APPENDIX 15:

REVIEW PROTOCOLS

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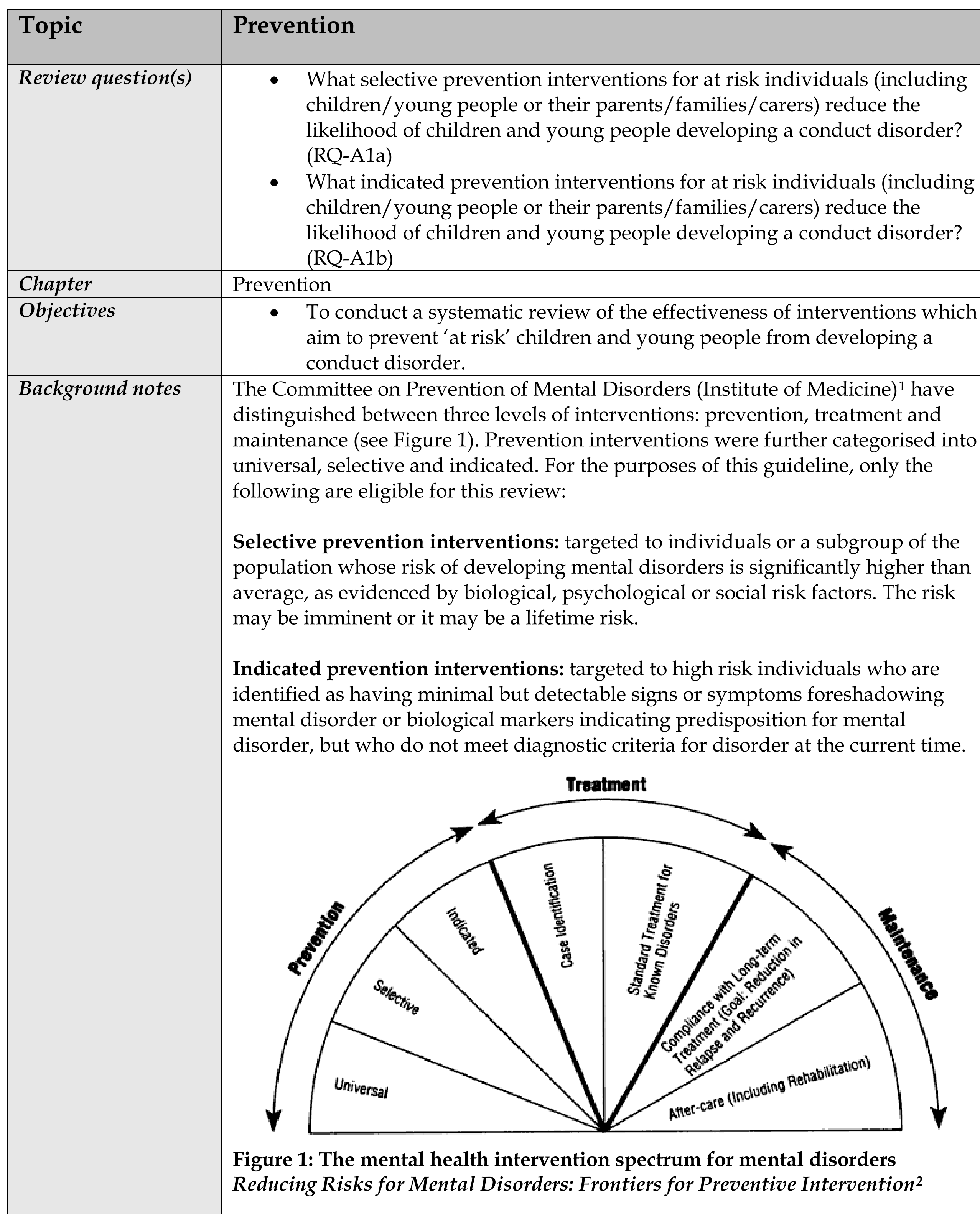
1.1 PREVENTION

