National Institute for Health and Clinical Excellence

Conduct disorders in children and young people
Scope Consultation Table
12 January – 9 February 2011

No.	Stakeholder	Section No	Comments	Developer's Response Please respond to each comment
4	Alder Hey NHS Foundation Trust	2	Why does the remit not specifically state that it will be considering prevention?	The remit is a directive for the project from the Department of Health, and as such we cannot amend it.
5	Alder Hey NHS Foundation Trust	3.1.a	There is a need for clearer criteria re: CD and ODD linked to different ages	Thank you. We are aware of the differences between conduct disorder and oppositional defiant disorder in current diagnostic schemes, and this is reflected in section 3.1 of the scope. However, we have used the general term 'conduct disorders' here, which covers both disorders as all features of oppositional defiant disorder are usually present in conduct disorder. In reviewing the evidence we will consider the two disorders separately where this is appropriate.
6	Alder Hey NHS Foundation Trust	3.1.b	Increased risk is mentioned in the lowest social classes. Is it appropriate to mention the associated environmental factors here i.e. poverty, poor housing and social deprivation?	Thank you for your comment. We will deal with this issue in more detail in the full guideline.
7	Alder Hey NHS Foundation Trust	3.1.b	For children who have been abused or on child protection registers is there behaviour not better conceptualised as post-trauma angry behaviour?	Thank you. We will consider this in the development of the assessment recommendations in the guideline but the focus will remain on conduct disorder.
8	Alder Hey NHS Foundation Trust	3.1.d	Is it better describing that 50% children with a CD diagnosis will go on to show (rather than develop) an antisocial personality disorder? Or say that they will go on to receive an antisocial personality disorder diagnosis as adults?	Thank you for your comment, however we have not made the change you suggest as to do so would change the meaning of this sentence.
9	Alder Hey NHS Foundation Trust	3.1.d	The mention of higher risk of CD in some ethnic groups emphasises the need to consider cultural factors. It also highlights the need to consider related environmental factors rather than presenting data in a way that could be construed as indicating a causal link between ethnicity and prevalence.	Thank you. In examining the evidence the GDG will not make assumptions about causality, but will consider whether there is an association between these factors.
10	Alder Hey NHS Foundation	3.1.e	The link between poor outcomes across the individual's lifespan is highlighted. Would it be worth noting the	Thank you for your comment. The scope acknowledges that young people with a diagnosis of conduct disorder have a

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	Trust		intergenerational difficulties faced by families? Those children who receive a diagnosis of CD may go on to be parents who struggle with parenting their children (for many reasons including environmental ones) and the cycle continues. (Links to the idea of targeted preventative programmes)	greater change of poorer educational and occupational outcomes in adulthood, as well as greater involvement with the criminal justice system and a higher level of mental health disorder. There may be evidence about the effectiveness of specific interventions designed to affect parenting styles.
11	Alder Hey NHS Foundation Trust	3.2.c	Is there evidence to suggest better outcomes if there is effective coordination of care across agencies?	The scope specifically mentions coordination of care across agencies because young people with conduct disorders are likely to be in contact with multiple services. We will review any relevant high quality evidence in this area.
12	Alder Hey NHS Foundation Trust	3.2.c	The inclusion of preventative programmes such as the Family Nurse Partnership is very positive	Thank you for your comment.
13	Alder Hey NHS Foundation Trust	3.2.c	Is it better to state that there is an increased risk where other diagnoses have been given (e.g. ADHD) rather than talk about the presence of other mental disorders? (Relates to later comment about the conceptualisation of diagnoses such as CD)	Thank you, however it would not be possible for this statement to be made before a review of the evidence has been made.
14	Alder Hey NHS Foundation Trust	4.1.1.b	Babies should be included when considering those at risk of being diagnosed with CD at a later stage (i.e. relates to work around early attachment patterns and later behaviour e.g. Pat Crittenden's work)	Thank you. The consultation version of the guideline scope states that 'children and young people identified as being at significant risk of developing conduct disorders' will be a group that is covered in the development of the guideline, and no lower age limit has been set. The developers will also look at the evidence for targeted preventative interventions, if evidence about them is uncovered in the literature search. However, it is not possible for us to comment on this issue further before a review of the evidence has been undertaken.
15	Alder Hey NHS Foundation Trust	4.1.c	In terms of attachment insecurity highlight 'type C' pattern in particular.	Thank you, we will bear your comment in mind during the development of the guideline.
16	Alder Hey NHS Foundation Trust	4.3.1.a	A developmental perspective needs to be taken i.e. is the same behaviour more or less worrying in a younger/older child?	Thank you. The GDG will take a developmental perspective when assessing the evidence.
17	Alder Hey NHS Foundation Trust	4.3.1.a	There should be consideration of the variables associated with 'signs' of CD in the future. Such risk factors may include attachment patterns/parents' own experiences of being	As stated in the consultation version of the guideline scope, the behaviours and other signs that should prompt health, education and social care professionals will be a focus of this

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			parented.	guideline.
18	Alder Hey NHS Foundation Trust	4.3.1.c	It is very positive to have family interventions (including preventative models) included. It is important to include attachment-based interventions from the perinatal period onward for vulnerable families.	Thank you for your positive comment. As stated in our response, above, the consultation version of the guideline scope states that 'children and young people identified as being at significant risk of developing conduct disorders' will be a group that is covered in the development of the guideline and no lower age limit has been set.
19	Alder Hey NHS Foundation Trust	4.3.1.c	The range of psychosocial interventions to be considered (including community based ones) is very positive.	Thank you for your comment.
20	Alder Hey NHS Foundation Trust	4.3.1.d	Considering that children with diagnoses of psychosis are being excluded why are 'antipsychotics' listed as the first pharmacological intervention?	Thank you for your comment. The evidence for a range of pharmacological interventions, including antipsychotics, is limited, however as they may be used in the treatment of conduct disorders it is important that the evidence for their effectiveness is reviewed.
21	Alder Hey NHS Foundation Trust	General	Having a diagnosis of 'conduct disorder' places the difficulty within the child. Conceptualising the difficulties in a more systemic manner can lead to interventions that work with whole families and communities.	Thank you for your comment. We understand your point will consider the importance of diagnosis on the child and family.
22	Alder Hey NHS Foundation Trust	General	It is important to consider that children with a 'conduct disorder' diagnosis are not just the concern of agencies working with children i.e. the Think Family agenda.	Thank you for your comment. The Think Family scheme was developed by the Department for Children, Schools and Families, and although its purpose is to support families and it is based on partnerships between adult's and children's services, securing better outcomes for children is central to its agenda. We believe that the well-being of young people with conduct disorder is primarily the focus of children's agencies.
23	Association for family therapy and systemic practice (AFT)	3.2.c.	Another relevant guideline is Looked After Children, and the value of early interventions with those at risk of becoming Looked after Children, as well as helping children and young people to return to their families if possible. Suggest recognition of more family relationship issues: For example, aggression in children may be linked to the relationship with a sibling (there is evidence for this); the influence of the quality of parental relationships, including the	Thank you for your comment. The NICE guideline you are referring to is a public health guideline developed in conjunction with SCIE (PH 28, 2010), and as such has a different focus to this clinical guideline. The recommendations in the public health guideline you refer to 'does not [...] cover treatments for specific illnesses or conditions', whereas clinical guidelines look at evidence for targeted interventions for individuals with specific illnesses or disorders, delivered in

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			model they provide for the children and young people; spouse abuse or domestic violence. Family interventions that cultivate good relationships will be important to reduce or manage conduct disorders in children / young people as well as addressing other difficulties.	healthcare or other care settings. However, it should be noted that although it would not be appropriate for public health or policy issues to be considered in this guideline, evidence for the effectiveness of family interventions will be searched for during development.
24	Association for family therapy and systemic practice (AFT)	4.1.1. 4.1.2.	The guidelines for Looked After children recommend dedicated services up to the age of 25. Can this be linked in some way?	Conduct disorder is only diagnosed up to the age of 18 years – after that, adults who had conduct disorder in childhood and adolescence may develop antisocial personality disorder, however they would no longer be considered as conduct disordered. For this reason, the guideline will not consider evidence relating to people over the age of 18 years. This reflects the remit for the guideline from the Department of Health, which specifically requests the guideline is developed with reference to 'children and young people'.
25	Association for family therapy and systemic practice (AFT)	4.1.1. 4.1.2.	Early family interventions can be helpful when parents have problems that mean they have difficulties in containing and helping a child with CD. They may also help parents and families to maintain more positive relationships before the CD has become entrenched. Treatments such as systemic family therapy have a proven capacity to restore positivity in family relationships even when they have become extremely negative.	Thank you for your comment and for this information.
26	Association for family therapy and systemic practice (AFT)	4.3.1.a.	Consider the possibility that families (and others with whom children have relationships such as teachers) are able to give early warnings. Waiting till healthcare and social care professionals become aware of problems means that they will be well established.	Thank you for your comment. We agree with what you say, and for this reason the consultation version of the guideline scope states: "The guideline will also comment on and include recommendations about the interface with other sectors such as education services […]", and that a key area to be covered is: "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".

