 20, young people with PD incur health care costs more than eight times higher than comparable young people without PD (Hastrup et al., 2019), and those who seek treatment have considerably higher health care costs than young people with depression or generalised anxiety (Project Air Strategy for Personality Disorders, 2026). These costs persist into adulthood (Sveen et al., 2023; Wagner et al., 2021) and contribute to the broader economic impact of mental illness, which accounts for billions of dollars in lost work productivity each year (Project Air Strategy for Personality Disorders, 2026). Together, these risks and costs highlight the importance of prioritising effective early intervention for PD.

Despite this, translation of contemporary evidence into clinical practice has been slow, and many clinicians remain hesitant to diagnose or actively work with young people presenting with PD (Hutsebaut et al., 2023). This hesitancy carries real consequences, as difficulties left unaddressed often become more entrenched and harder to treat in adulthood (Hutsebaut et al., 2023). Intervening early, rather than waiting for difficulties to become entrenched, offers the strongest opportunity to change this trajectory (Chanen et al., 2022). Yet, existing youth mental health services are frequently not equipped to recognise or respond to PD appropriately, leaving many young people without access to timely, suitable care (Hutsebaut et al., 2023).

Addressing this gap is also an opportunity to change how PD is understood and treated more broadly. Other areas of health care have shown that when detection and treatment improve, conditions once considered untreatable or heavily stigmatised can be reframed. There is growing evidence that the same is possible for PD (Hutsebaut et al., 2023). Achieving this will require a deliberate change in clinical culture, one that challenges outdated assumptions, addresses stigma directly, and closes the gap between what research has shown and what young people experience in services (Chanen, 2023).

The need to better recognise and respond to PD in young people has also been identified as a priority within Western Australia (WA), including by the WA Chief Psychiatrist (Office of the Chief Psychiatrist, 2020) and the Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0–18 years in WA (Mental Health Commission, 2022). In response, Child and Adolescent Health Service (CAHS) Child and Adolescent Mental Health Services (CAMHS) initiated a program of work to strengthen the management of PD.

As an initial step, a review of existing guidelines for the management of PD and self-harm in adolescence was undertaken (Louise et al., 2026). Existing guidelines largely converged on their core recommendations, including structured clinical assessment, family and carer involvement, psychoeducation, psychotherapy as the primary treatment, and, if required, short-term medication. However, existing guidance was not readily transferable to local CAMHS settings or the complexity of presentations CAMHS manages, and therefore a more flexible staged model of care is warranted. In addition to the limited transferability of existing guidelines, recent evidence suggests that the development of child and adolescent PD clinical guidance has generally not adhered to rigorous development standards (McKinlay et al., 2026). Taken together, these findings highlighted the need to develop high-quality clinical guidance that is feasible for implementation within relevant youth mental health services.

Purpose

CAMHS developed this framework to provide best practice guidance for the management of PD in young people aged 12 to 18 years across relevant services and settings. Central to this framework is the understanding that PD is not the fault of the young person and can be treated effectively; young people can and do recover, going on to lead productive and fulfilling lives. This framework guides service delivery, clinical practice, workforce capability and continuous improvement.

> ***Young people with PD have the "lowest published quality of life scores of any similar-aged 'disease group' (e.g. psychosis or cancers).***
>
> — Chanen, 2023

Intended Users

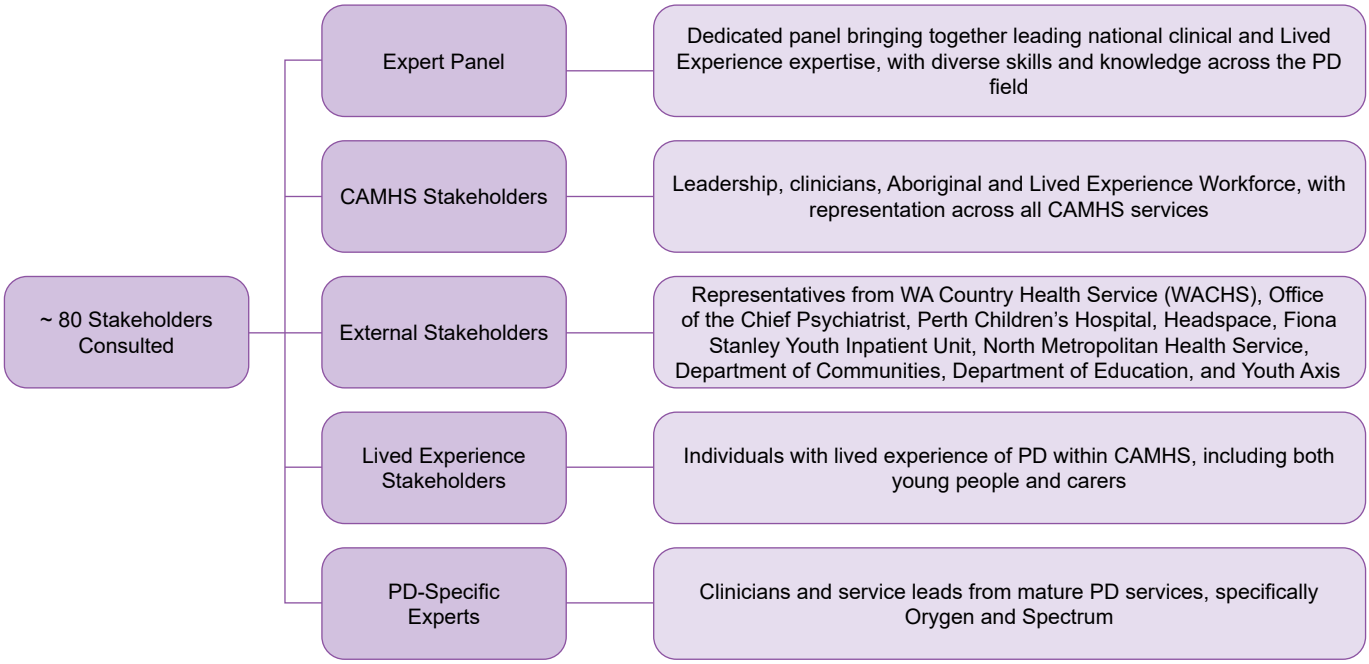
This framework is intended to be used by clinicians, including medical and allied health professionals, who support or care for young people with PD. Given its focus on workforce capability and service delivery, this framework is also of relevance to service leadership teams and other stakeholders involved in service planning and delivery.

How to use this Framework

This framework reflects the best available evidence on PD in young people at the time of writing. As the research base in this area remains more limited than in other areas of youth mental health, the framework also draws extensively on the guidance of the Expert Panel, the perspectives of young people and families with lived experience, and consultation with a wide range of stakeholders across CAMHS and the broader mental health sector. This combined approach ensures that the framework reflects both the available evidence and the practical, lived, and clinical knowledge needed to guide care in areas not yet well covered by research.

Various stakeholders were consulted across different stages of development, with approximately 80 people involved in total. Figure 1 below provides an overview of the broad stakeholder groups engaged throughout this process. Each chapter outlines the specific consultation undertaken to inform that section of the framework.

Figure 1: Overview of Stakeholder Groups Consulted in the Development of this Framework



This framework is not a treatment manual, training program, or a textbook. It does not aim to teach specific therapeutic techniques or replace formal training but instead provides clinicians with a shared framework of care that integrates evidence, clinical practice, and lived experience.

Clinical use of this framework needs to be individualised and appropriate to the context in which clinicians are working. This framework does not override existing service policies, procedures, or escalation pathways, and should be read alongside them rather than in place of them. Clinicians are encouraged to use their own clinical judgement when applying this guidance, particularly where a young person's presentation or circumstances call for a different approach to that outlined here.

Definitions of Terms

Personality Disorder (PD)

In line with contemporary dimensional classification systems (see section 'Understanding PD' below), this framework uses the term "PD" throughout. Unless otherwise specified, the use of the term PD refers primarily to PD with a borderline pattern. Within categorical classification systems, these presentations are diagnosed as borderline personality disorder (BPD) or emotionally unstable personality disorder (EUPD).

Complex Presentation(s)

In this framework, "complex," "complex PD," or a "complex presentation" describes a young person's overall situation and circumstances, not the young person themselves. A young person's presentation might be considered complex if, for example, they have co-occurring physical or mental health conditions, multiple services involved in their care, or significant psychosocial adversity.

This reflects that complexity arises from factors surrounding a young person, rather than from any deficit within the young person themselves.

Young People

For the purposes of this framework, “young people” refers to individuals aged 12 to 18 years.

Family and Carer

Family is defined by each young person according to their own circumstances and relationships. It may include parents, caregivers, siblings, partners, Elders, mentors, friends, or others who hold a significant emotional, cultural, or supportive role in a young person’s life, whether by birth, choice, or circumstance.

Throughout this framework, the terms “family”, “carer”, and “caregiver” are used somewhat interchangeably to reflect this diversity of support networks. Not every young person’s support network fits neatly into any of these terms, and not everyone accepts the term carer or caregiver for themselves; some may prefer terms such as loved one, partner, or supporter. Clinicians should work with each young person directly to understand who is included in their family and carer network, what role each person plays, and how that person prefers to be described, noting that this may change over time.

Clinician

Clinician refers to any medical or allied health professional involved in the assessment, treatment, or ongoing care of young people with PD. This includes, but is not limited to, psychiatrists, psychologists, mental health nurses, social workers, occupational therapists, and other allied health professionals working across services. The term is used broadly throughout this framework to reflect the fact that good clinical care for young people with PD is not restricted to specialist practitioners but is relevant to any clinician who may support a young person’s care.

LGBTIQA+

An umbrella term referring to people who are lesbian, gay, bisexual, transgender, intersex, queer, or asexual, and to other people with diverse sexualities, genders, and sex characteristics, including those who are otherwise not exclusively heterosexual or cisgender. Its use in this framework is not intended to limit or exclude any group, and it is recognised that not all people identify with this acronym or its associated terms.

Culturally and Linguistically Diverse (CALD)

CALD refers to individuals and communities who come from a variety of cultural backgrounds and may speak languages other than English. This includes people born overseas, as well as those in Australia who identify with different cultural traditions, languages, or beliefs. WA is a culturally diverse state, home to people from a wide range of backgrounds, ethnicities, and religions. CAHS recognises the strengths that diversity brings to the community and is committed to providing fair, equitable access to services and high-quality care for all.

CAHS also acknowledges the significant benefits of fostering a diverse and inclusive workplace, which supports the development of a respectful and positive organisational culture. As with any broad descriptor, the term CALD cannot fully capture the diversity of cultural, linguistic, and religious backgrounds it seeks to describe, and its use should not be taken to imply that individuals within CALD communities share a single identity or set of experiences.

Understanding PD

Classification Systems

PD has historically been diagnosed through named subtypes. This categorical approach treats PD as present or absent, despite little evidence that PD is qualitatively distinct from typical personality (Clark, 2007; Trull & Durrett, 2005; Hopwood et al., 2018). Diagnostic thresholds under this model are arbitrary, and apparent overlap between named PD types often reflects two labels describing the same underlying difficulty rather than genuinely distinct conditions (Kotov et al., 2018). These limitations have driven a shift toward dimensional models, which describe PD as a matter of degree along recognised trait domains. Three classification systems are currently used or referenced in clinical practice and are summarised below in Figure 2.

Figure 2: The Three Classification Systems for Personality Disorder

DSM-5-TR

The Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association (APA, 2022), is one of the primary classification systems used for mental health diagnosis. It retains a fully categorical model. BPD is diagnosed as a named disorder, met by satisfying 5 or more of 9 fixed criteria.

DSM-5 AMPD

Introduced within DSM-5 Section III as a research-informed, hybrid dimensional-categorical alternative. The DSM-5 Alternative Model for PDs (AMPD) reaches a diagnosis through two criteria rather than a symptom checklist: impairment across four domains of self and interpersonal functioning (identity, self-direction, empathy, and intimacy), and a corresponding pattern of maladaptive traits (APA, 2022). It retains a number of specific diagnostic categories, including BPD.

ICD-11

The International Classification of Diseases, published by the World Health Organization (WHO, 2024), replaces named types with a single PD diagnosis, graded by severity (mild, moderate, or severe). A qualifier (including a borderline pattern qualifier) may optionally be applied to describe the pattern of difficulty present.

The Shift to Dimensional Models

The DSM-5 AMPD (APA, 2022) and ICD-11 (WHO, 2024) both move away from categorical diagnosis, though they differ in how far that shift extends. The DSM-5 AMPD (APA, 2022) is a hybrid model. It still results in a named diagnosis, such as BPD, but reaches that diagnosis dimensionally, by rating both functioning and traits. The ICD-11 (WHO, 2024) takes this shift a step further, rather than retaining named diagnoses, it uses a single PD diagnosis described dimensionally through severity and trait domains.

DSM-5 AMPD (APA, 2022)

The DSM-5 AMPD (APA, 2022) retains some categorical elements. It keeps six named PD types, including BPD, each defined by a specific combination of two criteria. Criterion A rates the level of impairment in personality functioning across four elements (identity, self-direction, empathy, and intimacy). Criterion B then characterises the style of that impairment through five broad trait domains, built from 25 more specific facets in total:

1. Negative Affectivity (anxiety, worry, low mood, insecurity)
2. Detachment (social withdrawal, restricted emotional expression)
3. Antagonism (grandiosity, lack of empathy, manipulativeness)
4. Disinhibition (impulsivity, poor planning, distractibility)
5. Psychoticism (unusual beliefs, eccentricity)

A person is diagnosed with a specific named PD, such as BPD, only where their pattern of impairment (Criterion A) and traits (Criterion B) match the pre-defined combination for that type. BPD, for example, typically involves impairment in identity and self-direction, alongside prominent traits in the negative affectivity domain, and is often combined with disinhibition and/or antagonism.

ICD-11 (WHO, 2024)

The ICD-11 (WHO, 2024) diagnoses PD as a single condition, through two required steps. First, diagnosis requires problems in functioning of aspects of the self (e.g., identity, self-worth, self-direction) and/or interpersonal functioning (e.g., developing and maintaining relationships, understanding others' perspectives, managing conflict). These problems are enduring, maladaptive across a range of situations, not developmentally appropriate, and associated with substantial distress or impairment (WHO, 2024). Second, once this diagnostic threshold is met, severity is graded as mild, moderate, or severe. A clinician may then optionally describe the presentation further, using one or more of five trait domains:

1. Negative affectivity (anxiety, worry, low mood, insecurity)
2. Detachment (social withdrawal, restricted emotional expression)
3. Dissociality (disregard for others' rights and feelings)
4. Disinhibition (impulsivity, poor planning, distractibility)
5. Anankastia (rigid perfectionism, preoccupation with control)

In response to decades of clinical and research evidence supporting its clinical utility, the ICD-11 (WHO, 2024) also retains an optional borderline pattern qualifier, which may be applied alongside the above trait domains to describe a pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, as indicated by many of the following (WHO, 2024):

- Frantic efforts to avoid real or imagined abandonment
- A pattern of unstable and intense interpersonal relationships
- Identity disturbance, manifested in markedly and persistently unstable self-image or sense of self
- A tendency to act rashly in states of high negative affect, leading to potentially self-damaging behaviours
- Recurrent episodes of self-harm
- Emotional instability due to marked reactivity of mood
- Chronic feelings of emptiness
- Inappropriate intense anger or difficulty controlling anger
- Transient dissociative symptoms or psychotic-like features in situations of high affective arousal

Unlike the DSM-5 AMPD (APA, 2022), no named PD type is diagnosed under this model. Instead, the trait domains and borderline pattern qualifier describe the pattern of an existing PD diagnosis, rather than determining which diagnosis is given.

Relevance to Young People

A dimensional approach to understanding PD is particularly well suited to young people. Personality functioning continues to develop across this age period, with the capacities underpinning identity, self-direction, empathy, and intimacy continuing to mature well beyond age 18, into the mid-twenties (Dahl et al., 2018; Sawyer et al., 2018; Sharp et al., 2025). A categorical model, which requires a fixed present-or-absent judgement, is inconsistent with a stage of life defined by ongoing development and change. A dimensional model instead allows a young person's presentation to be described in terms of degree and pattern, consistent with the broader, long-established practice of describing child and adolescent psychopathology dimensionally rather than categorically (Achenbach & Edelbrock, 1978; Cicchetti, 2006).

Emotional reactivity, impulsivity, and identity exploration are common features of typical adolescent development (Chanen et al., 2022). Elevated traits in these areas are not inherently pathological and may reflect a range of emerging difficulties rather than PD specifically (Sharp et al., 2025). Clinical presentations of PD are distinguished from typical developmental variation not by the presence of these traits, but by their severity, persistence, and associated functional impairment across domains such as relationships, education, and safety (Chanen, 2021; Lawrence et al., 2010; Thompson et al., 2017; Kramer et al., 2017).

Dimensional models frame PD as differing in degree, rather than kind, from typical personality (Monaghan & Bizumic, 2023). This approach supports proportionate, staged intervention, matching the intensity of clinical response to the severity of presentation rather than requiring a young person to meet a full diagnostic threshold before support is offered (Sharp et al., 2025).

This framework adopts a dimensional lens throughout, describing the severity and pattern of a young person's difficulties rather than relying solely on a fixed threshold. As a result, it is intended to be relevant not only to young people who meet full diagnostic criteria for PD, but also to those experiencing significant PD-like difficulties who have not yet received a formal diagnosis.

Section 1

Good clinical care



Introduction

Young people living with PD, and the families who care for them, continue to encounter stigma and disbelief within the systems meant to support them (Chanen, 2021). Negative attitudes and mistaken beliefs about PD remain common among health professionals, including the belief that young people with PD are treatment-resistant, unlikely to improve or only able to improve with prolonged, intensive treatment delivered by specialists (Chartonas et al., 2017; Gunderson & Links, 2014; Sheehan et al., 2016).

This belief has contributed to a pattern of late intervention, in which meaningful treatment is withheld until a presentation becomes severe, or until a young person can meet the demands of a specialist service. In some cases, it also contributes to young people not being diagnosed at all, delaying their access to appropriate care and support. Evidence does not support this approach. Delay does not improve long-term outcomes and is instead associated with entrenched functional impairment and a persisting, unwarranted pessimism about the potential for recovery (Chanen & Thompson, 2018).

As previously noted, this framework places significant emphasis on the idea that PD is everybody's business. Working effectively with young people who have PD does not require specialist training or expert status. It requires Good Clinical Care, delivered early, consistently and well. It is neither feasible nor necessary for every clinician to receive specialist training in PD, and clinicians can be confident in their ability to support these young people without it. Much of what is covered in this chapter reflects care that clinicians will already be familiar with and providing as part of good practice more broadly.

Rather than prescribing a specific therapeutic modality, this chapter sets out the principles of Good Clinical Care that every young person with PD should receive from first presentation, regardless of the stage of their presentation or the tier or type of service providing their care. This is the baseline every young person is entitled to, and every clinician is expected to provide, from the point a young person first seeks help. Specific, evidence-based modalities, such as Mentalisation-Based Treatment (MBT), Acceptance and Commitment Therapy (ACT), Dialectical Behaviour Therapy (DBT) or group-based interventions, may be added on top of this baseline where clinically indicated. These modalities remain an important part of a young person's care; Good Clinical Care is not a substitute for these evidence-based modalities but is the universal standard that underpins them and that continues alongside them regardless of which psychotherapeutic modality, if any, a young person is receiving.

Our proposed conceptualisation of Good Clinical Care is informed by a particularly noteworthy approach, General Psychiatric Management for Adolescents (GPM-A; Choi-Kain & Sharp, 2021). GPM-A is a generalist model of care adapted from the adult General Psychiatric Management model (Gunderson & Links, 2014) and developed to be deliverable by all clinicians rather than only PD specialists. The principles of GPM-A have been adapted for this framework under the term Good Clinical Care. A clinician who consistently applies the principles set out in this chapter is, by definition, providing Good Clinical Care.

The 10 principles of Good Clinical Care are outlined in Figure 3. Each principle is then described in turn in the following sections.

Figure 3: Principles of Good Clinical Care

Person Centred Care	**Collaboration with Families**
Trauma-Informed Care	**Recovery Oriented Care**
Strengths-Based Approach	**Relational Care**
Formulation and Psychoeducation	**Handover and Transition Between Services**
Care Coordination	**Reflective Practice**

Person centred care

Care should be shaped around the young person's own needs, preferences, values and goals, rather than requiring the young person to fit a predetermined pathway (Smith & Williams, 2016). Preferences should be discussed and revisited throughout treatment rather than fixed at the outset. Young people are entitled to choice and autonomy in their care, and decisions should be made with them, not on their behalf.

When delivering care, clinicians can be person centred by:

- Being compassionate, demonstrating empathy, listening to and validating the young person's current experiences and emotional state.
- Taking the young person's experience seriously.
- Staying calm, non-judgemental, respectful and caring.
- Actively collaborating with the young person on their care plan, anchoring it to their own stated goals and treating their lived experience as expert input, not a secondary consideration to clinical judgement.
- Allowing flexibility in therapeutic approach, session structure, and pacing to support the young person's autonomy and self-determination.
- Adapting service access and delivery to individual and family needs, for example telehealth for regional areas, interpreters or yarning for CALD or Aboriginal and Torres Strait Islander families, or sensory accommodations for neurodivergent young people.
- Using person-first, plain, jargon-free language in conversation and documentation, for example "young person with PD," so young people and families can meaningfully participate in decisions about their own care.
- Accounting for population-specific risk drivers, such as complex family circumstances, chronic stigma, colonisation-related distrust, or disordered eating, rather than a one-size-fits-all risk framework, and recognising intersectional aspects of identity, such as Aboriginal and Torres Strait Islander status, CALD background, neurodivergence, and LGBTIQA+ identity, as core parts of who a young person is, not something to pathologise.

Collaboration with families

Involving and collaborating with families is integral to a young person's care. Most young people between 12 and 18 live with family, who are often the first to notice changes in their emotions or behaviour, the first point of contact when help is sought, and their primary support throughout treatment (Headspace, 2023). Even where a young person is not living with family, most continue to rely on them for support and hope for improved family relationships over time (Headspace, 2023).

Most of the time, meaningful family collaboration benefits everyone. For the young person, it is associated with improved psychological adjustment and quality of life, a quicker recovery process, and decreased parental stress (Headspace, 2023). For the clinician, it provides a fuller and more accurate picture of the young person's presentation. For the family, early engagement, psychoeducation, and practical assistance can ease the burden of their caregiving role (Baker-Ericzén et al., 2012; Betts et al., 2023). Families of young people with PD frequently report high levels of distress, high expressed emotion including critical comments toward the young person, and guilt or self-blame about whether they contributed to the young person's difficulties (Bailey & Grenyer, 2013; Lester et al., 2020). Many also report not knowing enough about PD and feeling excluded from their young person's care (Buteau et al., 2008; Lamont & Dickens, 2021).

Families should be understood as doing their best to support the young person with the resources available to them, rather than through a lens of deficit or blame. A family-inclusive approach reflects this, focusing equally on the young person's needs and the family's own strengths and difficulties (Lamont & Dickens, 2021), through psychoeducation, reducing family conflict and stress, improving communication and relational skills, and practical support such as links to financial assistance. Preliminary evidence suggests that this approach may improve family relationships, carer empowerment and mental health, and reduce carer burden over time (Whitson et al., 2025).

Clinicians can engage in family inclusive practice by:

- Understanding caregiving arrangements within a young person's cultural context, recognising that family, kinship, and caregiver structures vary across cultures and may include extended family or other significant caregivers.
- Listening to a family's own goals and giving them genuine choice in treatment decisions. Involving them in goal setting, care planning, discharge discussions, and regular progress reviews, to support shared understanding of goals, triggers, skills, and strategies, and to ensure care remains effective for everyone involved.
- Providing families with psychoeducation about PD, including how it affects emotion, communication, and risk, and how to respond in a helpful way.
- Offering families access to their own support to help prevent burnout, and providing direct, practical support such as links to financial assistance where relevant.
- Establishing and regularly revisiting agreement with the young person about what information will be shared with family, clearly documenting what has and has not been consented to, and encouraging direct, open communication between the young person and family rather than the clinician acting as the sole channel of information.
- Respecting the autonomy and legal rights of young people, particularly those who have capacity to make informed decisions about their own care, including where a young person does not want their family involved. Confidentiality should not be treated as a barrier to appropriately involving family; it is possible to maintain a young person's privacy while still engaging and supporting their family.

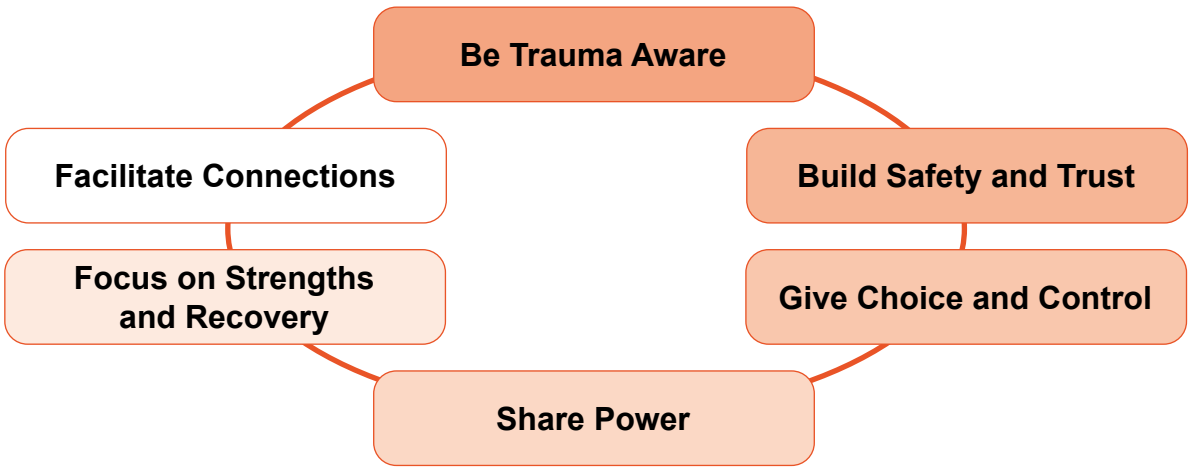
Trauma-Informed Care

Trauma and developmental adversity are closely linked to PD (Malafanti et al., 2024). Trauma often shapes how PD presents in a young person and how they experience and engage with treatment, including the intensity of their difficulties, how readily treatment helps, and challenges with emotion regulation, relationships, and self-concept (Ford & Courtois, 2021).

Trauma-informed care is not the same as trauma specific treatment. Trauma specific treatment refers to direct clinical interventions delivered by trained clinicians to reduce trauma symptoms, such as Trauma-Focused CBT. Trauma-informed care is broader, it is how a service operates day to day, embedded in culture and practice across the workforce, with a focus on safety, empowerment, and avoiding re-traumatisation (Fallot & Harris, 2001). As with the other principles in this chapter, trauma-informed care is part of the good clinical care every clinician should provide when working with young people with PD, not a specialist skill set. A clinician does not need to treat a young person's trauma directly, or be trained in trauma specific therapy, to work with them in a trauma-informed way.

