Conduct disorders and antisocial behaviour in children and young people: recognition, intervention and management

NICE and SCIE guideline

Draft for consultation, August 2012

If you wish to comment on this version of the guideline, please be aware that all the supporting information and evidence is contained in the full version.

This guidance has been developed jointly by the National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE).

Contents

This guidance is an update of NICE technology appraisal guidance 102 (published July 2006) and will replace it.

Introduction

Conduct disorders are the most common mental health disorder in children and young people. The Office of National Statistics (ONS) surveys of 1999 and 2004 reported that their prevalence was 5% among children and young people aged between 5 and 16 years. Conduct disorders nearly always have a significant impact on functioning and quality of life. The first ONS survey demonstrated that conduct disorders have a steep social class gradient, with a three- to fourfold increase in social classes D and E compared with social class A. The second survey found that almost 40% of looked-after children, those who have been abused and/or those on child protection/safeguarding registers have conduct disorders.

Conduct disorders are characterised by repetitive and persistent patterns of antisocial, aggressive or defiant behaviour that amounts to significant and persistent violations of age-appropriate social expectations. The current World Health Organization classification of the disorders (ICD-10) identifies 2 subgroups: conduct disorder and oppositional defiant disorder. Conduct disorder is more common in older children aged 11 years and older and oppositional defiant disorder is more common in those aged 10 years or younger. The major distinction between the disorders is the extent and severity of the antisocial behaviour. Isolated antisocial or criminal acts are not sufficient to support a diagnosis of conduct disorder or oppositional defiant disorder.

The prevalence of conduct disorders increases throughout childhood and they are more common in boys than girls. For example, 7% of boys and 3% of girls aged 5 to 10 years have conduct disorders; for children aged 11 to 16 years the number rises to 8% for boys and 5% for girls.

Conduct disorders commonly coexist with other mental health disorders: 46% of boys and 36% of girls have at least one other coexisting mental health disorder. The coexistence of conduct disorders with attention deficit hyperactivity disorder (ADHD) is particularly prevalent and in some groups more than 40% of children and young people with a diagnosis of conduct disorder also have a diagnosis of ADHD. The presence of conduct disorder in childhood is also associated with a significantly increased rate of mental health disorders in adult life, including antisocial personality disorder. (Up to 50% of children and young people with a conduct disorder go on to develop antisocial personality disorder.) The prevalence of conduct disorders in the UK varies between ethnic groups, being lower than average in some (for example, south Asian) but higher in others (for example, African-Caribbean).

A diagnosis of a conduct disorder is strongly associated with poor educational performance, social isolation, and in adolescence, drug and alcohol misuse and increased contact with the criminal justice system. This association continues into adult life with poorer educational and occupational outcomes, involvement with the criminal justice system (as high as 50% in some groups) and a high level of mental health disorder (at some point in their lives 90% of people with antisocial personality disorder will have another mental disorder).

Conduct disorders are the most common reason for referral of young children to child and adolescent mental health services (CAMHS). Children with conduct disorders also comprise a considerable proportion of the work of the health and social care system. For example, 30% of a typical GP's child consultations are for behavioural problems in children, 45% of community child health referrals are for behaviour disturbances, and psychiatric disorders are a factor in 28% of all paediatric outpatient referrals. In addition, social care services have significant involvement with children and young people with conduct disorders, with more vulnerable or disturbed children often being placed with a foster family or, less commonly, in residential care. The demands on the educational system are also considerable and include the provision of special-needs education. The criminal justice system also has significant involvement with older children with conduct disorders.

Multiple agencies may be involved in the care and treatment of children with conduct disorders, which presents a major challenge for current services in the effective coordination of care across agencies.

Several interventions have been developed for children with conduct disorder and related problems, such as parenting programmes typically focused on younger children and multisystemic approaches usually focused on older children. Other interventions focused on prevention, such as the Nurse Family Partnership (known as the Family Nurse Partnership in the UK), have recently been implemented in the UK and are currently being evaluated. Three themes are common to these interventions: a strong focus on working with parents and families, recognition of the importance of the wider social system in enabling effective interventions, and a focus on preventing or reducing the escalation of existing problems.

Uptake of these interventions and the outcomes achieved vary across England and Wales. Parenting programmes are the best established; implementation of multisystemic approaches and early intervention programmes is more variable. In addition to the programmes developed specifically for children with a conduct disorder, a number of children (and their parents or carers) are treated by both specialist CAMHS teams and general community-based services such as Sure Start.

Identifying which interventions and agencies are the most appropriate is challenging, especially for non-specialist health, social care and educational services. Further challenges arise when considering the use of preventive and early intervention programmes and identifying which vulnerable groups stand to gain from such interventions. Factors that may be associated with a higher risk of developing conduct disorders include parental factors such as harsh and inconsistent parenting style and parental adjustment (such as depression, antisocial personality disorder and substance misuse), environmental factors such as poverty, being looked after, and the presence of other mental health disorders.

The guideline covers a range of interventions including treatment, indicated prevention and selective prevention (but not universal prevention). The definitions used in this guideline follow those developed by the Institute of Medicine[1]. For a description of the criteria used in determining whether an intervention was judged to be selective or indicated prevention please see chapter 5 of the full guideline.

A number of recommendations in this guideline have been adapted from recommendations in other NICE clinical guidelines. Where this occurred, the Guideline Development Group was careful to preserve the meaning and intent of the original recommendations. Changes to wording or structure were made in order to fit the recommendations into this guideline. In all cases, the original source of an adapted recommendation is indicated in a footnote.

The guideline assumes that prescribers will use a drug's summary of product characteristics to inform decisions made with individual service users.

This guideline recommends some drugs for indications for which they do not have a UK marketing authorisation at the date of publication, if there is good evidence to support that use. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. The patient (or their parent or carer) should provide informed consent, which should be documented. See the General Medical Council's Good practice in prescribing medicines – guidance for doctors for further information. Where recommendations have been made for the use of drugs outside their licensed indications ('off-label use'), these drugs are marked with a footnote in the recommendations.