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27	Association for family therapy and systemic practice (AFT)	4.3.1.c.	Suggest including the range of interventions: Multidimensional Treatment Foster Care (Chamberlain and Smith, 2003, 2005), Functional Family Therapy, Brief Strategic Family Therapy, systemic multi-family work. See Stratton, P. et al: Review of family, couples and systemic therapy outcome research 2000-2009 on www.aft.org.uk pp 85-93.	Thank you for your comment, and for supplying these references.
28	Association for family therapy and systemic practice (AFT)	4.3.2.c.	Difficulties may manifest in different ways – and CD may dominate later or sporadically. This may lead to females and children from different cultures being excluded from consideration because their problems don't show up as primary – and 4.1.1.says 'suspected' CD is included.	Thank you for your comment, which we will bear in mind during the development of the guideline.
29	Association for family therapy and systemic practice (AFT)	4.4.	Appreciate that there is a negative and a positive outcome being evaluated.	Thank you for your comment.
30	Association for family therapy and systemic practice (AFT)	4.5.	Suggest that the economic evaluation includes a wider range of costs, not just around the children, What about the QULY of the teachers as well as other children in the family and the parents? Russ Crane found much higher usage of health services by all members of the family that could be substantially reduced by appropriate family therapy.	Thank you for your comment. In developing the health economic model the GDG will principally be concerned with the cost of health and personal social service costs. We may also include costs arising from criminal justice interventions – However we do not intend to consider educational costs ij the development of the economic model(s) as we are not concerned with educational interventions.
31	Association of Child Psychotherapists	3.1a	We feel the scope needs to include greater clarification and discussion of the differences between Conduct Disorder (CD) and Oppositional Defiance Disorder (ODD).	Thank you for your comment. As has been stated previously, we are aware of the differences between conduct disorder and oppositional defiant disorder in current diagnostic schemes. However, we have used the general term 'conduct disorders' here, which covers both disorders as all features of oppositional defiant disorder are usually present in conduct disorder. In reviewing the evidence we will consider the two disorders separately where this is appropriate.
32	Association of Child	3.1b	In our view it is difficult to diagnose a "pure" conduct disorder, which renders the statement "conduct disorders are the most	Thank you. In developing this guideline we are reliant on existing diagnostic systems. Your suggestion refers to possible

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	Psychotherapists		common mental health disorder in children and young people" potentially misleading. Vanderkolk is trying to get developmental traumas which affect conduct written into the ICD-10 and the DSMIV – the link between developmental trauma and conduct disorders seems key but is not mentioned in the scope.	developments to diagnostic systems which may or may not be implemented. We therefore think it important we continue to use the current diagnostic systems.
33	Association of Child Psychotherapists	3.1c	We wonder whether the figures for those females diagnosed with CD are up to date? There is anecdotal evidence in a number of CAMHS clinics of growing numbers of young females presenting with CD-type presentations. Statistics are available for self harm in females, which is not unconnected in terms of destructive behaviours and CD and drop-out from school (3.1e).	Thank you. We have reviewed our data and think it is accurate. You refer to anecdotal data and data on self-harm which we do not consider to be relevant to this clinical guideline.
35	Association of Child Psychotherapists	3.2c	We are in agreement that negative parenting styles and exposure to parental conflict, including domestic violence, can impact on the child's behaviour. A great deal of evidence points towards young males in particular identifying with an adult (often male) who demonstrates dominance, power and control in the parental relationship (*Jaffe, Wolfe and Wilson, 1990; Rosenbaum and O'Leary, 1981; Glaser, 2000).* We welcome the scope's emphasis on parent training. We consider this crucial, along with psycho-educational programmes for parents. Interventions such as Family Nurse Practitioners (FNP) attempt to help parents to understand behaviour as a communication (*Gunner. M, 1998: Quality of early care and buffering of neuroendocrine stress reactions: Potential effects on the human brain).* We also support the scope's emphasis on early intervention programmes, which could include early observation of behaviours in nursery or school reception settings as well as presentation of CD behaviours in the home environment. The presentation of CD behaviours in the home, school and the community must be linked, and highlighting the resilience of the child and young person is key.	Thank you for your comment and for sharing these references with us. The guideline will make recommendations for the use of interventions based on a review of the interventions you refer to, where high quality evidence is available.

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			More detail may need to be provided in terms of treatment options for those children and young people diagnosed with CD. Psychoanalytic/psychodynamic child and adolescent psychotherapists in CAMHS work successfully with children and young people with diagnoses of CD or ADHD and their wider networks in conjunction with colleagues from other disciplines. Psychoanalytically-based child psychotherapy can focus on developing a reflective capacity in the young person and thereby lessen aspects of the impulsivity which is a common component of CD.	
36	Association of Child Psychotherapists	4.1.1a	We believe that adopted children should be among the groups specifically covered by the guidance. In our experience CD is prevalent in children and young people who have been adopted, linked to significant attachment difficulties including early trauma and losses. Children demonstrating CD traits in educational settings, often linked with low educational attainment and poor engagement with learning, might also be considered.	Thank you for this comment – a number of groups such as those you refer to may have a higher prevalence of conduct disorder. We will consider these issues in the evidence review and developing our recommendations but from an initial scope of the evidence and the discussion at the stakeholder workshop that of the many possible special populations identified in the current scope these gave the greatest cause for concern (see section 4.1.1)
37	Association of Child Psychotherapists	4.1.1c)	We welcome the inclusion of "attachment insecurity" (first bullet point) but wonder whether the term is a little vague. We wonder whether replacing this with the more widely used and understood term "attachment disorders" might offer greater clarity.	Thank you for your comment. The choice of the term 'attachment insecurity' was consciously made, in order that children with attachment difficulties were not excluded from consideration because they do not have diagnosed reactive attachment disorder or disinhibited attachment disorder.
38	Association of Child Psychotherapists	4.3.1c	Clinicians with an in-depth training are likely to be able to provide a containing function to the child or young person and to have the capacity to consider the impact of their difficulties on the wider network around them i.e. the family, the school, the community, social services where relevant. Interventions with a psychoanalytic/psychodynamic child and adolescent psychotherapy component are valuable in terms of managing high levels of stress, being trained in understanding parent-infant interactions and their impact on behaviour and also in working with aggression and complexities in the system.	Thank you for your comment.
34	Association of	3.1d	We welcome the scope's recognition that CD commonly co-	Thank you for your comment. We will review assessment

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	Child Psychotherapists		exists with other mental health disorders. As well as links with ADHD, the presence of attachment disorders is also key. (*Morality, Disruptive behaviour….Fonagy, Target, et al., 1997)* We feel care needs to be taken within this diagnostic category to provide greater distinction, where possible, between CD and ADHD where there is not a co-existence of the two disorders. In our experience there is a tendency in some settings to give a primary diagnosis of ADHD where a diagnosis of CD may be more appropriate. This can lead to a preponderance of treatment involving medication more likely to target ADHD.	procedures and therefore may potentially provide information on differential diagnosis.
39	Association of Child Psychotherapists	4.3.2a	We would advocate greater consideration of the link between CD and trauma. There is a great deal of research exploring the impact on children of witnessing domestic violence, experiencing physical abuse and identifying with an aggressor. Experiencing such trauma can be linked with developing disorders such as CD. *(Anda, Felitti, Bremner et al, 2006; Cleaver et al, 1999; Gorin, 2006; Vanderkolk, 2009; Fonagy & Higgit, 2000; Bremner et al, 2006; CD and poverty: Halpern, 1993)*	Thank you for your comment. We agree this is an important issue, however it would not be the place of this guideline to review the evidence relating to the multiple effects of trauma; the NICE clinical guideline on post-traumatic stress disorder (CG 26, 2005) makes recommendations about the management of PTSD in adults and children.
40	Association of Child Psychotherapists	4.4a	Greater clarification is needed about what is meant by 'anti-social behaviour' at home and at school.	Thank you for your comment. We will be considering carefully the definition of 'anti-social behaviour' when assessing the evidence. Defining outcomes clearly is a key task in the development of a guideline.
41	Association of Child Psychotherapists	4.4b	Despite the scope's reference to educational tools and input, we note that work in educational settings will not be considered in this guidance. Perhaps the guidance should consider quantitative measurement tools for professionals working with children across a range of settings. These could be in the form of questionnaires, for example.	Thank you for your comment. Recognition of conduct disorder is a key component of this guideline, and as such we will review evidence about case identification.