Trauma-informed care can be embedded into everyday practice with young people with PD using six principles adapted from Phoenix Australia's Trauma-Informed Practice framework (Phoenix Australia, 2025). These six principles are shown below in Figure 4.

Figure 4: Six Principles of Trauma-Informed Practice



Each of the six principles in Figure 4 is outlined below, along with how clinicians can apply it in their work with young people with PD.

Be trauma aware. Understand how trauma and adversity may have shaped a young person's needs, behaviours, and relationships, and how this can present alongside PD.

Build safety and trust. Create an environment that feels physically and emotionally safe, minimise the risk of further harm, and build trust by understanding a young person's identity and background.

Give choice and control. Help young people make informed decisions about their care by explaining what to expect, and involve them, and the people they trust, wherever possible.

Share power. Work alongside young people rather than deciding for them, ensuring they know their right to make decisions about their care and that their knowledge and experience shape their goals.

Focus on strengths and recovery. View young people as resourceful and resilient and support them to draw on their existing strengths and work towards goals that matter to them.

Facilitate connections. Consider a young person's needs within the context of their family, community, and relationships, and support coordinated, connected care.

Recovery Oriented Care

People can and do recover from PD (Leichsenring et al., 2024). Drawing on the lived experience of people who have recovered from PD, Project Air Strategy for Personality Disorders (2026) emphasises that key factors supporting recovery include a consistent therapeutic relationship, holding onto hope through setbacks rather than treating them as failure, understanding how past experiences shape present difficulties, and building acceptance of one's emotions and sense of self. It is necessary to recognise that recovery is not a passive process and requires ongoing, daily effort from the young person as well as the system around them.

Project Air Strategy for Personality Disorders (2026) describes recovery from PD as following four processes, active engagement, hope, treatment, and meaningful activities and relationships. Early recovery centres on a young person moving past feeling stuck, coming to terms with their diagnosis, and building the capacity to understand their own emotions, identity, and relationships, including the ability to see things from others' perspectives. A diagnosis is often a turning point in this process. Once a young person understands what they are experiencing, they are better placed to see the value of treatment and begin working towards goals that are personally meaningful to them.

Recovery work also relies on a degree of stability in a young person's life, including in their housing, family and relationships. A young person in crisis typically has limited capacity to engage meaningfully in treatment. Building this stability is not merely a step to complete before "real" recovery work begins. It is itself an essential part of that work.

Clinicians can support recovery-oriented care by:

- Conveying genuine hope for a young person's capacity to change, while validating their current experience, for example, "I can see this is hard for you," and "people recover from this, and help is available."
- Using strengths-based, compassionate language that acknowledges a young person's effort, without minimising what they are going through.
- Prioritising consistency and continuity in the therapeutic relationship, recognising this as one of the most valued parts of recovery for young people with lived experience.
- Reinforcing hope actively during setbacks, rather than treating a setback as a sign that recovery has stalled or failed.
- Supporting stability, such as housing, financial, or relational stability, as an early priority, recognising that broader therapeutic work is unlikely to progress while a young person remains in crisis.
- Supporting a young person's own pace of insight and acceptance, rather than expecting recovery to be immediate or linear.

Strengths-Based Approach

A strengths-based approach is about how care is delivered, not what specific therapy or intervention is used. Traditional approaches often frame mental health difficulties through a deficit-based lens, leaving both young people and clinicians feeling that little can be done to help (Ramon, 2013). A strengths-based approach counters this by focusing on a young person's existing abilities and resources, rather than defining them by their difficulties, symptoms, or diagnosis. Specifically, rather than avoiding or minimising problems, challenges, or risks, this approach seeks to identify the strengths that can be built on to help a young person manage them, work towards goals that hold genuine personal meaning, and build a sense of agency, hope, and self-efficacy (Ramon, 2013).

Clinicians can take a strengths-based approach by:

- Focusing on a young person's strengths, interests, and experience to build a shared understanding of what they can draw on, as well as what support may still be needed.
- Supporting the young person to take the lead in setting their own goals, rather than adopting a problem or need defined by someone else.
- Treating the young person and their family as experts in their own lives, working alongside them rather than trying to solve or fix on their behalf.
- Using questions that keep the focus on moving forward, such as "What is currently working?" or "How can we build on existing strengths?", and using positive language rather than deficit-focused questions like "What's wrong?" or "What's missing?"
- Aiming to help the young person build toward outcomes they have chosen for themselves, rather than treating risk reduction as the primary purpose of the intervention.

Relational Care

Difficulties in relationships are a core feature of PD, not simply a context in which it occurs (McCutcheon et al., 2024). The Project Air Strategy for Personality Disorders (2026) describes PD as "a disorder of relationships," where "the medicine is relationships" (page. 7). From this perspective, a young person's difficulties can be understood as stemming from relationship patterns that have developed over time. These patterns are both intrapersonal, reflecting how a young person relates to themselves, including their thoughts and feelings, and interpersonal, reflecting how they relate to others. Understanding these patterns helps clinicians make sense of a young person's unmet relational needs and the extent of their identity diffusion and self-criticism. For example, a young person may be highly self-critical while also struggling to understand and integrate their own emotional experience.

Taking a relational approach means that formulation, treatment planning, and day-to-day care should all account for a young person's relationships and attachment patterns directly, rather than focusing on symptoms or behaviours in isolation (McCutcheon et al., 2024). Behaviours that appear extreme, maladaptive, or unhelpful have often developed as the only viable way a young person could express or meet their needs, given their circumstances (e.g., attachment insecurity, experiences of trust being violated, or chronic invalidation from others; Orygen, 2024).

Working relationally can involve sitting with a wide range of interpersonal challenges, including neediness, aggression, hypersensitivity, ambivalence, and self-destructive behaviour, as well as narratives of neglect and trauma (Project Air Strategy for Personality Disorders, 2026).

Clinicians should approach young people with active, engaged compassion, remaining reflective rather than reactive during moments of crisis. This involves balancing validation of the young person's distress with clear and consistent boundaries and responding to aggression calmly to maintain safety (Project Air Strategy for Personality Disorders, 2026). Taking this stance helps a young person build a stronger sense of self and a greater capacity for healthy relationships (McCutcheon et al., 2024).

The principles of Relational Care outlined below in Table 1, are adapted from relational clinical care approaches described by Orygen's Helping Young People Early (HYPE) program and are not exhaustive (Orygen, 2024).

Table 1: Relational Care Principles in Practice

Principle	In Practice
Establishing a Collaborative Working Relationship	Engage the young person, family, and others as partners in care, not recipients of treatment. Discuss session expectations, such as length, frequency, and cancellations, collaboratively from the outset rather than through a written contract, signalling a more equal relationship. Anticipate tension and disagreement as likely and discuss openly how these moments will be managed together.
Pacing Care to a Young Person's Shifting Capacity	A young person's capacity to reflect, negotiate, or tolerate distress can shift day to day, or within a session. Actively considering this allows a clinician to anticipate when a different pace or approach may be needed, rather than assuming capacity stays constant.
Formulating from a Relational and Attachment Lens	Formulation should account for the relational patterns and attachment history underlying a young person's difficulties, and how the clinician can best relate to support change. Treat this as a working hypothesis, revised over time and developed collaboratively with the young person and family.
Setting Shared, Functional Goals	Set goals collaboratively, drawn from the formulation, balancing symptom relief with building the young person's own capacity to manage their emotions, relationships and seek support effectively. Care should generally prioritise improvements in real-world functioning and relationships, such as engagement in education or peer relationships. Treatment should, however, remain goal-based, and a focus on functional outcomes should not override the young person's own stated priorities. Where a young person identifies reducing self-harm as their primary goal, for example, this should guide the immediate focus of care.
Planning Transitions and Endings Throughout Care	Plan endings throughout care, not only at its conclusion, and discuss time limits early. Resist the pull to delay an ending even when it feels overwhelming, since delay reinforces a sense that endings are unmanageable. Frame future episodes of care as a normal part of a young person's journey, not a sign of failure.
Seeking Regular Supervision and Working as a Team	Expect rapid shifts in a young person's relational stance, such as swinging between anger and helplessness. Use supervision to notice, name, and repair relational tension, not just for general support. Clarify who else is involved in care and how consistency is maintained across the team, rather than relying on one clinician alone.

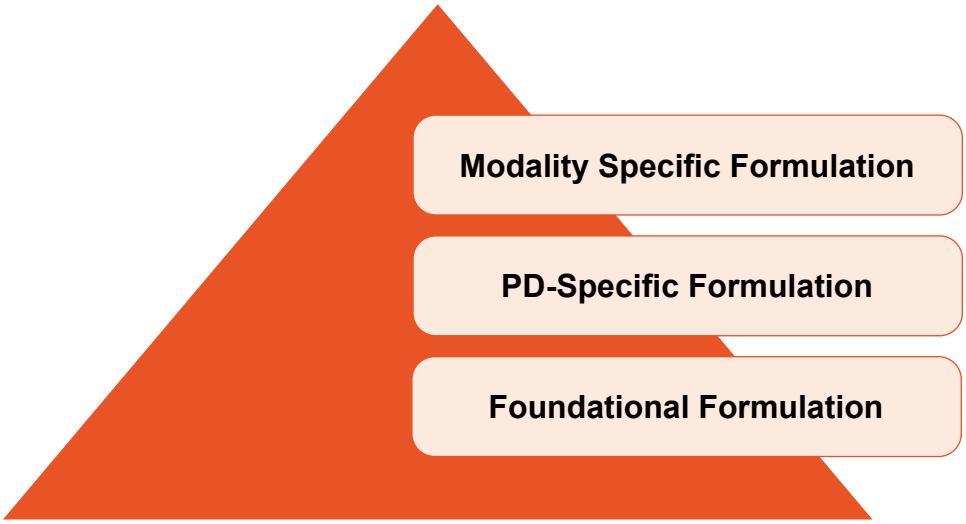
Formulation and Psychoeducation

Formulation

A clinical formulation explains how a young person's difficulties have developed and are being maintained, going beyond simply naming the symptoms present (Aveline, 1999). Good formulation identifies the key factors contributing to a young person's difficulties, guides treatment planning and helps anticipate challenges that may arise during treatment (Eells, 2013; Kuyken et al., 2011; Macneil et al., 2012).

As part of Good Clinical Care, this framework proposes a layered approach to formulation (see Figure 5). Rather than relying on a single formulation model, it is recommended that clinicians build understanding in stages, starting with a general foundation and adding further layers of detail as they become relevant to a young person's care. This approach ensures every young person receives a formulation that is thorough and specific to them, while remaining flexible enough to accommodate young people at different stages of care.

Figure 5: A Layered Approach to Formulation



1. Foundational formulation: Every young person should have a foundational, biopsychosocial formulation as the starting point for understanding their presentation, regardless of what care they go on to receive. This may take the form of a 5Ps formulation (presenting, predisposing, precipitating, perpetuating, and protective factors) or another appropriate biopsychosocial model.
2. PD-specific formulation: This foundation should then be built on with a formulation specific to PD, considering the young person's inter- and intrapersonal (relational) patterns, behavioural patterns, risk formulation, and the treatment relationships itself. This layer should be completed for every young person with PD, not only those going on to receive a specific therapeutic modality.
3. Modality-specific formulation: Where a young person goes on to receive a specific therapeutic intervention, such as DBT, a formulation specific to that modality should be added on top of the foundational and PD-specific layers already completed, rather than used as a substitute for them.

This layered approach ensures every young person receives a thorough, PD-informed formulation as part of good clinical care.

Psychoeducation

Formulation and psychoeducation are closely connected. A clear understanding of a young person's presentation enables a clinician to communicate it back to the young person and their family in a way that is accurate and meaningful, grounded in the young person's own experience.

Many young people and their families arrive at their first appointment without a clear understanding of what they are experiencing. Providing an accurate and timely diagnosis, alongside psychoeducation about PD, offers a destigmatising way to help the young person understand their difficulties (e.g., what PD is, why it develops, and what can help). This transforms what may otherwise feel confusing and overwhelming into something they can meaningfully engage with (Project Air Strategy for Personality Disorders, 2026). For many, receiving a diagnosis marks an important turning point in their recovery, marking the end of feeling stuck and the start of a path towards the right kind of support (Project Air Strategy for Personality Disorders, 2026). Psychoeducation alone, without any other treatment, has been shown to reduce PD symptoms (Ridolfi et al., 2019; Zanarini & Frankenburg, 2008; Temes & Zanarini, 2018). Realistic, hopeful, and tailored psychoeducation tends to be experienced by young people as a genuine relief, rather than something to fear or avoid (McCutcheon et al., 2024).

Psychoeducation provides a young person with the means to understand their own patterns, such as what triggers their distress, what tends to follow, and what steps they can take in response. Naming these patterns equips a young person to recognise and respond to them, rather than experiencing them as unpredictable or overwhelming each time (Choi-Kain & Sharp, 2021).

Clinicians can provide effective psychoeducation by:

- Reviewing diagnostic criteria collaboratively with the young person, relating each to their individual experiences, rather than simply telling them their diagnosis.
- Adjusting language and format to the young person's developmental level and how they best process information, such as verbally, visually, in writing, or online, using relatable, non-jargon language.
- Talking about PD in a non-judgemental, practical, and honest way, and proactively naming the stigma a young person may encounter, including online, rather than avoiding the topic.
- Framing the diagnosis as something a young person can understand and manage, not something that defines who they are, and conveying realistic hope alongside it.
- Explaining PD's causes as a mix of factors, such as neurobiological factors and attachment relationships, in an affirming and non-blaming way.
- Discussing conditions that may co-occur with or resemble PD, such as depression, neurodevelopmental conditions, or eating disorders.
- Providing written information or fact sheets the young person and family can revisit later.
- Extending psychoeducation beyond the diagnosis itself to practical guidance, such as study skills or staying organised, and supporting a young person to think through longer-term goals, such as future study, work, or relationships, where these are goals the young person holds for themselves.
- Making use of natural opportunities for psychoeducation throughout care, particularly in initial meetings with the young person, family, and other clinicians, and through psychoeducational workshops connecting families with others facing similar experiences.
- Liaising with a young person's school where appropriate and where staying engaged with school is a goal for the young person, helping teachers understand PD and its impact, and working with them to identify ways to adapt schoolwork or activities to what the young person can currently manage.
- Equipping parents and carers with psychoeducation about PD, its causes, and available treatment in accessible language, addressing stigma and parental blame directly, and offering a hopeful message that treatment works, and recovery is possible. Referral to dedicated carer workshops, where available, can support this further.

Handover and Transition Between Services

Warm clinical handovers are central to safe, continuous care as a young person moves between different levels or types of support, transitions from inpatient to community care, or is referred elsewhere. Handover processes and requirements vary across services, and clinicians should follow their own service's existing policies and procedures for clinical handover in the first instance. The guidance that follows adds PD-specific considerations for services to layer on top of their existing approach, rather than replacing it. A good handover goes beyond transferring diagnostic and risk information; it should centre on the shared formulation, ideally developed collaboratively with the young person, so the receiving team understands not only what has happened, but what has helped, and what goals remain.

A thorough handover should include the shared formulation, the most recent risk assessment and safety plan, and a clear plan for what should happen should the young person present to a service outside their existing care team, such as an emergency department. Where a young person is admitted to an inpatient unit, handover should also specify the goals of admission and, on discharge, a clear plan for returning to community care, ensuring continuity is maintained across the transition rather than care beginning again from scratch.

Endings, whether marking the conclusion of an episode of care or a planned step-down, should be regarded as therapeutically meaningful in their own right, rather than a mere administrative closure. Ending active treatment can itself communicate confidence in a young person's capacity to manage more independently. Planned follow-up checkpoints offer a means of responding early should difficulties re-emerge, support a young person in applying the skills they have developed, and reinforce their confidence in managing future difficulties (McCutcheon et al., 2024).

Clinicians should be mindful that transition from child and adolescent services to adult or youth mental health services can be a vulnerable time for a young person. It often coincides with other significant life changes, and differences in service models and ways of working can make it harder for a young person to stay engaged. Allowing time to plan for this transition and involving the young person and their family in that planning can help it feel less abrupt. Careful discharge planning and a clear, comprehensive handover to the receiving service are particularly important at this point. A good handover often includes the young person's shared formulation, what has helped and any goals that remain, so the new team can provide continuity of care from the outset.

Beyond established policies and procedures, clinicians can support effective handovers and transitions by:

- Sharing the formulation, developed collaboratively with the young person, as the core of any handover, rather than relying on diagnostic or risk information alone.
- Including the most recent risk assessment, safety plan, and a clear plan for presentations to an emergency department as standard parts of any handover.
- Specifying the goals of an inpatient admission at the outset, and ideally a plan for returning to community care on discharge.
- Ensuring a handover conveys what has helped so far and what goals remain, so the receiving team can pick up care with genuine continuity.
- Treating endings as a planned, purposeful part of care, discussed well in advance, rather than an abrupt stop.
- Using planned follow-up checkpoints after an episode of care ends, to check in early if difficulties resurface and reinforce the young person's own progress and skills.
- Allowing time to plan transitions to adult or other youth services and conducting thorough warm clinical handovers.

Care Coordination

Care coordination, sometimes referred to as case management, is a core part of good clinical care for young people with PD. It involves actively coordinating between the services and people involved in a young person's care, ensuring everyone works from the same care plan and that practical needs are addressed alongside clinical treatment, rather than leaving the young person or their family to hold everything together themselves. This is often best delivered by a multidisciplinary team, in which a case manager (e.g., a psychologist, social worker, occupational therapist, or mental health nurse) works alongside a psychiatrist to provide a consistent, coordinated approach to the young person's care (McCutcheon et al., 2024).

Continuity of care coordination can be particularly valuable whenever a young person moves between levels or types of care. For example, maintaining some contact with their community care coordinator during an inpatient admission, even through brief check-ins, may help preserve the therapeutic relationship and ease the young person's return to community care. The same principle can apply to other transitions, such as moving between CAMHS community teams or between CAMHS services and other external services.

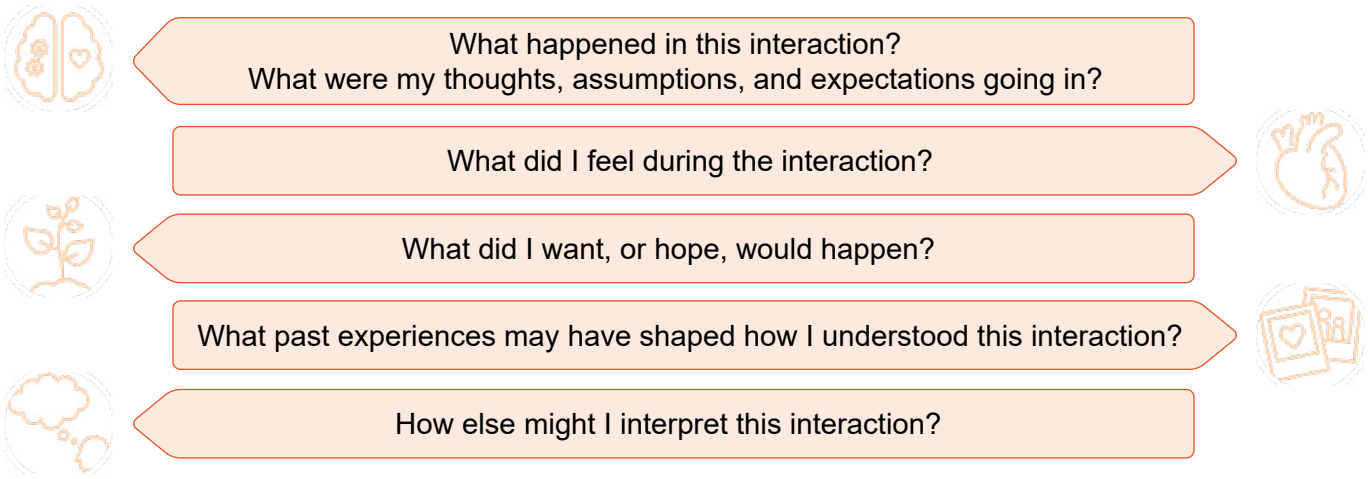
Care coordination should be tailored to a young person's individual needs and goals, rather than applied uniformly. Where educational or vocational difficulties are identified, for example, this may involve facilitating access to targeted supports as a complementary part of care. For a young person whose goal is finding employment, this might mean referring them to Headspace's work and study support program, which uses the Individual Placement and Support (IPS) model to provide one-on-one assistance with job applications, resumes, interview preparation, study enrolment, and navigating systems such as Centrelink. The young person's care coordinator can collaborate with the program to ensure this support aligns with their broader goals. Within the treating team, it may also be helpful to draw on the skills of different disciplines. For example, an occupational therapist may support a focus on occupational recovery, while a social worker may be well placed to assist with housing or financial support. More broadly, the same principle applies regardless of the specific goal: coordinating practical, goal-directed support alongside clinical care, even where a dedicated program is not available.

Care coordination should also be developmentally informed, supporting a young person to build capacities and skills they may not yet have had the opportunity to develop, such as organising their own appointments or communicating their needs to a new service, rather than assuming a level of independence they have not yet reached.

Reflective Practice

Reflective practice is a core component of work with young people experiencing complex mental health difficulties. It involves the deliberate, ongoing process through which a clinician critically examines their own thoughts, emotions, and actions to build awareness and professional competence (Finlay, 2008). Clinicians working with young people with PD often encounter strong emotional responses, rapid shifts in relational dynamics, and situations that evoke discomfort, uncertainty, or self-doubt, at times leaving a clinician feeling powerless, out of their depth, or frustrated. Reflective practice allows clinicians to notice, name, and work through these responses, rather than being overwhelmed by them or acting on them unintentionally. Figure 6 provides examples of reflective questions that clinicians can use to explore their own response and consider how these may influence their interactions with young people.

Figure 6: Examples of Reflective Questions to Ask Yourself as a Clinician



A clinician's own emotional reactions to a young person, sometimes called countertransference, can provide useful clinical information, offering insight into how the young person may affect others in their life. At other times, these reactions can create challenges. For example, a clinician who feels guilty about being unable to solve a young person's problems may unconsciously do more for them than is helpful, in an effort to relieve that guilt (Project Air Strategy for Personality Disorders, 2026). Without support, clinicians can develop negative attitudes or biases, particularly toward young people early in their recovery journey, so regular clinical supervision or consultation is important for working effectively (Project Air Strategy for Personality Disorders, 2026).

Supervision and consultation support clinicians to respond thoughtfully rather than reactively, build realistic expectations of treatment and recovery, and share responsibility for significant clinical decisions rather than leaving them with one clinician alone. A supervisor or consultant can also act as an anchor, helping a clinician step back and make sense of the clinical process when they feel caught off guard (Project Air Strategy for Personality Disorders, 2026). Many clinicians, particularly earlier in their career, can feel reluctant to share intense feelings in supervision. Where this is the case, a helpful approach is to balance exploring the clinician's own reactions with a practical, educative focus on the treatment itself (Project Air Strategy for Personality Disorders, 2026).

Clinicians can ensure they engage in reflective practice by:

- Noticing and naming emotional responses, such as discomfort, frustration, the urge to rescue, avoidance, or strong liking or disliking, and treating this as useful relational information rather than something to suppress.
- Setting aside regular time for structured reflection, whether through writing, supervision, or discussion with a colleague.
- Examining the assumptions and expectations shaping their responses, including how personal or professional history may be influencing a given interaction.
- Noticing urges to over-involve or withdraw, reflecting on what these urges communicate about the relational dynamic, and re-establishing consistent, safe boundaries.
- Seeking regular clinical supervision or consultation, particularly when working with complex presentations or strong personal reactions, rather than carrying this alone.
- Being open with a supervisor or consultant about difficult feelings, even where this feels uncomfortable, since this openness is part of what makes supervision useful.
- Prioritising their own self-care and wellbeing, recognising the emotional demands of this work and engaging in practices that support resilience and prevent burnout.

Section 2

The Integrated Clinical Staging–Tiered Care Model



Introduction

This chapter describes how a young person with PD may move through the broader mental health system, with a specific focus on CAMHS services. It presents a novel conceptualisation that integrates officially recognised service tiers, clinical stages, and the key considerations for managing PD within each setting. This chapter has been written specifically for application within CAMHS, though other services may draw on its underlying principles to inform their own models.

PD has traditionally been treated as a disorder that always requires prolonged, intensive individual psychological treatment, often only once it has become fully entrenched (Chanen et al., 2022). There is now a growing shift toward early identification instead, recognising that detecting and intervening in the development of PD early can help prevent its more enduring effects. This shift also reflects a broader move away from traditional diagnostic approaches that treat PD as simply present or absent, which struggle to capture subtle, evolving, or subthreshold presentations and offer little sense of how the disorder changes across a young person's life. PD is not fixed. It is dynamic, and can improve, intensify, or shift in presentation over time, meaning care needs to be able to shift with it.

This chapter and model apply that logic directly to service delivery within CAMHS, linking a young person's clinical stage to the tier of service best matched to their needs. In doing so, it supports earlier identification, clearer and more consistent decision-making around service matching, and flexible movement between tiers as a young person's presentation changes over time. Ultimately, this chapter is about matching care to the young person's current need, allowing movement between tiers so that service delivery can align with the dynamic, evolving nature of PD.

Model Development Process

Development of the Integrated Staging-Tiered Care Model began with a review of existing tier systems and clinical staging models. Kidane et al. (2026) examined the two staging models proposed by Chanen et al. (2016) and Hutsebaut et al. (2019) and this review served as the main empirical basis for adopting a staged approach to care. This review shaped an initial draft staging framework, which was then mapped against CAMHS's existing four-tier service structure (Tiers 1–4), linking each clinical stage to the tier of care best suited to that level of need. The draft model then went through consultation. It was first reviewed by the Chair, and then by the Expert Panel, who gave feedback on its clinical and conceptual validity, and the staging component was refined accordingly. A consultation deck was also presented to WACHS Infant Child and Adolescent Mental Health Service (ICAMHS) stakeholders and CAMHS senior service and clinical leads.

The stakeholders were asked whether they agreed with the defined tier system, for feedback on the staging model itself, and whether the stage-tier matching was correct for their service. They also outlined the clinical decision thresholds that would guide movement between tiers within their own service. Separately, and outside the model itself, they were consulted on risk, drawing on their expertise to identify what risk thresholds or indicators should trigger immediate senior clinician review, and what could wait for routine MDT discussion. The model was then revised to incorporate this feedback.