[1] Munoz RF, Mrazek PJ, Haggerty RJ (1996) Institute of Medicine report on prevention of mental disorders. Summary and commentary. The American Psychologist 5119325 (Suppl 11):1116–22

Person-centred care

This guideline offers best practice advice on the care of children and young people (aged 18 years and younger) with a diagnosed or suspected conduct disorder, including looked-after children and those in contact with the criminal justice system.

Treatment and care should take into account people's needs and preferences. Children and young people with a conduct disorder should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If the child or young person does not have the capacity to make decisions, healthcare professionals should follow the Department of Health's advice on consent and the code of practice that accompanies the Mental Capacity Act In Wales, healthcare professionals should follow advice on consent from the Welsh Government.

If the child or young person is under 16, healthcare professionals should follow the guidelines in the Department of Health's Seeking consent: working with children.

Good communication between healthcare professionals, children and young people and their parents and carers is essential. It should be supported by evidence-based written information tailored to the person's needs. Treatment and care, and the information people are given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English.

Parents and carers should also be given the information and support they need. Other family members (such as siblings and grandparents) and significant others (such as valued friends) may be involved in the treatment and care of the child or young person and they also need information and support. Recommendations that include 'parents or carers' may also be relevant to them and to local authorities that have parental responsibility, for example for fostered children and young people.

Care of young people in transition between paediatric and adult services should be planned and managed according to the best practice guidance described in the Department of Health's Transition: getting it right for young people.

CAMHS and adult services should work jointly to provide assessment and services to young people with a conduct disorder. Diagnosis and management should be reviewed throughout the transition process, and there should be clarity about who is the lead clinician to ensure continuity of care.

Key priorities for implementation

The following recommendations have been identified as priorities for implementation.

Identification and assessment

Case identification and initial assessment of children and young people with a possible conduct disorder

- For the initial assessment of a child or young person with a suspected conduct disorder, consider using the Strengths and Difficulties Questionnaire[2] (completed by both a parent and a teacher) and also assess for the presence of:
  - a coexisting mental disorder (for example, depression, post-traumatic stress disorder)
  - a neurodevelopmental condition (in particular ADHD and autism)
  - a learning disability or difficulty. **[1.2.4]**

Comprehensive assessment

- The standard components of a comprehensive assessment of conduct disorders should include asking about and assessing the following:
  - core conduct disorders symptoms including:
    - ◊ patterns of negativistic, hostile, or defiant behaviour in children aged under 11 years
    - ◊ aggression to people and animals, destruction of property, deceitfulness or theft and serious violations of rules in children aged over 11 years
    - ◊ current functioning at home, at school or college and with peers
    - ◊ parenting quality
    - ◊ history of any past or current mental disorders and/or physical health problems. **[1.2.9]**

[2] Goodman R (1997) The Strengths and Difficulties Questionnaire: a research note. Journal of Child Psychology and Psychiatry, and Allied Disciplines;38 (Suppl. 5):581–6

Psychosocial interventions

Parent training programmes

- Offer a group parent training programme to the parents of children and young people aged between 3 and 11 years with oppositional defiant disorder or conduct disorder. **[1.4.2]**

Foster carer/guardian training programmes

- Offer a group foster carer/guardian training programme to foster carers and guardians of children and young people aged between 3 and 11 years with oppositional defiant disorder or conduct disorder. **[1.4.6]**

Child-focused programmes

- Offer group social and cognitive problem solving programmes to children and young people aged between 7 and 14 years with oppositional defiant disorder or conduct disorder. **[1.4.12]**

Multimodal interventions

- Offer multimodal interventions (for example, multisystemic therapy) to children and young people aged between 11 and 17 years with a conduct disorder. **[1.4.14]**

Pharmacological interventions

- Offer methylphenidate[3] or atomoxetine[4] for the management of ADHD in children and young people with oppositional defiant disorder or conduct disorder. For advice on the general treatment and management of ADHD

[3] At the time of publication (February 2013) methylphenidate did not have a UK marketing authorisation for use in children aged under 6 years. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. The child's parent or carer should provide informed consent, which should be documented. See the General Medical Council's Good practice in prescribing medicines – guidance for doctors for further information.

[4] At the time of publication (February 2013) atomoxetine did not have a UK marketing authorisation for use in children aged under 6 years. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. The child's parent or carer should provide informed consent, which should be documented. See the General Medical Council's Good practice in prescribing medicines – guidance for doctors for further information.

see Attention deficit hyperactivity disorder (NICE clinical guideline 72). **[1.5.2]**

Organisation and delivery of care

Improving access to services

- Provide information about the services and interventions that constitute the local care pathway, including the:
  - range and nature of the interventions provided
  - settings in which services are delivered
  - processes by which a child or young person moves through the pathway
  - means by which progress and outcomes are assessed
  - delivery of care in related health and social care services[5] [**1.6.2]**

[5] Adapted from 'Common mental health disorders' (NICE clinical guideline 123).

1 Guidance

1.1 *General principles of care*

In this section, a number of the recommendations on the care of children and young people with a conduct disorder, and their parents and carers, draw on general principles from Service user experience in adult mental health (NICE clinical guideline 136), as indicated by a footnote.

Working safely and effectively with children and young people

1.1.1 Health and social care professionals working with children and young people who present with behaviour suggestive of a conduct disorder, or who have conduct disorder, should be trained and competent and able to work with different levels of learning ability, cognitive capacity, emotional maturity and development.al levels.

1.1.2 Health and social care professionals should ensure that they:

- can assess capacity and competence, including 'Gillick competence', in children and young people of all ages **and**
- understand how to apply the legislation in the care and treatment of children and young people, including the Children Act (1989), the Mental Health Act (1983; amended 1995 and 2007) and the Mental Capacity Act (2005)[6].

1.1.3 Health and social care providers should ensure that children and young people with a conduct disorder:

- are routinely offered care and treatment from a single team or professional
- are not passed from one team to another unnecessarily

[6] Adapted from Service user experience in adult mental health (NICE clinical guideline 136).

- do not undergo multiple assessments unnecessarily [7] .