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42	Association of Child Psychotherapists	General	We are impressed by the scope's recognition of the aetiology of children and young people who appear to use behaviour as their primary method of communication and of the 'bigger picture' around CD, including the issues for the family, education services and the wider network around the child. We also welcome the scope's emphasis on early intervention and treatment.	Thank you for your comment.
43	Association of Child Psychotherapists	General	We would like to reiterate that the scope needs to give far greater consideration to the impact of developmental trauma and attachment difficulties on the developing brain and therefore on the conduct of children and adolescents.	Thank you for your comment. As previously stated, we agree that trauma is an important issue, however the NICE clinical guideline on post-traumatic stress disorder (CG 26, 2005) already makes recommendations about the management of PTSD in adults and children, and to review this large body of evidence would not be possible during the time available for development.
44	British Association of Counselling and Psychotherapy	3.2 c)	In this section on interventions that have been developed for children with conduct disorders and related problems, counselling and/or psychotherapy are not referred to, although many children are referred to school counsellors for behavioural problems or conduct disorders.	Thank you for your comment. The examples of psychological interventions provided in this section are exemplars. We will consider any interventions in this area for which high quality evidence is available, including counselling and psychotherapy.
45	British Association of Counselling and Psychotherapy	4.3.2 a) b) c) d)	Generally, the exclusion criteria cover several of the issues that could lead to, or be the cause of conduct disorders. Is it taken to be that conduct disorders are classed a completely separate entity, without cause and effect? It may be that some causes are not identifiable, but where they are, exclusions could be difficult. BACP is concerned that by not covering these issues, children with these issues that are co-morbid with conduct disorder may not have the appropriate support for the whole problem, by having part of the problem excluded. In these excluded cases it is possible that the child's conduct disorder arises from the	Thank you for your comment. We are not concerned with the aetiology of conduct disorders in this guideline, but we are aware of overlap between diagnostic grouping in children. We will take this into account when reviewing and making recommendations. You also make a point about setting-based interventions. The scope is limited to those preventative interventions that are for special groups identified as being at high risk of developing conduct disorders, Broad-based school interventions focussed on general emotional well-being are outside the scope of this guideline.

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			trauma, abuse or disability and, by addressing this, the associated conduct problem will also respond. It would be helpful for professionals to work across problems where appropriate for the child. BACP is unclear why under 4.3.2 e) setting based interventions will not be covered. School based interventions, are a form of early intervention, and can help those at risk of developing conduct disorders. Specific interventions in schools, such as psychological interventions can help young people with conduct disorders.	
46	British Association of Counselling and Psychotherapy	4.3	In 4.3c) under individual and group psychological interventions, BACP would suggest that relational one-to-one therapy with young people is included. It is important that the evidence base for a range of psychological interventions is looked at, to ensure a broad spectrum of interventions are offered to children. It is well noted that no one approach will work for all.	Thank you for your comment. As has been previously stated, the examples of psychological interventions provided in this section are exemplars. We will consider any interventions in this area for which high quality evidence is available.
47	British Association of Counselling and Psychotherapy	4.4	The main outcomes are simplistic and leave out any sense of improvement in quality of life or feelings about self, making the assumption only that the behaviour is the problem.	Thank you, however we feel that quality of life is covered by the key outcome (section 4.4): "Psychological, educational and social functioning as rated by self, professionals (including teachers) and parents". It should be noted that the impact that conduct disorders have on quality of life is stated as a reason this guideline is needed.
48	British Association of Dramatherapists	General comment	The British Association of Dramatherapists welcomes the opportunity to respond to this consultation relating to CD, ODD and associated disorders in children and young people. The Association broadly agrees with the scope as defined in the consultation document.	Thank you for your comment.
49	British Association of Dramatherapists	4.3.1 C	Dramatherapy is a psychosocial & psychotherapeutic intervention which is effective in changing behaviours of children with conduct disorders and those presenting as being	Thank you for your comment and for bringing these references to our attention.

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			at severe risk of developing conduct disorders. We would draw attention to some of the evidence base for this contention. 1) McArdle, P., Moseley, D., Quibel. T., Johnson. R., Allen. A, Hammal. D. and LeCouteur. A. (2002), School-based indicated prevention: a randomized trial of group therapy. *Journal of Child Psychology & Psychiatry*. 43: 705-712 117 children were involved in this RCT which compared the outcomes of being involved in a dramatherapy group to engaging in small group curriculum studies. 2) Quibel provides further data in *The Searching Drama of* *Disaffection; Dramatherapy Groups in a Whole School Context* in V. Karkou (ed.) Arts Therapies in Schools: Research & Practice. London. Jessica Kingsley. 3) In another chapter in the same book, Christensen uses case study research to examine the role of Dramatherapy to help children excluded from school due to behavioural difficulties become re-integrated into mainstream education. 4) Dramatherapy is included in the article *Arts therapies for young* *offenders in secure care – A practice-based research.* Henk Smeijsters PhD, Julie Kil, MSc, MDATh., SRDATH., Han Kurstjens	

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			MA., Jaap Welten MDTh., SRDTh., CP., ECP. and Gemmy Willemars MATh. SRATH. The Kenvak Research Centre, Zuyd University of Applied Sciences. The authors used naturalistic/constructivist research methods to examine arts therapists interventions with young offenders with conduct disorders to discover which interventions would most meet treatment goals. Their findings published in *Arts in* *Psychotherapy* on-line Nov. 2010 5) Dramatherapist, Susan Pearson-Davis is the joint author of a pilot RCT study on the effects of video-taped improvisational drama on emotionally disturbed children – Videotaped improvisational drama with emotionally disturbed adolescents: a pilot study. Dequine. A. and Pearson-Davis. *Arts in Psychotherapy.2002.* The results were significant at the .05 level. During post-treatment interviews the adolescents & staff reported increased pro-social behaviours. *Bibliography* Christensen. J (2010) "Making Space inside: The Experience of Dramatherapy within a School-based Student Support Unit" in V. Karkou (ed.) *Arts Therapies in Schools: Research & Practice.* Jessica Kingsley. London Dequine. E, Pearson-Davies. S (1983) "Video-taped	

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			improvisational drama with emotionally disturbed adolescents: a pilot study" in *The Arts in Psychotherapy,* 10, 1, pp15-21 McArdle. P, Moseley. D, Quibel. T, Johnson. R, Allen. A, Hammal. D & LeCouteur. A (2002) "School-based indicated prevention: a randomized trial of group therapy" in *Journal of Child Psychology & Psychiatry,* 43, pp705-712 Quibel. T, (2010) "The Searching Drama of Disaffection: Dramatherapy Groups in a Whole School Context" in V. Karkou (ed.) *Arts Therapies in Schools: Research & Practice.* Jessica Kingsley. London Smeijsters. H, Kil. J, Kurstjens. H, Welten. J, Willemars (online Nov. 2010) "Arts Therapies for young offenders in secure care – A Practice-based research" in *Arts in Psychotherapy*	
50	British Paediatric Mental Health Group	4.1.2c	It would be unfortunate to exclude all children with autism spectrum disorders from this guideline, for the following reasons: • The autism spectrum is a spectrum, so that many children have autistic features without necessarily having a diagnosis. This will be formally recognised in ICD-11. Children with conduct disorders are particularly likely to have autistic features, and children with autistic features are particularly likely to have conduct disorder. • Many such children may present initially with behaviour problems and their autistic diagnosis may not be recognised for several years, if ever. • In any one child with autistic features, there is likely to be debate between involved professionals about the presence of an autistic diagnosis. The way in which a multi-professional agreement is reached, and thresholds for diagnosis, vary geographically.	Thank you. This is a guideline for children with conduct disorders. We will consider individuals with other co-existing conditions, such as autism spectrum disorders. However this will only be insofar as the review may suggest modifications to treatments for conduct disorders. The forthcoming NICE guideline on autism in children will deal properly with treatment.

