NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE AND SOCIAL CARE INSTITUTE FOR EXCELLENCE

SCOPE

1 Guideline title

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

Short title

Conduct disorders in children and young people

2 The remit

The Department of Health has asked NICE and the Social Care Institute for Excellence (SCIE): 'To produce a clinical guideline on the recognition, identification and management of conduct disorder (including oppositional defiance disorder) in children and young people.'

3 Clinical need for the guideline

3.1 Epidemiology

a) 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 two subgroups: conduct disorder and oppositional defiant disorder. Conduct disorder is more common in older children (11 to 12 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 the severity of the antisocial behaviour. Isolated

antisocial or criminal acts are not sufficient to support a diagnosis of conduct disorder or oppositional defiant disorder.

b) Conduct disorders are the most common mental health disorder in children and young people. The Office of National Statistics surveys of 1999 and 2004 reported that the prevalence of conducts disorders and associated impairment was 5% among children and young people. The prevalence without impairment was not much larger, because conduct disorders nearly always have a significant impact on functioning and quality of life. The first survey demonstrated that conduct disorders have a steep social class gradient, with a three to fourfold increase in the 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, between 5 and 17 years old, have conduct disorders.

c) 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.

d) Conduct disorders commonly coexist with other mental health disorders, for example, 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 high and in some groups more than 40% of 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 may go on to develop antisocial personality disorder). The prevalence of conduct disorders varies between ethnic groups, being lower than

average in some groups (for example, south Asians) but higher in other groups (for example, African-Caribbeans).

e) A diagnosis of a conduct disorder is strongly associated with poor educational performance, social isolation, 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).

3.2 Current practice

a) 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 conduct disorders, 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, in a small number of cases, 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.

b) 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.

c) Several interventions have been developed for children with conduct disorder and related problems. These have been covered in 'Parent-training/education programmes in the management of children with conduct disorders', NICE technology appraisal guidance 102 (2006) and 'Antisocial personality disorder: treatment, management and prevention', NICE clinical guideline 77 (2009). Other interventions focused on prevention, such as the Nurse Parent Partnership, have recently been implemented in the UK and are current 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.

d) Uptake of the majority of these interventions varies across the country. Parenting programmes are the best established; implementation of multi-systemic approaches and early intervention programmes is more variable. In addition to the programmes developed specifically for children with conduct disorders, a number of children (and their families) are treated by both specialist CAMHS teams and general community-based services such as Sure Start.

e) Identifying which of the above 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 parenting style and parental adjustment (the impact of any mental health disorder or personality factors that affect a parent's ability to effectively function as a parent), environmental factors

such as poverty and place of residence (for example, foster care), and the presence of other mental health disorders.

4 The guideline

The guideline development process is described in detail on the NICE website (see section 6, 'Further information').

This scope defines what the guideline will (and will not) examine, and what the guideline developers will consider. The scope is based on the referral from the Department of Health.

The areas that will be addressed by the guideline are described in the following sections.

4.1 Population

a) Children and young people

4.1.1 Groups that will be covered

a) 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.

b) Children and young people identified as being at significant risk of developing conduct disorders.

c) Consideration will be given to the specific needs of:

- children and young people with conduct disorders and coexisting conditions (such as ADHD, depression, anxiety disorders and attachment insecurity)
- children and young people from particular black or minority ethnic groups
- girls with a diagnosis of, or at risk of developing conduct disorders
- looked after children and young people

- children and young people in contact with the criminal justice system.

4.1.2 Groups that will not be covered

Recommendations will be not be made specifically for the following groups, although the parts of the guideline may be relevant to their care.

a) Adults (aged 19 and older).

b) Children and young people with coexisting conditions if conduct disorder is not a primary diagnosis.

c) Children and young people with psychosis.

d) Children and young people with autism spectrum conditions.

e) Primary drug and alcohol problems.

f) Children and young people with speech and language difficulties whose behavioural problems arise from the speech and language difficulties.