1.1.4 When providing assessment or treatment interventions for children and young people with a conduct disorder, ensure that the nature and content of the intervention is suitable for the child or young person's developmental level.

1.1.5 Evaluate the need for assessment according to local safeguarding procedures if there are concerns about exploitation or self-care, or if the child or young person has had contact with the criminal justice system[8].

Establishing relationships with children and young people and their parents or carers

1.1.6 Be aware that many children and young people with a conduct disorder may have had poor or punitive experiences of care from family members or statutory services and may be mistrustful or dismissive of offers of help as a result. Offer help, treatment and care in an atmosphere of hope and optimism. Develop a positive, caring and trusting relationship with the child or young person and their parents or carers as a first step in ensuring their engagement with services and maintain continuity of individual therapeutic relationships wherever possible.

1.1.7 Health and social care professionals working with children and young people with a conduct disorder should be trained and skilled in:

- negotiating and working with parents and carers **and**
- managing issues relating to information sharing and confidentiality as these apply to children and young people.

[7] Adapted from Service user experience in adult mental health (NICE clinical guideline 136).
[8] Adapted from Service user experience in adult mental health (NICE clinical guideline 136).

1.1.8 If a young person is 'Gillick competent' seek their consent before speaking to their parent or carers[9].

1.1.9 When working with children and young people with a conduct disorder and their parents or carers:

- make sure that discussions take place in settings in which confidentiality, privacy and dignity are respected
- be clear with the child or young person and their parents or carers about limits of confidentiality (that is, which health and social care professionals have access to information about their diagnosis and its treatment and in what circumstances this may be shared with others)[10].

1.1.10 When coordinating care and involving children and young people with a conduct disorder and their parents and carers in treatment decisions, ensure that:

- everyone involved understands the purpose of any meetings and why information might need to be shared
- the right to confidentiality is respected throughout the process.

Working with parents and carers

1.1.11 Discuss with young people how they want their parents or carers to be involved in their care. Repeat the discussion at intervals to take account of any changes in circumstances, including developmental level.[11].

1.1.12 Be aware that parents and carers of children and young people with a conduct disorder might feel blamed for their child's problems or stigmatised by their contact with services. When offering or providing interventions such as parent training programmes,

[9] Adapted from Service user experience in adult mental health (NICE clinical guideline 136).
[10] Adapted from Service user experience in adult mental health (NICE clinical guideline 136).
[11] Adapted from 'Service user experience in adult mental health' (NICE clinical guideline 136).

directly address any concerns they have and set out the reasons for and purpose of the intervention.

1.1.13 Offer parents and carers an assessment of their own needs including:

- personal, social and emotional support
- support in their caring role, including emergency plans
- advice on practical matters such as childcare, housing and finances, and help to obtain support.

Communication and information

1.1.14 When communicating with children and young people with a conduct disorder and their parents or carers:

- take into account the child or young person's developmental level, emotional maturity and cognitive capacity, including any learning disabilities, sight or hearing problems and delays in language development
- use plain language if possible and clearly explain any clinical language
- check that the child or young person and their parents or carers understand what is being said
- use communication aids (such as pictures, symbols, large print, Braille, different languages or sign language) if needed[12].

1.1.15 When working with a child or young person with conduct disorder or their parents or carers ensure that you are:

- familiar with local and national sources (organisations and websites) of information and/or support for children and young people with a conduct disorder and their parents or carers
- able to discuss and advise how to access these resources

[12] Adapted from Service user experience in adult mental health (NICE clinical guideline 136).

- able to discuss and actively support children and young people and their parents or carers to engage with these resources [13].

1.1.16 When communicating with a child or young person with a conduct disorder, use diverse media, including letters, phone calls, emails or text messages, according to their preference[14].

Culture, ethnicity and social inclusion

1.1.17 When working with children and young people with a conduct disorder and their parents or carers:

- take into account that stigma and discrimination are often associated with using mental health services
- be respectful of and sensitive to children and young people's gender, sexual orientation, socioeconomic status, age, background (including cultural, ethnic and religious background) and any disability
- be aware of possible variations in the presentation of mental health problems in children and young people of different genders, ages, cultural, ethnic, religious or other diverse backgrounds[15].

[13] Adapted from Service user experience in adult mental health (NICE clinical guideline 136).
[14] Adapted from Service user experience in adult mental health (NICE clinical guideline 136).
[15] Adapted from Service user experience in adult mental health (NICE clinical guideline 136).

1.1.18 When working with children and young people with a conduct disorder and their parents or carers provide interpreters if needed and offer a list of local education providers who can provide English language teaching for children and young people and their parents or carers who have difficulties speaking and understanding English.

1.1.19 Health and social care professionals working with children and young people with a conduct disorder and their parents or carers should have competence in:

- assessment skills and using explanatory models of conduct disorder for people from different cultural, ethnic, religious or other diverse backgrounds
- explaining the possible causes of different mental health problems, and care, treatment and support options
- addressing cultural, ethnic, religious or other differences in treatment expectations and adherence
- addressing cultural, ethnic, religious or other beliefs about biological, social and familial influences on the possible causes of mental health problems[16].

Transfer and discharge

1.1.20 Anticipate that withdrawal and ending of treatments or services, and transition from one service to another, may evoke strong emotions and reactions in children and young people with a conduct disorder and their parents or carers. Ensure that:

- such changes, especially discharge and transfer from child and adolescent mental health services (CAMHS) to adult services, are discussed and planned carefully beforehand with all involved, and are structured and phased

[16] Adapted from Service user experience in adult mental health (NICE clinical guideline 136).

- children and young people and their parents or carers are given comprehensive information about the way adult services work and the nature of any potential interventions provided
- the care plan supports effective collaboration with social care and other care providers during endings and transitions, and includes details of how to access services in times of crisis[17].

1.1.21 When referring a child or young person for an assessment in other services (including for psychological interventions), ensure they are supported during the referral period and arrangements for support are agreed beforehand with them[18].

1.2 *Identification and assessment*

Case identification and initial assessment of children and young people with a possible conduct disorder

1.2.1 Adjust delivery of case identification tools and assessment methods to:

- the needs of children and young people who are suspected of having a conduct disorder **and**
- the setting in which they are delivered (for example, health and social care, educational settings or the criminal justice system).