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51	British Paediatric Mental Health Group	4.1.2f	It would be unfortunate to exclude all children with speech and language disorders from this guideline, for the following reason. As indicated in 3.1 (d) and (e), conduct disorder is strongly associated with other conditions, including specific learning disability – for instance, dyslexia (specific literacy disability). To exclude children with dyslexia from the scope would be to omit discussion of a very large group of children. Similarly, to exclude children with speech and language disorder would be to exclude a very large group of children, who are in many ways similar to the dyslexic group. It is as fruitless to debate regarding speech and language disorder as it is with dyslexia which disorder is primary (the conduct disorder or the specific learning disability): either may be regarded as primary; each may contribute to the severity of the other; and/or they may both have a common cause.	Thank you for your comment. Children with speech and language disabilities will not be excluded if they also have a diagnosis of a conduct disorder. The purpose of this exclusion is to ensure that children with primary language difficulties that lead to behavioural problems will not be considered.
52	British Psychological Society	3.1b	It would appear that the prevalence rates listed here are lower than that which would normally be expected. Ford (2008) reports UK studies indicating a prevalence of 9% of British adolescents. A US sample (Nock et al 2006) indicates a prevalence of 9.5%, with a gender distribution of 12% in males and 7.1% in females.	Thank you – you are correct in pointing to some variation in the prevalence rates reported in a number of studies. We consider the studies we have listed to be representative of the studies so far published. We will of course consider this matter in more detail in the full guideline.
53	British Psychological Society	3.2a	Although it is common for young people who would meet the diagnostic criteria for Conduct Disorder to be referred to a CAMHS service, it would be rare for them to be accepted into services, unless a comorbid problem such as Pervasive Developmental Disorder was identified. The resources in CAMHS would be overwhelmed by the level of need. Members' experience shows that some CAMHS teams would explicitly state that they would not see this as a role for their service, and would not see Conduct Disorder as a mental disorder. The nature of social deviance and delinquency being labelled as mental disorder is long and complex. This results in conduct disorder often being regarded as a diagnosis of exclusion. The 'medical' and 'social' philosophies often	Thank you for your comment. The purpose of NICE guidelines is to set standards for care and treatment in the NHS and related services. The issue raised here is an important one but it is more appropriately dealt with as an implementation matter, although the GDG will take it into account when formulating the recommendations.

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			struggle to accommodate the concept of conduct disorder. The medical exclude as it is often seen as not a 'proper' mental illness whereas social care philosophies struggle with the idea of categorising behaviour as a disorder. These conflicts often result in tensions between services over whose issue it is. Any thorough review of the area needs to make reference to these complex ethical and philosophical issues, and views the issue criminologically as well as medically.	
54	British Psychological Society	4.1.1c	The Society believes that looked-after children should be regarded as a special group, as interventions are often harder to implement owing to the lack of an identified family unit.	Thank you, looked after children have been included in the guideline population. Additionally, the scope states that a key issue for the guideline will be: "The organisation, co-ordination and delivery of care, and care pathways for the components of treatment and management (including transition planning)."
55	British Psychological Society	4.1.2d	We believe that care should be taken when excluding substance abuse problems. We question whether it is appropriate to refer to children and young people as having a 'primary' substance use problem. It is more likely to be a symptom of distress or part of the antisocial network. The issue of substance use can be used by both health and social care services to exclude young people who are often most in need.	Thank you for your comment. We are referring here to primary substance misuse. We agree that substance misuse may be associated with a range of difficulties experiences by children and young people with conduct disorders. We will of course consider substance misuse where centrally related to conduct disorders. Specific interventions designed for people who misuse drugs and alcohol were reviewed during the development of the forthcoming NICE clinical guideline 'Alcohol dependence and harmful alcohol use', and NICE clinical guidelines 'Drug misuse: opioid detoxification', CG52 (2007), and 'Drug misuse: psychosocial interventions', CG51 (2007).
56	British Psychological Society	4.3.1 & General	Although there is mention of risk assessment, there is no mention of risk and *needs* assessment as a means to define treatment needs in the population. Effective treatment of antisocial behaviour in young people should focus on the specific risk factors and address these through treatment (Farrington and Welsh 2007).	Thank you. Of course our clear intention is that the section of this guideline that deals with assessment will focus not only on behaviour that is considered during assessment but also on needs for care and intervention that will arise from assessment.
57	British	4.3.2	This section states that issues not to be covered include	Thank you for your comment. This guideline focuses on the

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	Psychological Society		specific interventions for sexually abused/traumatised children and young people. This would exclude many young people with a diagnosis of conduct disorder, and therefore we would recommend that this group be covered.	treatment and management of conduct disorders. Other NICE guidelines (for example, the guideline on post-traumatic stress disorder, CG 26, 2005) make specific recommendations about the treatment of abused and traumatised children. We will therefore be referring to this guideline for the treatment of young people with conduct disorder who have experienced trauma.
58	British Psychological Society	4.4a	We believe it would be useful to add 'community' to 'home and at school'.	Thank you, we have made this change to the scope as you suggest.
59	British Psychological Society	4.4	We believe that it is important to be clear about the direction of outcome i.e. a reduction of antisocial behaviour and an increase in functioning.	Thank you, however we do not agree that this needs to be specified in the scope. Poor outcomes and changes in behaviour, and psychological, educational and social functioning that are not clearly 'directional' will also be evaluated by the GDG when the recommendations are formulated.
60	British Psychological Society	4.5	We would recommend that costs to the criminal justice system are definitely included.	Thank you. During development the health economist will review the relevant evidence, however, given the high proportion of children with conduct disorders who are in contact with the criminal justice system, it is likely that the model developed will take these costs into account.
61	British Psychological Society	General	There is no critique of the use of the diagnostic term and its utility to accurately describe a population with common characteristics and with a definable treatment strategy. This is a central theme in most discussions of conduct disorder. Reviewers have noted that: there are 32,000 possible combinations of symptoms that could be used to give a diagnosis of conduct disorder; the population defined has diverse treatment needs; and a significant number of young people with high levels of antisocial behaviour would not meet diagnostic criteria (Tremblay 2003, Kazdin 2010).	Thank you. A consideration of diagnostic criteria (currently under review by international groups) will not be considered in this guideline.
62	British Psychological Society	General	We welcome the Department of Health recognition of conduct disorder related issues as a serious problem requiring mental health and social care services. We welcome the proposed NICE guidance as this should ensure that services focus on	Thank you for your comment.

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			addressing this important issue.	
63	British Psychological Society	General	We feel that the focus should be on multi-systemic, not individual interventions. These interventions should be carried out by one organisation, not multi-agency, as this is counter-productive with work being duplicated and families being over-burdened with too many professionals involved.	Thank you for your comment. It would not be possible for the guideline developers to draw conclusions about which interventions are most effective before the evidence has been reviewed.
64	British Psychological Society	General	References: Farrington, D.P. & Welsh, B.C. (2007). *Saving Children From a Life of Crime: Early risk factors and effective interventions*. Oxford: Oxford University Press. Ford, T. (2008). Practitioner Review: How can epidemiology help us plan and deliver effective child and adolescent mental health services? *Journal of Child Psychology and Psychiatry, 49(9)*, 900-914. Kazdin, A.E. (2010). *Problem-solving Skills Training and Parent Management Training for Oppositional Defiant Disorder and Conduct Disorder*. In J. R. Weisz & A. E. Kazdin. (Eds.). *Evidence-based Psychotherapies for Children and Adolescents* (2nd edn.), pp.211-226. New York, NY: Guildford Press. Nock, M.K., Kazdin, A.E., Hiripi, E., & Kessler, R.C. (2006). Prevalence, Subtypes and Correlates of DSM IV Conduct Disorder in the National Comorbidity Survey Replication. *Psychological Medicine*, *36(5)*, 699-710. Tremblay, R.E. (2003). *Why Socialization Fails: The causes of chronic physical aggression*. In B. B. Lahey, T. E. Moffitt & A. Caspi (Eds.). *Causes of conduct disorder and juvenile delinquency,* pp.182-226. London: Guildford Press.	Thank you for drawing our attention to these references.
65	College of Occupational Therapists	General	The document makes clear that conduct disorders significantly impact on an individual's ability to successfully participate in everyday tasks. The College believes that any impairment in functioning should be assessed in the relevant context, form	Thank you. We will be considering assessment and intend to cover some of the issues you have raised.