4.2 Health and social care setting

a) Primary, secondary and tertiary healthcare, and social care settings.

b) The criminal justice system and forensic services.

c) Children's services and educational settings.

d) Other settings in which NHS and social care services are funded or provided, or where NHS or social care professionals are working in multi-agency teams.

e) The guideline will also comment on and include recommendations about the interface between the NHS and social care and other sectors and services, such as education services, youth service settings, the criminal justice system and the voluntary sector.

4.3 Areas to be considered

4.3.1 Key areas that will be covered

a) The behaviours, signs or symptoms that should prompt healthcare, education and social care professionals and others working with children and young people, to consider the presence of a conduct disorder.

b) Validity, specificity and reliability of the components of diagnostic assessment after referral, including:

- the structure for assessment
- diagnostic thresholds
- assessment of risk.

c) Psychosocial interventions, including:

- individual and group psychological interventions
- parenting and family interventions (including family-based prevention models)
- social care (including interventions for looked after children and young people), vocational, educational and community interventions, and work with peer groups
- multi-modal interventions.

d) Pharmacological interventions, including antipsychotics and antidepressants. Note that guideline recommendations will normally fall within licensed indications; exceptionally, and only if clearly supported by evidence, use outside a licensed indication may be recommended. The guideline will assume that prescribers will use a drug's summary of product characteristics to inform decisions made with individual patients.

e) Physical interventions, such as diet.

f) The organisation, coordination and delivery of care, and care pathways for the components of treatment and management. This will include transition planning and will be based on an ethos of multi-agency and multi-professional working.

4.3.2 Interventions that will not be covered

a) Specific interventions for sexually abused or traumatised children and young people.

b) Specific interventions for children and young people with speech and language difficulties.

c) Preventive interventions for the general population.

d) Setting-based interventions (for example, school-based interventions) for those who are not at significant risk of developing a conduct disorder.

4.4 Main outcomes

a) Antisocial behaviour at home, at school and in the community (including offending behaviour).

b) Psychological, educational and social functioning as rated by the child or young person, professionals (including teachers) and parents.

4.5 Economic aspects

The guideline will take into account both clinical and cost effectiveness when making recommendations involving a choice between alternative interventions. A review of the economic evidence will be conducted and analyses will be carried out as appropriate. The preferred unit of effectiveness will be the quality-adjusted life year (QALY), but a different unit of effectiveness may be used depending on the availability of appropriate clinical and utility data for children and young people with conduct disorders and associated antisocial behaviours. Costs considered will be from an NHS and personal social services (PSS) perspective in the main analyses, and a

criminal justice perspective may also be considered. Further detail on the methods can be found in 'The guidelines manual' (see section 6, ‘Further information’).

4.6 Status

4.6.1 Scope

This is the final scope.

4.6.2 Timing

The development of the guideline recommendations will begin in April 2011.

5 Related NICE guidance

5.1 NICE guidance to be updated

Depending on the evidence, this guideline might update and replace parts of the following NICE guidance:

- Parent-training/education programmes in the management of children with conduct disorders. NICE technology appraisal guidance 102 (2006). Available from www.nice.org.uk/guidance/TA102

5.2 Other related NICE guidance

- Promoting the quality of life of looked-after children and young people. NICE public health guideline 28 (2010) Available from www.nice.org.uk/guidance/PH28
- Antisocial personality disorder. NICE clinical guideline 77 (2009). Available from www.nice.org.uk/guidance/CG77
- Attention deficit hyperactivity disorder. NICE clinical guideline 72 (2008) Available from www.nice.org.uk/guidance/CG72

6 Further information

Information on the guideline development process is provided in:

- ‘How NICE clinical guidelines are developed: an overview for stakeholders the public and the NHS’
- ‘The guidelines manual’.

These are available from the NICE website (www.nice.org.uk/GuidelinesManual). Information on the progress of the guideline will also be available from the NICE website (www.nice.org.uk).