1.2.2 Consider an initial assessment for a suspected conduct disorder if a child or young person's parents or carers, health or social care professionals, school or college, or peer group raise concerns about persistent antisocial behaviour.

1.2.3 Do not regard a history of a neurodevelopmental condition (for example, attention deficit hyperactivity disorder [ADHD]) as a barrier to assessment.

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[17] Adapted from Service user experience in adult mental health (NICE clinical guideline 136).
[18] Adapted from Service user experience in adult mental health (NICE clinical guideline 136).

1.2.4 For the initial assessment of a child or young person with a suspected conduct disorder, consider using the Strengths and Difficulties Questionnaire[19] (completed by both a parent and a teacher) and also assess for the presence of:

- a coexisting mental disorder (for example, depression, post-traumatic stress disorder)
- a neurodevelopmental condition (in particular ADHD and autism)
- a learning disability or difficulty.

1.2.5 If no significant complicating factors (as set out in recommendation 1.2.4) are present consider direct referral for an intervention.

1.2.6 If significant complicating factors are present (as set out in recommendation 1.2.4), refer the child or young person to a specialist CAMHS for a comprehensive assessment.

Comprehensive assessment

1.2.7 A comprehensive assessment of a child or young person with a suspected conduct disorder should be undertaken by a health or social care professional who is competent to undertake the assessment and should:

- offer the opportunity for the child or young person to meet the professional on their own
- involve a parent, carer or other third party known to the child or young person who can provide information about current and past behaviour
- if necessary involve more than one health or social care professional to ensure a comprehensive assessment is undertaken.

[19] Goodman R (1997) The Strengths and Difficulties Questionnaire: a research note. Journal of Child Psychology and Psychiatry, and Allied Disciplines;38 (Suppl. 5):581–6

1.2.8 Before starting a comprehensive assessment, explain to the child or young person how the outcome of the assessment will be communicated to them. Involve a parent, carer or advocate to help explain the outcome.

1.2.9 The standard components of a comprehensive assessment of conduct disorders should include asking about and assessing the following:

- core conduct disorders symptoms including:
  - patterns of negativistic, hostile, or defiant behaviour in children aged under 11 years
  - aggression to people and animals, destruction of property, deceitfulness or theft and serious violations of rules in children aged over 11 years
- current functioning at home, at school or college and with peers
- parenting quality
- history of any past or current mental disorders and/or physical health problems.

1.2.10 As part of a comprehensive assessment, take into account and address possible coexisting conditions such as:

- learning difficulties or disabilities
- neurodevelopmental conditions such as ADHD and autism
- neurological disorders including epilepsy and motor impairments
- other mental disorders (for example, depression, post-traumatic stress disorder and bipolar disorder)
- drug and alcohol misuse
- communication disorders (for example, speech and language problems, selective mutism).

1.2.11 Consider using formal assessment instruments to aid the diagnosis of coexisting conditions such as:

- the Child Behavior Checklist (CBCL) [20] for all children and young people
- the Strengths and Difficulties Questionnaire (SDQ) [21] for all children or young people
- the Connors Scale[22] for a child or young person with suspected ADHD
- a validated measure of autistic behaviour for a child or young person with a suspected autism spectrum disorder (see Autism diagnosis in children and young people [NICE clinical guideline 128])
- the Wechsler Abbreviated Scale of Intelligence (WASI)[23] for a child or young person with a suspected learning disability
- the Wechsler Objective Reading Dimensions (WORD)[24] for a child or young person with a suspected reading difficulty.

1.2.12 As part of a comprehensive assessment, assess the risks faced by the child or young person and if needed develop a risk management plan for self-neglect, exploitation by others, self-harm or harm to others.

1.2.13 As part of a comprehensive assessment, assess for the presence or risk of physical, sexual and emotional abuse in line with local protocols for the assessment and management of these problems.

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[20] Achenbach TM (1991). Manual for the Child Behavior Checklist and 1991 Profile. Burlington, VT: University of Vermont, Department of Psychiatry, 1991.
[21] Goodman R (1997). The Strengths and Difficulties Questionnaire: a research note. Journal of Child Psychology and Psychiatry, and Allied Disciplines 1997;38 (Suppl. 5):581–-6.
[22] Conners CK, Wells KC, Parker JDA, et al .(1997) A new self-report scale for assessment of adolescent psychopathology: factor structure, reliability, validity and diagnostic sensitivity. Journal of Abnormal Child Psychology 1997;25:487–-497.
[23] Psychological Corporation (1999). Wechsler Abbreviated Scale of Intelligence manual. San Antonio, TX: Psychological Corporation, 1999.
[24] Rust J, Golombok S, Trickey, G (1993). WORD, Wechsler Objective Reading Dimensions Manual. London: Psychological Corporation, 1993.

1.2.14 Conduct a comprehensive assessment of the child or young person's parents or carers, which should cover:

- positive and negative aspects of parenting, in particular any use of coercive discipline
- the parent–child relationship
- positive and negative adult relationships within the child or young person's family, including domestic violence
- parental wellbeing, including mental health and/or substance misuse problems and criminal behaviour.

1.2.15 Develop a care plan with the child or young person, and their parents of carers, which includes a profile of their needs, risks to self or others, and any further assessments that may be needed, including the extent and nature of:

- the conduct disorder and any associated behavioural problems
- any coexisting mental or physical health problems
- speech, language and communication difficulties
- personal and social functioning to indicate any needs (personal, social, occupational, housing or educational)
- family or carer needs
- the child or young person's strengths, and those of the parents or carers.

1.3 *Identifying effective treatment and care options*

1.3.1 When discussing treatment or care interventions with a child or young person with a conduct disorder and, if appropriate, their parents or carers, take account of :

- their past and current experience of the disorder
- their experience of, and response to, previous interventions and services
- the nature, severity and duration of the problem(s)
- the impact of the disorder on educational performance

- any chronic physical health problem
- the presence of any social or family factors that may have a role in the development or maintenance of the identified problem(s)
- the presence of any coexisting conditions[25].