Tier System

A tier system describes the different levels of service intensity available to meet a young person's mental health needs, ranging from broad, low-intensity support to specialist, high-intensity care. The tier system used in this framework draws on existing tier systems used in both WA and the United Kingdom (UK). In WA, a four-tier structure for CAMHS was outlined in the Review of the Admission or Referral to and the Discharge and Transfer Practices of Public Mental Health Facilities/Services in Western Australia (Stokes, 2012).

In the UK, a similar four-tier model is widely used to organise CAMHS across the National Health Service (Hertfordshire Partnership University NHS Foundation Trust, 2025). These existing tier systems provided a foundation that was then refined through consultation with CAMHS leadership and relevant external stakeholders, including WACHS. This ensured the tier system reflects current service reforms and contemporary models of care, including the introduction of newer community CAMHS models.

Clinical Staging

What is Clinical Staging?

Clinical staging is an approach to understanding mental illness that focuses on where a person sits along the course of a disorder, rather than treating a diagnosis as simply present or absent. It applies the same practical logic across different conditions, distinguishing early or milder presentations from those marked by progression and chronicity, and pointing toward the type of intervention that fits that stage (Chanen et al., 2016). The approach originated in oncology and was later adopted in psychiatry, including in the treatment of psychosis (Hutsebaut et al., 2019), but its application to PD is far more recent.

Clinical Staging in PD

The transition from childhood to adulthood is a sensitive developmental period for PD (Chanen et al., 2022). Both the DSM-5 AMPD and the ICD-11 now reflect this, describing PD as developmental and dimensional rather than a fixed set of behavioural criteria (Chanen et al., 2022; Hutsebaut et al., 2019). This shift matters for young people specifically, since it moves away from requiring a firm, categorical diagnosis before support can begin and instead allows presentations that are still emerging or subthreshold to be recognised and responded to in their own right. Clinical staging builds directly on this developmental, dimensional view, giving it a practical structure for guiding care at each point along that continuum.

Two staging models for PD have been proposed to date. Chanen et al. (2016) developed a combined model for BPD and mood disorders, given how closely the two overlap and share risk factors in young people. Their model moves from an at-risk Stage 0, where a person shows no current symptoms but has known risk factors such as family history or early adversity, through mild or subthreshold symptoms in Stage 1, a first full episode of either disorder in Stage 2, a stage of recurrence and relapse in Stage 3, and a persistent, unremitting presentation in Stage 4.

Hutsebaut et al. (2019) proposed a separate model specific to BPD, also across five stages (0 to IV), but built around three dimensions at each stage: (i) the extent and severity of Borderline features themselves, (ii) the severity of any co-occurring mental health difficulties, and (iii) the level of disability in social, educational, or vocational functioning.

Kidane et al. (2026) provided one of the first empirical tests of these two models, evaluating them against real treatment data rather than clinical theory alone. Both models could be applied reliably by independent assessors, and patients staged earlier generally required less treatment and achieved better outcomes than those staged later. The shift from Stage 1 to Stage 2 stood out as a particularly important turning point, reinforcing the case for early identification and intervention. A separate risk profiling model added little beyond staging itself, suggesting stage alone carries most of the clinical value in anticipating treatment need and prognosis.

For this framework, these findings support clinical staging as a credible, evidence-based tool for guiding care, and justify building a staging model into how PD is managed within CAMHS. The staging model used here draws on some adaptations from both Chanen et al. (2016) and Hutsebaut et al. (2019), including the concept of an at-risk stage prior to any current difficulties. For clarity and consistency, it also draws heavily from the ICD-11's (WHO, 2024) severity structure, describing a young person's current level of functioning and impairment rather than the pattern of their difficulties over time. A young person's stage in this framework therefore uses the ICD-11's descriptors of Personality Difficulty, Mild PD, Moderate PD, and Severe PD, preceded by an At Risk stage. Our clinical stages, alongside examples of how each might look in clinical practice, are described in Table 2 below.

Table 2: Clinical Stage Definitions and Presentations

Stage	Definition	How Difficulties May Present
At Risk	No current PD-related difficulties, but known risk factors present, such as family history, early adversity, or early risk-taking behaviour.	May affect school and social functioning in subtle ways, such as difficulties with concentration, peer contact, or social anxiety.
Personality Difficulty	Noticeable PD characteristics are present, but not to a degree that would meet the threshold for a PD diagnosis. These characteristics tend to appear only under stress or at low intensity, rather than constantly, and don't meaningfully disrupt a young person's relationships overall, though they may affect specific relationships or situations.	May include occasional peer conflict, sensitivity to setbacks, or difficulty coping under stress, without pervasive disruption to a young person's relationships or roles.
Mild PD	Meets general diagnostic requirements for PD. Difficulties appear in some areas of a young person's functioning but not others and may not be obvious in every setting. Most relationships and expected roles, such as school, are still maintained, even where problems exist in some areas. Harm to self or others is uncommon, though distress or impairment can still be present.	A young person's sense of self may be somewhat inconsistent with how others perceive them, and injuries to their self-esteem can be difficult to recover from. Goal setting may be compromised, with even minor setbacks proving difficult to manage. They may experience conflict with teachers or peers while remaining able to attend school, and limitations in understanding others' perspectives can make close relationships difficult to develop, more often marked by minor, non-lasting conflict, or by deference to others to avoid conflict. Under stress, their appraisal of situations may be somewhat distorted, though their broader understanding of reality, distinguishing what is actually happening from their fears or assumptions about it, typically remains intact.
Moderate PD	Meets general diagnostic requirements for PD. Difficulties affect multiple areas of a young person's functioning, such as identity, close relationships, or managing impulses, though some areas may still be less affected. Most of their relationships and roles are noticeably affected, often marked by conflict, withdrawal, or dependency. Harm to self or others is more likely than at the mild level.	A young person's sense of self may become incoherent during periods of crisis. They may have considerable difficulty maintaining positive self-esteem or hold an unrealistically positive self-view. Setbacks often bring marked distress and disengagement, or unreasonable persistence in pursuing unlikely goals, alongside little genuine interest in sustained engagement with school. Major limitations in understanding others' perspectives hinder close relationships, and existing relationships tend to involve serious, volatile conflict or significant imbalance. Under stress, their appraisal of situations may be markedly distorted, occasionally accompanied by mild dissociation or paranoid-type beliefs.
Severe PD	Meets general diagnostic requirements for PD. There are severe disturbances in a young person's sense of self. Problems relating to others seriously affect virtually all relationships, and the ability or willingness to fulfil expected social or educational roles is absent or severely compromised. These disturbances are severe and affect nearly all areas of personality functioning and are often associated with harm to self or others, alongside severe impairment across personal, family, social, educational, and other important areas of life.	A young person's self-view is typically highly unrealistic, unstable, or contradictory, with serious difficulty regulating self-esteem, emotional experience, and impulses, and limited capacity to set or pursue realistic goals. Relationships, where present, lack mutuality and are often shallow, one-sided, or highly conflictual, at times to the point of violence; family relationships may be absent or marred by significant conflict. They may have extreme difficulty acknowledging difficult emotions and may be unable to sustain engagement with school due to poor effort, performance, or behaviour such as outbursts. Under stress, their appraisal of situations may become extremely distorted, often accompanied by dissociation or paranoid-type beliefs.

The Integrated Clinical Staging — Tiered Care Model

Clinical staging and the tier system each serve a different purpose. Staging describes where a young person's current presentation sits in terms of severity, while the tier system describes the level of service intensity available to respond to that need. Historically, these two frameworks have existed separately, with no formal link between a young person's clinical stage and the tier of care they are matched to. This creates a gap: a young person's presentation might be well understood clinically, but the connection between that understanding and where they should actually be seen, and at what intensity, is left to individual clinical judgement rather than a shared, consistent structure. This is the first model to bring clinical staging and tiered care together in this way for PD, directly linking each clinical stage to the tier of service best matched to it. In doing so, it gives clinicians a single, practical reference point for matching care to needs. The model is presented below.

Table 3: Integrated Clinical Staging—Tiered Care Model

Inpatient Unit, Hospital in the Home, CAMHS Crisis Connect and WACHS Emergency Telehealth Service*

Tier System			Clinical Staging	
Tier	**Definition of Tier**	**Service Examples**	**Clinical PD Stages Covered**	**What This Range Includes**
1	Non-specialists in mental health that provide development opportunities that promote mental health and wellbeing, initiate prevention strategies, identify mental health problems early and refer children for assessment. Some case management, advice and treatment are also provided.	Primary care (GPs), ReachOut, school staff (teachers, school psychologists, nurses, and counsellors), Department of Communities, and professionals working in residential care, among others.	**At Risk**	No current PD-related difficulties, but known risk factors present, such as family history, early adversity, or early risk-taking behaviour.
2	Identify children with mental health problems and disorders and assess less complex, severe or persistent cases.	Headspace, Moderated Online Social Therapy (MOST)	**At Risk – Mild PD**	Ranges from known risk factors with no current difficulties (At Risk), through noticeable personality characteristics not yet meeting diagnostic threshold (Personality Difficulty), to PD with mild difficulties in some areas of functioning (Mild PD).
3	Provide emergency services, assessment, and some aspects of treatment for complex, persistent and more severe cases; case manage multi-modal service provision; screen and refer to tier 4, train and consult to tier 1 and 2 services; undertake research and development programs.	Community CAMHS Intake and Intensive Treatment (IIT)	**Moderate – Severe PD****	Ranges from PD with marked impairment across multiple areas of functioning (Moderate PD), through to severe, pervasive PD affecting nearly all areas of functioning (Severe PD).
		WACHS ICAMHS	**Moderate – Severe PD**	Same as above.
		Acute Care Response Team (ACRT; Metropolitan and Regional)	**Personality Difficulty – Severe PD**	Spans the full severity range, from noticeable personality characteristics below diagnostic threshold (Personality Difficulty), through to severe, pervasive PD (Severe PD).
4	Provide complex assessment, treatment of the most complex, persistent or severe presentations.	Community CAMHS Continuing Treatment (CT)	**Severe PD**	Severe, pervasive PD affecting nearly all areas of functioning.

* Services shown in the arrow (Inpatient Unit, Hospital in the Home, CAMHS Crisis Connect, and WACHS Emergency Telehealth Service) can be accessed by young people at any stage, according to need, as their primary focus is risk stabilisation. Any emergency department can contact CAMHS Crisis Connect or the WACHS Emergency Telehealth Service for support.

** Some young people may already present with severe PD at their first contact with services.

Clinical Decision Thresholds

Clinical decision thresholds were developed in consultation with the Expert Panel, WACHS ICAMHS stakeholders and CAMHS senior service and clinical leads. These decision thresholds guide when a young person's care should move between tiers, based on their level of risk, functional impairment, and distress to self and others. These thresholds do not replace existing policies and procedures, which continue to apply as normal; they provide a shared structure for considering when care should shift. The decision-making examples set out in Table 4 are illustrative rather than exhaustive, and clinical judgement should always apply.

Matching Tier of Care to Current Need

A young person's clinical stage may remain stable over time, even while their needs change. Tier of care should therefore be matched to a young person's current need, not their stage alone. For example, where a young person's primary need is functional support, such as help re-engaging with school or securing stable housing, care should focus on that need directly, rather than automatically prescribing individual psychotherapy because of their clinical stage.

Need, rather than risk, should drive this tier matching. High-quality care responds to what a young person actually needs, and doing so tends to reduce risk as a result, rather than treating risk as the primary driver of care, with need addressed only incidentally.

This same principle applies to movement between tiers. Movement up a tier should be understood as titrating care, adjusting the amount and intensity of support to match a young person's current need, rather than as escalation. This distinction matters. Tier movement should never be framed or experienced as a "fail up" system, in which access to a service depends on having first shown that other, less intensive options were ineffective.

Movement Between Tiers Is Not Inherently Helpful

Repeated movement between services or tiers can itself cause iatrogenic harm, for example, by reinforcing a young person's difficulties or fostering dependence on services rather than their own capacity to cope. Decisions about continued service involvement should always consider whether ongoing involvement may become dependency-promoting or otherwise unhelpful.

Avoiding movement between tiers may require clinically indicated risk-taking, informed by relational formulation. This means a clinician may discharge a young person who remains at some ongoing risk, but who has made meaningful functional gains, such as returning to school. The model gives greater weight to functional progress and a young person's current need than to requiring risk or symptoms to fully resolve before care is titrated down or ended.

Flexibility in Applying Staging and Tier Mapping

The integrated staging and tier model is intended to be applied flexibly, with care matched to a young person's needs as they change over time. Young people are not required to begin at Tier 1 or to progress through each tier in sequence. Entry into care is determined by presentation, and tiers may be bypassed where clinically appropriate. Staging and tier mapping should therefore be used as a guide to clinical decision-making, not as a fixed rule. Decisions about the most appropriate tier should consider a young person's treatment goals as well as the severity of their presentation. A young person may meet criteria for a more severe stage but be better served at a lower tier if their primary goals relate to practical needs, such as securing stable housing or finding employment. Regardless of where a young person enters care, clear communication and well-coordinated handovers between services remain essential to maintaining continuity of care.

Handover, Families, and Systems Work

Warm clinical handover between services needs to be thorough at every transition between tiers. See the Handover and Transition Between Services section of Good Clinical Care chapter for further detail on what this should include.

Families and carers should be collaborated with regarding decisions about titrating care. However, they should not be expected to hold ongoing risk without being adequately equipped and supported to do so, particularly where a young person is discharged. This is consistent with this framework's Good Clinical Care principles on psychoeducation and skills-building for families and carers.

At more severe clinical stages, care extends beyond the young person and their immediate treatment team. Clinicians should expect greater involvement with the systems around a young person, working directly with families, liaising with schools to support engagement or adjust expectations, and coordinating with child protection where relevant to a young person's safety or living situation. This systems-level work should be built into care planning at these stages, not treated as an occasional add-on when a crisis arises.

Table 4: Example Clinical Decision Thresholds for Moving Between Tiers and Stages

Inpatient Unit, Hospital in the Home, CAMHS Crisis Connect and WACHS Emergency Telehealth Service*

Tier	Example Service	Clinical PD Stage	Moving Up	Moving Down
1	Primary Care	**At Risk**	A young person may be referred to tier 2 when a service identifies emerging or subthreshold difficulties needing more targeted support than a tier 1 setting can offer, or when their difficulties don't yet meet CAMHS intake criteria.	N/A
2	Headspace	**At Risk – Mild PD**	A young person may be referred to tier 3 (e.g. by a GP or school) into CAMHS or may present through CAMHS Crisis Connect with their family. For example, if a young person's difficulties escalate beyond what Headspace can safely manage, such as emerging self-harm or a marked decline in functioning at school, this would prompt referral into CAMHS.	A young person may return to tier 1 once their presentation stabilises and tier 2 level intervention is no longer needed.
3	Community CAMHS IIT Stream	**Moderate – Severe PD****	Whether a young person continues with Community CAMHS IIT depends on their distress to self and others, overall functioning, and treatment goals, not on whether self-harm is occurring or how severe it is. A young person may remain here while self-harm is present, if their level of functioning is not severely impacted and they are still engaging (e.g., attending school), or if their goals are clearly suited to Community CAMHS IIT.	A young person may transition out of Community CAMHS IIT once their engagement and functioning have stabilised and intensive treatment is no longer required, or when the young person and their team agree their goals have been met.
	WACHS ICAMHS	**Moderate – Severe PD**	See WACHS ICAMHS section below.	See WACHS ICAMHS section below.
	ACRT (Metropolitan and Regional)	**Personality Difficulty – Severe PD**	A front-door, short-term service for young people with acute but not necessarily complex needs (two contacts a week for eight weeks). A young person may be supported by ACRT when a safety plan can't be established at home, or when they are already in a DBT program or Community CAMHS IIT/CT and experience an acute risk episode.	A young person typically completes their engagement with ACRT once risk has stabilised over the short-term period.
4	Community CAMHS CT Stream	**Severe PD**	A young person may enter Community CAMHS CT from Community CAMHS IIT, or be referred to Community CAMHS CT directly, when their treatment needs and goals extend beyond shorter-term, intensive treatment. This may occur where there is declining functioning and/or increasing risk. What matters is whether these patterns are persistent and chronic, not a single incident.	A young person may return to tier 3 (e.g., Community CAMHS IIT), or exit tier 4, once their presentation has stabilised, once the young person, their family and their team agree their goals have been met, or if engaging with this level of care is not possible for them or their family.

* Services shown in the arrow (Inpatient Unit, Hospital in the Home, CAMHS Crisis Connect, and WACHS Emergency Telehealth Service) can be accessed by young people at any stage, according to need, as their primary focus is risk stabilisation. Any emergency department can contact CAMHS Crisis Connect or the WACHS Emergency Telehealth Service for support.

Service-Specific Considerations

ACRT (Metropolitan and Regional)

ACRT is a front-door service for young people with acute, but not necessarily complex, needs. It is more intensive than community CAMHS (two contacts a week for eight weeks, compared with one a week) and is short-term by design. Like other services in this model, it can be accessed across a range of stages, for example, when a safety plan cannot be established at home, or when a young person already engaged in a DBT program experiences an acute risk episode.

Inpatient Unit

It is important to be clear about the role of the inpatient unit within this model. The inpatient unit is not positioned as a tier, or as the next step beyond tier 4. Admission is determined by acute risk rather than PD stage, so the inpatient unit sits alongside the tier system and can be accessed at any point, according to need. For young people with PD, the role of the inpatient unit is to provide a safe, contained environment through an acute period, while working to return the young person to their family and community as safely as possible. Admissions are generally kept brief and goal-focused, as longer stays can disrupt a young person's connections with family, school, and community supports. Admission does not in itself reduce or change a young person's underlying risk, and the inpatient unit is not intended as rehabilitation.

A young person may be admitted to the inpatient unit when their risk becomes too high to safely contain within community hours, their safety plan, or their family's care plan. Admission usually occurs via CAMHS Crisis Connect. Most young people admitted will already be engaged with a tier 3 or 4 community team, which remains involved throughout the admission, and decisions about admission are made together with that team. In some cases, however, a first presentation may reveal a level of risk that was not previously known. Before admission, the team weighs what admission would achieve that could not be achieved at home, such as safety, communication, medication management, or assessment of a co-occurring disorder, against its potential risks.

A young person may return home and to community care once a parent or carer can tolerate holding some ongoing risk. The goal is to support the family to manage risk, not to eliminate it. All decisions during admission, including leave, are made by the consultant psychiatrist, with chronic elevated risk discussed daily. A young person can be readmitted to the inpatient unit later if needed, so this remains a flexible, ongoing process rather than a one-way decision.

CAMHS Crisis Connect

CAMHS Crisis Connect provides crisis stabilisation rather than diagnostic assessment. Referral decisions are based on the severity of a young person's presentation at the time of contact, irrespective of the underlying cause. A young person may initially present for reasons unrelated to PD, with a PD-related pattern becoming apparent only through ongoing engagement with the service. Where a young person presents repeatedly, the team typically considers whether admission to the inpatient unit or referral to more intensive community treatment would better serve their longer-term needs than continued short-term crisis intervention.

Assessment in CAMHS Crisis Connect differs according to whether contact occurs by telephone or in person. Telephone contact is typically the first point of engagement, with the team assessing the nature of the crisis based on the account provided by the young person or their caregiver, and the level of engagement achievable by phone. The majority of crises are resolved through this contact alone. Attendance at an emergency department is common for presentations involving a high level of risk, or where telephone engagement with the young person or caregiver is insufficient to manage the situation safely. Face-to-face assessment provides a clearer basis for decision-making.

The same considerations inform decisions between ACRT, admission to the inpatient unit, and continued community care. These being the precipitants of the current crisis, the family or social supports available to maintain the young person's safety, and the capacity to engage an existing treatment team without delay. A caregiver's capacity to support the young person is a central consideration, consistent with the service's priority of maintaining care in the community wherever safe to do so. Community CAMHS is generally appropriate where a young person has a supportive family and an existing treatment team. ACRT is indicated where distress is high and the family system, though under strain, remains functional, with a caregiver able to provide some support but requiring more intensive input than is currently available. Admission to the inpatient unit is warranted where caregiver capacity has been substantially or entirely exhausted, such as in cases of significant carer burnout.

Governance of these decisions is tiered according to setting. Face-to-face assessments in the emergency department are discussed with the consultant psychiatrist as standard practice. On the telephone line, escalation is graded: staff first consult a clinical nurse consultant or their proxy, escalating to the consultant psychiatrist only where the level of risk warrants this, while the referral decision itself remains the responsibility of the treating clinician. Warm handover should follow every decision: a follow-up call after an emergency department assessment, a further call following crisis line contact where indicated, and direct notification to a young person's existing community CAMHS team wherever admission to the inpatient unit occurs.

WACHS ICAMHS

Applying this model in regional and rural WA looks somewhat different in practice, given the service context in which WACHS operates. WACHS regions do not have a local child and adolescent inpatient unit. Where inpatient admission is required, a young person is therefore usually transferred to Perth, most often to Perth Children's Hospital. ACRT typically manages this transition, with the inpatient unit receiving the young person.

The WACHS ICAMHS Specialist Hub (WISH) operates alongside WACHS ICAMHS teams to support specialist care across country WA. WISH is a virtual service delivered by a multidisciplinary team of specialist practitioners, including Aboriginal Mental Health Workers and Lived Experience (Peer) Workers. It provides specialist consultation, assessment, treatment, and intervention for children, young people, and their families, with areas of expertise including PD, complex trauma and attachment, Aboriginal social and emotional wellbeing, infant mental health, eating disorders, family therapy, and neurodevelopmental disorders. Young people can only be referred to WISH through their local hospital or WACHS ICAMHS team.

WISH supports continuity of care between metropolitan and regional services and extends what can be delivered locally by working in partnership with WACHS ICAMHS teams. It also builds regional workforce capability through training, mentoring, and clinical supervision, enabling more young people to receive care closer to their home.

Statewide Services

Services such as Complex Attention and Hyperactivity Disorders Service (CAHDS), the Gender Diversity Service, and the Eating Disorders Service are not included in this model, as they are not primary providers of PD care. A young person may nonetheless remain engaged with one of these services for the assessment or clinical intervention it offers within its own area of focus, without PD being treated there. Where PD is identified or relevant, these services are expected to screen, diagnose, and refer the young person into the appropriate CAMHS tier and stage, rather than delivering that treatment themselves. In some instances, care may instead be shared between CAMHS services.

Case Study

Maya is a 15-year-old girl living with her mother and younger brother. She was referred to CAMHS by her GP following escalating concerns from both her mother and school, including worsening low mood, marked irritability, and frequent, escalating episodes of self-harm used to manage overwhelming distress. She presented with intense, rapidly shifting mood states, a pervasive fear of abandonment that drove frequent, volatile conflict with friends and her mother, and a highly unstable and contradictory sense of self, describing uncertainty about "who she really is" outside of how others perceived her. Under stress, she described feeling detached from herself and becoming convinced that others were turning against her. She had recently disengaged from school entirely and had withdrawn from most of her friendships. Her mother reported being up through the night on multiple occasions, unable to keep her safe or de-escalate her distress at home.

At CAMHS triage, Maya's presentation was assessed against her sense of self, her capacity to regulate her emotions and impulses, and the state of her relationships with family and peers. Her difficulties affected nearly all areas of her functioning, including her relationships, her capacity to attend school, and her safety, and were consistent with Severe PD. Given the severity, persistence, and level of risk and distress involved, she was placed directly with the Tier 4 Community CAMHS Continuing Treatment team, rather than through a shorter-term intake pathway. A foundational biopsychosocial formulation was developed collaboratively with Maya and her mother, layered with a PD-specific formulation considering Maya's relational patterns, particularly her fear of abandonment and its impact on her friendships and her relationship with her mother. Maya's own goals were central to care planning: she wanted to rebuild her friendships and eventually return to school. Maya commenced individual therapy alongside family-focused sessions with her mother, with a shared safety plan developed collaboratively and reviewed regularly.

Several weeks into treatment, Maya's presentation deteriorated further. Her self-harm increased in frequency, and she made a suicide attempt at home. Her mother contacted CAMHS Crisis Connect, and following assessment, it was determined that Maya's risk could no longer be safely contained within her existing safety plan or within community working hours. She was admitted to the inpatient unit for stabilisation. Her Community CAMHS Continuing Treatment team was consulted throughout and provided a full handover, including Maya's shared formulation, her updated risk assessment, her existing safety plan, and her current goals, so the inpatient team could understand not only what had happened, but what had helped so far and what Maya was still working towards.

Following a period of stabilisation, and once her mother felt able to tolerate holding some ongoing risk with additional supports in place at home, Maya's care was handed back to her Community CAMHS Continuing Treatment team. On discharge, a warm clinical handover between the inpatient and community teams ensured continuity of care: Maya's inpatient unit and community teams were both fully briefed on her admission, her updated formulation, her current risk assessment, her revised safety plan, and her goals moving forward, before treatment resumed in the community.

Risk Escalation Thresholds

Alongside the tier and stage thresholds set out above, stakeholders were also consulted on a related but separate question: what determines whether a risk concern needs urgent escalation to a senior clinician, rather than being able to wait for routine MDT review.

The existing risk assessment documentation process (CAMHS Risk Assessment and Management Plan; CRAMP) provides a basis for this. A CRAMP score of 3 or above sets the minimum threshold: at this point, escalation to a senior clinician is required. This should happen at the time, rather than being deferred to routine MDT discussion. This model does not introduce a new or separate risk process; it relies on the same CRAMP thresholds and existing procedures already in place. In practice, a young person presenting with PD will often meet CRAMP level 3 or 4 readily, and recent self-harm or a recent attempt will, by definition, reach level 4.

Importantly, this threshold does not replace clinical judgement or a dynamic risk assessment. A clinician who remains concerned about a young person, even where CRAMP does not reach 3 (for example, in the context of a fluctuating or dynamic risk picture), should still seek senior clinician input. This is encouraged practice, not an exception to be justified.

More broadly, what differentiates a case needing urgent escalation from one that can wait for routine review is the young person's level of risk and the level of containment available to manage it. Concern tends to escalate for clinicians when a viable safety plan cannot be put together; for example, where a young person or their carers are not engaging with what would help or where the young person is working around the boundaries that carers have tried to set. Additionally, risk is not limited to self-harm or suicidality: it can also include risk to others, physical aggression, or a family reaching the point where they can no longer safely manage a young person's distress at home. These circumstances warrant urgent attention and should not wait, even where the CRAMP rating may fall below a 3.