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			the basis of client identified goals and be directly addressed as part of an intervention programme. Specifying this need more clearly, will broaden the assessment to include a wider range of everyday tasks, (alongside social and educational activities), such as managing self care, domestic tasks and leisure activities. The College also believes that the requirement for a holistic assessment and intervention plan should be specified within the document.	
66	College of Occupational Therapists	3.1.d	The College is concerned that the document does not detail the range of non mental health conditions that commonly co-exist with conduct disorder such as specific learning disabilities (including dyslexia, developmental co-ordination disorder/ dyspraxia, which in term commonly co-exist with ADHD). COT also believes that the guideline should include young people with speech, language and communication needs who themselves have a high prevalence of conduct disorder.	Thank you. However, this guideline and its remit focus on conduct disorders and therefore it would not be appropriate to review other primary disorders such as speech and language difficulties which, as you state here, include groups without conduct disorders.
67	College of Occupational Therapists	3.2.b	It is accurate to say that a wide multi-agency team are involved in the care and management of young people with conduct disorders. Therefore it is vital to name and reflect the wide range of possible co-morbidities and be explicit about how these needs might be addressed. Due to the small numbers of occupational therapists employed in CAMHS, referrals for problems that often co-exist with conduct disorder such as DCD, sensory processing etc, are often referred to local Child Development Teams. This disrupts pathways of care and the co-ordination of services. Providing occupational therapy within the CAMHS service would eliminate this disruption. Pathways should highlight clinical indicators for onward referral.	Thank you. We will cover pathways into care in this guideline. It will be for local services to determine how to allocate their resources in implementing recommendations.
68	College of Occupational	4.1.1.b and c	Those at significant risk of developing a conduct disorder will include those with commonly associated conditions such as	Thank you. However, as stated above, this guideline and its remit focus on conduct disorders and therefore it would not be

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	Therapists		speech, language and communication needs, which the College suggests should be included here. Although other conditions have not been so explicitly excluded the emphasis has been placed on 'other mental health conditions'. In reality a range of learning, sensory and communication disorders commonly co-exist with conduct disorders. It needs to be made clear that those assessing and treating conduct disorders need to have an understanding of the range of specific learning disabilities such as dyslexia and developmental co-ordination disorder which may require assessment.	appropriate to review other primary disorders such as speech and language difficulties, which include groups without conduct disorders.
69	College of Occupational Therapists	4.1.2 c	The co-existence of autistic spectrum disorder and conduct disorder is stated within the NICE guidelines for parent training so it is contradictory to exclude it here. In practice many professionals struggle to meet the needs of young people with autism and CD and it is recommended that this be included in the guidelines.	Thank you for your comment. However, as previously stated, this is a guideline for children with conduct disorders. We will consider individuals with other co-existing conditions, such as autism spectrum disorders. However this will only be insofar as the review may suggest modifications to treatments for conduct disorders. The forthcoming NICE guideline on autism in children will deal properly with treatment.
70	College of Occupational Therapists	4.1.2.f	The College believes that children with speech, language and communication needs are at risk of developing conduct disorder and therefore should be included within this guideline.	Thank you for your comment, however, we are covering coexisting conditions in this guideline. Section 4.1.2 has been amended to make this point clearer.
71	College of Occupational Therapists	4.3.1. c	Given the impact that conduct disorder has on every day function, the inclusion of assessment and intervention based on every day activity and performance, as carried out by an occupational therapist, should be made explicit here.	Thank you for your comment, however we are covering assessment in this guideline.
72	College of Occupational Therapists	4.3.2.d	The College is aware that the diagnostic process for conduct disorder varies significantly amongst CAMHS teams and some standardisation through these guidelines is very welcome. However, assessing the disorder as a primary as opposed to secondary diagnosis is complex and will vary widely across services. The diagnostic process is a complex decision and the	Thank you. We are not excluding conduct disorders as a 'secondary diagnosis'; we will cover all presentations of conduct disorders.

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			guidelines need to reflect this. Given that the number of children with conduct disorder *with* an associated impairment is very similar to those *without* an associated impairment, the exclusion of conduct disorder when it is a secondary diagnosis seems to limit the potential impact of the guidelines once produced.	
73	College of Occupational Therapists	4.4	The main outcomes should include an improvement in the ability to participate in everyday activities including, but not limited to, educational and social activities. The ability to participate in activities of everyday life enable role and relationship building, develop skills and competences for education and work and build self esteem. Inclusion in the guidelines is recommended.	Thank you, but we believe the areas we have covered in the scope are essentially the same as those you have mentioned.
74	Department for Education	4.1.1b	Our comments are as follows, Will children at risk of developing a conduct disorder include pre school children and looking at intervening at the earliest possible point?	Thank you for your comment. We will examine the best available evidence for targeted preventative interventions during the development of the guideline, however it will not be possible for us to comment on this issue before the evidence has been reviewed.
75	Department for Education	4.3.1	Will it be possible for alternative models of education be considered as part of this strand	Thank you for your comment. The focus of this guideline is health care and related interventions. Broader educational interventions which do not have a specific focus on conduct disorders in children are outside of the scope.
76	Department for Education	4.5	Could some consideration be given to Social Return on Investment, SROI type costing to give some indication of the potential effectiveness of early intervention to prevent the need for some of the higher cost services.	Thank you for your comment, which we will bear in mind when development begins and the economic model is considered.
77	Department for Education	3.2	Needs to include special educational needs provision	Thank you for your comment. These issues will be considered only insofar as they directly concern the provision of related health care and related interventions – it would be beyond the scope of the guideline to be concerned with the provision of specialist educational services.
78	Department for Education	4.1.2	Further clarity needed on this section. For example children and young people with just autism spectrum conditions or	Thank you. Children and young people with coexisting conditions will not be excluded, provided that a conduct

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			speech and language difficulties would be excluded - which is fair enough - or whether children with ASCs and SLDs who also have conduct disorders would also be excluded and if so why	disorder is a primary diagnosis. Section 4.1.2 of the scope has been amended to emphasise this point.
79	Department for Education	4.3.1 a and b	This section jumps from para a 'consider the presence of a conduct disorder' to para b elements of 'diagnostic assessment'. Is there a process in between these steps, that could be explored, which is about how best and who best to access a service for diagnosis and treatment? And at what point of severity should this happen?	Thank you. Whereas we agree that access to services forms a vitally important part of a care pathway, the scope should not be read as an exhaustive set of recommendations; we believe this issue is covered by part (f) of this section: "The organisation, co-ordination and delivery of care, and care pathways for the components of treatment and management (including transition planning). This will include transition planning and will be based on an ethos of multi-agency and multi-professional working."
80	Department of Health	General	No comments	Thank you.
81	Greater Manchester West Mental Health NHS Foundation Trust	2	Oppositional Defiant Disorder, not defiance	Thank you for your comment, however you are referring to the guideline scope which was received by the Department of Health and cannot be editing here.
82	Greater Manchester West Mental Health NHS Foundation Trust	3.1	Organisation not Organization	Thank you for your comment, however you are referring to the organisation title of the World Health Organization (WHO).
83	Greater Manchester West Mental Health NHS Foundation Trust	3.2a	Child and Adolescent Mental Health Services should be capitalised as should General Practitioner	Thank you for your comment, however it is our house style not to capitalise these titles.
84	Greater	3.2b	Needs semicolons after families (line 11) and interventions	Thank you for your comment, however it is not obvious what

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	Manchester West Mental Health NHS Foundation Trust		(line 12)	you are referring to, as section 3.2b only contains four lines of text.
85	Greater Manchester West Mental Health NHS Foundation Trust	4.1.1a	Young people in contact with the CJS will almost all fulfil criteria for conduct disorder	Thank you for your comment. We will consider appropriate interventions involved with the criminal justice system.
86	Greater Manchester West Mental Health NHS Foundation Trust	4.1.1c	Attachment insecurity – surely it is insecure attachment, although probably better to state attachment disorder/difficulties	Thank you for your comment. 'Attachment insecurity' is a commonly understood term, and was chosen in preference to 'attachment disorder' so as not to exclude children without a diagnosis of attachment disorder.
87	Greater Manchester West Mental Health NHS Foundation Trust	4.1.2e	Full-Scale IQ	Thank you, but we feel to make this change at this point would be over-prescriptive.
88	Greater Manchester West Mental Health NHS Foundation Trust	4.3.1b	I think these are the core areas and are often poorly done	Thank you for your comment.
89	Greater Manchester West Mental Health NHS Foundation Trust	4.3.2e	Both school-based and setting-based need to be hyphenated	Thank you for drawing out attention to this.