1.3.2 When discussing treatment or care interventions with a child or young person with a conduct disorder and, if appropriate, their parents or carers, provide information about:

- the nature, content and duration of any proposed intervention
- the acceptability and tolerability of any proposed intervention
- the possible impact on interventions for any other behavioural or mental health problem
- the implications for the continuing provision of any current interventions[26].

1.3.3 When making a referral for treatment or care interventions for a conduct disorder, take account of the preferences of the child or young person and, if appropriate, their parents or carers when choosing from a range of evidence-based interventions[27].

1.4 *Psychosocial interventions*

Staff supervision

1.4.1 Health and social care services should ensure that staff supervision is built into the routine working of the service, is properly resourced within local systems and is monitored. Supervision should:

- make use of direct observation (for example, recordings of sessions) and routine outcome measures
- support adherence to the specific intervention
- focus on outcomes

[25] Adapted from 'Common mental health disorders' (NICE Clinical Guideline 123).
[26] Adapted from 'Common mental health disorders' (NICE Clinical Guideline 123).
[27] Adapted from 'Common mental health disorders' (NICE Clinical Guideline 123).

- be regular and apply to the whole caseload.

Treatment and indicated prevention

Parent training programmes

1.4.2 Offer a group parent training programme to the parents of children and young people aged between 3 and 11 years with oppositional defiant disorder or conduct disorder.

1.4.3 Group parent training programmes should involve both parents if this is possible and in the best interests of the child or young person, and should:

- typically have between 10 and 12 parents in a group
- be based on a social learning model, using modelling, rehearsal and feedback to improve parenting skills
- typically consist of 10 to 16 meetings of 90 to 120 minutes' duration
- have demonstrated efficacy in well-conducted clinical trials.

1.4.4 Offer an individual parent training programme to the parents of children and young people aged between 3 and 11 years with oppositional defiant disorder or conduct disorder who are not able to participate in a group parent training programme.

1.4.5 Individual parent training programmes should involve both parents if possible and should:

- be based on a social learning model using modelling, rehearsal and feedback to improve parenting skills
- typically consist of up to 8 to 10 meetings of 60 to 90 minutes' duration.

Foster carer/guardian training programmes

1.4.6 Offer a group foster carer/guardian training programme to foster carers and guardians of children and young people aged between 3 and 11 years with oppositional defiant disorder or conduct disorder.

1.4.7 Group foster carer/guardian training programmes should involve both of the foster carers or guardians if possible and should:

- modify the intervention to take account of the care setting in which the child is living
- typically have between 8 and 12 parents in a group
- be based on a social learning model using modelling, rehearsal and feedback to improve parenting skills
- typically consist of between 12 and 16 meetings of 90 to 120 minutes' duration.

1.4.8 Offer an individual foster carer/guardian training programme to the foster carers and guardians of children and young people aged between 3 and 11 years with oppositional defiant disorder or conduct disorder who are not able to participate in a group programme.

1.4.9 Individual foster carer/guardian training programmes should involve both of the foster carers if possible and should:

- modify the intervention to take account of the care setting in which the child is living
- be based on a social learning model using modelling, rehearsal and feedback to improve parenting skills
- consist of up to 10 meetings of 60 minutes' duration

Parent and child training programmes for children with complex needs

1.4.10 Offer individual parent and child training programmes to children and young people aged between 3 and 11 years with oppositional defiant disorder or conduct disorder and their parents, foster carers or guardians if the problems are severe and complex.

1.4.11 Individual parent and child training programmes should involve both parents, foster carers or guardians if possible and should:

- be based on a social learning model using modelling, rehearsal and feedback to improve parenting skills
- consist of up to 10 meetings of 60 minutes' duration.

Child-focused programmes

1.4.12 Offer group social and cognitive problem solving programmes to children and young people aged between 7 and 14 years with oppositional defiant disorder or conduct disorder

1.4.13 Group social and cognitive problem solving programmes should be adapted to the children or young people's developmental level and should:

- be based on a cognitive–behavioural problem solving model
- use modelling, rehearsal and feedback to improve skills
- typically consist of 10 to 18 weekly meetings of 2 hours' duration.

Multimodal interventions

1.4.14 Offer multimodal interventions (for example, multisystemic therapy) to children and young people aged between 11 and 17 years with a conduct disorder.

1.4.15 Multimodal interventions (for example, multisystemic therapy) should involve the child or young person and their parents and carers and should:

- have an explicit and supportive family focus
- be based on a social learning model with interventions provided at individual, family, school, criminal justice and community levels
- be provided by specially trained case managers
- typically consist of 3 to 4 meetings per week over a 3 to 5-month period.

Selective prevention

1.4.16 Offer classroom-based emotional learning and problem solving programmes to children aged typically between 3 and 7 years who are assessed to be at risk of developing oppositional defiant disorder or conduct disorder as a result of the following factors:

- low socio-economic status
- low school achievement
- child abuse or abused mother
- divorced parents
- parental mental health or drug problems
- parental contact with the criminal justice system.

1.4.17 Classroom-based emotional learning and problem solving programmes should be provided in a positive atmosphere that promotes emotional learning and consists of interventions intended to:

- increase children’s awareness of their own and others' emotions
- teach self-control of arousal and behaviour
- promote a positive self-concept and good peer relations
- develop children’s problem solving skills. Typically the programmes should consist of up to 30 classroom-based sessions over the course of a year.

1.5 *Pharmacological interventions*

1.5.1 Do not offer pharmacological interventions for the routine management of behavioural problems in children and young people with oppositional defiant disorder or conduct disorder.

1.5.2 Offer methylphenidate[28] or atomoxetine[29] for the management of ADHD in children and young people with oppositional defiant disorder or conduct disorder. For advice on the general treatment and management of ADHD see Attention deficit hyperactivity disorder (NICE clinical guideline 72).

1.5.3 Consider risperidone[30,31] for the short-term management of severely aggressive behaviour in young people with a conduct disorder who have problems with explosive anger and severe emotional dysregulation.