Section 3

Clinical Recommendations

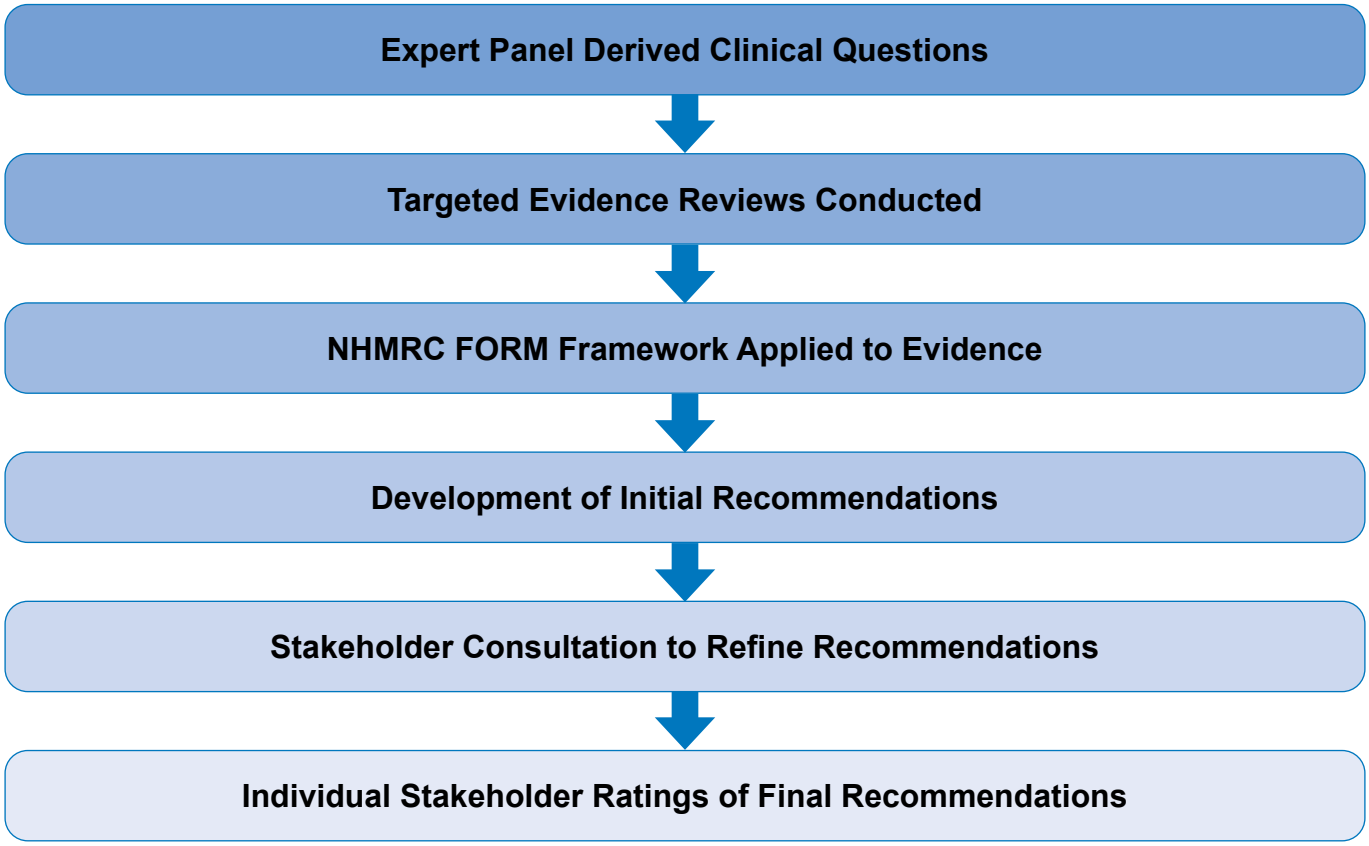
32 clinical recommendations across 7 clinical domains, developed through Expert Panel guidance, evidence review, and structured stakeholder consultation.



Recommendation Development Process

The development of the clinical recommendations was modelled on established guideline development processes, including those by the APA (APA, 2020) and National Health and Medical Research Council (NHMRC; Hillier et al., 2011). Consistent with this process, a multidisciplinary national Expert Panel was convened to guide the development process (outlined in Figure 7 below and described in detail in the following sections). As the evidence base for managing PD in young people remains emerging, the clinical recommendations were developed through a combination of systematic evidence review and extensive stakeholder consultation, incorporating clinical, research, and lived experience perspectives. This approach is consistent with the APA's approach of supplementing evidence reviews with expert opinion where high-quality research evidence is limited (APA, 2020). The NHMRC FORM Framework (Hillier et al., 2011) was applied to assess and grade the evidence identified through this process.

Figure 7: Overview of the Process Used to Develop the Clinical Recommendations



Expert Panel

The role of the Expert Panel was to guide the development of the clinical recommendations from inception through to finalisation. The panel comprised clinicians, researchers, and system experts from across the child and adolescent mental health field, including specialists in PD in young people, as well as a CAMHS Lived Experience Coordinator. The panel first identified the clinical areas most in need of best practice guidance, initially agreeing on six priority domains: assessment and formulation; treatment; risk and governance management; collaboration; outcome measurement; and out of home care. Following stakeholder consultation, the risk and governance management domain was separated into two distinct domains, Clinical Risk Management and Risk Governance, reflecting the panel's view that clinical risk assessment and management is conceptually distinct from the governance and workforce structures that support it. This resulted in a final set of seven clinical domains. The panel remained centrally involved throughout, contributing to the refinement and finalisation of the clinical recommendations at each stage of the process.

Evidence Reviews

Targeted evidence reviews addressed each of the clinical domains. Searches were carried out across relevant scientific databases, with existing national and international guidelines and policies also consulted. Evidence was screened for relevance and applicability to young people under 18 years of age. Where the evidence base was limited to adult populations, the Expert Panel played a greater role in contextualising and applying findings to young people within a CAMHS setting.

Grading the Evidence

To ensure the evidence underpinning each clinical recommendation was assessed in a rigorous and transparent way, the NHMRC's FORM Framework was applied (Hillier et al., 2011). The FORM Framework is an established Australian method for evaluating and grading evidence in clinical guideline development and was selected for its applicability to the local healthcare context.

For each clinical domain, evidence was assessed against five criteria: the strength of the evidence base; consistency of findings across studies; clinical impact; generalisability to young people with PD; and applicability to a CAMHS context. Each criterion was graded from A (excellent) to D (poor), and an evidence statement was written to reflect the findings of the evidence base for each domain. As the FORM assessment was completed prior to the separation of the risk and governance management domain into two distinct domains (Clinical Risk Management and Risk Governance), the assessment reflects the original six domains. The FORM Framework assessment for each domain is reported in Appendix B.

Development of Initial Clinical Recommendations

Following the evidence reviews and grading of the evidence base, an initial set of 54 clinical recommendations was developed across the clinical domains. Consistent with the FORM Framework, the wording of each clinical recommendation was chosen to reflect the strength of the underlying evidence. Stronger language such as "must" or "should" was used where evidence was more robust, while more tentative language such as "consider", "may" or "could" was used where evidence was more limited or emerging (Hillier et al., 2011). An overall grade was then assigned to each clinical recommendation to indicate the degree of confidence that can be placed in the evidence supporting it, ranging from A (evidence can be trusted to guide practice) to D (evidence is weak and recommendations must be applied with caution).

Consulting Stakeholders

Following the development of the initial 54 clinical recommendations, an extensive stakeholder consultation process was undertaken to ensure the clinical recommendations were applicable, feasible, and safe to apply when working with young people with PD, their families and carers.

Four key groups were involved, each received a summary of the evidence reviews and initial clinical recommendations prior to discussion, with conversations tailored to the expertise and perspective of each group. These groups were:

Expert Panel: The Expert Panel reviewed the clinical recommendations with a focus on the applicability of the evidence base, drawing on their specialist clinical, research, and system expertise across the PD field.

Internal CAMHS stakeholders: This comprised a multidisciplinary group of CAMHS clinicians and staff, including child and adolescent psychiatrists, clinical psychologists, nurses, social workers, and Lived Experience Coordinators, some of whom had existing experience working in the PD space. Their consultation focused on the feasibility of implementing the clinical recommendations within routine CAMHS practice.

External stakeholders: This group represented a broad range of services and systems, including representatives from the Office of the Chief Psychiatrist, the Department of Communities, the Department of Education, emergency medicine at Perth Children's Hospital, WACHS, South Metropolitan Health Service, North Metropolitan Health Service and Headspace. Their consultation focused on the alignment of the clinical recommendations with broader service contexts and systems.

People with lived and living experience: This group, including young people with lived and/or living experience of PD and carers of young people with PD, reviewed the clinical recommendations with a focus on their relevance and safety from a consumer and carer perspective.

Additional targeted consultation was undertaken with Aboriginal Mental Health Workers to ensure cultural considerations were adequately reflected throughout the clinical recommendations. Following all consultation sessions, feedback was synthesised, and the clinical recommendations were refined, resulting in a final set of 32 clinical recommendations.

Finalising the Recommendations

Following stakeholder consultation, the refined set of 32 clinical recommendations was circulated to all stakeholders via an online survey. For each clinical recommendation, respondents rated the perceived balance of benefits and risks, with response options ranging from "benefits clearly outweigh risks" to "risks clearly outweigh benefits". This approach is consistent with established guideline development practice and provides a measure of the clinical utility and appropriateness of each clinical recommendation (Kremer et al., 2012). Stakeholder ratings supported the final set of 32 clinical recommendations, with the perceived benefits of each recommendation outweighing the risks.

The subsequent sections present the clinical recommendations under each clinical domain. For each domain, the clinical recommendations are first presented, followed by a brief summary of the evidence that informed those recommendations, and finally, a summary of feedback from the stakeholder consultation. This is followed by a brief summary of the evidence review that informed the clinical recommendations, and a summary of feedback from the stakeholder consultation.

Assessment and Formulation

Clinical domain 1 of 7. This domain focuses on the assessment and formulation of PD in young people and includes six clinical recommendations to guide best practice (outlined below in Table 5).

Table 5: Clinical Recommendations for the Assessment and Formulation Domain.

No.	Recommendation
1	As PD is common in mainstream care, all CAMHS clinicians should be able to undertake comprehensive, developmentally informed assessments to inform diagnosis. In complex presentations (e.g., multiple comorbidities or prolonged non-response to treatment), clinicians should seek specialist input in line with governance processes/ procedures. All diagnoses within CAMHS must be endorsed by the relevant consultant psychiatrist.
2	Assessment should be collaborative, clearly explained, and both diagnostic and therapeutic. Clinicians should involve the young person, their family/caregivers, and other key supports identified by the young person where appropriate, and explain the purpose, structure, and expected timeframe of the assessment. The process should be flexible and responsive to the young person's needs. Assessment should include: a. A structured clinical interview, supported by screening tools where appropriate. b. Exploration of how the young person typically thinks, feels, and relates to others, to distinguish between usual patterns and changes related to current stress or mental state. c. Functioning across key domains (e.g., relationships, education, occupational), including strengths and protective factors. d. Risk assessment. e. Consideration of neurodevelopmental conditions (e.g., attention deficit hyperactivity disorder [ADHD], autism spectrum disorder [ASD], fetal alcohol spectrum disorder [FASD]), ensuring these are identified and differentiated where relevant. f. Assessment of the young person's support network, for example, trusted professionals, services currently involved, and who is in their family, friends, and wider support structures.
3	Clinicians should consider and assess a broad range of risks beyond self-harm and suicidality in assessment, formulation, and care planning, and understand how these risks may contribute to the development and maintenance of symptoms. Risk should be understood as dynamic and fluctuating and reviewed regularly over time. Risk factors to consider include: a. Physical and behavioural health, including sleep, eating patterns, substance use, self-medication with irregularly obtained gender-affirming medical treatments, smoking, obesity, chronic health conditions, and chronic pain. b. Sexual and reproductive health, including unsafe sexual activity, inconsistent contraception use, coercive experiences, hypersexuality, vulnerability to exploitative or harmful relationships and factors related to menstrual cycles (e.g., premenstrual symptoms). c. Developmental adversity, recognising that adverse experiences are common but not universal and should not be assumed. For Aboriginal and Torres Strait Islander young people, consider the impact of intergenerational trauma. d. Family, social, and environmental context, including family adversity, socioeconomic disadvantage and parental mental health. e. Social, interpersonal, and educational functioning, including difficulties in relationships, peer conflict or bullying, including exposure to homophobic and transphobic bullying, social isolation, disengagement from peers or activities, and educational disruption (e.g., school refusal, non-attendance, or poor engagement).
4	Formulation should adopt a dimensional and developmental approach, identifying patterns in self and interpersonal functioning (e.g., emotional reactivity, coping styles, impulsivity) that vary in severity from mild to severe and change over time. Clinicians should consider the severity, persistence, rigidity, and functional impact of these patterns. Formulation should be collaborative and revisited over time as an evolving hypothesis.
5	PD should be diagnosed in young people aged 12 years and older when DSM-5-TR or ICD-11 criteria are met and should not be withheld solely due to concerns about stigma or assumptions of developmental instability.
6	Clinicians should explain the diagnosis in a way that supports engagement with the young person and their family, beginning with an individualised formulation that explains how the young person's difficulties have developed and are being maintained, followed by introduction of the diagnosis in a developmentally appropriate and sensitive manner. Clinicians should explain what the diagnosis means, emphasise the realistic possibility of recovery, and support the young person to understand their difficulties in a way that reduces self-blame.

Evidence Summary

A summary of the evidence used to inform the clinical recommendations in this clinical domain is provided in the section below.

The evidence review for this domain focused on four key areas in assessing and formulating PD in young people:

1. Validity and appropriateness of a PD diagnosis in young people
2. Best practice in conducting assessments
3. Role of clinical formulation
4. Range of psychosocial and health-related risk factors, beyond self-harm and suicidal ideation

Diagnostic Validity and Reliability

PD can be reliably and validly diagnosed in young people, with diagnostic stability comparable to adults (Chanen et al., 2008; Miller et al., 2008). PD is not rare in youth mental health settings (Chanen & Thompson, 2018). Yet, clinician reluctance to diagnose remains common, often reflecting concerns that symptoms represent normative adolescent development or that a diagnosis may harm future care (Griffiths, 2011; Laurenssen et al., 2013; Paris, 2004; Silk, 2008). The evidence suggests these concerns are better addressed through improved training than through diagnostic avoidance, as failure to diagnose risks inappropriate alternative diagnoses and missed early intervention (Chanen et al., 2008; Papadopoullos et al., 2022).

Best Practice in Assessment

National and international guidelines consistently agree that PD in young people should be diagnosed through a comprehensive, developmentally informed clinical assessment using structured or semi-structured interview, with screening tools used only as an adjunct (APA, 2024; National Institute for Health and Care Excellence [NICE], 2009; Project Air Strategy for Personality Disorders, 2026). Diagnostic criteria must be applied with developmental sensitivity to distinguish PD symptoms from normative adolescent emotional lability and identity exploration. Where a diagnosis is made, it should be discussed openly with the young person and their support system, alongside psychoeducation and collaborative formulation.

Dimensional and Formulation-Based Approach

The evidence supports moving beyond categorical diagnosis toward a dimensional, formulation-informed approach. Clinical formulation (for example using predisposing, precipitating, perpetuating, and protective factors) explains how a young person's difficulties have developed and are maintained, and is associated with better intervention selection, reduced risk incidents, and improved understanding among young people and multidisciplinary teams (Macneil et al., 2012; Boschen & Oei, 2008; Houghton & Jones, 2016).

Both DSM-5 AMPD and ICD-11 now use a dimensional framework to define PD. Rather than treating PD as something a young person either has or doesn't have, PD traits are understood to sit on a continuum with normal developmental traits. What separates a diagnosable disorder from normal personality development is the severity, persistence, and functional impact of these traits (Chanen, 2021).

Psychosocial and Health-Related Risk Factors

Assessment and formulation should consider a broad range of psychosocial and health-related factors, not just self-harm and suicidal ideation. Relevant factors include temperamental vulnerabilities, insecure attachment, familial adversity, bullying and peer victimisation, and socioeconomic disadvantage, all of which are associated with the onset and severity of PD in young people (Bozzatello et al., 2021; Carlson et al., 2009; Winsper et al., 2016; Porter et al., 2020). Developmental adversity and trauma exposure are commonly associated with PD but should not be assumed universal, as many adults with the condition report no such history (Porter et al., 2020). Sexual and reproductive health concerns, eating disorders, and sleep disturbance are also commonly experienced by young people with PD (Thompson et al., 2017; Martinussen et al., 2016; Jenkins et al., 2021). This breadth underscores the need for a comprehensive, formulation-informed assessment considering the full developmental and contextual picture.

Consultation Feedback

Stakeholder consultation brought several important perspectives that refined and extended the initial recommendations for this domain, beginning with broad consensus that the term “PD” should be used consistently throughout this framework, rather than “BPD” or “EUPD”, with language remaining non-pathologising and focused on self and interpersonal functioning.

Who Should Assess and Diagnose

A significant area of discussion concerned who should be responsible for assessment and diagnosis. The Expert Panel emphasised that PD is diagnosable within mainstream care, consistent with the ICD-11 framework, and that all CAMHS clinicians should be supported to develop the confidence and competence to assess and diagnose. Internal CAMHS stakeholders broadly supported this but raised questions about implementation, including the need for clear guidance on training, supervision, governance, and escalation pathways. The final recommendations balanced these perspectives, affirming that all CAMHS clinicians should be supported to develop competence in assessment and diagnosis, while clarifying that specialist input should be sought in complex presentations and that all diagnoses require endorsement by a consultant psychiatrist.

> ***PD should be positioned as a common part of mainstream care. Diagnosing it should be core business for clinicians in mainstream care.***
>
> — Expert Panel member

Assessment Tools and Cultural Safety

Across groups, there was consistent feedback that assessment tools should not be overemphasised. The Expert Panel and internal CAMHS stakeholders agreed diagnosis should remain clinically driven, with structured tools used adjunctively rather than to determine diagnosis. External stakeholders and the Aboriginal Mental Health Workforce emphasised cultural safety and flexibility in assessment, noting structured interviews may be burdensome or inappropriate for some young people, including those in out-of-home care, and highlighting the importance of transparency with young people and families about what assessment involves.

The Aboriginal Mental Health Workforce also drew attention to the distinction between shame and guilt, noting that shame relating to feelings of not belonging or not being heard is a particularly significant experience for many Aboriginal and Torres Strait Islander young people, and highlighted the importance of making these conversations accessible and culturally safe. Consultation also raised the need to more explicitly address co-occurring neurodevelopmental conditions, including ASD, ADHD, and FASD, which may overlap with or be mistaken for PD.

> ***Shame and guilt are two different things. The sense of not belonging and not being heard, that is shame. This is how Aboriginal people feel.***
>
> — Aboriginal Mental Health Worker

Communicating a Diagnosis

All groups agreed that how a diagnosis is communicated is just as important as the diagnosis itself. The Expert Panel emphasised that formulation should be developed collaboratively and shared before introducing the diagnosis, with a genuine, realistic message of hope for recovery woven throughout. Lived experience stakeholders emphasised strengths-based and trauma-informed language and communicating clearly that a young person's difficulties are not their fault and do not define them.

> ***It is very important to tell the person that they have this diagnosis, and what it means. It doesn't mean it's anyone's fault and it doesn't define them, and there is realistic hope that they can get better."***
>
> ***"Having PD does not mean anyone did something wrong, it may be because of what they have been through.***
>
> — Lived experience panel members

Broadening The Scope of Risk Factors

Consultation led to a significant broadening of risk factors included in assessment and formulation. The Expert Panel emphasised assessment should extend well beyond self-harm and suicidality to include sexual and reproductive health, substance use, physical health, and broader contextual factors. External stakeholders highlighted hormonal factors and online coercive or exploitative experiences. Lived experience stakeholders noted some young people present with less visible symptoms, sometimes described as quiet presentations, with implications for how risk is identified. The Aboriginal Mental Health Workforce raised the importance of recognising intergenerational trauma, particularly for Aboriginal and Torres Strait Islander young people, while cautioning against assuming trauma is universally present or attributing blame to families.

Care Planning (Treatment)

Clinical domain 2 of 7. This domain focuses on treatment of PD in young people and includes four clinical recommendations to guide best practice for planning their care.

Table 6: Clinical Recommendations for the Care Planning (Treatment) Domain.

No.	Recommendation
7	Clinicians should adopt a dimensional and relational approach to care. The therapeutic relationship should be central, with clinicians maintaining a reflective, empathic stance that supports the young person and models adaptive ways of relating that can generalise beyond therapy. Care should be time limited and delivered within a staged model, with the level of care matched to the young person's level of need. Family/caregiver involvement and collaboration should be routine across all stages of care.
8	Care should prioritise coordinated, developmentally informed good clinical care rather than a single therapy modality. This should include flexible care management, practical support (e.g., educational and vocational functioning), and family engagement and intervention. In delivering care, clinicians should: a. Select the specialist psychotherapy (e.g. DBT-A, MBT-A) best matched to the young person's formulation, goals and needs, and integrate this therapy within broader clinical care rather than delivering it in isolation. b. Use group-based interventions as an adjunct to individual therapy, and not as the sole or default modality.
9	Trauma or developmental adversity should not be assumed to be present in all young people with PD and is not required for access to care. Co-occurring trauma and PD do not require separate care pathways. Trauma-informed care should be applied, and where trauma-related symptoms or PTSD are present, these should be recognised and treated with appropriate interventions.
10	Pharmacotherapy should not be used as a standalone treatment for PD in young people but may be considered as an adjunct to psychological intervention where clinically indicated. In prescribing medication, clinicians should: a. Use medication if needed to target clearly defined co-occurring mental health conditions, in line with standard treatment guidelines. b. Provide psychoeducation regarding purpose, potential side effects, and interactions. Clinicians should also actively monitor benefits, avoid polypharmacy where possible, and deprescribe ineffective medications.

Evidence Summary

The evidence review for this domain focused on four key areas in treating and managing PD in young people:

1. The relational treatment model
2. Specialist psychotherapies
3. The utility of group therapy
4. Pharmacotherapy

Relational Treatment Model

The evidence consistently supports a relational approach to treatment, in which understanding and working with a young person's relational patterns, both with themselves and others, is central to care rather than incidental to it. This model recognises that a young person's difficulties can be shaped not only by their internal experience but also by how clinicians and others respond to them. How a clinician responds to a young person with PD meaningfully influences treatment outcome, and a relational understanding helps clinicians maintain empathy and consistency even during crises or intense emotional reactions (Barnicot et al., 2012).

Specialist Psychotherapies

A number of specific psychotherapies have been developed and trialled for young people with PD. DBT-A has been the most extensively studied, with multiple randomised controlled trials showing reductions in suicidal ideation and self-harm, although some studies suggest this advantage diminishes over time. MBT-A has also shown benefit, particularly in reducing self-harm, though findings on PD-specific symptoms are more mixed. Evidence for other approaches, including Transference-Focused Psychotherapy and Schema-Focused Therapy, is more limited in adolescent populations, with most supporting evidence drawn from adult studies.

The evidence supports selecting the specialist psychotherapy based on the young person's individual formulation, goals and needs, and that the selected specialist psychotherapy is integrated within broader clinical care rather than provided in isolation.

Pharmacotherapy

Australian and international guidelines consistently agree that medication should not be used as a primary or standalone treatment for PD, and where used, should be limited to brief, adjunctive use. Guidelines recommend medication be reserved for situations where it can target a clearly defined co-occurring condition, with psychotherapy remaining the first-line approach and polypharmacy avoided wherever possible (Project Air Strategy for Personality Disorders, 2026; Rao et al., 2024; NHMRC, 2012; NICE, 2009; APA, 2024).

Consultation Feedback

Language And Staged Care

The evidence review initially described care using the term "intensity", but consultation found this risked being misinterpreted or felt vague to clinicians. Stakeholders recommended shifting the language to focus on need rather than fixed levels of severity. The staged care model itself was strongly supported, with stakeholders endorsing an approach that meets the young person where they are at and allows flexible movement between stages, rather than a single fixed pathway.

> ***A young person shouldn't have to 'fail' a level of treatment or care in order to progress to the next one. It's about matching the resources to the problem, you don't have to start at the lowest tier, match care to needs.***
>
> — Expert Panel member

Generalist Care and Specialist Psychotherapy

A significant area of refinement concerned the relationship between generalist care and specialist psychotherapy. The Expert Panel emphasised that generalist approaches should be recognised as valid treatments in their own right, noting the evidence base for specialist psychotherapy in young people remains limited, with no single approach demonstrating clear superiority. Stakeholders further emphasised that the principles outlined in the Good Clinical Care chapter principles should form the standard foundation of treatment, with psychotherapy considered an adjunct rather than necessary or sufficient on its own. Stakeholders recommended limiting interventions to those with evidence in child and adolescent populations rather than relying on adult literature, and emphasised that formulation, developed collaboratively with the young person and their family, should guide the level and type of care, reflected in a "doing with" rather than "doing to" approach.

> ***It is very important to partner with the young person and their family, clinicians need to keep in mind that care planning and treatment should be done 'with' them rather than 'to' them.***
>
> — Internal CAMHS clinician

Co-Occurring Trauma

Feedback on co-occurring trauma led to a shift away from a fixed, phased treatment sequence. The Expert Panel noted there is insufficient evidence to recommend specific trauma treatments, and clinicians should not feel required to deliver particular therapeutic modalities. External stakeholders supported integrating trauma-informed care within formulation rather than treating it as a standalone step. Lived experience stakeholders raised concerns about young people who may not reach stabilisation, and how services can continue to support them. This shaped the final recommendation that trauma should not be assumed present in all young people with PD and is not required for access to care.

> ***Clinicians should look at utilising curiosity when working with trauma, and keep it person-focused, for example, asking what is happening and why they feel this way, rather than focusing so much on trauma specifically. Trauma is often going to be ongoing, and clinicians should always put safety first.***
>
> — Lived experience panel member

Pharmacotherapy

Consultation on pharmacotherapy surfaced two competing concerns. Stakeholders cautioned the recommendations could be read as discouraging medication use altogether, noting some young people experience frustration when medication isn't offered, and that medication can be important for co-occurring conditions such as ADHD, where access should not be unnecessarily restricted. At the same time, stakeholders emphasised the limited evidence for pharmacological treatment of PD specifically, recommending medication be clearly directed toward defined co-occurring conditions rather than the disorder itself, and flagging the risks of polypharmacy. Lived experience stakeholders added the importance of clear psychoeducation about medication purpose and side effects, and planning for continuity of medication following discharge from inpatient settings. Together, this led to pharmacotherapy being positioned as an adjunct to psychological intervention where clinically indicated, without discouraging appropriate use.

> ***It can be frustrating to not get medication. For some people therapy does work really well, but for me, I really needed the medication, and sometimes if you rely too much on therapy and it doesn't work, it feels useless.***
>
> ***Medication is not the 'end all or be all' for treatment but should be considered as an adjunct for therapy.***
>
> — Lived experience panel members

Group Interventions

The evidence base for therapeutic communities and/or group-based interventions for adolescents with PD is mixed. Some studies have found no statistically significant difference in outcomes between group and individual therapy in adolescent samples (Beck et al., 2019), and comparable findings in adolescent anxiety treatment suggest group therapy can be as effective as individual work (Guo et al., 2021). However, individual therapy allows for a more individualised, formulation-driven approach that can be tailored to a young person's specific relational patterns, needs, and goals. Group interventions may therefore be most useful as an adjunct to, rather than a replacement for, individual therapy. Developmental evidence also suggests that adolescents are more susceptible to peer influence and risk-taking within group settings than adults (Gardner & Steinberg, 2005), raising concerns about the potential impact of group dynamics for young people with PD.