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90	Greater Manchester West Mental Health NHS Foundation Trust	4.4a	What about antisocial behaviour in the community???	Thank you, we have made this change as you suggest.
91	NHS Direct	General	NHS Direct welcome the guideline and have no comments on the content of the scope.	Thank you.
92	Nottingham Support Group for Carers of Children with Eczema	4.1.2a	Hopefully, by excluding adults from the scope this will not prevent considering the adults who have an impact on the children and young people in question and being able to consider the help and support that such carers may need. Although you mention parenting and family interventions in 4.3.1.c, this seems to assume that the adults are simply appendages to the young person, rather than perhaps needing their own help to cope and handle the situation.	Thank you for this comment – the focus on parenting interventions in on building parents own capacities and skills. This will of course involve consideration of their needs as well as those of the children.
93	Nottingham Support Group for Carers of Children with Eczema	4.1.2e	Learning disabilities is a much wider group of problems than simply lower IQ. Where do dyslexics stand, for instance.	Thank you for your comment, we think you are referring to learning difficulties which would encompass areas such as dyslexia.
94	Royal College of General Practitioners	3.2c	Mention shld be made of preventive work currently happening in childrens centres- see SCIE guide Think Child , Think Parent, Think Family for details on evidence base and good practice. Early interventions include programmes like Watch Wait Wonder (individual work with mother and baby/infant) and other group based programmes working with attachment theory and mother baby/infant/child dyad. It wld be good to expand on attachment theory- Shirley Gracias may be the most useful medical expert – www.my-incite.co.uk in the UK but of course Social Care has many experts in this area	Thank you for your comment, and for your advice. We will consider interventions for which there is evidence that meets our inclusion criteria.
95	Royal College of General Practitioners	4.3a	When I see a child with behavioural issues in general practice (for the purposes of this guide with anti social tendancies eg aggression, opposition) I refer on this basis- under 5 to the health visitor and childrens centre. If I feel the mother or	Thank you for your comment.

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			primary carer – has significant attachment issues herself and may not be emotionally resilient enough to follow through the referral herself I either ask a friend or family member to help or telephone the childrens centre and refer to a family support worker or refer to the local service team (through social care) - When the child is over 5 I either refer to a Parent Support Advisor or to the Local Service Team. Most Parent Support Advisors are best accessed through the child's school and many parents are able to sort this out themselves but where the mother or prinmary carer is unable to do this I would make the referral myself. In Somerset we also have Emotional Health Workers for ages 0-19 yrs and Personal Advisors for age 13-19 yrs- both accessed through the Local Service Team.	
96	Royal College of General Practitioners	4.3c	Again early interventions in childrens centres- mother baby work- group baby massage and other largely group based interventions using attachment theory as the back drop. Again the SCIE guide goes into great detail re theories behind these early interventions	Thank you for your comment, and for your advice. As previously mentioned, we will consider interventions for which there is evidence that meets our inclusion criteria.
97	Royal College of Paediatrics and Child Health	General	The College thinks this scope is comprehensive.	Thank you.
98	Royal College of Paediatrics and Child Health	General	We think it is appropriate that children with learning disabilities are excluded from the guidelines.	Thank you for your comment.
99	Royal College of Paediatrics and Child Health	General	We would like clarification on whether the guideline will cover oppositional defiant disorder.	Thank you for your comment, however we do not agree that this needs clarification, as it is clearly stated in the remit for the guideline.
100	Royal College of Paediatrics and Child Health	General	Information on medications to be used and indications would be of great help to make decisions.	Thank you for your comment. The evidence for a range of pharmacological interventions is limited, however they are used in the treatment of conduct disorders and their effectiveness will be reviewed in the development this guideline.
101	Royal College of Paediatrics and Child Health	3.1	We think it would be useful to add a paragraph about the current police involvement and youth offending team.	Thank you for this comment, as the primary focus is on healthcare and related interventions we do not think it appropriate to include the level of detail you suggest on police

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				and the criminal justice system.
102	Royal College of Paediatrics and Child Health	3.1 a)	The WHO ICD-10 classifies CD in five groups and not two. See http://apps.who.int/classifications/apps/icd/icd10online/.	Thank you for this comment. The ICD-10 classification includes four sub-groupings of conduct disorders – we therefore think the two broad categories we have adopted in the scope appropriate.
103	Royal College of Paediatrics and Child Health	3.1 d)	We think that references are required for the statements, 46% of boys and 36% girls have a coexisting disorder, and that 40% have ADHD.	Thank you, however this is an issue for NICE as their house style does not allow references in scopes or NICE guidelines.
104	Royal College of Paediatrics and Child Health	3.2 a)	We think that a reference is required for the statement that CD is the most common reason for referral either; or the word "most" should be removed.	Thank you, however as previously stated this is an issue for NICE as their house style does not allow references in scopes or NICE guidelines.
105	Royal College of Paediatrics and Child Health	3.2 c)	The three themes should be put in bullet points.	Thank you, however we do not agree that this is necessary.
106	Royal College of Paediatrics and Child Health	4.1.1 c)	The term, "attachment security" is not used WHO ICD-10. We think the word "insecurity" should be removed.	Thank you for your comment, however the ICD-10 is not the only diagnostic guide used by NICE guidelines. As has been expressed elsewhere, the choice of the term 'attachment insecurity' was consciously made, in order that children with attachment difficulties were not excluded from consideration because they do not have diagnosed reactive attachment disorder or disinhibited attachment disorder.
107	Royal College of Paediatrics and Child Health	4.1.2 (c)	It would be unfortunate to exclude all children with autism spectrum disorders from this guideline, for the following reasons: • The autism spectrum is a spectrum, so that many children have autistic features without necessarily having a diagnosis. This will be formally recognised in ICD-11. Children with conduct disorders are particularly likely to have autistic features, and children with autistic features are particularly likely to have conduct disorder. • Many such children may present initially with behaviour problems and their autistic diagnosis may	This is a duplicate comment; please see the response to comment 50.

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			not be recognised for several years, if ever. • In any one child with autistic features, there is likely to be debate between involved professionals about the presence of an autistic diagnosis. The way in which a multi-professional agreement is reached, and thresholds for diagnosis, vary geographically.	
108	Royal College of Paediatrics and Child Health	4.1.2 e)	It is desirable to state IQ 69 or less.	Thank you for pointing this out.
109	Royal College of Paediatrics and Child Health	4.1.2 (f)	It would be unfortunate to exclude all children with speech and language disorders from this guideline, for the following reason. As indicated in 3.1 (d) and (e), conduct disorder is strongly associated with other conditions, including specific learning disability – for instance, dyslexia (specific literacy disability). To exclude children with dyslexia from the scope would be to omit discussion of a very large group of children. Similarly, to exclude children with speech and language disorder would be to exclude a very large group of children, who are in many ways similar to the dyslexic group. It is as fruitless to debate regarding speech and language disorder as it is with dyslexia which disorder is primary (the conduct disorder or the specific learning disability): either may be regarded as primary; each may contribute to the severity of the other; and/or they may both have a common cause. We agree with 4.3.2 (b).	This is a duplicate comment; please see the response to comment 51.
110	Royal College of Paediatrics and Child Health	4.3.1	An awareness building in the police force and youth offending team about the condition, and a psycho-social approach to the problem that they may adopt, should be highlighted. This includes expanding leisure facilities specifically for children with conduct disorders supervised by trained physical instructors to "keep them off streets". We think that highlighting good practice from various parts of UK would be useful.	Thank you for your comment, however considerations of public health are outside of the scope of any clinical guideline.