1.5.4 Risperidone[30,31] should be initiated by an appropriately qualified health care professional with expertise in conduct disorders and should be based on a comprehensive assessment and diagnosis. The effects of the medication should be reviewed after 3–4 weeks and risperidone[30,31] discontinued if there is no indication of a clinically important response at 6 weeks.

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[28] At the time of publication (February 2013) methylphenidate did not have a UK marketing authorisation for use in children aged under 6 years. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. The child's parent or carer should provide informed consent, which should be documented. See the General Medical Council's Good practice in prescribing medicines – guidance for doctors for further information.

[29] At the time of publication (February 2013) atomoxetine did not have a UK marketing authorisation for use in children aged under 6 years. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. The child's parent or carer should provide informed consent, which should be documented. See the General Medical Council's Good practice in prescribing medicines – guidance for doctors for further information.

[30] At the time of publication (February 2013) risperidone did not have a UK marketing authorisation for use in children aged under 5 years. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. The child's parent or carer should provide informed consent, which should be documented. See the General Medical Council's Good practice in prescribing medicines – guidance for doctors for further information.

[31] At the time of publication (February 2013) some risperidones did not have a UK marketing authorisation for this indication. The prescriber should consult the summary of product characteristics for the individual risperidone.

1.5.5 Provide children and young people and their parents or carers with age-appropriate information and discuss the likely benefits and possible side effects of risperidone[32,33] including:

- metabolic (including weight gain and diabetes)
- extrapyramidal (including akathisia, dyskinesia and dystonia)
- cardiovascular (including prolonging the QT interval)
- hormonal (including increasing plasma prolactin)
- other (including unpleasant subjective experiences).

1.5.6 Before starting risperidone[32,33], the appropriately qualified health care professional with expertise in conduct disorders should undertake and record the following baseline investigations:

- weight and height (both plotted on a growth chart)
- waist and hip measurements
- pulse and blood pressure
- fasting blood glucose, glycosylated haemoglobin (HbA_{1c}), blood lipid profile and prolactin
- assessment of any movement disorders
- assessment of nutritional status, diet and level of physical activity.

[32] At the time of publication (February 2013) risperidone did not have a UK marketing authorisation for use in children aged under 5 years. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. The child's parent or carer should provide informed consent, which should be documented. See the General Medical Council's Good practice in prescribing medicines – guidance for doctors for further information.

[33] At the time of publication (February 2013) some risperidones did not have a UK marketing authorisation for this indication. The prescriber should consult the summary of product characteristics for the individual risperidone.

1.5.7 Treatment with risperidone[34,35] should be carefully evaluated, and include the following:

- Record the indications and expected benefits and risks, and the expected time for a change in symptoms and appearance of side effects.
- At the start of treatment give a dose at the lower end of the licensed range and slowly titrate upwards within the dose range given in the British National Formulary for Children (BNFC) or the SPC.
- Justify and record reasons for dosages above the range given in the BNFC or SPC.
- Monitor and record systematically throughout treatment, but especially during titration:
  - efficacy, including changes in symptoms and behaviour
  - the emergence of movement disorders
  - weight and height (weekly)
  - fasting blood glucose, HbA_{1c}, blood lipid and prolactin levels
  - adherence to medication
  - physical health.
- Record the rationale for continuing or stopping treatment and the effects of these decisions[36].

1.6 *Organisation and delivery of care*

In this section, recommendations on improving access to services and developing care pathways for children and young people with a conduct

[34] At the time of publication (February 2013) risperidone did not have a UK marketing authorisation for use in children aged under 5 years. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. The child's parent or carer should provide informed consent, which should be documented. See the General Medical Council's Good practice in prescribing medicines – guidance for doctors for further information.

[35] At the time of publication (February 2013) some risperidones did not have a UK marketing authorisation for this indication. The prescriber should consult the summary of product characteristics for the individual risperidone.

[36] Adapted from 'Schizophrenia' (NICE clinical guideline 82).

disorder and their parents and carers draw on Common mental health disorders (NICE clinical guideline 123), as indicated by a footnote.

Improving access to services

1.6.1 Health and social care professionals, managers and commissioners should collaborate with colleagues in educational settings to develop local care pathways (see also recommendations 1.6.9–1.6.18) that promote access to services for children and young people with a conduct disorder and their parents and carers by:

- supporting the integrated delivery of services across all care settings
- having clear and explicit criteria for entry to the service
- focusing on entry and not exclusion criteria
- having multiple means (including self-referral) of access to the service
- providing multiple points of access that facilitate links with the wider care system, including educational and social care services and the community in which the service is located[37].

1.6.2 Provide information about the services and interventions that constitute the local care pathway, including the:

- range and nature of the interventions provided
- settings in which services are delivered
- processes by which a child or young person moves through the pathway
- means by which progress and outcomes are assessed
- delivery of care in related health and social care services[38] .

[37] Adapted from 'Common mental health disorders' (NICE clinical guideline 123).
[38] Adapted from 'Common mental health disorders' (NICE clinical guideline 123).

1.6.3 When providing information about local care pathways for children and young people with a conduct disorder and their parents and carers:

- take into account the person's knowledge and understanding of conduct disorders and their care and treatment
- ensure that such information is appropriate to the communities using the pathway[39].

1.6.4 Provide all information about services in a range of languages and formats (visual, verbal and aural) and ensure that it is available in a range of settings throughout the community to which the service is responsible.[40]

1.6.5 Health and social care professionals, managers and commissioners should collaborate with colleagues in educational settings to develop local care pathways (see also recommendations 1.6.9–1.6.18) that promote access to services for children and young people with a conduct disorder and their parents and carers from a range of excluded groups, including:

- girls
- black and minority ethnic groups
- people with a coexisting condition (such as ADHD or autism).[41]

1.6.6 Support access to services and increase the uptake of interventions by:

- ensuring systems are in place to provide for the overall coordination and continuity of care of children and young people with a conduct disorder and their parents and carers

[39] Adapted from 'Common mental health disorders' (NICE clinical guideline 123).
[40] Incorporated from 'Common mental health disorders' (NICE clinical guideline 123).
[41] Adapted from 'Common mental health disorders' (NICE clinical guideline 123).