That said, groups offer distinct benefits that individual therapy cannot replicate, including efficiency of time, space, and staffing, and the opportunity to observe skill use in real peer interactions (Ninan et al., 2019). Co-rumination among adolescent peers, often viewed as a risk, has also been linked to increased friendship closeness rather than social isolation (Rose et al., 2014; Rose et al., 2016), and emerging evidence points to symptom reduction from group therapy specifically in PD (Bartsch et al., 2026). While McLaughlin et al.'s (2019) meta-analysis found group treatment superior to treatment as usual across PD features, suicidality, depression, anxiety, and general mental health, this evidence was drawn from adult populations and cannot be assumed to generalise directly to adolescents.

Taken together, the literature suggests group interventions carry meaningful therapeutic value, particularly for skills consolidation, social learning, and engagement, but should not be delivered as a standalone treatment for adolescents with PD. Given adolescents' heightened susceptibility to peer influence and the added relational challenges that can emerge in adolescent groups, such as resistance to authority (Ninan et al., 2019), groups should be carefully facilitated and paired with individual therapy wherever possible to address the specific needs of each young person.

Specific consultation was sought from the Expert Panel on the role of day programs and group-based interventions in addressing the gap between community and inpatient care.

The panel noted that existing day program options are limited, involve small numbers of participants, and have limited evidence supporting their effectiveness. Caution was also raised about positioning group programs as a primary treatment modality, particularly given the difficulty of sustaining engagement for young people with higher levels of complexity and risk. In particular, the panel noted that structured group programs, including DBT and MBT formats, may not adequately address the practical and individualised needs of young people, such as goal setting and functional outcomes, and that group environments can carry both benefits and risks depending on the individual. The panel emphasised that group programs should not be the default or sole modality of care, and that the principles outlined in the Good Clinical Care chapter, including clinical case management, practical supports, direct engagement with the young person and their family, and collaboration with families and schools, should guide how flexible, individualised support is structured alongside any group-based component.

Clinical Risk Management

Clinical domain 3 of 7. This domain focuses on best practice in managing risk in young people with PD and includes three clinical recommendations.

Table 7: Clinical Recommendations for the Clinical Risk Management Domain.

No.	Recommendation
11	Young people with PD should be recognised as having an elevated risk of death by suicide and premature mortality. Risk assessment and management should therefore be embedded as a core component of care planning from the point of first presentation.
12	When assessing risk in young people with PD, clinicians should: a. Develop a collaborative, individualised risk formulation with the young person and their caregivers to guide care planning and escalation decisions. This should adopt a biopsychosocial and developmental approach, integrating key biological (e.g., neurodiversity, impulsivity, sleep), psychological (e.g., affective instability, depression), and social factors (e.g., family conflict, relationship instability, cultural context, peer bullying and/or assaults). b. Remain attentive to fluctuations in risk over time. Changes from baseline, particularly increasing variability or escalation, should be treated as clinically meaningful, as fluctuating risk may be more predictive of suicide than chronic, stable self-harm. c. Assess act, intent, and lethality as distinct but related components, and weigh these clinically rather than inferring risk from behaviour type alone. d. Ensure clinical judgement, formulation, and multidisciplinary consultation guide decisions regarding escalation, admission, and discharge. Risk assessment tools may support decision-making but should not replace it. e. Distinguish between situations requiring urgent escalation to a consultant psychiatrist and those appropriate for routine MDT review.
13	Where there is risk of self-harm or suicidality, safety planning should be an integral component of overall care and risk management. Safety planning should be collaborative, structured, developmentally appropriate, and embedded within a broader formulation. Safety planning should: a. Actively involve the young person and parents/carers, supporting age-appropriate autonomy and ownership, while recognising that for younger adolescents, implementation will primarily sit with the caregiver. b. Empower parents and carers as key agents of change, with clear roles and guidance on recognising warning signs, supervision, emotional validation, and means restriction, while balancing adolescent autonomy and therapeutic engagement. Safety planning should identify and address, as a high therapeutic priority, recurring parent/carer-young person conflict, misunderstandings, or misattunements. c. Identify warning signs, coping strategies, and supports, including simple strategies the young person can use independently, and trusted adults, peers, professional contacts, and crisis services. d. Include explicit strategies to reduce access to lethal means, with clear responsibility for implementation and ongoing monitoring. e. Clearly define roles and responsibilities, including who is responsible for f. initiating, implementing, and reviewing the plan, and ensure integration across systems (e.g., schools, child protection or case workers, and other services), with involvement of a responsible adult where caregiving support is limited (e.g., out-of-home care contexts). g. Be practical, clearly written, and accessible during periods of crisis, shared with relevant parties (with consent), use engaging formats where appropriate and be reviewed and updated regularly as risk fluctuates.

Evidence Summary

The evidence review for this domain focused on three key areas in assessing and managing risk in young people with PD:

1. Elevated risk (particularly suicide and self-harm)
2. Conducting risk assessments
3. Safety planning

Elevated Risk

Young people with PD face elevated risk across a broad range of domains, many outlined in the Assessment and Formulation section. The evidence strongly supports recognising young people with PD as at significantly elevated risk of suicide and premature mortality, with PD consistently associated with both greater severity and recurrence of suicidal behaviour (Goodman et al., 2017; Moselli et al., 2021). Adolescents who attempt suicide are more likely to be diagnosed with PD than adults who attempt suicide and are more commonly exposed to contextual stressors such as parental loss or school difficulties, with higher rates of hospitalisation and previous attempts (Kawashima et al., 2012). Risk is further compounded by trait-level features such as impulsivity, affective instability, and identity disturbance, which contribute independently to suicide risk beyond co-occurring depression or substance use (Yalch et al., 2014; Glenn et al., 2013). This evidence underpins the recommendation that risk assessment and management be embedded as a core, ongoing component of care from first presentation, rather than addressed only once risk becomes apparent.

Risk Assessment

Research highlighted a broad range of biological, psychological, and social risk factors for suicidality and self-harm, including family adversity, trauma exposure, psychiatric comorbidity, and destabilising life events (Hawton et al., 2012; Francey et al., 2017). Risk should be understood as dynamic and fluctuating, with changes from baseline treated as clinically meaningful. Research consistently supported a respectful, collaborative approach to assessment embedded within a broader biopsychosocial understanding of the young person, rather than as a standalone task (Brent, 2011; NICE, 2022). The evidence also favoured formulation-based risk assessment over reliance on screening tools or risk stratification, both of which have limited predictive validity and may restrict access to care or perpetuate stigma (Franklin et al., 2017; NICE, 2022). Clinical judgement and multidisciplinary consultation should guide decisions on escalation and care, with act, intent, and lethality assessed as distinct but related considerations.

Safety Planning

Safety planning was consistently identified as essential for young people at risk of self-harm or suicide. While several structured models exist internationally (Stanley & Brown, 2012; Asarnow et al., 2015; Ginnis et al., 2013; Wolff et al., 2018),

the evidence converges on core components that make safety plans effective: identifying personal warning signs and triggers, developmentally appropriate coping strategies young people can use independently, identification of trusted adults and peers who can provide immediate support, accessible guidance on professional and crisis services, and collaborative strategies to reduce access to lethal means. Safety plans are most effective when brief, practical, and flexible, developed in partnership with the young person, and reviewed regularly as risk fluctuates, rather than used as a static, one-off document.

Active parent and carer involvement is consistently associated with improved outcomes, including reduced suicide attempts and suicidal behaviour, particularly when carers are supported to recognise warning signs and implement means restriction within the home (Asarnow et al., 2015; Anastasia et al., 2014). Despite this, some parents report feeling excluded from the safety planning process, pointing to a gap between best practice and what is often experienced in services. Flexibility in how and when carers are involved is also needed, particularly with young people, balancing autonomy with the protective role carers can play.

Consultation Feedback

Restructuring of Domains

A significant outcome of consultation was structural. As previously mentioned, Risk and Governance Management was initially one domain, but the Expert Panel noted grouping them together made it difficult to distinguish clinical risk assessment and management from the broader governance and workforce structures supporting it. This led to the domain being separated into Clinical Risk Management and Risk Governance, allowing each the clarity and depth it requires.

Guarding Against Desensitisation

Discussions centred on the risk that, given how commonly self-harm and suicidal ideation are experienced by young people with PD, clinicians may become desensitised and assess these experiences with less rigour than for a young person without the diagnosis. Stakeholders were clear this must be actively guarded against, with each young person's experience taken seriously and assessed in its own right. Established CAMHS risk assessment principles continue to apply, alongside recognising what may present differently for young people with PD, including subtle changes that could otherwise be overlooked. Risk also extends beyond self-harm and suicidality, and assessment should include physical health and lifestyle factors such as diet, sleep, and screening for eating disorders or restrictive eating patterns.

Assessing Risk

Stakeholders raised concerns about overemphasis on NSSI as a discrete category, recommending greater weight be placed on assessing act, intent, and lethality separately at the time of presentation. The Expert Panel highlighted that significant fluctuations in risk should be treated as clinically meaningful, with escalating or changing risk potentially more predictive of suicide than chronic, stable self-harm. This doesn't mean chronic or stable presentations warrant less attention, but that changes from baseline are an important additional signal clinicians should remain alert to. External stakeholders raised cultural considerations, noting some cultural practices may involve forms of self-injury, such as in the context of grief or mourning, and that clinicians need guidance on assessing and responding to this in a culturally safe way.

Safety Planning in Practice

Safety planning was consistently framed as a core component of risk assessment and management, not something to be overlooked. External stakeholders highlighted empowering parents and carers as active agents of change, noting the appropriate degree of autonomy for the young person varies by age and developmental stage, with responsibility often shared with or held by parents where relevant. Young people should be actively involved in safety planning in a developmentally appropriate way that supports their autonomy and moves beyond a tick-box approach, with flexible formats, including digital or app-based tools, encouraged to support genuine participation. Schools, Child Protection caseworkers for children in care, and a responsible adult for young people experiencing homelessness were all identified as important to involve. Lived experience stakeholders noted safety plans can be difficult to implement in school or workplace settings where they may limit autonomy or create a sense of being constantly monitored, and that confidentiality and privacy need careful consideration, as visible or widely shared plans may cause discomfort or stigma for the young person.

> ***All families should be informed of the safety plan but sometimes plans can be quite frustrating in the work or school setting, not being allowed any freedom and feeling constantly looked over. You could have a safety plan at CAMHS, but it can be hard at school or work if the plan is enforced everywhere, since you don't necessarily want everyone to know. There needs to be a balance.***
>
> — Lived experience panel member

Risk Governance

Clinical domain 4 of 7. This domain focuses on the governance structures and processes that support risk management for young people with PD and includes five clinical recommendations to guide best practice.

Table 8: Clinical Recommendations for the Risk Governance Domain.

No.	Recommendation
14	Clinical documentation should align with established CAMHS processes (e.g., CRAMP), including documentation of risk assessment and management plans, clinical decision-making and rationale, actions taken, communication with relevant services, and follow-up and outcome summaries.
15	Risk of self-harm and suicidality should be managed as a shared service responsibility, with clearly defined multidisciplinary roles. Young people with ongoing or complex risk should have care that involves more than one clinician, with collaboration in formulation, treatment planning, and risk management. Escalation in risk or changes in presentation should prompt discussion with the young person and their family or carers, and timely review with the multidisciplinary team, including notifying the consultant psychiatrist. Crisis management plans should be reviewed and endorsed in line with governance processes.
16	Services should implement structured post-incident review processes in line with relevant policy (e.g., WA Health). Following self-harm or suicide attempts, services should review clinical and organisational processes to support learning and safety and provide appropriate support to young people and families. Clinicians should have access to debriefing and support, which should be voluntary and separate from patient care processes.
17	Clinicians working with young people presenting with self-harm or suicidality should receive regular, role-specific training. This should include assessment, collaborative risk formulation, safety planning, compassionate communication, cultural competence, understanding of service pathways, and professional boundaries. Services should also support capability development across partner systems (e.g., schools and community services) to promote consistent and informed responses.
18	Regular supervision and reflective practice should be embedded within services. This should include structured individual and team-based reflective spaces to support formulation, manage emotional impact, and reduce unhelpful dynamics. Clinician wellbeing should be supported through access to supervision and reflective spaces, alongside individual responsibility for maintaining self-awareness and managing the impact of the work.

Evidence Summary

This domain's evidence reviews focused on five key areas in supporting clinicians to manage risk safely and consistently for young people with PD:

1. Clinical documentation
2. Multidisciplinary roles and escalation pathways
3. Post-incident review
4. Clinician training
5. Supervision

Clinical Documentation

Clear and accurate documentation was identified as a foundational component of risk governance. The evidence consistently points to documenting the clinician's risk formulation and rationale, actions taken to manage identified risk, and planned follow-up steps as essential to continuity of care, enabling information to be shared effectively across services (Pettit et al., 2018; Joiner et al., 1999; Linehan et al., 2012).

Multidisciplinary Roles and Escalation

Shared responsibility is the most effective way to manage risk for young people with complex or ongoing presentations. Involving more than one clinician in formulation, treatment planning, and risk management, supported by regular multidisciplinary review, helps distribute responsibility and strengthen decision-making (Francey et al., 2015). Clear escalation pathways and defined team roles are similarly essential to timely assessment, continuity of care, and safe handover between services (Francey et al., 2015).

Post-Incident Review

Following self-harm, suicide attempts, or other risk incidents, the evidence supports structured post-incident processes that prioritise both learning and care. These include prompt contact and emotional support for families, structured team debriefing for staff, and access to supervision and employee assistance programs (Pettit et al., 2018; Joiner et al., 1999; Linehan et al., 2012).

Clinician Training

Clinician confidence, attitudes, and effectiveness in working with young people who self-harm are strongly influenced by the training they receive. Regular, role-specific training that addresses knowledge, skills, and attitudes, and includes the voices of people with lived experience, is consistently associated with greater confidence and reduced avoidant or negative responses to self-harm (Dickinson & Hurley, 2011; NICE, 2022).

Supervision

Working with young people who are at elevated risk carries an emotional toll, with clinicians at risk of emotional distancing, desensitisation, and burnout over time (Rouski et al., 2017). Regular, high-quality supervision is essential to processing this impact, supporting reflective practice, and helping ensure clinical responses remain grounded in formulation rather than driven by reactivity in the moment (NICE, 2022; Francey et al., 2015).

Consultation Feedback

Aligning with Existing Governance

Consultation reinforced that many of the governance practices recommended in this section, such as documentation and structured senior review, should align with existing CAMHS governance processes rather than introducing new or parallel systems. Key processes to be affirmed include established psychiatric review pathways as the appropriate mechanism for senior oversight and existing WA Health post-incident procedures to guide post-incident review rather than creating separate guidance.

The Value of Supervision

Several stakeholders spoke positively about the value of supervision in this work. One clinician reflected that working with young people with PD and their families can generate intense feelings in clinicians, who may then respond in ways that are not ideal, and that engagement in supervision at both a team and individual level, alongside weekly reflective spaces, is essential to sustaining clinicians in this work. This reinforced the importance of regular, structured supervision and reflective practice at both an individual and team level, beyond standard clinical review processes. Consistent with this, external stakeholders emphasised that participation in debriefing processes should be voluntary rather than compulsory, with clearer guidance needed on how structured debriefing should be approached.

> ***My experience supervising clinicians is that engagement in supervision at a team and individual level is imperative to sustaining clinicians in this work. Young people and their families can generate intense feelings in clinicians, who can then respond in less-than-ideal ways, and splitting between team members is also quite common. In my team, we have a reflective space facilitated weekly…and this has been crucial to sustaining clinicians and managing team dynamics. I can see real benefit in a regular reflective supervision space being available in all Community CAMHS teams, outside of typical clinical reviews.***
>
> — Internal CAMHS clinician

Collaboration

Clinical domain 5 of 7. This domain focuses on collaboration with families, schools and external services involved in the care of young people with PD and includes four clinical recommendations to guide best practice.

Table 9: Clinical Recommendations for the Collaboration Domain.

No.	Recommendation
19	Clinicians should treat family/caregiver engagement as a core component of care. Caregivers should be involved from the outset within appropriate confidentiality and legal boundaries, balancing the young person's autonomy with developmental stage and carer involvement. Clinicians should: a. Maintain regular, collaborative and relationship-focused contact with carers, including sharing relevant treatment information and involving them in review and discharge planning. b. Provide timely information about care planning, with ongoing feedback. c. Involve carers across assessment, formulation, treatment planning, and risk/safety planning. d. Provide developmentally appropriate, evidence-informed psychoeducation to support understanding and reduce self-blame, including where relevant, psychoeducation about acceptance and support of diversity of gender and sexuality. e. Offer a Family/Carer Care Plan and access to ongoing supports (e.g., meetings, support groups). Where a young person is reluctant to involve family: a. Explore and address reasons for reluctance as part of clinical care and maintain family involvement as a treatment goal. b. Review and revisit family involvement regularly, recognising this as a dynamic and changing process. c. Continue to support carers within appropriate confidentiality and legal frameworks.
20	Clinicians should actively promote structured collaboration with schools and education providers to support educational and vocational engagement for young people with PD. When working with schools, clinicians should: a. Engage in shared planning processes (e.g., case conferences) to clarify roles, communication pathways, and responsibilities for risk management and educational support. b. Provide appropriate psychoeducation and person-centred guidance to support recognition of distress and promote compassionate, consistent responses, including non-stigmatising advice on de-escalation and environmental adjustments where appropriate. c. Ensure schools are not expected to deliver specialist mental health interventions; school-based supports should prioritise engagement and safety and complement, not replace, clinician-delivered therapy. d. Where school engagement is limited or not feasible, collaborate with young people and families to identify alternative educational, vocational, or training pathways.
21	Care for Aboriginal and Torres Strait Islander young people with PD should be culturally sensitive, safe and developed in partnership with their family and relevant services, recognising the impacts of intergenerational trauma, colonisation, and systemic harms. To support cultural safety and sensitivity in clinical care, clinicians should: a. Prioritise building rapport and trust before treatment, including (where guided by the young person) discussions about family, kinship, Country, and community. b. Use clear, non-medical language, allow time for reflection and response, and recognise that mainstream services may feel intimidating or alienating. c. Engage in ongoing reflective practice, prioritising cultural safety over competency and actively addressing power imbalances by inviting questions, disagreement, or refusal, and ensuring consent is informed and ongoing. d. Work in partnership with Aboriginal and Torres Strait Islander colleagues (e.g., Aboriginal Mental Health Workers) to support culturally appropriate communication, consent processes, and explanations of care.
22	Clinicians should work collaboratively with other agencies involved, completing a warm clinical handover, in a person-centred approach. All information must be communicated in a manner that is clear, accurate, timely, directive and suitable for the needs of all of those involved in the clinical handover, while respecting consent and confidentiality. This includes involvement from the child and their family, parents or guardians, and where applicable, their nominated person. It also includes coordination with other services involved in the individual's care (such as general practitioners and other clinical providers) and culturally appropriate engagement with Aboriginal children, young people and families.

Evidence Summary

This domain's evidence review focused on three key areas in collaborating with families, schools, Aboriginal and Torres Strait Islander communities and other services to support young people with PD:

1. Family and caregiver engagement
2. School collaboration
3. Culturally safe practice with Aboriginal and Torres Strait Islander young people and families

Family and Caregiver Engagement

The evidence highlights the importance of collaborating with families as a core component of care, showing that outcomes for young people with PD improve when care extends beyond individual therapy to include families, schools, and broader community systems.

Families of young people with PD carry a substantial burden, with carers consistently reporting elevated stress, grief, guilt, and social isolation, and many reporting difficulty accessing adequate support (Seigerman et al., 2020; Buteau et al., 2008; Lawn & McMahon, 2015). Research suggests that early and ongoing family involvement improves treatment engagement and outcomes, and that the alliance between clinicians and carers is closely linked to the therapeutic alliance with the young person (Karver et al., 2018). Structured psychoeducation targeting burden, disorder knowledge, and expressed emotion is the most responsive and valued form of carer support, with emerging programs and online delivery models showing promise in increasing accessibility (Lamont & Dickens, 2021; Betts et al., 2023; Gleeson et al., 2020). The evidence also points to the importance of balancing family involvement with the young person's autonomy, with the appropriate degree of involvement varying according to developmental stage, preferences, and clinical context. Where a young person is reluctant to involve family, the evidence supports maintaining this as an ongoing treatment goal rather than a prerequisite for care (Project Air Strategy for Personality Disorders, 2026).

School Collaboration

In terms of school collaboration, the evidence shows that structured capacity building improves teacher knowledge, confidence, and skills in recognising and responding to emerging PD presentations (Townsend et al., 2018; Sharp et al., 2018), with ecological models offering a broader framework for whole-school support (Harris & Jones, 2023). Educational and vocational disengagement is identified as a significant adverse outcome for young people with PD, making school collaboration an important component of care.

Culturally Safe Practice

The evidence highlights cultural safety as essential when working with Aboriginal and Torres Strait Islander young people and families. Cultural safety requires ongoing reflection on power dynamics, systemic racism, and the impacts of colonisation and intergenerational trauma, and is distinguished from cultural competency in that it involves a reflective and relational practice rather than the acquisition of fixed cultural knowledge (Curtis et al., 2019; Laverty et al., 2017).

The evidence supports trauma-informed, strengths-based approaches that centre cultural connection, kinship, and community, and highlights the importance of collaboration with Aboriginal and Torres Strait Islander colleagues, including Aboriginal Mental Health Workers, as essential to building trust and ensuring care is genuinely accessible and safe for young people and their families.

Consultation Feedback

Supporting Families When Involvement Is Limited

A central theme across groups was the importance of continuing to support families even when a young person is reluctant to involve them. Stakeholders emphasised that reluctance to involve family should be understood as a dynamic and fluid process requiring ongoing review, rather than a fixed position. Internal CAMHS stakeholders suggested separating guidance into two components: how to actively support and facilitate family involvement, and how care should proceed when involvement is limited or not possible, taking into account the young person's rights, relevant legal frameworks, and duty of care. External stakeholders highlighted the importance of balancing family involvement with the young person's autonomy, noting that excessive family involvement may be experienced as invalidating, and that the young person's voice should remain central throughout.

> ***If a young person doesn't want family involvement, this needs to be investigated. Family involvement is a goal of treatment, not a prerequisite. Refusal should be treated as a dynamic, fluid process that needs to be followed up and reconsidered regularly.***
>
> — Expert Panel member

Interagency Communication and Handovers

Interagency communication and warm clinical handovers were identified as an important area requiring clearer guidance. Stakeholders emphasised that information shared across services should be clear, accurate, timely, and person-centred, and that all relevant parties including the young person, their family, and other services involved in their care should be appropriately included in handover processes.

School Collaboration

In relation to school collaboration, stakeholders were consistent in emphasising that expectations placed on schools should be realistic and that recommendations should not be prescriptive about specific school-based interventions. The focus should be on how CAMHS can support schools to support the young person, rather than implying schools are required to deliver additional interventions. Vocational disengagement was identified as a significant adverse outcome that warranted more explicit attention, with stakeholders recommending that where school engagement is not feasible, alternative educational or vocational pathways should be explored collaboratively with the young person and their family.

> ***If a young person isn't engaging with school, help them and their family find another school or another way to study, so the family knows what else is out there and doesn't feel like they're doing something wrong. Try to get them back into some kind of school system.***
>
> — Expert Panel member

Care for Aboriginal and Torres Strait Islander Young People

Regarding care for Aboriginal and Torres Strait Islander young people, stakeholders across groups felt the initial recommendations and evidence review were potentially too prescriptive given the limited evidence base in this area. It was emphasised that care should be developed collaboratively with Aboriginal and Torres Strait Islander communities rather than through the application of specific models.

The Aboriginal Mental Health Workforce raised several important practical points, including that some Aboriginal and Torres Strait Islander young people may present as quiet or agreeable in ways that do not reflect genuine understanding or agreement, that language should be clear and accessible particularly where English may not be a first language, and that building rapport and trust prior to other aspects of care is essential. The involvement of Aboriginal Mental Health Workers was identified as critical to supporting culturally appropriate communication, consent processes, and engagement with services.

> ***Cultural safety and sensitivity are two different things, it's about developing a sensitive environment, so the person feels safe. Once you develop a culturally sensitive environment well, you create safety. You need to develop a sensitive space before anything else, so people can drop their walls and let you in.***
>
> ***Aboriginal people can be shy and timid, and are often accustomed to always saying yes, sometimes called 'yes syndrome' or gratuitous concurrence, so developing a space where they don't have to just say yes is important. Language matters too, English may be a person's third language, and it can be very scary coming to a medical appointment, for example travelling from the Kimberley. Questions should be simple, not overly medical, and people should be given time to think and answer.***
>
> — Aboriginal Mental Health Worker

Outcome Measurement

Clinical domain 6 of 7. This domain focuses on the use of outcome measurement to monitor progress and inform care for young people with PD and includes four clinical recommendations to guide best practice.

Table 10: Clinical Recommendations for the Outcome Measurement Domain

No.	Recommendation
23	Routine outcome monitoring (ROM) may be embedded in care where clinically meaningful. The purpose should be clearly explained to the young person and carers, with clear distinction between ROM used for individual care and that used for research or service-level reporting, ensuring participation is voluntary and based on informed consent. Where utilised: a. ROM should combine brief self-report and clinician-rated measures to capture both the young person's experience and clinical assessment of change. b. Measures should be psychometrically sound, feasible, developmentally appropriate, and sensitive to change (see Appendix A for list of all recommended measures). c. Data should be collected at baseline, during treatment, and at follow up. d. Results should be presented visually to support reflective discussion, with clinical judgement prioritised where data is incomplete.
24	Change over time should be monitored using a longitudinal approach across key domains of functioning. Where utilised: a. Monitoring should capture personality functioning, emotional distress, and quality of life, alongside structured assessment of suicidality and self-harm to support consistent monitoring and risk assessment. b. Assessment of personality functioning should include identity integration, impulsivity, and interpersonal difficulties. c. Where clinically indicated, monitoring may be supplemented with brief mechanism-focused measures (e.g., emotion regulation, clinician-rated measures of aggression) alongside routine risk assessment.
25	Social and relational outcomes should be routinely assessed alongside global personality functioning and quality-of-life outcomes. Where utilised: a. Assess interpersonal functioning, social participation, and sense of belonging using measures that capture real-world functioning and social connectedness. b. Measures should capture functioning across peer, family, and broader social domains. c. Where relevant, perceived social connection or isolation should be assessed using brief self-report measures to monitor changes in social integration and recovery.
26	Educational outcomes should be monitored using simple indicators of school engagement. Where utilised, school attendance rate (%) and change of chronic absenteeism status should be the primary outcome, supported by contextual information on engagement or re-engagement where available.