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111	Royal College of Paediatrics and Child Health	4.3.2 (d)	We agree that general interventions for the population are probably unrealistic, financially not viable and of no guaranteed success, but should we not be aiming at prevention as well as treatment? Surely, targeting preventative measures at the high risk groups mentioned before the problems occur, e.g. the first few years of life, seems sensible.	Thank you for your comment. The scope makes clear we will be considering targeted preventative interventions
112	Royal College of Paediatrics and Child Health	4.4 a)	The term "offending behaviour" is not generally recognised.	Thank you, however we think this term can be readily understood.
113	Royal college of speech and language therapy	General	RCSLT is very concerned that speech, language and communication needs will be excluded. There is extensive research and evidence in this area that shows the relationship between conduct disorder and communication disability. We strongly recommend that children and young people with speech and language difficulties are included in the scope of the guideline.	Thank you for your comment, however it is not the case that children and young people with speech and language problems will be excluded, provided that they have a primary diagnosis of a conduct disorder and that their behavioural problems do not arise from their speech and language difficulties. Section 4.1.2 of the scope has been amended to emphasise this point.
114	Royal college of speech and language therapy	3.1	We are concerned that within the epidemiology the co-existence of conduct disorder and speech, language and communication needs is not detailed. Evidence should be included on the relationship between young people with speech, language and communication needs and conduct disorder. See below for further evidence.	Thank you for this comment. The purpose of the scope is not to review the epidemiology of the disorder in full, but rather to describe a number of pertinent issues. We will consider the relationship to speech and language problems more extensively in the full guideline.
115	Royal college of speech and language therapy	4.1.1.b.	Children with speech, language and communication needs are at risk of developing conduct disorder and as such should be included within this guideline. Children with conduct disorder have a high incidence of speech, language and communication needs and this should be included in the scope of the guideline.	Thank you for your comment. However, as mentioned above, it is not the case that young people with conduct disorders and speech and language disorders will be omitted from the guideline. Section 4.1.2 of the scope has been amended to emphasise this point.
116	Royal college of speech and language therapy	4.1.1. (c)	Consideration should be given to the specific needs of children and young people with coexisting speech, language and communication needs and conduct disorder.	Thank you for your comment. However, as mentioned above, it is not the case that young people with conduct disorders and speech and language disorders will be omitted from the guideline. Section 4.1.2 of the scope has been amended to

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				emphasise this point.
117	Royal college of speech and language therapy	4.1.2.f	The RCSLT is very concerned that one of the groups that will not be covered is "f) Children and young people with speech and language difficulties". This exclusion is inappropriate; speech, language and communication needs should be considered within the guideline. We understand that a previous draft was only going to exclude those with "significant problems" and would like to receive an explanation for why this entire group is being omitted. The published notes from the expert stakeholder workshop call for speech, language and communication to be included in section 4.1.1. The comments clearly highlight that the group felt that it is often difficult "to separate out in the diagnosis of people with conduct disorders…the group felt the co-morbidity is so high that all these problems should be looked at in relation to conduct disorders". We would like to know why the views of these experts have been deliberately ignored. There is a growing body of evidence documenting the link between speech and language problems and behavioural difficulties in children. Evidence has showed that core receptive and expressive language functions children demonstrated at kindergarten predicted later conduct problems (Hooper, Roberts, Zeisel, & Poe, 2003). These findings are supported by numerous earlier studies that demonstrate a higher rate of language problems amongst children with behavioural disorders (e.g., Cohen, Davine, Horodezky, & Isaacson, 1993; Vallance, Cummings, & Humphries, 1998; Brownlie, et al., 2004). Further evidence	Thank you for your comment. As we have stated above, it is not the case that young people with conduct disorders and speech and language disorders will be omitted from the guideline, provided their behavioural problems do not arise from their speech and language disorder. In addition, we will review studies on the aetiology of conduct disorder in order to provide a context in which to develop our recommendations, and we will also consider targeted prevention. Both of these areas may cover issues relating to communication difficulties.

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			found that even mild receptive language difficulties in 3-year-olds were linked to increased temper tantrums and negativism (Beitchman (1985). Evidence has found that receptive language problems were predictive of disinhibited behaviour in adolescents with conduct disorder (Linz, Hooper, Hynd, Isaac, & Gibson (1990). There are multiple studies that demonstrate that excluded boys had undetected language impairments and performed significantly below their peers, with higher levels of behavioural problems in those with both receptive and expressive language impairments (Ripley & Yuill, 2005). These results were supported by Silva, Justin, McGee, & Williams (1984). A longitudinal study found that boys with language impairment were rated higher on delinquency scales than their peers with speech impairment and controls. Language impaired boys also scored higher than the other groups for aggression (Brownlie, et al., 2004). In a psychiatric clinic sample of 7-14year olds, two thirds of those diagnosed with conduct disorder also had a language impairment (Cohen, Menna, Valannce, Barwick, Im, & Horodezky, 1998). The association between behavioural difficulties and speech and language disorders is well established Humber and Snow 2001). There is very strong evidence from Canada and the USA that speech, language and communication needs tend to be labelled a "behaviour problems". A study from a youth offending team found that children are misdiagnosed as having a conduct disorder or a mental health problem where in fact they have undiagnosed speech, language and communication needs (Lanz, 2009).	

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			Even young children with undiagnosed speech, language or communication difficulties were perceived as being more delinquent / difficult by their own mothers than a matched control group. Two thirds of 7 to 14 year olds with severe behavioural problems have communication needs (Cohen et al, 1998). Research in Sheffield has shown that children about to be excluded from school showed high levels of speech, language and communication needs (Clegg et al, 1999). There is a high incidence of speech, language and communication needs within the children and young people referred to psychiatric services – approximately 50% with at least a third being previously undiagnosed.	
118	Royal college of speech and language therapy	4.3.2 (b)	We are concerned that one of the issues that will not be covered is interventions for children and young people with significant speech and language difficulties. As stated the evidence shows a relationship between speech, language and communication needs and conduct disorder. The two should be considered jointly within this guideline. This exclusion is inappropriate, speech and language needs to be included in the guideline and that assessment should include SLT routinely	Please see our previous responses to your comments, in which we think we have already addressed this issue.
119	Royal college of speech and language therapy	4.3.2 (c)	This is too restricting. There is a relationship between conduct disorder and speech, language and communication needs. For some young people speech, language and communication needs may be the primary diagnosis yet they still have a conduct disorder. The evidence clearly shows the strong correlation between speech, language and communication needs and criminal	Thank you for this comment – the focus of this guideline is conduct disorder and it would beyond the scope of the guideline to consider primary speech and language problems or their treatment .

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			behaviour problems (Tomblin 2000). Over 60% of young people at risk of behavioural problems or offending have speech, language and communication needs. Young people with conduct disorder as a secondary diagnosis and speech, language and communication needs as a primary diagnosis should be included.	
120	Sussex Partnership NHS Foundation Trust	3.1 a	I would suggest adding 'self-destructive behaviours' to the epidemiology, as conduct disorders are further characterised by dangerous behaviours which put the children and young people concerned at risk of injury, sexual exploitation, drug misuse etc.	Thank you for this comment. As you imply a number of the behaviours you describe are associated with conduct disorder. We will consider these in our review of the evidence but do not think it necessary to include them in the section on the epidemiology of the disorder.
121	Sussex Partnership NHS Foundation Trust	3.1 d	It would be helpful to also mention the co-existence of depressive symptoms (which in parts of the literature are considered to be secondary to the behaviour problems, due to the estrangement between the young person and their family and peer group) and anxiety-related symptoms in young people with conduct disorders. There is a further high rate of co-incidence with ASD. This is particularly important in view of the fact that many CAMHS in the UK still do not see conduct disorders as a mental health problem and tend to reject a significant number of referrals for this reason.	Thank you. We believe that this issues you raise about depression and anxiety disorders are covered by section 4.1.1 (c) 'Groups that will be covered': "children and young people with conduct disorders and coexisting conditions (such as ADHD, depression, anxiety disorders and attachment insecurity)". The issue of ASD will be dealt with by the soon to be established treatment guideline for AD in children and yoing people. With regards your point that CAMHS do not always view conduct disorders as mental health issues, and therefore reject a number of referrals – we agree that this implementation issue is very important. We intend to set standards for care in the NHS such that this will not be the case.
122	Sussex Partnership NHS Foundation Trust	4.1.1 c	I feel that 'ASD' should be mentioned here, as a significant number of children with CD will also have been diagnosed with ASD.	Thank you for your comment. However, as mentioned previously, it would not be possible to specifically search for evidence that looks at AUS during the time available for development.
123	Sussex Partnership NHS Foundation Trust	4.1.2 c	I do not feel it would be productive to exclude children with ASD from these guidelines due to the high incidence of children with CD and a concomitant diagnosis of ASD. It would be especially significant to ascertain, which approaches can be recommended for the general population of children and young	As with our previous comment, we accept this is an important issue but one we think will be better dealt with by the forthcoming NICE clinical guideline on autism in children.