- designating a professional to oversee the whole period of care (for example, a staff member in a CAMHS or social care setting)[42].

1.6.7 Support access to services and increase the uptake of interventions by providing services for children and young people with a conduct disorder and their parents and carers, in a variety of settings. Use an assessment of local needs as a basis for the structure and distribution of services, which should typically include delivery of:

- assessment and interventions outside normal working hours
- interventions in the person's home or other residential settings
- specialist assessment and interventions in accessible community-based settings (for example, community centres, schools and colleges and social centres) and if appropriate, in conjunction with staff from those settings
- both generalist and specialist assessment and intervention services in primary care settings [43].

1.6.8 Health and social care professionals, managers and commissioners should collaborate with colleagues in educational settings to look at a range of services to support access to and uptake of services. These could include:

- crèche facilities
- assistance with travel
- advocacy services [44].

[42] Adapted from 'Common mental health disorders' (NICE clinical guideline 123).
[43] Adapted from 'Common mental health disorders' (NICE clinical guideline 123).
[44] Adapted from 'Common mental health disorders' (NICE clinical guideline 123).

Developing local care pathways

1.6.9 Local care pathways should be developed to promote implementation of key principles of good care. Pathways should be:

- negotiable, workable and understandable for children and young people with a conduct disorder and their parents and carers as well as professionals
- accessible and acceptable to all people in need of the services served by the pathway
- responsive to the needs of children and young people with a conduct disorder and their parents and carers
- integrated so that there are no barriers to movement between different levels of the pathway
- focused on outcomes (including measures of quality, service user experience and harm)[45].

1.6.10 Responsibility for the development, management and evaluation of local care pathways should lie with a designated leadership team, which should include health and social care professionals, managers and commissioners. The leadership team should work in collaboration with colleagues in educational settings and take particular responsibility for:

- developing clear policy and protocols for the operation of the pathway
- providing training and support on the operation of the pathway
- auditing and reviewing the performance of the pathway.[46]

[45] Adapted from 'Common mental health disorders' (NICE clinical guideline 123).
[46] Adapted from 'Common mental health disorders' (NICE clinical guideline 123).

1.6.11 Health and social care professionals, managers and commissioners should work with colleagues in educational settings to design local care pathways that promote a model of service delivery that:

- has clear and explicit criteria for the thresholds determining access to and movement between the different levels of the pathway
- does not use single criteria such as symptom severity or functional impairment to determine movement within the pathway
- monitors progress and outcomes to ensure the most effective interventions are delivered[47].

1.6.12 Health and social care professionals, managers and commissioners should work with colleagues in educational settings to design local care pathways that promote a range of evidence-based interventions in the pathway and support children and young people with a conduct disorder and their parents and carers in their choice of interventions [48].

1.6.13 All staff should ensure effective engagement with parents and carers, if appropriate, to:

- inform and improve the care of the child or young person with a conduct disorder
- meet the needs of parents and carers [49].

1.6.14 Health and social care professionals, managers and commissioners should work with colleagues in educational settings

[47] Adapted from 'Common mental health disorders' (NICE clinical guideline 123).
[48] Adapted from 'Common mental health disorders' (NICE clinical guideline 123).
[49] Adapted from 'Common mental health disorders' (NICE clinical guideline 123).

to design local care pathways that promote the active engagement of all populations served by the pathway. Pathways should:

- offer prompt assessments and interventions that are appropriately adapted to the cultural, gender, age and communication needs of children and young people with a conduct disorder and their parents and carers
- keep to a minimum the number of assessments needed to access interventions [50].

1.6.15 Health and social care professionals, managers and commissioners should work with colleagues in educational settings to design local care pathways that respond promptly and effectively to the changing needs of all populations served by the pathways. Pathways should have in place:

- clear and agreed goals for the services offered to children and young people with a conduct disorder and their parents and carers
- robust and effective means for measuring and evaluating the outcomes associated with the agreed goals
- clear and agreed mechanisms for responding promptly to changes in individual needs[51].

1.6.16 Health and social care professionals, managers and commissioners should work with colleagues in educational settings to design local care pathways that provide an integrated programme of care across all care settings. Pathways should:

- minimise the need for transition between different services or providers

[50] Adapted from 'Common mental health disorders' (NICE clinical guideline 123).
[51] Adapted from 'Common mental health disorders' (NICE clinical guideline 123).

- allow services to be built around the pathway and not the pathway around the services
- establish clear links (including access and entry points) to other care pathways (including those for physical healthcare needs)
- have designated staff who are responsible for the coordination of people's engagement with the pathway[52].

1.6.17 Health and social care professionals, managers and commissioners should work with colleagues in educational settings to ensure effective communication about the functioning of the local care pathway. There should be protocols for:

- sharing information with children and young people with a conduct disorder, and their parents and carers, about their care
- sharing and communicating information about the care of children and young people with other professionals (including GPs)
- communicating information between the services provided within the pathway
- communicating information to services outside the pathway[53].

1.6.18 Health and social care professionals, managers and commissioners should work with colleagues in educational settings to design local care pathways that have robust systems for outcome measurement in place, which should be used to inform all involved in a pathway about its effectiveness. This should include providing:

- individual routine outcome measurement systems
- effective electronic systems for the routine reporting and aggregation of outcome measures

[52] Adapted from 'Common mental health disorders' (NICE clinical guideline 123).
[53] Adapted from 'Common mental health disorders' (NICE clinical guideline 123).

- effective systems for the audit and review of the overall clinical and cost effectiveness of the pathway.[54]

[54] Adapted from 'Common mental health disorders' (NICE clinical guideline 123).

2 Notes on the scope of the guidance

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover. The scope of this guideline is available here.

How this guideline was developed

NICE commissioned the [National Collaborating Centre for [add full name] / National Clinical Guideline Centre] to develop this guideline. The Centre established a Guideline Development Group (see appendix A), which reviewed the evidence and developed the recommendations.

There is more information about how NICE clinical guidelines are developed on the NICE website. A booklet, 'How NICE clinical guidelines are developed: an overview for stakeholders, the public and the NHS' is available.