Evidence Summary

This domain's evidence review focused on four key areas in monitoring outcomes for young people with PD:

1. Clinical outcome measures
2. Social outcome measures
3. Educational outcome measures
4. Best practice in Routine Outcome Monitoring (ROM)

Clinical Outcome Measures

A range of psychometrically sound measures exist to capture clinical outcomes for young people with PD, spanning symptom severity, emotional regulation, depression, and self-harm and suicidality. A combination of brief self-report tools and clinician-rated measures is well supported across the literature, capturing both the young person's own experience and a clinician's independent assessment of change. Appendix A includes a detailed list of specific tools and their psychometric properties.

Beyond Clinical Symptoms

Monitoring should extend beyond core clinical symptoms. Research shows much of why young people respond differently to therapy is explained by factors outside treatment itself, such as relationships, social context, and broader life circumstances, rather than the specific therapy approach used (Wampold, 2015; Slone & Owen, 2015). This supports routine monitoring of social and relational outcomes, such as attachment, peer relationships, and broader social functioning, alongside clinical symptoms. Educational and vocational functioning is similarly affected for many young people with PD, and the evidence supports monitoring simple, practical indicators such as school attendance and engagement alongside other outcome data.

Routine Outcome Monitoring (ROM)

In relation to how outcomes should be monitored, the evidence supports the use of ROM to incorporate young people's own feedback into care, helping to counter a documented tendency for clinicians to be overly optimistic about treatment progress (Walfish et al., 2012). ROM involves systematically and regularly collecting standardised measures of symptoms, functioning, or wellbeing across treatment, with this information fed back into clinical decision-making and discussed collaboratively with the young person. The evidence for ROM is well established in adults, with meaningful improvements in treatment outcomes demonstrated when it is incorporated, but the evidence in children and adolescents remains less certain, with mixed findings reported due to the limited quality of available studies (Lambert et al., 2018). The value of ROM depends on consistent, good-quality data collection, and clinical judgement and routine assessment should continue to guide care where ROM data is incomplete or unavailable. Finally, the evidence supports presenting outcome data visually to facilitate collaborative discussion between clinicians and young people about progress over time.

Consultation Feedback

Embedding ROM in Practice

ROM was broadly endorsed by stakeholders as important and consistent with best practice, though internal stakeholders noted that embedding it meaningfully into routine care may require broader cultural change within services. A key clarification to emerge from consultation was the need to clearly distinguish between information collected as part of a young person's individual care, information used for research, and data collected to meet service or reporting requirements, with external stakeholders emphasising that any outcome measures used should have clear justification and be meaningfully integrated into treatment planning rather than collected for its own sake. Stakeholders also raised the importance of considering how additional measures could be implemented alongside existing WA Health outcome measurement requirements, rather than creating a separate or duplicative process.

Choosing Outcome Tools

Several specific tools and approaches were discussed during consultation, including measures developed specifically for PD populations and measures young people themselves may prefer. However, stakeholders ultimately favoured a more flexible approach, recommending that specific tools be listed as options in an Appendix rather than mandated within the recommendations themselves, allowing services to select measures appropriate to their context and the young person's needs. Some stakeholders also noted that real-world functional outcomes, such as school attendance, may provide a more practical and meaningful indicator of progress than detailed psychometric tools in some circumstances.

Educational Outcome Measures

In relation to educational outcomes, stakeholders were clear that measurement within school settings needs to remain simple and feasible, recognising that schools are unlikely to have the capacity or time to support more complex data collection. Lived experience stakeholders raised the importance of discretion and confidentiality when any measurement occurs in school settings, given the risk of stigma or peer judgement. Following these discussions, further targeted consultation was undertaken with a representative from the Department of Education, who confirmed that school attendance rate and change in chronic absenteeism status are the most appropriate and practical indicators of school engagement, and these were adopted as the primary educational outcome measures in the final recommendations.

Out-of-Home Care

Clinical domain 7 of 7. This domain focuses on the care of young people with PD who are in out of home care and includes six clinical recommendations to guide best practice.

Table 11: Clinical Recommendations for the Out-of-Home Care Domain

No.	Recommendation
27	Clinicians working with young people in OOHC should apply the principles outlined in the 'Good Clinical Care' chapter, including trauma-informed, strengths-based, person-centred, and relationally focused care, as these principles are particularly important in OOHC contexts.
28	Clinicians should develop a working understanding of how OOHC systems operate in Western Australia, including key roles and responsibilities across services. Practice should align with relevant interagency agreements, including the Bilateral Schedule between the Department of Communities and Child and Adolescent Health Service.
29	Clinicians should routinely assess young people in OOHC for experiences of abuse, neglect, family and domestic violence, attachment disruption, and placement instability, alongside common co-occurring presentations (e.g., trauma, mood and anxiety disorders, externalising difficulties, and neurodevelopmental conditions).
30	Formulation should consider how OOHC-related adversity (e.g., placement instability, disrupted attachment relationships, absence of a consistent caregiving figure, and multiple service involvement) interacts with PD and is maintained over time. Care planning should recognise that ongoing exposure to unsafe or unstable environments may limit the effectiveness of individual therapy, and clinicians should adopt a flexible and persistent approach to engagement.
31	Clinicians should consider young people's experiences of OOHC in assessment, care planning, and intervention. Specifically, clinicians should: a. Use clear, developmentally appropriate communication and support young people's participation in care planning and decision-making. b. Promote safety, stability, and predictability, recognising that placement changes and professional turnover may undermine trust. c. Support relationships, belonging, and cultural connection, particularly for Aboriginal and Torres Strait Islander young people. Access to peer support, information and community connection is also particularly important for LGBTIQA+ young people in OOHC. d. Support young people to process experiences of family contact and provide clinical input where appropriate, recognising that decisions regarding contact are made by statutory services.
32	Clinicians should recognise structural barriers to coordinated healthcare in OOHC (e.g., placement instability, movement across regions, fragmented communication, incomplete records, unclear roles, and confidentiality constraints) and support coordination and advocacy by gathering information, clarifying roles, and facilitating communication between carers, caseworkers, schools, and health providers. Changes in placement and location may disrupt continuity of care and impact engagement, requiring a flexible and persistent approach, including proactive follow-up. Unstable care environments should be recognised as a risk factor and responded to accordingly.

Evidence Summary

This domain's evidence review focused on three key areas in supporting young people with PD who are also in out-of-home care (OOHC):

1. Mental health needs and lived experiences of young people in OOHC
2. Barriers to effective care
3. Practice principles for clinicians working in this context

It is important to note that research specifically examining PD in OOHC is limited across both adult and youth literature, so the review drew on broader literature regarding mental health, psychosocial outcomes, and service delivery in OOHC, considering its relevance for young people with PD.

Mental Health Needs and Lived Experiences

Children in OOHC experience substantially higher rates of mental health difficulties than those in the general community, including trauma-related presentations, attachment difficulties, mood and anxiety disorders, externalising behaviours, neurodevelopmental conditions, and PD (Engler et al., 2022; Tarren-Sweeney & Hazell, 2006). Attachment disruption, chronic maltreatment, and repeated caregiver changes are associated with relational instability and emotion dysregulation, and emerging evidence indicates children in residential care report higher levels of PD symptoms compared to other groups (Didier & Terradas, 2025). While OOHC experience does not imply causation, domains such as attachment disruption, loss, placement instability, and relational sensitivity are highly relevant to assessment and formulation for young people with PD. Longer-term risks include self-harm, suicidality, substance use, homelessness, and justice system involvement (Healy et al., 2024).

Young people in OOHC consistently report wanting clear information and meaningful participation in decisions affecting their care, and emphasise the importance of felt safety, stability, predictability, and continuity of carers and professionals (Miller & Alla, 2024). Placement instability and disrupted relationships may undermine this sense of security and impact engagement with services, making consistency in professional relationships particularly important. Connection to family, siblings, peers, culture, and community is also central to wellbeing, particularly for Aboriginal and Torres Strait Islander young people, for whom ongoing connection to kin, culture, and Country is especially significant (Krakouer et al., 2018; Raman et al., 2017). Exclusion from decision-making and inconsistent communication are associated with distress and disengagement.

Barriers to Effective Care

Despite high levels of need, significant structural and systemic barriers may impede effective care. These include placement instability, fragmented interagency communication, incomplete health histories, unclear coordination responsibilities, workforce constraints, and crisis-driven service models (James et al., 2006). Confidentiality complexities and caseworker turnover may further disrupt continuity of care, and missing early health information can complicate assessment and formulation.

Practice Principles

The evidence supports a set of practice principles as a foundation for effective clinical work with young people in OOHC, as identified by the National Workforce Centre for Child Mental Health (Miller & Alla, 2024). These include trauma-informed care, culturally safe practice, strengths-based approaches, child-centred practice, holistic and collaborative care, and relationship-focused care. Across these principles, the evidence emphasises understanding the impact of trauma before, during, and after placement; embedding cultural safety and supporting connection to family, kin, and community; positioning young people as active participants in care planning; coordinating multidisciplinary and wraparound supports; and prioritising stability, predictability, and relational continuity.

Consultation Feedback

Embedding Practice Principles Framework-Wide

A significant outcome of consultation was a reframing of how the practice principles were positioned. The evidence review had identified trauma-informed, culturally safe, strengths-based, child-centred, relational, and holistic care as principles particularly relevant to working with young people in OOHC. Stakeholders across all groups broadly agreed these principles should not be confined to this domain but should underpin the entire framework, helping shape the dedicated Good Clinical Care chapter that runs across all clinical domains. While foundational to working with all young people with PD, these principles take on heightened importance for young people in OOHC given the additional barriers to care, placement instability, relational disruption, and systemic complexity they often face. This is reflected in the final recommendations, which direct clinicians to the broader Good Clinical Care chapter while acknowledging their particular significance in OOHC contexts.

Grounding Recommendations in the WA Context

Consultation also highlighted the importance of grounding recommendations in the Western Australian context. External stakeholders drew attention to the Bilateral Schedule between the Department of Communities and Child and Adolescent Health Service, which provides guidance on improving access to mental health services for children and young people in care, and recommended this be explicitly referenced to support clinicians in understanding their responsibilities and relevant interagency agreements.

Clarifying CAMHS's Role in Family Contact

A recurring theme was the need to clarify CAMHS's role in family contact decisions. External stakeholders emphasised that decisions regarding family contact are made by the Department of Communities and, in some cases, the Children's Court, and recommendations should reflect this clearly. This clarification helps avoid ambiguity and clarifies clinicians' specific role: to provide clinical input and support the young person in processing experiences of family contact, rather than to make decisions about contact arrangements.

Complexity and Engagement in OOHC

The Expert Panel noted that young people in OOHC often present with more severe and longstanding PD difficulties, reflecting extensive histories of adversity and disruption, with difficulties often well established by the time they present to CAMHS. This has important implications for how clinicians approach intervention and engagement. Lived experience stakeholders reinforced the importance of a flexible and persistent approach to engagement, recognising the impact of mental health difficulties, childhood experiences, neurodivergence, and life context on a young person's capacity to engage with services.

Documentation and Sources of Safety

External stakeholders highlighted that family and domestic violence is a common pathway into OOHC and should be routinely considered and assessed as part of clinical assessment. Lived experience stakeholders raised two further points: clinicians should approach clinical documentation in a person-centred and family-centred way, mindful that records carry significant weight and may influence how parents or caregivers are perceived; and clinicians should actively consider the range of community relationships that may provide a sense of safety for the young person, including teachers and other trusted adults, seeking the young person's own perspective on who they identify as safe.

Section 4

Recognising Specific Needs

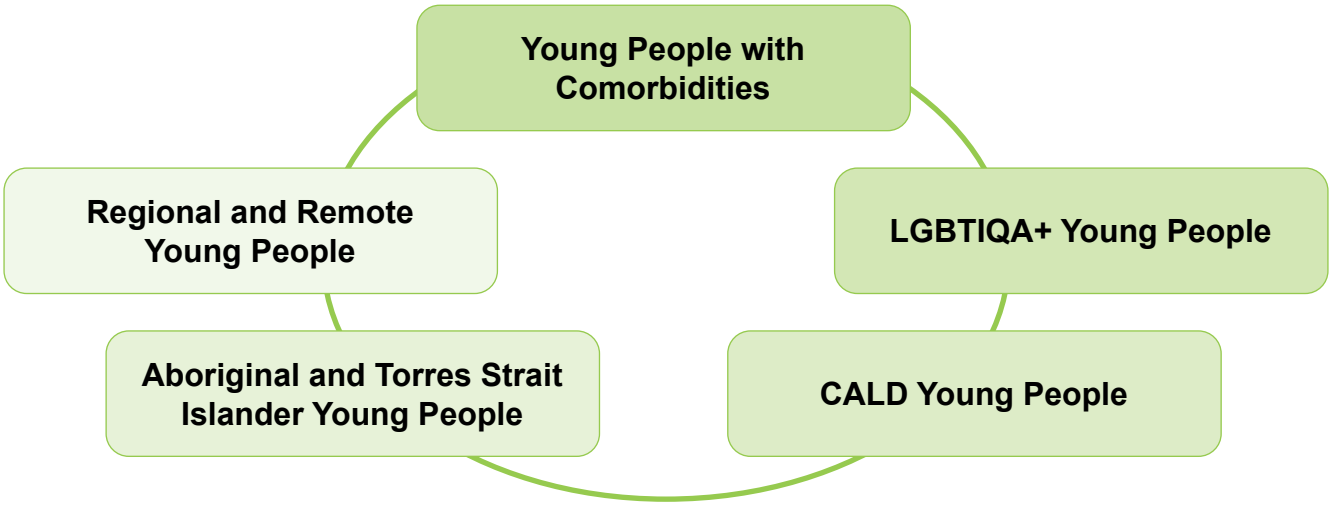


Introduction

PD can present across diverse identities, cultures, and clinical contexts. While the 32 clinical recommendations previously outlined apply to all young people regardless of background, five population groups (outlined in Figure 8) were identified as requiring considerations above and beyond these recommendations, reflecting population-specific needs that may not be adequately addressed by generalist guidance alone.

This chapter sets out these additional considerations for each group, to support earlier identification, safer engagement, and more developmentally attuned practice. Groups were selected on the basis that PD presentations are most commonly seen within these cohorts, representing areas of greatest clinical relevance to CAMHS.

Figure 8: Population Groups Requiring Considerations Above and Beyond the General Clinical Recommendations



Considerations Development Process

The considerations outlined in this chapter were developed through a two-stage process. An evidence review was first conducted to identify relevant considerations based on the available literature. Relevant stakeholders were then identified, in consultation with the Chair, across services with roles with expertise relevant to these population groups.

Stakeholders were drawn from a range of services, including CAMHS consultant clinical psychologists, the Eating Disorder Service, the Gender Diversity Service, CAHDS, WACHS, the Aboriginal Mental Health Workforce, and staff with relevant CALD expertise.

Stakeholders were initially provided with the 32 clinical recommendations previously outlined and asked to identify any additional considerations relevant to the populations they work with. This input was incorporated to ensure the guidance reflects population-specific needs and real-world clinical practice.

Young People with Co-occurring Mental Health Issues

PD rarely appears in isolation and commonly co-occurs with other mental health conditions (Leichsenring et al., 2024). Given many of these conditions also involve self-injury, suicidality, and emotional instability, they can add to or amplify the risks associated with PD. It is therefore essential that treatment does not overlook these comorbidities, as addressing them is critical for accurate risk assessment and effective intervention.

General considerations when treating PD with co-occurring conditions

- Clinicians should recognise that co-occurring mental health conditions may increase overall risk.
- Formulation should be shared and integrated across the PD presentation and any co occurring conditions.
- Clinicians should not withhold a PD diagnosis solely because a co occurring mental health condition is present.
- Clinicians must ensure that diagnostic criteria for each condition are independently met, and that symptoms are not better accounted for by another disorder.
- Clinicians should complete targeted screening and obtain consultant psychiatrist review before proceeding with treatment.
- The presence of co-occurring mental-health conditions should not exclude a young person from receiving PD-focused care within CAMHS.
- Clinicians should ensure collaborative working with any existing care teams from the outset, establishing shared care and coordinated communication.

The following sections summarise the main co-occurring conditions observed in young people with PD. Each comorbidity is presented separately to highlight its unique clinical considerations.

Eating Disorders

- Young people with PD often have an unstable self-concept, while eating disorders tend to centre identity around body shape and weight. Together, these can intensify developmental derailment; treatment should therefore address both disorders' combined impact on identity development.
- Comprehensive assessment is essential, as starvation and malnutrition can mimic PD symptoms, such as emotional instability and irritability. Clinicians should differentiate true PD features from starvation-related dysregulation, since misattributing malnutrition-driven symptoms to PD can lead to inappropriate treatment planning and missed opportunities for early medical intervention.
- While starvation can affect cognitive functioning, clinicians should take care that a young person's views are not dismissed on this basis, particularly in highly medicalised settings. Relational care remains central even when medical risk is high.
- When both PD and an eating disorder are present, clinicians should consider how best to sequence treatment. Ideally, both conditions are addressed within an integrated formulation, as this allows shared factors (e.g., difficulties identifying and responding to emotional experiences, identity disturbance, and interpersonal sensitivity) to be understood together. Decisions about sequencing of treatment are therefore formulation-driven and may include phased or concurrent treatment. For example, for some young people with PD, disordered eating behaviours may function primarily as a coping strategy for distress or emotional dysregulation (e.g., in much the same way as self-harm or other externalising behaviours may serve this function). Developing a collaborative formulation of the young person's eating difficulties enables identification of when, where, and how best to intervene.
- Where severe anorexia nervosa or bulimia nervosa is present, medical stabilisation should be prioritised due to the immediate risks associated with starvation and purging. However, care should not become binary, with one difficulty treated only once the other has resolved. Where possible, psychological work on PD should continue alongside stabilisation, with the eating disorder formulated in the context of PD-related difficulties.

- The focus of care is likely to shift over time. At one point, the eating disorder may need to take priority, while at another, PD-related difficulties may need more attention. Clinicians should remain flexible and adjust the focus of care as needs change, while maintaining a relational approach throughout.
- Young people with co-occurring PD and eating disorders, can find themselves caught between services, as their needs do not fit neatly within the scope of any one team. One primary service should hold overall responsibility for the young person's care, so that the young person and their family are not divided into separate parts across services. Where appropriate, shared care arrangements may support flexible additions to care.
- Collaboration between other CAMHS services and the Eating Disorders Service is essential, particularly when a young person moves between them. Clear communication, a shared formulation, and joint planning help maintain continuity of care.
- Formulation and treatment planning should also consider any cultural pressures around appearance or food that may influence how the young person experiences and expresses both their identity and their eating disorder.
- The presence of disordered eating can raise the overall risk profile for young people with PD, especially where self-harm or suicidality is already a concern. Necessary management strategies for the eating disorder (e.g., supervising food intake) can temporarily heighten distress and may increase reliance on self-harm as an alternative regulation strategy; therefore, clinicians should maintain dynamic risk assessment that considers how change in one area may affect risk in another.

How this may present in clinical practice:

A young person with PD and a co-occurring eating disorder begins family-based supervision of meals to reduce dietary restriction. As dietary restriction has been serving an emotion regulation function, the young person begins using self-harm as an alternative coping strategy. Clinicians should therefore monitor self-harm risk alongside eating disorder treatment.

Mood Disorders

- Young people with PD often have co occurring mood disorders, which can exacerbate the emotional regulation, identity and relationship difficulties already present in PD.
- Depressive symptoms in PD are usually reactive and short-lived, triggered by interpersonal stress, such as rejection or conflict. These "micro-depressive episodes" often reflect underlying emotions the young person struggles to express and typically respond better to emotional exploration and addressing the interpersonal trigger than to antidepressants.
- Clinicians should take a longitudinal history to reach an accurate diagnosis, as cross-sectional assessment can lead to misdiagnosis of major depressive disorder or bipolar disorder. Viewed in isolation, reactive depressive symptoms in PD may appear indistinguishable from major depression. A diagnosis of major depressive disorder should only be made where mood has been consistently low for at least two weeks, alongside sufficient additional symptoms to meet diagnostic criteria.
- When PD and a mood disorder co-occur, clinicians should consider how best to sequence treatment. Concurrent treatment is often appropriate but severe depressive episodes, suicidality, or significant functional decline may warrant prioritising mood-focused intervention first, to ensure safety and restore the young person's capacity to engage in PD-specific work.
- Ongoing, dynamic risk assessment is essential, as mood shifts can interact with PD-related vulnerabilities to affect emotional regulation, interpersonal sensitivity, and self-harm risk.

Neurodevelopmental disorders

- Young people with PD frequently present with neurodevelopmental conditions such as intellectual disability, motor disorders, ADHD, and ASD, which can complicate both diagnosis and treatment planning. All conditions present with symptoms that can be similar to PD, making accurate diagnosis of each condition difficult when comorbidity exists.
- To aid in diagnosis, a developmentally informed interview is essential. Clinicians should map the onset, duration, progress, stability, and context of symptoms across childhood and adolescence, as this helps differentiate neurodevelopmental traits from personality-related difficulties. PD features tend to consolidate later, during mid-adolescence when identity formation, attachment patterns, and interpersonal sensitivity intensify. Assessing whether attentional, social-communication, sensory, or behavioural difficulties were present long before the onset of emotional instability or self-harm may provide an anchor for differential diagnosis.
- Even when a formal neurodevelopmental diagnosis has not yet been made, clinicians should flag key indicators early in assessment rather than conducting a purely PD-focused evaluation. Where a neurodevelopmental condition is suspected, clinicians should seek input from other treating professionals (such as an existing paediatrician) or arrange a specialist assessment if none is already involved. Early consultation and shared care are important, as neurodevelopmental conditions can shape emotional, cognitive, and interpersonal functioning in ways that resemble or obscure emerging PD features.

How this may present in clinical practice:

A young person with PD describes early emerging attentional difficulties, sensory sensitivities, and emotional dysregulation linked to cognitive overload rather than interpersonal threat. Clinicians should recognise these as potential indicators of an underlying neurodevelopmental disorder and liaise with other treating clinicians to establish shared care or, where appropriate, facilitate referral for specialist assessment.

- Clinicians should encourage and welcome parents to bring preferred sensory tools or aids to appointments, provided they do not interfere with treatment or assessment, to support the young person's regulation.
- Clinicians should enquire about the young person's preferred method of communication, such as using a communication board, or other assistive technology, particularly for young people who are non-verbal or have limited verbal communication.
- Intellectual disability can present with self-harm, impulsivity, and affective lability, which are also features of PD. Additional distinguishing features should therefore be sought before making a PD diagnosis.
- Diagnosis and treatment are further complicated as a young person with a comorbid intellectual disability may be harder to assess due to decreased self-report abilities, communication challenges, and problem-solving difficulties. Therefore, clinicians should be prepared to adapt treatment to match the young person's cognitive understanding (e.g. focus on simple concrete skill building rather than exploring abstract concepts).
- Where a motor disorder is present, clinicians should consider referral to occupational therapy or physiotherapy alongside PD-focused treatment, as improving functional motor skills and confidence in physical tasks can help address a contributing source of low self-worth.
- For young people with co-occurring tic disorders, clinicians should be mindful that tics may increase under stress or emotional dysregulation and should avoid mistaking tic-related movements or vocalisations for agitation, defiance, or self-harm gestures, ensuring accurate differentiation before responding therapeutically.

- ADHD can exacerbate the impulsivity, emotional instability and low self-esteem seen in PD. Emotional dysregulation may occur in ADHD, but it is not a core diagnostic feature, and the presence of self-harm should prompt consideration of co-occurring PD. The decision to prioritise treatment for either condition should be guided by the young person's current clinical presentation and functional impairment. When ADHD is confirmed, treatment should commence as soon as clinically appropriate, as addressing ADHD symptoms can support overall symptom reduction and may assist in clarifying differential diagnosis.
- ASD can present with emotional dysregulation and interpersonal difficulties which may stem from sensory overload, cognitive rigidity, or communication challenges rather than attachment-based emotional instability. Clinicians should take a clear developmental history to differentiate ASD-driven dysregulation from PD features, and adapt therapy to include predictability, structure, sensory supports, and clear and simplified communication. Frequently, a clear differentiation may not be apparent but the general principles of managing emotional dysregulation should apply.

LGBTIQA+ Young People

- LGBTIQA+ young people experience higher rates of suicidality, rejection sensitivity and trauma, which can resemble or amplify PD features. Whereas suicidality is often driven as a response to separation/rejection in PD, for sexual and gender diverse young people, it is often caused by chronic stigma and entrapment. This minority stress often experienced by these young people can also drive behaviours that look like PD (e.g. emotion dysregulation). Clinicians should understand these various drivers during assessment and take them into account during safety planning.
- LGBTIQA+ young people may endorse behaviours associated with PD but not report the functional impairment typical of PD. Accurate diagnosis requires exploring whether distress stems from identity related stress, not personality pathology.
- Clinicians should explore safety and acceptance across home, school, community and cultural contexts. Family non acceptance is a major modifiable risk factor; affirming caregivers are strongly protective however non-accepting caregivers majorly exacerbate risk.
- Confidentiality around a young person's sexual orientation or gender identity is a core safety requirement, not a discretionary courtesy. For many LGBTIQA+ young people, disclosure outside the therapeutic space (especially to parents or carers) can carry risks such as rejection. Clinicians must therefore treat this information as sensitive health information and apply the same protections used for disclosures of trauma, abuse, or mental-health risk.
- Clinicians should assess for conversion or suppression practices, as these are associated with elevated suicidality and must be treated as a significant risk factor. Such practices can occur formally (e.g., organised programs) or informally within families, schools, peer groups, or religious communities. They typically involve attempts to change, deny, or discourage a young person's sexual orientation or gender identity, and are linked to increased rates of self harm, suicidal ideation, depression, and trauma symptoms.
- LGBTIQA+ young people often disengage early when forms don't reflect or include them. Inclusive documentation signals that their identities and needs have been considered and helps prevent experiences of discrimination. Forms seen/filled out by the young person should therefore use gender-neutral language, allow young people to specify or decline preferred names, pronouns, titles, self-described gender/sexuality and chosen family, explain why sex/gender information is collected, and clearly state that names and pronouns can be updated at any time. Table 12 provides recommended wording to support safe and inclusive communication with LGBTIQA+ young people.