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			people with conduct problems, and whether these approaches can include or exclude children with ASD, or require specific modifications.	
124	Sussex Partnership NHS Foundation Trust	4.3.1 c	This should read 'multi-modal systemic' rather than 'multi-systemic interventions', as 'multi-systemic' is associated with the particular treatment approach called 'Multi-systemic Therapy', thereby appearing to prejudice the results of the GDG.	Thank you for this comment, we have revised the scope to reflect a broader view of family and parent interventions.
125	Sussex Partnership NHS Foundation Trust	4.3.2 a	A large number of complex cases with CD as the foreground clinical presentation will involve young people who have been traumatised by childhood sexual abuse or other forms of abuse. Such histories of abuse will often become more apparent in the course of treatment. Where there are post-traumatic symptoms associated with serious behaviour problems, or aggressive and violent behaviour patters appear to have developed within a post-traumatic response, children still need appropriate interventions to deal with their conduct problems, as clinical experience shows that trauma-focused therapy alone does not ameliorate the CD; there is also to my knowledge no research evidence to this extent. Therefore, it would be necessary in my view to consider adaptations to the interventions where post-traumatic difficulties play a major role within conduct problem.	Thank you for your comment. We agree this is an important issue, however it would not be possible for the evidence in this area to be reviewed in the time available for the development of the guideline, or for adaptations to interventions to be considered. We refer you to the NICE clinical guideline on post-traumatic stress disorder (CG 26, 2005), which makes recommendations about the management of PTSD in children.
126	Sussex Partnership NHS Foundation Trust	4.4 a	There are three areas in which conduct problems need to be ameliorated – home, school and the social environment outside of these contexts such as community and peer-group. It will be important in my view to ascertain the clinical utility and efficacy of psychological interventions that also aim to reduce risk taking behaviour and the improvement of appropriate and supportive peer relationships. It is increasingly seen as good practice for psychological interventions to extend beyond the family and to base them within a community network, if they are to be effective, especially in adolescents. Therefore, I feel that 'community' needs to be included as third relevant context for CD interventions.	Thank you, we have amended the guideline scope so that antisocial behaviour in the community is added to the key outcomes to be considered.

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127	Sussex Partnership NHS Foundation Trust	4.5	Cost implications are in my view best ascertained if they are linked to the complexity of the intervention required. Some interventions may appear more cost-effective when they target a specific symptom area. However, especially in Tier 3 CAMHS, we work with a high level of complexity with children and families, in which the complexity of the interventions needs to mirror the different aspects of the problems as they present themselves on an individual, family and wider system level. Therefore, it would not be helpful to link cost-effectiveness to approaches which aim to deal with specific conduct problems in a uni-directional manner. This relates to comment no.9.	Thank you for your comment, which we will bear in mind when we start developing the guideline and considering the health economic model.
128	Sussex Partnership NHS Foundation Trust	general	A number of my comments relate to the exclusion of certain contributing factors, such as ASD or trauma, from the scope for the guideline development. I am concerned about such an exclusion, as the guidelines would not be applicable to the real-life clinical situations as they present themselves in CAMHS from a systemic point of view. Many of the children and young people seen in CAMHS with very serious CD live in multi-stressed families, i.e. families with many contributing factors. Typically, the contributing factors include family histories of trauma, as well as concomitant diagnoses of ADHD, ASD etc. Such families require a wide-ranging multi-modal approach. There is a serious risk of compartmentalizing the difficulties, and e.g. looking to AMH to deal with the parental mental health problems, anger management programmes to deal with a father's aggression, etc., and treating all of these as unrelated medical 'conditions'. It is therefore not only important that the guidelines recommend specific interventions for the behaviour problems themselves, but address treatment for all the relationship aspects of these problems. For CD in multi-stressed families, it will be important to address the service structures that are necessary to deliver highly complex composite interventions, which meet the differential needs of families. E.g., a family in which a single parent with a history of domestic violence and childhood abuse	Thank you for your comment. We are aware that comorbidity is common in children and young people and we will take this into account in the guideline. We will do this by linking to existing NICE guidance on these comorbidities. It will be for the GDG to determine how this might be best achieved after reviewing the evidence for the treatment of conduct disorders. We have as yet not reviewed the evidence and so are not in a position to comment on the adequacy of current RCTs to address the issues you raise concerning the quality or relevance of the evidence.

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			is caring for several aggressive children, there will need to be an integration of interventions focusing on the child, with interventions focusing on reducing the parent's traumatic responses to her children's expressed anger. Outcomes derived from RCTs of specific manualised interventions do not adequately capture these complex clinical situations. It would therefore be helpful to utilise additional sources of evidence to be able to recommend treatments that are (a) sufficiently comprehensive in order to adequately meet the needs of multi-stressed families with CD, and to recommend service structures that enable and support the delivery of such integrated comprehensive multi-modal interventions.	
129	Welsh Assembly Government	General	This stakeholder responded with no comments to make.	Thank you.
130	Whitstone Head Educational (Charitable) Trust Ltd	General	Our comments are as follows: The draft scope successfully addresses the main issues and concerns raised by the stakeholder scoping workshop in November 30, 2010 and in doing so extends equality of access, by explicitly stating additional descriptors in key sections.	Thank you for this positive comment.

These organisations were approached but did not respond:
Action for ADHD – Northants
Association for Rational Emotive Behaviour Therapy
Association of Directors of Childrens Services
Association of Professional Music Therapists
Association of Psychoanalytic Psychotherapy in the NHS
BMJ
British Association for Adoption and Fostering
British Association of Play Therapists
British Dietetic Association
British National Formulary (BNF)
British Paediatric Mental Health Group
British Psychoanalytic Council
British Psychological Society, The

Care Quality Commission (CQC)
Caspari Foundation
Cerebra
Cochrane Devlopmental, Psychosocial and Learning Problems
College of Mental Health Pharmacy
Connecting for Health
Critical Psychiatry Network
Department for Communities and Local Government
Department of Health Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI)
Department of Health, Social Services & Public Safety, Northern Ireland (DHSSPSNI)
East London NHS Foundation Trust
Education Otherwise
Fostering Network Wales, the
Hampshire Partnership NHS Foundation Trust
Humber NHS Foundation Trust
Kent & Medway NHS and Social Care Partnership Trust
La Leche League GB
Lancashire Care NHS Foundation Trust
Liverpool Community Health
Medicines and Healthcare Products Regulatory Agency (MHRA)
Ministry of Defence (MoD)
National Association for Children of Alcoholics
National CAMHS Support Service
National Commissioning Group
National Offender Management Service
National Organisation for Fetal Alcohol-UK (NOFAS-UK)
National Patient Safety Agency (NPSA)
National Public Health Service for Wales
National Treatment Agency for Substance Misuse
Neonatal & Paediatric Pharmacists Group (NPPG)
NETSCC, Health Technology Assessment
NHS Buckinghamshire
NHS Clinical Knowledge Summaries Service (SCHIN)
NHS Plus
NHS Quality Improvement Scotland
NHS Sheffield
NHS Western Cheshire
Northumberland, Tyne & Wear NHS Foundation Trust

Nottinghamshire Healthcare NHS Trust
Parenting UK
PERIGON Healthcare Ltd
Qbtech Ltd
Rotherham NHS Foundation Trust
Royal College of Anaesthetists
Royal College of General Practitioners Wales
Royal College of Midwives
Royal College of Nursing
Royal College of Obstetricians and Gynaecologists
Royal College of Pathologists
Royal College of Physicians London
Royal College of Psychiatrists
Royal College of Radiologists
Royal College of Surgeons of England
Royal Society of Medicine
Scottish Intercollegiate Guidelines Network (SIGN)
Sheffield Children's NHS Foundation Trust
Social Care Institute for Excellence (SCIE)
Social Exclusion Task Force
Solent Healthcare
South West London and St Georges Mental Health NHS Trust
St John's RC School
Tees Esk & Wear Valleys NHS Trust
Triple P International Pty Ltd
UNITE THE UNION-CPHVA
University of Edinburgh
Welsh Scientific Advisory Committee (WSAC)
West London Mental Health NHS Trust
Western Health and Social Care Trust
Worcestershire PCT
York Teaching Hospital NHS Foundation Trust
Young Minds