3 Implementation

NICE has developed tools to help organisations implement this guidance.

Note: these details will apply when the guideline is published.

4 Research recommendations

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future.

4.1 *What is the effectiveness of parent training programmes for children aged 12 years and over with a conduct disorder?*

Why this is important

The evidence for parent training programmes is well established for children with conduct disorders aged 11 years and younger, with well-developed models for the delivery of care. In contrast there is little evidence for these programmes in older children despite the recognition that parenting problems

continue to play a part in the development and maintenance of conduct disorders.

This question should be answered using a randomised controlled trial (RCT) design reporting short- and medium-term outcomes (including cost effectiveness) over at least 18 months. Attention should be paid to the adaptation of the treatment model to older children and training and supervision in the intervention to ensure robust and generalisable results. The outcomes should be rated by independent observers, as well as parent, and teacher rated assessments and the acceptability of the intervention. The study needs to be large enough to determine the presence of clinically important effects, and mediators and moderators of response should also be investigated.

4.2 *What methods are effective in improving uptake and engagement with interventions for conduct disorders?*

Why this is important

Effective interventions exist for conduct disorders but access to and uptake of services is limited. This question should be addressed by a programme of work that tests a number of strategies to improve uptake and engagement, including:

- A cluster RCT comparing valid case identification tools with standard methods of case identification in non-healthcare settings, to ascertain whether they improve identification and uptake.
- Development and evaluation of pathways into care, in collaboration those who have been identified as low users of services through, a series of cohort studies with the outcomes including uptake of and retention in services.
- Adapting existing interventions for conduct disorder in collaboration with children and young people with a conduct disorder and their parents or carers. Adaptations could include changes to the settings for, methods of delivery or staff delivering the interventions. These interventions should be

tested in an RCT design that reports short- and medium-term outcomes (including cost effectiveness) of at least 18 months' duration.

4.3 *What is the effectiveness of interventions to maintain the benefits or prevent relapse in children and young person who have been successfully treated for a conduct disorder?*

Why this is important

The long-term effectiveness of interventions for the treatment of conduct disorder is not well established, with evidence of the attenuation of the effect over time. Little attention has been paid to the prevention of relapse.

This question should be addressed in two stages:

(1) New interventions to maintain treatment effects should be developed in collaboration with service users and may include the use of 'booster' sessions, self-help materials or support groups.

(2) These interventions should be tested using an RCT design comparing them with standard care. It should report short-, medium- and long-term outcomes (including cost-effectiveness) of at least 48 months' duration. The outcomes chosen should be rated by independent observers, as well as by parents and teachers and the acceptability of the interventions should be assessed. The study needs to be large enough to determine the presence of clinically important effects, and mediators and moderators of response should be investigated.

4.4 *What is the efficacy of combining the treatment of parental mental health problems with the treatment of conduct disorders?*

Why this is important

Parental mental health is as a factor in the development and maintenance of conduct disorders. This suggests that interventions targeting parental mental health could improve child outcomes. Current evidence does not provide

support for this. If successful, the research will have implications for future collaborations between adult mental health services and CAMHS.

This question should be addressed by:

(1) Systematic reviews to establish: (a) effective interventions for adults as part of a combined intervention; (b) effective interventions for children in combination with a parental intervention; (c) which groups of parents and children may benefit from a combined intervention.

(2) The combined intervention should compared in an RCT design with the best child-only intervention. It should report outcomes (including cost effectiveness) of at least 24 months' duration. Outcomes should be rated by independent observers, as well as parents and teachers. The study should be large enough to determine the presence clinically important effects, and mediators and moderators of response should be investigated.

4.5 *What is the efficacy of classroom-based indicated or selective interventions for conduct disorders?*

Why this is important

Interventions for children and young people with, or at risk of developing, conduct disorder have been designed for delivery in schools. Classroom-based interventions have the potential advantage of improving access to treatment for children who otherwise might not access treatment and of having a more direct impact on school performance.

This question should be addressed in an RT design by comparing a novel school based intervention with standard care. The trial should report short-, medium and long-term outcomes (including cost effectiveness) of at least 24 months' duration. The outcomes chosen should be rated by independent observers, as well as parents and teachers and the acceptability of the intervention should also be assessed. The study needs to be large enough to determine the presence of clinically important effects, and mediators and moderators of response should be investigated

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5 Other versions of this guideline

5.1 *Full guideline*

The full guideline, 'Conduct disorders and antisocial behaviour in children and young people: recognition, intervention and management' contains details of the methods and evidence used to develop the guideline. It is published by the National Collaborating Centre for Mental Health, and is available from our website. Note: these details will apply to the published full guideline.

5.2 *NICE pathway*

The recommendations from this guideline have been incorporated into a NICE pathway. Note: these details will apply when the guideline is published.

5.3 *Information for the public*

NICE has written information for the public explaining this guidance. Note: these details will apply when the guideline is published.

6 Related NICE guidance

Published

- Service user experience in adult mental health. NICE clinical guideline 136 (2011).
- Promoting the quality of life of looked-after children and young people. NICE public health guidance 28 (2010).
- Antisocial personality disorder. NICE clinical guideline 77 (2009).
- Attention deficit hyperactivity disorder. NICE clinical guideline 72 (2008).
- Bipolar disorder. NICE clinical guideline 38 (2006).
- Depression in children and young people. NICE clinical guideline 28 (2005).
- Post-traumatic stress disorder. NICE clinical guideline 26 (2005).

Under development

NICE is developing the following guidance (details available from the NICE websitehttp://www.nice.org.uk/):

- Autism: management and support of children and young people on the autism spectrum. NICE clinical guideline. Publication expected November 2013.

7 Updating the guideline

NICE clinical guidelines are updated so that recommendations take into account important new information. New evidence is checked 3 years after publication, and healthcare professionals and patients are asked for their views; we use this information to decide whether all or part of a guideline needs updating. If important new evidence is published at other times, we may decide to do a more rapid update of some recommendations. Please see our website for information about updating the guideline.

Appendix A: The Guideline Development Group, National Collaborating Centre and NICE project team

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