Table 12: Recommended Wording for Safe Communication with LGBTIQA+ Young People

Clinicians Should Not	Clinicians Should
Assume heterosexuality when not made clear (referring to a partner as "boyfriend/ girlfriend" or assuming "mum and dad" rather than "parents").	Use gender-neutral relationship terms unless a specific term has been made clear by the young person (e.g. "partner" or "significant other").
Assume sexuality based on appearance.	Mirror the sexuality terms the young person uses for themselves.
Assume cisgender identity.	Use the gender terms the young person uses.
Assume sexuality or gender are binary (e.g., "are you a boy or girl?" or "are you gay or straight?")	Use open, non-binary questions (e.g. "how would you describe your gender/sexuality?")
Assume pronouns or identity are fixed.	Treat identity as fluid, understanding that it may evolve over time.
Ask about body characteristics without clinical relevance.	Only ask about anatomy when directly relevant to care.
Ignore mistakes (e.g. misgendering).	Invite correction and explicitly encourage the young person to let them know if the clinician misspoke.

Adapted from Strauss et al., (2022). Suicide prevention in LGBTIQA+ young people: Best practice guidelines for clinical and community service providers. Page 14.

CALD Young People

CAMHS recognises that Australian mainstream culture is the dominant cultural framework within which services operate. This creates inherent power imbalances, cultural differences, and risks of cultural misattunement for young people from culturally and linguistically diverse backgrounds.

- Young people from CALD backgrounds often face barriers to accessing mainstream services, including reduced trust in systems that have historically misunderstood or marginalised their communities. These barriers can delay help seeking until difficulties become acute. Establishing culturally safe and responsive care is therefore essential to support engagement, build trust, and ensure early intervention.
- Cultural competency, the understanding of different cultural backgrounds, aims to address ethnic health inequities in the health system. However, it can end up seeming like a 'static' achievement if the focus shifts to 'mastering' it:
- Cultural competency only focuses on learning about other cultures on a surface-level but does not address that a clinician can be "competent" while still practising in ways that feel unsafe or invalidating. Therefore, a shift to cultural safety, rather than simple competency is needed. In the context of PD, culturally safe engagement is fundamental to developing a therapeutic relationship, collaborative formulation, and treatment engagement.

- Clinicians can create a culturally safe space by:

Reflecting on their own position, biases, and assumptions

Letting the young person and their family define cultural safety, as it is what they feel is comfortable (not the clinician) that is key

Avoiding assumptions about the young person's cultural background (based on outward appearance/country of origin) or interpreter needs (unless given explicit permission)

Building relationships with culturally diverse staff, attend cultural awareness trainings, and facilitate cultural discussions with the MDT where relevant

- Clinicians should consider how culture may influence the assessment and formulation of PD, recognising that culturally normative behaviours may be mistaken for personality pathology and vice versa. Where uncertainty exists, clinicians should seek cultural consultation or multidisciplinary input.
- Autonomy and personhood may be understood differently across cultures. Rather than assuming a Western, individualistic model of autonomy, clinicians should explore how the young person understands their identity and whether they would like their family and/or community involved, recognising these relationships as a potential source of strength and identity.
- Clinicians should recognize that some cultures take a whole-of-community approach to raising young people, where extended family or community elders may hold as much, or more, influence over decisions than parents alone. Where appropriate, these relationships should be incorporated into collaborative care planning.
- Clinicians should be aware that some cultures may not share the same underlying assumptions about why a particular treatment or intervention is necessary, and families may question the rationale rather than readily accepting clinical recommendations. Clinicians should therefore explain the formulation, rationale for diagnosis, benefits of treatment, and confidentiality using culturally sensitive and recovery-oriented language.
- Clinicians should routinely ask about the use of traditional, cultural, or spiritual healing practices, including traditional healers, bush medicines, natural supplements, or herbal remedies. Clinicians should understand the role these practices may play in cultural wellbeing and holistic health, explore their use without judgement, and integrate them into formulation and care planning where appropriate. Potential interactions with prescribed medications should be considered.
- Clinicians should ensure all family members involved in the young person's care understand medication information, using plain English and a professional interpreter where needed.

How this may present in clinical practice:

A young person with PD from an Iranian family presents with school refusal. Rather than assuming this reflects poor functioning, clinicians should explore the behaviour within the young person's cultural and family context and identify whether, for example, they are staying home to support their mother. The cultural and relational significance of this responsibility should inform formulation and care planning.

Aboriginal and Torres Strait Islander Young People

Yarning as a Tool to Build Rapport

- An important part of caring for Aboriginal and Torres Strait Islander young people is to begin by building rapport rather than immediately moving into discussing treatment. Clinical yarning is a relaxed, conversational approach to consultations; rather than following a rigid question and answer format, it uses storytelling to understand a person's health within the context of their broader life, and to share health information in return (Lin et al., 2016).
- Where needed, clinicians should reach out to Aboriginal health staff (e.g., Aboriginal Mental Health Workers) for support, and where appropriate, to attend yarns or care discussions.
- Clinical yarning is divided into three core segments:
  1. **Social yarn** – establishing rapport and understanding the young person within the context of their family, culture, and Country
  2. **Diagnostic yarn** – using open-ended questions and storytelling to understand the young person's experiences and inform diagnosis
  3. **Management yarn** – collaboratively discussing the young person and family's understanding of the young person's difficulties, while adapting communication to their needs

Table 13 below provides examples of each yarn type in practice.

Table 13: Examples of Clinical Yarning

Social Yarn	**C:** Before we get into anything, how has your week been? Still listening to that new band you found? **YP:** Yeah, and wrote some songs too. **C:** That's cool, do you play anything with anyone? **YP:** Mostly on my own. Used to jam with my mate but we don't really talk anymore. **C:** Sounds like that's been a bit of a rough patch, we don't have to get into it now, just wanted to check in and see how you're doing generally. You alright to keep chatting today? **YP:** Yeah, let's keep going.
Diagnostic Yarn	**C:** You mentioned things got rough with your mate. What happened? **YP:** We had a massive fight. She said something and I just lost it. **C:** Does that happen a lot, big reactions that come on fast? **YP:** Yeah. I'm fine, then something small hits and I flip. Can't control it. **C:** When it's overwhelming, do you do anything to cope? **YP:** Sometimes I scratch my arms. Just to feel something else. **C:** Thanks for telling me. Sounds like these feelings hit fast and hard. That fits with something we'd call a personality disorder, and there's a lot we can do to help. Want to talk more about that? **YP:** Yeah, I would.
Management Yarn	**C:** Your emotions are a bit like weather. Most people have weather that shifts pretty gradually, cloudy in the morning, some sun by the afternoon. Does that sound like how it is for you, or different? **YP:** Nah, definitely different. Mine's more all over the place. **C:** That's what I was thinking. For you it's more like living somewhere that gets sudden storms. One minute it's clear skies, then out of nowhere there's, heavy rain, and it can pass just as fast as it came. Does that feel familiar? **YP:** Yeah, actually. Like with my family, one second, I'm fine, then something small happens and I just...explode. Then an hour later I don't even know why I was that upset.

Note: 'C' refers to the clinician and 'YP' refers to the young person.

The Lasting Effects of Colonisation

- Clinicians must understand the lasting influence of colonisation on Aboriginal and Torres Strait Islander young people and their families, with intergenerational trauma stemming from historical policies (forced removals, dispossession of land, and cultural suppression) continuing to shape health, family life, and trust in institutions today.
- Clinicians must recognise that Aboriginal and Torres Strait Islander young people and families may hold justified wariness of non-Aboriginal healthcare practitioners given the history of health services as sites of harm, and should stay attentive to power imbalances, actively sharing power with the patient.
- Symptoms often associated with PD (e.g. fear of abandonment, difficulty trusting others), can be tied to this history, with family trauma compounding emotional regulation and trust difficulties. Wariness towards mental health services may be misread as poor engagement, when it's often a reasonable protective response shaped by generations of unsafe systems. Clinicians should treat this wariness as context, not pathology.

Verbal And Non-Verbal Communication

- Clinicians should recognise that Aboriginal and Torres Strait Islander people may communicate differently. Behaviours such as apparent agreement (e.g., repeated 'yes'), avoiding eye contact, or extended silence may reflect culturally appropriate communication. Clinicians should avoid making assumptions and instead gently check understanding and seek clarification where needed.
- Clinicians should recognise that "Aunty" or "Uncle" are terms of respect used for someone older, not necessarily a blood relative or Elder, and should only use these titles once approval is given or a positive relationship has been established.
- Clinicians should be aware that gender can shape communication patterns and expectations, including how comfort, assertiveness, eye contact, or emotional expression are conveyed. These differences should be explored with the young person rather than assumed, and clinicians should check understanding gently to avoid misinterpreting gender related communication styles as diagnostic features.

Regional and Remote Young People, Families, and Carers

Geography is not just a peripheral logistical detail, but a core component that actively shapes access to care, continuity of relationships, and the coordination of everyone involved in a young person's safety and treatment.

WACHS is the state government health service responsible for delivering public healthcare across regional and remote Western Australia, spanning seven geographically vast and diverse regions. This geography means that "regional and remote WA" is not a single, uniform context (e.g. a young person in Albany faces a very different service landscape to one in Kalumburu or Ravensthorpe). The following considerations outline key implications of this service landscape for the care of young people with PD.

Access to Care

- Access to specialist services and interventions for PD in youth is limited and, in some regions, only available in specific locations (e.g., DBT-A groups may only be delivered in Albany within the Great Southern region). Accordingly, access to the specialist care a young person requires should be considered from day one of care planning, rather than addressed reactively once a gap becomes apparent. Clinicians should ask "how will this young person realistically access this intervention?" as a day-one planning question, not an afterthought.

- Where standard delivery models (e.g. weekly in-person individual therapy plus a face-to-face skills group) are not feasible, alternative delivery structures should be incorporated into care planning. Telehealth should be viewed as a legitimate and necessary mode of specialist care delivery rather than a compromised alternative. Its use should still account for practical prerequisites (e.g. technology access, privacy at home, stable internet).

How this may present in clinical practice:

A young person living in Ravensthorpe requires DBT-A but the nearest face-to-face DBT-A skills group is delivered in Albany and is not feasible to attend weekly. From the outset, clinicians adapt the care plan by exploring alternative delivery structures, such as the young person joining the skills group via telehealth and providing parents with recorded resources.

Geographic Separation of Care Team and Guardian

- For young people based in regional and remote areas, it is common for their case worker to be based in metro while care is delivered locally. This separation creates a structural barrier to collaborative, in-the-moment decision-making. While escalation pathways may exist to manage this, they should not replace direct, collaborative involvement and should be considered a workaround for distance rather than a substitute for proximity.
- Where the legal guardian is metro-based and the young person is regional or remote, engaging the guardian meaningfully in risk management can be difficult. Clinicians should proactively provide contextual information about the young person's regional circumstances (e.g., travel distance, service availability, and schooling options), rather than assuming this understanding will develop organically.
- Clinicians should prioritise building consistent, trusting relationships with young people in regional and remote areas, recognising that geographic distance from the primary care team can make trust harder to establish and maintain. This includes deliberate, regular contact and clear communication so the young person experiences the care team as reliable and present despite the separation.
- Identify and engage a locally based trusted adult who can act as the young person's "first point of contact" or "best ally." This is someone physically present and already trusted, rather than relying solely on clinicians or workers based elsewhere. Deliberate thought should go into how this person is brought into the care team, so the young person experiences them as a consistent safety net, not an informal add-on.

Potential trusted adults:

- School staff (teacher, school psychologist, chaplain)
- Aboriginal health service staff
- Local GP or practice nurse
- Youth worker
- Sports coach or club leader
- Community elder
- Residential/OOHC house staff member
- Grandparents

Planned, Proactive Communication as the Mitigating Strategy

- Because geographic separation is common, planned and regular communication becomes more important, not less, and should be built into routine practice rather than triggered reactively. Needs should be flagged early and with lead time, as last-minute requests are harder to action across distance and compound the existing coordination burden.
- Lead workers from Department of Communities and CAMHS should maintain specific, planned contact on a regular schedule, irrespective of whether the young person's situation is stable or deteriorating. Consistency of contact should not be contingent on crisis.
- Where multiple agencies are involved (e.g. Department of Communities, CAMHS, school, guardian), consideration should be given to a shared communication structure (e.g. regular review meetings) rather than relying solely on bilateral contact between pairs of workers.
- Information-sharing expectations and consent arrangements should be clarified early, so that when communication is needed it isn't delayed by uncertainty about what can be shared with whom (e.g. between clinical and non-clinical stakeholders, or with a metro-based guardian).

Section 5

Workforce and Service Capabilities



Introduction

The Good Clinical Care chapter highlights that every young person with PD should receive a consistent standard of warm, respectful, trauma-informed, and recovery-oriented care as a universal baseline, regardless of which service they are seen in. Delivering this in practice depends on clinicians having the specific skills and confidence to work with PD, and on a service system that supports them to apply these skills safely and consistently.

This chapter outlines the core clinical competencies relevant to clinicians working with young people with PD, above and beyond the Good Clinical Care baseline, covering areas such as understanding the diagnosis, working with co-existing disorders, and managing suicidal and self-injurious behaviours. It then considers how workforce capability in this area can be developed and sustained over time, recognising that training alone is often not enough to translate learning into confident, everyday practice. Finally, it sets out the service infrastructure that could support clinicians to deliver this care, including coordinated consultation and reflective practice structures, access to specialist input, space to process the relational demands of this work, and guidance on how to support the Lived Experience peer workforce to effectively support young people with PD and their families.

This chapter was developed through consultation with mature national PD services, specifically Spectrum and Orygen, drawing on their experience establishing and sustaining workforce and service capability for PD care over time. The consultation process explored how these services structure their training and supervision pathways, the implementation supports they use to help clinicians translate training into practice, the service infrastructure they have found necessary to sustain this work including reflective practice and access to specialist consultation, and how they support and embed their Lived Experience peer workforce. These insights, alongside broader evidence and Expert Panel input, have informed the recommendations set out in this chapter.

Core Clinical Competencies

The Australian BPD Foundation (2023) has identified ten core competencies clinicians should hold for safe and effective generalist PD care, relevant across the workforce from support workers to psychiatrists. This framework builds on and adopts these ten competencies, described below in Figure 9.

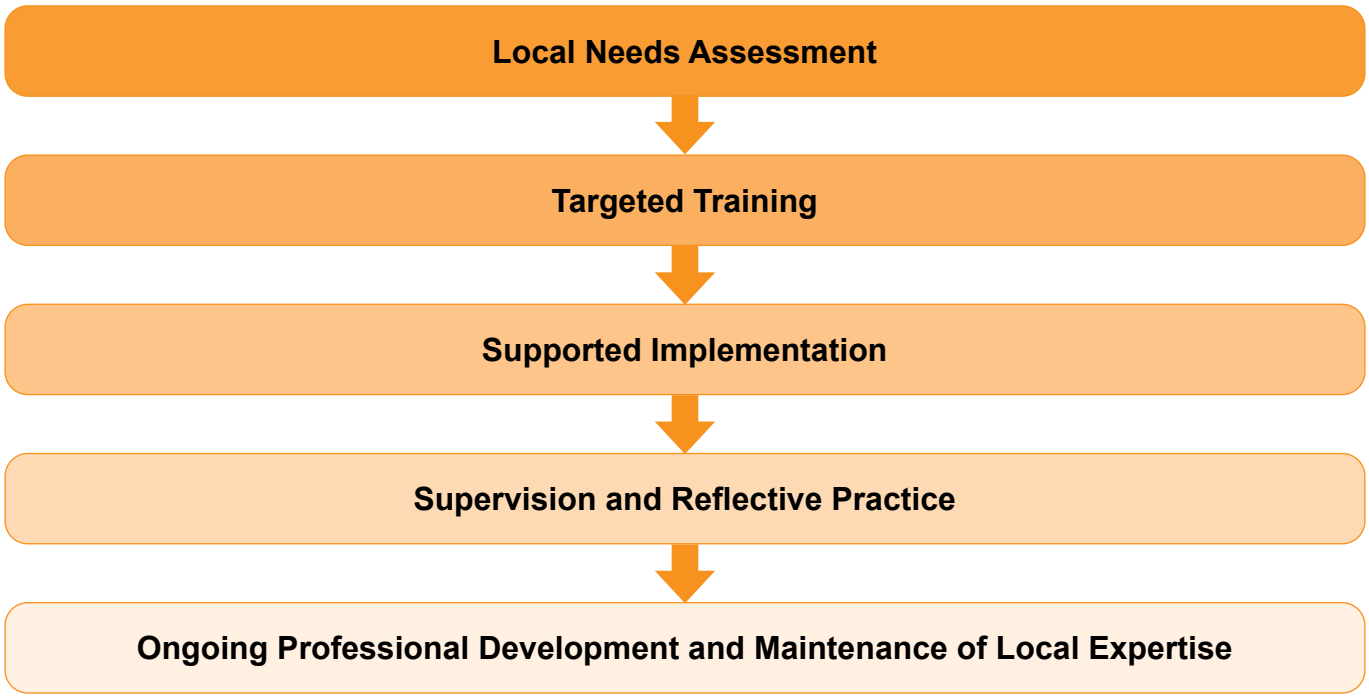
Figure 9: Adapted Core Clinical Competencies

Understanding the Diagnosis	Clinicians should be able to explain the diagnosis to young people and families in accessible terms, including its symptoms, prevalence, causes, and evidence-based treatments.
Recognising and Managing Co-Existing Disorders	Given high rates of comorbidity, clinicians should be able to identify how co-occurring conditions interact with PD presentations and adjust formulation and treatment accordingly.
Applying Core Treatment Principles	Clinicians should be equipped to apply generalist treatment principles directly with young people, using psychoeducation to help them and their families understand their diagnosis and treatment approach.
Understanding Treatment Structure	Clinicians should understand the different structures PD-informed treatment can take, including the role of medication and how care is coordinated across different services involved in a young person's treatment.
Building and Maintaining the Therapeutic Relationship	Clinicians should recognise the therapeutic relationship as central to effective PD care, rather than something that develops incidentally alongside other treatment tasks. Building trust with a young person who may have had difficult past experiences of care takes deliberate effort and consistency, and clinicians should prioritise this relationship throughout treatment, particularly during periods of relational rupture or conflict.
Applying a Skills Development Focus	Clinicians should focus on developing their skills in whichever treatment modality they are working within, which may include developing skills drawn from specific psychotherapeutic approaches such as DBT-A or MBT, to help young people build practical coping and regulation skills.
Partnering With Families, Partners, and Carers	Clinicians should actively involve families and carers as partners in care, recognising their role in a young person's wellbeing and recovery.
Working With Suicidal and NSSI Behaviours	Clinicians should be able to distinguish what acute versus chronic risk looks like, recognise risk factors specific to PD, undertake risk formulation, and identify dynamic and static risk factors, including changes from a young person's baseline presentation.
Maintaining Clinician Self-Awareness	Clinicians need to be self-aware of their own reactions, biases, and attitudes when working with young people with PD, recognising these as they arise rather than acting on them unreflectively. Clinicians need to actively manage these responses, whether through self-care, supervision, reflective practice, or other means, to sustain safe and effective care over time.
Maintaining a Recovery Focus	Clinicians should hold a recovery orientation as central to care, maintaining hope for a young person's future and instilling this hope in young people and their families, recognising that meaningful improvement in quality of life is possible.

Developing and Sustaining Workforce Capability

This section describes how a service such as CAMHS may develop and sustain workforce capability over time, recognising that capability building is best understood as an ongoing process rather than a one-off training event. Consultation with mature PD services indicated that standalone training is often insufficient to produce sustained clinical uptake. Without ongoing implementation support, professional development, and mechanisms to maintain fidelity, services may find it difficult to sustain new ways of working. Workforce development could therefore be conceptualised as an ongoing capability-building process, structured around a pathway such as that outlined in Figure 10.

Figure 10: A Potential Pathway for Developing and Sustaining Workforce Capability



A local needs assessment could help inform implementation within individual services or teams, so that training and support are responsive to local need rather than applied uniformly. Where a needs assessment identifies a specific capability gap, targeted training could potentially be commissioned to address it. Following training, clinicians may benefit from a period of active implementation support to help translate learning into day-to-day practice. This could include access to an experienced local practitioner who could identify opportunities to apply new learning and recognise clinicians or cases requiring additional input, alongside structured follow-up reflective practice sessions with the team.

Structured supervision and reflective practice provide a space for consolidating this capability. One approach is an Adaptive Mentalisation-Based Integrative Treatment (AMBIT) informed model, a team-based framework that helps clinicians stay curious about a young person's mental state rather than reacting on autopilot, particularly when working with complex or high-risk presentations (Bevington et al., 2017). Over time, capability development would ideally aim to embed and maintain expertise within local services. Ongoing professional development could support sustainability once more intensive implementation support is withdrawn, and train-the-trainer approaches could progressively extend and embed local expertise.

Supporting Service Infrastructure

This section describes the service infrastructure a service such as CAMHS may put in place around clinicians, so they are supported to deliver this care in practice. Workforce capability alone is unlikely to be sufficient without a service system that enables clinicians to apply it consistently and safely, and this section sets out three areas of infrastructure that could support this.

Establish a Coordinated PD Consultation and Capability Function

Whilst PD capability should remain everybody's business, embedded across CAMHS, rather than concentrated within a separate specialist PD team, consultation with mature PD services, highlighted the value of clinicians having access to additional expertise and reflective distance from the treating team, particularly for complex presentations. Where a young person requires additional clinical input, secondary consultation could be made available through a panel coordinated by the CAMHS Director of Clinical Services (DCS).

This could take the form of a virtual panel, convened on an ad hoc basis at the request of the treating team. Rather than sitting above existing supports such as senior psychiatrist input, MDT discussion, or clinical supervision, the panel would be intended to complement these. That is, the panel would provide an additional avenue for input where a treating team judges this would be of benefit, whether due to complexity, risk, or a need for reflective distance.

Such a panel could potentially support:

- Consultation on complex and high-risk presentations
- Specialist supervision and reflective input
- Workforce training and capability development

The detail of how such a panel would be structured, resourced, and accessed in practice would need to be developed and tested with CAMHS leadership; what is proposed here is a future direction for consideration, rather than a fully specified model.

Access to consultation should ideally be available early, to support proactive care, rather than requiring a young person to reach extreme levels of complexity or risk before additional expertise can be accessed. Consultation of this kind should complement, rather than replace, local clinical capability and AMBIT-informed practice. A function such as this would likely require high-level backing, potentially at the Office of the Chief Psychiatrist level, to remain sustainable across changes in leadership and service priorities. Given Western Australia's geography, a traditional hub-and-spoke model may not be feasible, and a more workable approach could combine central expertise with flexible consultation and capacity-building tailored to different regional contexts.

Embed Reflective Practice Within an AMBIT-Informed Framework

Reflective practice was identified by mature PD services as fundamental to safe and effective care for young people with personality difficulties. Complex presentations can generate strong responses within clinicians and teams, and clinicians may benefit from dedicated opportunities to reflect on these relational dynamics and countertransference, maintain a mentalising stance under pressure, and avoid reactive responses.

Reflective practice could be embedded within an AMBIT-informed framework, complementing supervision and secondary consultation, each of which would serve a related but distinct function. Reflective practice would be primarily team-focused, providing a space for the team to reflect on relational dynamics and complexities, including intersections such as neurodiversity.

Supervision, by contrast, would be primarily clinician-focused, supporting the individual to reflect on what is happening for them and how this may be influencing their work. Secondary consultation would provide additional clinical expertise to understand the young person's presentation and inform care, including, for complex cases, consultation with the DCS-coordinated panel described above.

Supporting the Lived Experience (Peer) Workforce

The Lived Experience (Peer) workforce makes a unique and valuable contribution to PD care. Peer Workers offer young people and their families relational connection, hope and practical support that complements what clinicians can provide. This work can also carry a significant emotional burden, and Peer Workers need adequate support structures to do it safely and sustainably.

Consultation with mature PD services found that supporting Peer Workers depends less on specific wellbeing initiatives and more on creating the organisational conditions for them to succeed. This includes clear role definition that sets out scope of practice and boundaries. It also includes strong, regular supervision from someone who understands the Peer Worker role and its specific demands, alongside peer supervision from a peer supervisor trained to provide it. Peer Workers should be meaningfully included in team discussions and decision-making, and the organisation should recognise Lived Experience as a discipline in its own right rather than an adjunct to clinical work.

Services also noted that Peer Workers benefit from a clear point of contact for clinical questions, access to debriefing after difficult interactions, and inclusion in reflective practice spaces alongside the broader team. Where possible, services should also consider flexibility in how Peer Workers engage with their role, including working hours and scheduling, to support sustainability.

Section 6

Research, Evaluation, and Continuous Improvement



This chapter outlines service-level considerations for building the infrastructure required to support research, evaluation, and continuous improvement in PD care across CAMHS. These considerations were informed by consultation with mature PD services with established research and evaluation functions (Spectrum and Orygen). Three interconnected priorities emerged from this consultation: protecting dedicated research capacity, embedding routine outcome monitoring (ROM) in clinical care, and using that monitoring to build a Clinical Quality Registry (CQR) that supports both service improvement and research.

Protect Dedicated Research Capacity

Dedicated research capacity is required to implement and sustain the research and evaluation activities outlined below. Consultation with mature PD services highlighted that combined clinical-research positions can be difficult to sustain, as clinical demands tend to take priority.

CAMHS already has a dedicated Research Manager (1 FTE), in line with PD services such as Spectrum, which also has full-time research leadership. Building on this existing foundation, consideration should be given to at least 1 FTE dedicated research capacity to support PD research and evaluation.

Embed ROM within Clinical Care and Prioritise Clinician Buy-in

New models of care should be developed with an evaluation mindset from inception with ROM embedded within clinical processes and defined review points (e.g., three monthly clinical reviews).

However, embedding ROM in process is not sufficient on its own; clinical buy-in is critical to sustained implementation. Strategies may include identifying clinical champions within teams (e.g. DBT-A clinical research champions) and ensuring measures are clinically meaningful.

Capitalise on ROM to Develop a Clinical Quality Registry (CQR)

ROM should be embedded within a CQR comprising a minimum clinically useful dataset collected as part of routine care, with its primary purpose being to support clinical decision-making and continuous quality improvement. Young people could separately consent for their routinely collected data to contribute to research. The core clinical outcomes specified in Recommendations 23-26 (see Clinical Recommendations chapter) should form the foundation of the CQR.

Relevant case-mix variables should also enable outcomes to be understood in context, including factors such as living arrangement and out-of-home care (OOHC) status. Other relevant domains, such as sexual and reproductive health, may be captured where they meaningfully inform risk, formulation, or care.

CQR data could also support continuous improvement and service planning by identifying variation in outcomes and trajectories across CAMHS services and cohorts, for example by identifying groups experiencing slower recovery or not improving despite treatment, to inform where care or resources may need to be adapted. Data linkage should similarly be explored to enable longer-term follow-up of key educational, vocational, and other functional outcomes after discharge, as is currently pursued by mature PD services such as Spectrum.

A hub-and-spoke model could be used, with the registry forming the core longitudinal dataset and individual research projects forming the spokes. Research questions should be driven by defined CAMHS strategic priorities rather than primarily by external or university-led opportunities. This is consistent with mature PD services such as Spectrum, which aligns its research portfolio with strategic priorities including suicide prevention, treatment innovation, and health economics.

Consideration should also be given to establishing a broader youth mental health registry rather than a PD-specific registry. A PD-specific registry may inadvertently create opportunities for selective inclusion associated with ongoing stigma or diagnostic hesitancy. A broader registry would allow participation to be diagnosis-independent while still allowing PD-specific measures to be included and research questions to be examined.

Appendix A



Outcome Measure Recommendations

The Outcome Measurement domain of the Clinical Recommendations chapter recommends the routine use of a small core set of outcome measures, approximately five to six in total, to track a young person's progress over the course of their care. Table 14 below sets out the core outcome domains and their associated recommended measures.

Table 14: Core Outcome Measures

Outcome Domain Measured	Recommended Measure	Measure Explained
Personality Functioning (Severity of PD)	The PD Severity ICD-11 (PDS-ICD-11)	14-item clinician-rated scale measuring a single, unidimensional construct: how effectively a person can understand themselves, regulate emotions, maintain a stable identity, and form healthy, reciprocal relationships (personality functioning). 13 core personality dysfunction domains are assessed, with a single PD score produced (ranging from 0 to 32) aligned directly with ICD 11 diagnostic guidelines.
Global Functioning	The World Health Organisation Disability Assessment Schedule - Children and Youth version (WHODAS-Child)	40-item self-report measure that provides a standardised assessment of child functional impairment across 6 domains: Cognition, mobility, self-care, getting along, life activities, and participation.
Social Functioning		
Interpersonal Functioning		
Suicide Ideation and Behaviour	Self-Injurious Thoughts and Behaviours Interview (SITBI)	The SITBI is available in long- and short-form versions and assesses the presence and frequency of six domains of suicide-related symptoms: suicidal ideation, suicide plans, suicide gestures, suicide attempts, thoughts of NSSI, and NSSI itself. For ROM purposes, the SITBI should not be administered in full. Instead, selected items should be used to monitor key outcomes over time, particularly the frequency of NSSI and suicide attempts within a defined timeframe.
Sense of Belonging	PROMIS short form v2.0 - Social isolation 4a	4 item self report form that provides a brief, standardised assessment measuring the extent a young person feels disconnected, left out, unsupported, or isolated.
Self-care	Recovering Quality of Life 10 (ReQoL-10)	10 item self report measure that provides a brief, standardised assessment of mental health–related quality of life.
Emotional Distress		
Educational and Vocational Functioning	Brief clinician-recorded questions	Brief clinician-recorded questions e.g., • Are you in school or engaged in other education or training? • Are you working? • Are you volunteering? For each activity endorsed: • How many days have you missed? • How many days were you unable to perform to the best of your ability?

Item Sets

This section provides the complete item content for each recommended measure listed in Table 14. It is designed to give clinicians and services a clear sense of the structure, item style, and response format of each tool.

PDS-ICD-11

Developer: Sellbom, M., Brown, T. A., & Bach, B. (2023). Development and Psychometric Evaluation of the PD Severity ICD-11 (PDS-ICD-11) Clinician-Rating Form. Personality and Mental Health.

Scoring: Scored by summing the scores for all 14 items, producing a total severity score ranging from 0 to 32. Higher scores indicate greater global personality dysfunction. Domains 1-10 are scored 2 – 1 – 0 – 1 – 2. Domains 11-14 are scored 0 – 1 – 2 – 3. In cases where the respondent can be rated with more than one answer to an item, the answer with highest score counts

The full item list for the PDS-ICD-11 is listed below as this measure is brief:

Please select the one statement for each area that best describes the person in general over the past two years.

1. Identity

2	Often has no sense of self or identity, especially when with other people (e.g., has very weak boundaries between self and others; bases identity on external factors)
1	Is sometimes confused about own sense of self or identity, especially when with other people (e.g., overidentification with others; mirrors others' behaviours or interests)
0	Has a stable sense of self or identity
1	Has a sense of self or identity that is generally too fixed and restricted (e.g., rigidly focusing on a particular personal or occupational role)
2	Has a sense of self or identity that is overly restricted and unchangeable no matter the circumstances (e.g., extreme focus on a particular personal or occupational role at any cost)

2. Self-worth

2	Feels worthless most of the time, which causes significant distress or affects relationships with other people
1	Often experiences low self-worth which causes distress or sometimes affects relationships with other people
0	Usually experiences no difficulties with self-worth
1	Often feels better than others which affects relationships with other people
2	Feels superior to others which affects how they relate to other people

3. Self-perception

2	Believe that they have no strengths or abilities (i.e., lack of positive qualities)
1	Believe that they have few strengths or abilities (i.e., few positive qualities)
0	Has a good sense of own strengths and limitations
1	Believe that they have few limitations or weaknesses (i.e., few negative qualities)
2	Believe that they have no limitations or weaknesses (i.e., absence of negative qualities)

4. Goals

2	Is rarely able to set and follow realistic goals (e.g., impulsive or rash behavior that causes problems with goal-directedness; significant goal inhibition due to fear or shame)
1	Sometimes finds it hard to set and follow realistic goals (e.g., due to insecurity, dependency, impulsivity, or lack of planning)
0	Has no problem setting and following realistic goals
1	Sometimes becomes overly goal-driven and has difficulties with adjusting or changing goals (e.g., rigid standards, overly stubborn, or unrealistic expectations; persists unreasonably in pursuit of goals that have little chance of success)
2	Regularly becomes overly goal-driven and finds it nearly impossible to adjust or change goals (e.g. completely uncompromising or extremely stubborn)

5. Interest in relationships

2	Strives to avoid other people to a degree where it causes significant problems (e.g., extreme isolation, or feeling extremely distressed when interacting with others)
1	Sometimes avoids other people to a degree where it causes problems (e.g., social isolation, or feeling distressed when interacting with others)
0	Has a good balance of being comfortable with being alone versus being with others
1	Sometimes becomes distressed or upset when not around others (e.g., feels lonely, or yearning for attention)
2	Often becomes distressed, upset, or desperate when not around others (e.g., feels extreme loneliness, abandonment, or severe yearning for attention)

6. Perspective-taking

2	Never considers or understands other people's thoughts and feelings, which causes serious problems in relationships
1	Often doesn't consider or understand other people's thoughts and feelings, which causes problems in relationships
0	Considers and can easily understand other people's thoughts and feelings
1	Often spends too much time with or considers too intensively what others think or feel, which causes distress
2	Always considers far too intensively what others think or feel even for extended periods of time, which causes serious distress

7. Mutuality in relationships

2	Is always very selfish which causes problems in relationships (e.g., abusive, manipulative, or highly controlling behaviour that involve harm to or severe distress in other people)
1	Is sometimes too selfish which causes problems in relationships (e.g., rude, uncaring, insubordinate, or domineering behaviour that involve conflicts with or distress in other people)
0	Is able to establish and maintain close and mutually satisfying relationships (e.g., appropriately prioritizes the needs of self and others)
1	Is sometimes unable to prioritize self in relationships, even when harmful (e.g., putting others' needs above their own which causes distress; staying in a dysfunctional relationship)
2	Is rarely able to prioritize self in relationships, even when harmful (e.g., overly compliant to the degree of feeling unable to leave despite being abused, controlled, or otherwise victimized by others)

8. Disagreement management

2	Often seeks out arguments or conflicts with others, which causes serious relationship problems (e.g., results in absence of reliable friendships or romantic relationships)
1	Sometimes gets into arguments or conflicts with others, which causes relationship problems (e.g., results in fewer friendships or difficulty maintaining romantic relationships)
0	Is able to manage disagreements or conflicts in relationships in a cooperative manner
1	Often avoids disagreements and conflicts with others which causes problems for them (e.g., having difficulties asserting their needs resulting in low fulfillment)
2	Avoids disagreements and conflicts with others at any cost, which causes serious problems (e.g., being unable to assert their needs resulting in a lack of fulfillment)

9. Emotional control and expression

2	Frequently cannot regulate emotions which causes serious problems for them or others
1	Sometimes have trouble regulating emotions which causes problems for them or others
0	Is generally able to regulate and express emotions in an appropriate way
1	Sometimes suppresses or do not express emotions, including alexithymia, which causes some problems for them or others
2	Almost always suppresses or never expresses emotions at all, including severe alexithymia, which causes serious problems for them or others

10. Behavioural control

2	Often acts so rashly or impulsively that it causes serious problems for them
1	Sometimes acts on impulse without considering the consequences, which causes problems for them
0	Is generally able to be spontaneous while keeping appropriate control of own actions
1	Is sometimes so controlled in their actions that they don't get the same out of life as others do
2	Is often so over-controlled in their actions that they hardly get anything out of life

11. Experience of reality during stress

0	Experience of situational or interpersonal reality is usually accurate when feeling stressed out
1	Experience of situational or interpersonal reality is somewhat distorted when feeling stressed out (e.g., expecting the worst to happen; feeling rejected when criticized by others)
2	Poor experience of situational or interpersonal reality is significantly distorted when feeling stressed out (e.g., overly suspicious of others; experiences of dream-like states)
3	Often loses touch with situational or interpersonal reality when feeling stressed out (e.g., transient hallucinations or other aberrant experiences; depersonalization experiences; extreme suspiciousness)

12. Harm to self (intentional or unintentional)

0	Never harms themselves
1	Rarely harms themselves (e.g., one or two minor self-injuries; no suicidal gestures)
2	Sometimes harms themselves (e.g., a few self-injuries; at least one suicidal gesture)
3	Often harms themselves (e.g., several self-injuries; significant suicidal gestures)

13. Harm to others (intentional or unintentional)

0	Never harms others
1	Rarely harms others (e.g., one physical assault; one incident of endangering others)
2	Sometimes harm others (e.g., multiple physical assaults or incidents of endangering others)
3	Often harms others (e.g., recurrent physical assaults or incidents of endangering others)

14. When considering all ratings (i.e., domains 1-13), how much do they cause impairment in important areas of the person's life (e.g., personal, family, social, school, work)?

0	**None or some difficulty** (e.g., no notable disruption in social, occupational, and interpersonal relationships; problems are limited to specific relationships or situations)
1	**Mild impairment** (e.g., limited to circumscribed areas such as romantic relationships and employment; present in more areas but of milder severity; is generally able to sustain employment and maintain some relationships but may have issues with supervisors, co-workers, and friends)
2	**Moderate impairment** (e.g., marked impairment while functioning in circumscribed areas may be maintained; relationships are likely to be characterized by conflict, avoidance, withdrawal, or extreme dependency)
3	**Severe impairment** (e.g., severe impairment in all or nearly all areas of life; seriously affecting virtually all relationships; absent or severely compromised ability and willingness to perform expected social and occupational roles)

WHODAS-Child

Developer: Scorza, P., Stevenson, A., Canino, G., Mushashi, C., Kanyanganzi, F., Munyanah, M., & Betancourt, T. (2013). Validation of the "World Health Organization Disability Assessment Schedule for children, WHODAS-Child" in Rwanda. PloS One, 8(3), e57725–e57725. https://doi.org/10.1371/journal.pone.0057725

Scoring: Uses a domain-weighted scoring system, where each of the six domains the total score are expressed as a percentage of the maximum possible score (0–100), with higher scores indicating greater disability. The 6 domains are: Cognition (items 1-6), Mobility (items 7-11), Self-care (items 12-15), Getting along (items 16-20), Life activities (items 21-29), and Participation (items 30-34). Average domain and general disability scores can also be calculated using the WHODAS 5-point severity bands (none, mild, moderate, severe, extreme), and the Life Activities domain adjusts automatically by excluding the five optional school-related items for children not attending school.

The full item list for the WHODAS-Child is listed below as this measure is brief:

This question asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems may be short or long-lasting, injuries, mental or emotional problems.

Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities.

In the past 30 days, how much difficulty did you have in:

	Item	None	Mild	Moderate	Severe	Extreme or cannot do
1	Concentrating for 10 minutes at a time or more while doing homework, playing a game, or doing something you were asked to do?	0	1	2	3	4
2	Remembering to do important things, such as crossing the street safely, taking the right books to school, and remembering to do homework assignments?	0	1	2	3	4
3	Finding a way to deal with common, everyday problems that other people your age can manage?	0	1	2	3	4
4	Learning how to do something new, for example, how to play a new game, or learning something new at school?	0	1	2	3	4
5	Generally understanding what people say?	0	1	2	3	4
6	Telling your family or friends about things you have done, or people you have met, or places you have been?	0	1	2	3	4
7	Standing for a reasonable period of time, for example, in PE or school assembly, or church/temple?	0	1	2	3	4
8	Getting up from a sitting position?	0	1	2	3	4

	Item	None	Mild	Moderate	Severe	Extreme or cannot do
9	Moving around inside your home?	0	1	2	3	4
10	Getting around at school or at a friend's?	0	1	2	3	4
11	Walking for as long a distance as other people your age can?	0	1	2	3	4
12	Keeping yourself and your clothes clean, taking baths or showers, and brushing your teeth without being asked?	0	1	2	3	4
13	Getting dressed on your own?	0	1	2	3	4
14	Eating meals without help?	0	1	2	3	4
15	Staying safe when you are alone or not putting him/herself in danger when there are no adults around?	0	1	2	3	4
16	Getting along with people you do not know well?	0	1	2	3	4
17	Keeping a friendship?	0	1	2	3	4
18	Getting along with family members?	0	1	2	3	4
19	Making new friends?	0	1	2	3	4
20	Getting along with your teachers or adults who aren't in your family?	0	1	2	3	4
21	Doing chores or other things you are expected to do at home to help out?	0	1	2	3	4
22	Finishing chores or home activities that you are supposed to do?	0	1	2	3	4
23	Doing chores or other home activities well?	0	1	2	3	4
24	Doing these home activities quickly when it is important?	0	1	2	3	4
25	If you go to school, complete questions 25-29 below. Otherwise, skip to question 30. Because of your health condition, in the past 30 days, how much difficulty did you have in: Doing your regular school assignments?	0	1	2	3	4
26	Studying for important school tests?	0	1	2	3	4
27	Completing all of the school assignments and activities that you needed to do?	0	1	2	3	4
28	Getting your school work done as quickly as needed?	0	1	2	3	4

	Item	None	Mild	Moderate	Severe	Extreme or cannot do
29	Following the rules or fitting in with others?	0	1	2	3	4
30	Joining in on community activities (e.g., clubs, religious groups, after-school activities)?	0	1	2	3	4
	Item	**None**	**Mild**	**Moderate**	**Severe**	**Extreme**
31	Getting invited to parties, play dates, hanging out?	0	1	2	3	4
	Item	**None**	**A little**	**Some**	**Quite a bit**	**A lot/ Nearly all the time**
32	How much time do your parents or other family members spend on your health condition problems?	0	1	2	3	4
	Item	**None**	**Mild**	**Moderate**	**Severe**	**Extreme**
33	How much have you been upset by your health condition?	0	1	2	3	4
34	How much of a problem do you have in doing things you enjoy or relaxing by yourself?	0	1	2	3	4
35	In the past 30 days, how much did your difficulties get in the way of your life?	0	1	2	3	4
36	Making new friends?					
37	In the past 30 days, how many days were you totally unable to carry out your usual activities or school/work because of your health condition?					
38	In the past 30 days, not counting your answer in number 37, how many days did you cut back or reduce your usual activities or school/work because of your health condition?					
39	In the past 30 days, how many days were you absent from school/work?					
40	In the past 30 days, how many days were you late for school/work?					

SITBI

Developer: Nock, M. K., Holmberg, E. B., Photos, V. I., & Michel, B. D. (2007). The Self-Injurious Thoughts and Behaviors Interview: Development, reliability, and validity in an adolescent sample. Psychological Assessment, 19, 309-317.

Scoring: While the long- and short-form versions of the SITBI have their own administration and scoring procedures, clinicians are encouraged to use selected items for ROM purposes. It is entirely appropriate to draw on individual items or subsets of items relevant to the clinical picture at hand, rather than working through the full interview. In support of this notion, previous research on adolescents with PD have opted to ask only a small number of targeted questions. For instance, some researchers have stuck to simply asking for the number of days in the past 12 months that a NSSI, suicidal thoughts, and suicidal attempts have occurred (Cavelti et al., 2023). This selective approach reduces burden on the person being assessed while still capturing meaningful, quantifiable indicators across the core domains the SITBI was designed to measure.

Below are some recommended questions drawn from the SITBI. The timeframe used to assess frequency (e.g., past month, three months, or 12 months) can be adapted according to the purpose and frequency of monitoring but should be applied consistently over time.

Suicidal Ideation

- Have you ever had thoughts of killing yourself? **0)** no **1)** yes
- How many separate times in the past year?

Suicide Plan

- Have you ever actually made a plan to kill yourself? **0)** no **1)** yes
- How many separate times in the past year?

Suicide Gesture

- Have you ever done something to lead someone to believe that you wanted to kill yourself when you really had no intention of doing so? **0)** no **1)** yes

Only score if there was NO suicidal intent, and they wanted someone else to BELIEVE they wanted to make a suicide attempt

- How many separate times in the past year?

Suicide Attempt

- Have you ever made an actual attempt to kill yourself in which you had at least some intent to die? **0)** no **1)** yes
- How many have you made in the past year?

Thoughts of Non-Suicidal Self-Injury

- Have you ever had thoughts of purposely hurting yourself without wanting to die? (for example, cutting or burning) **0)** no **1)** yes
- How many separate times in the past year?

Non-Suicidal Self-Injury

- Have you ever actually engaged in NSSI? **0)** no **1)** yes
- How many times in the past year?

PROMIS Social Isolation

Developer: PROMIS (Patient Reported Outcomes Measurement Information System), U.S. National Institutes of Health (NIH) Common Fund; developed by PROMIS Social Health Domain Working Group.

Scoring: raw scores (sum of the four items) are converted to T-scores using PROMIS scoring tables. T-scores can then be interpreted using standard PROMIS severity ranges, where higher scores indicate greater social isolation.

The full item list for the PROMIS Social Isolation is listed below as this measure is brief:

Please respond to each item by marking one box per row.

	Item	Never	Rarely	Sometimes	Usually	Always
1	I feel left out	1	2	3	4	5
2	I feel that people barely know me	1	2	3	4	5
3	I feel isolated from others	1	2	3	4	5
4	I feel that people are around me but not with me	1	2	3	4	5

ReQoL-10

Developer: Keetharuth, A. D., Brazier, J., Connell, J., Bjorner, J. B., Carlton, J., Taylor Buck, E., Ricketts, T., McKendrick, K., Browne, J., Croudace, T., & Barkham, M. (2018). Recovering Quality of Life (ReQoL): A new generic self-reported outcome measure for use with people experiencing mental health difficulties. The British Journal of Psychiatry, 212(1), 42–49. https://doi.org/10.1192/bjp.2017.10

Scoring: scored by summing the responses to all 10 items, producing a total score that reflects the individual's recovery related quality of life.

The full item list for the ReQoL-10 is listed below as this measure is brief:

For each of the following statements, please tick one box that best describes your thoughts, feelings and activities over the last week.

	Item	None of the time	Only occasionally	Sometimes	Often	Most or all of the time
1	I found it difficult to get started with everyday tasks	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
2	I felt able to trust others	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
3	I felt unable to cope	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
4	I could do the things I wanted to do	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5	I felt happy	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
6	I thought my life was not worth living	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
7	I enjoyed what I did	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
8	I felt hopeful about my future	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
9	I felt lonely	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
10	I felt confident in myself	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

Item	None of the time	Only occasionally	Sometimes	Often	Most or all of the time
Please describe your physical health (problems with pain, mobility, difficulties caring for yourself or feeling physically unwell) over the last week	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

Appendix B



NHMRC FORM Framework

This appendix presents the NHMRC FORM Framework evidence assessment for the six clinical domains. As noted in the Clinical Recommendations chapter, the FORM assessment was completed prior to the separation of the Risk and Governance Management domain into two distinct domains and therefore reflects the original six domains. The FORM evidence assessment for each domain is presented in Table 15 below.

Table 15: NHMRC FORM Evidence Assessment of Clinical Domains

Clinical Topic Area	Evidence Base	Consistency	Clinical Impact	Generalisability	Applicability	Grade of Recommendation
Assessment and Formulation	**B – Good** Evidence includes multiple Level III cohort and longitudinal studies with low risk of bias.	**B – Good** Consistency in assessment tools and principles. Some inconsistency and ongoing debate regarding clinician uptake and diagnosis in adolescents.	**C – Moderate** Evidence impacts treatment planning, service access, and care trajectory, although direct outcome effects attributable solely to assessment/formulation processes are limited.	**B – Good** Evidence is broadly generalisable to the target population. Caveats include reliance on some adult and international evidence, as well as variability in samples and settings (e.g., specialist services, predominantly female samples, differing diagnostic thresholds).	**B – Good** Largely applicable across services, with commonly used frameworks and accessible tools, though structured interviews and formulation require training and may be resource dependent.	**B – Body of evidence can be trusted to guide practice in most situations.**
Care Planning (Treatment)	**B – Good** Evidence includes predominantly multiple Level II RCTs and Level III models with low risk of bias.	**B – Good** Consistency regarding overall treatment recommendations. Inconsistency between studies can be explained by differences in experimental design.	**C – Moderate** Evidence impacts treatment framework, informing intervention specifics for outpatient settings; however, inpatient-focused evidence remains limited.	**C – Moderate** Evidence is mostly generalisable to the target population. However, several psychotherapies (besides DBT-A and MBT-A) lack adolescent specific studies; and some evidence focuses on broader features (e.g. self-harm) rather than PD specifically	**C – Moderate** Largely applicable across services with evidence specifically investigating Australian populations (e.g. general psychiatric management, DBT-A, MBT-A, CAT); although some psychotherapies lack Australian specific investigation (e.g. TFP, ERT, SFT).	**B – Body of evidence can be trusted to guide practice in most situations.**
Clinical Risk Management and Risk Governance	**B – Good** Evidence includes Level I studies with a low risk of bias and multiple Level III cohort studies with generally acceptable methodological quality.	**B – Good** Most studies consistently identified young people with PD as high risk and emphasised collaborative risk assessment, safety planning, and carer involvement. Inconsistencies explained by sample characteristics (inpatient vs outpatient) and comorbidity profiles rather than disagreement in direction of findings.	**B – Substantial** Evidence addresses high-stakes outcomes (suicide and self-harm) and are likely to produce substantial net benefit through improved safety planning, escalation, and continuity of care, with minimal direct harm.	**B – Good** Evidence is primarily drawn from adolescent samples presenting with self-harm and suicidality in outpatient, inpatient, and emergency settings, which is broadly comparable to the target population. However, several sources are general youth self-harm guidelines rather than PD specific.	**B – Good** Applicable to Australian healthcare context in most settings, including specialist and acute services. However, some evidence is derived from high-acuity or inpatient contexts and may not fully reflect community CAMHS settings.	**B – Body of evidence can be trusted to guide practice in most situations.**

Clinical Topic Area	Evidence Base	Consistency	Clinical Impact	Generalisability	Applicability	Grade of Recommendation
Collaboration	**D – Poor** Mostly Level III/IV studies (small pilots, observational burden data, one underpowered RCT, and theoretical models) with high risk of bias.	**B – Good** Most studies consistently identified that early systemic engagement, structured capacity building (psychoeducation), and relational practices are associated with improved retention, reduced burden, and better symptom trajectories. Inconsistencies reflect both methodological variation and the fact that studies focus on different systems (families, schools, Aboriginal and Torres Strait Islander contexts) with differing aims and outcomes.	**C – Moderate** Pilots show replicated carer burden/ expressed emotion reductions; school training boosts staff knowledge/ skills; broader reviews confirm family engagement links to better retention/ symptom outcomes, and theoretical models show promise in case studies, including school-based open-systems ecological frameworks (integrating DBT skills across people, policy, and processes) and integrative systemic models for Aboriginal and Torres Strait Islander people (combining trauma-informed, DBT, collaborative, and cultural components); although no PD-specific RCTs.	**B – Good** Evidence is primarily drawn from child/adolescent samples presenting with PD in outpatient and educational settings. Although Aboriginal and Torres Strait Islander people models are based on adolescent evidence, they lack clinical trial data.	**B – Good** Largely applicable across different family dynamics and schools. Largely applicable to Australian contexts with a large focus on Aboriginal and Torres Strait Islander people and Australian school collaboration.	**C – Body of evidence provides some support for recommendations, but care should be taken in its application.**
Outcome Measurement	**C – Moderate** Level II RCTs validate core PD measures with strong psychometrics (moderate bias); ROM adult meta-analysis robust but youth evidence mixed/low-quality.	**B – Good** Consistency is high in regard to core clinical measures reliably tracking change, although moderate for social outcome measures ROM given small PD specific evidence base.	**C – Moderate** Evidence shows reliable symptom reduction measures from clinical tools in DBT-A/MBT-A RCTs; ROM enhances adult outcomes with promising youth cases; social tools capture functioning gains but smaller effects.	**C – Moderate** Evidence regarding clinical and educational outcomes focuses on child/adolescent populations, although the evidence base for utilising ROM in PD specific populations is small.	**B – Good** Applicable to Australian healthcare context in most settings, including specialist and acute services. However, some evidence presents youth specific gaps.	**C – Body of evidence provides some support for recommendations but care should be taken in its application.**
Out-of-Home Care (OOHC)	**C – Satisfactory** Predominantly Level III studies with a low risk of bias.	**B – Good** Evidence consistently demonstrates elevated mental health vulnerability among children in OOHC, though studies are heterogeneous and not specific to PD populations.	**C – Moderate** Body of evidence on young people in OOHC, which emphasises trauma-informed and relational models of care, is likely to have a positive clinical impact on engagement and psychosocial outcomes. However, the evidence is largely indirect and not specific to PD presentations.	**C – Satisfactory** Evidence predominantly focuses on children and adolescents in OOHC rather than those diagnosed with PD. While there is conceptual and clinical overlap (e.g., trauma exposure, attachment disruption, relational instability), the evidence is not directly generalisable to the target population but may be sensibly applied.	**B – Good** Broadly applicable across Australian child protection and mental health services, though implementation may vary depending on system coordination and resourcing.	**C – Body of evidence provides some support for recommendations but care should be taken in its application.**

Note: Level of evidence determined from the NHMRC Evidence Hierarchy: I – a systematic review of all relevant randomised controlled trials; II – at least one properly designed randomised controlled trial; III-1 – well-designed pseudo-randomised controlled trials (alternate allocation or some other method); III-2 – comparative studies with concurrent controls and allocation not randomised (cohort studies), case-control studies, or interrupted time series with a control group; III-3 – comparative studies with historical control, two or more single-arm studies, or interrupted time series without a parallel control group; IV – case series, either post-test or pre-test and post-test.

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