Topic	Prevention
Review question(s)	• What selective prevention interventions for at risk individuals (including children/young people or their parents/families/carers) reduce the likelihood of children and young people developing a conduct disorder? (RQ-A1a) • What indicated prevention interventions for at risk individuals (including children/young people or their parents/families/carers) reduce the likelihood of children and young people developing a conduct disorder? (RQ-A1b)
Chapter	Prevention
Objectives	• To conduct a systematic review of the effectiveness of interventions which aim to prevent 'at risk' children and young people from developing a conduct disorder.
Background notes	The Committee on Prevention of Mental Disorders (Institute of Medicine)[1] have distinguished between three levels of interventions: prevention, treatment and maintenance (see Figure 1). Prevention interventions were further categorised into universal, selective and indicated. For the purposes of this guideline, only the following are eligible for this review: **Selective prevention interventions:** targeted to individuals or a subgroup of the population whose risk of developing mental disorders is significantly higher than average, as evidenced by biological, psychological or social risk factors. The risk may be imminent or it may be a lifetime risk. **Indicated prevention interventions:** targeted to high risk individuals who are identified as having minimal but detectable signs or symptoms foreshadowing mental disorder or biological markers indicating predisposition for mental disorder, but who do not meet diagnostic criteria for disorder at the current time.  **Figure 1: The mental health intervention spectrum for mental disorders** ***Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention***[2]

[1] Muñoz RF, Mrazek PJ, Haggerty RJ. Institute of Medicine report on prevention of mental disorders. Summary and commentary. The American Psychologist. 1996;51:1116-22.
[2] Mrazek PM, Haggerty RJ (eds). Committee on Prevention of Mental Disorders, Division of Biobehavioral Sciences and Mental Disorders, Institute of Medicine. Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention. Washington DC: National Academy Press, 1994.

<table>
<tr><th>Criteria for considering studies for the review</th><th></th></tr>
<tr><td>Population</td><td>Children and young people and their parents/families/carers, including looked-after children, who are considered to be 'at risk' of developing conduct disorders (conduct disorder and oppositional defiance disorder; characterised by repetitive and persistent patterns of antisocial, aggressive or defiant behaviour that amounts to significant and persistent violations of age-appropriate social expectations).

'At risk' was defined as:
significant aggressive behaviour (measured using an appropriate scale, for example, Teacher's Rating Form of the Child Behavior Checklist's Aggression Scale, 10-item Authority Acceptance scale of the Teacher Observation of Classroom Adaptation-Revised, and/or
significant deviant and noncompliant behaviours
an individual, family or socioeconomic risk factor or scoring above the cut-off on a screening instrument based on risk factor research.
Categorisation of intervention based on participants' risk:
Selective prevention intervention: inclusion of children/young people was done on the basis of risk factors (individual, family or socioeconomic status) or a screening instrument based on risk factor research.
Indicated prevention intervention: inclusion of children/young people was done of the basis of high risk with minimal but detectable signs or symptoms foreshadowing a diagnosis, but who do not meet diagnostic criteria for conduct disorder or oppositional defiant disorder at the current time. (In March 2012, it was decided that studies meeting these criteria should be included in the psychological/psychosocial treatment review [meta-regression will be used to examine if indicated prevention versus treatment interventions produce different effects].)
Where possible, consideration will be given to the specific needs of:
children at risk of a conduct disorder with coexisting conditions (such as ADHD, depression, anxiety disorders and attachment insecurity)
children and young people from particular cultural and minority ethnic groups
girls at risk of developing conduct disorders
looked-after children.</td></tr>
<tr><td>Intervention</td><td>Child-focused (for example, social skills training).
Foster-family focused (for example, Attachment and Biobehavioral Catch-up).
Family-focused (for example, functional family therapy).
Foster carer-focused (for example, Keeping Foster Parents Trained and Supported).
Multi-modal (for example, multisystemic therapy).
Parent–child-based (for example, Incredible Years Parent Training and Incredible Years Dina Dinosaur Child Training).
Foster carer-child based (for example, preventive behaviour problems intervention for children/foster carers).
Parent-focused (for example, Incredible Years Parent Training; Triple P).
Parent–teacher-based (for example, the early impact intervention for parents and for teachers).
Classroom-based interventions (for example, Early Literacy Intervention).</td></tr>
<tr><td>Comparison</td><td>Treatment as usual, no treatment, waitlist control, attention control.
Another active preventative intervention</td></tr>
<tr><td>Critical outcomes</td><td>Antisocial behaviour (at home, at school, in the community) – measured</td></tr>
</table>

	with, for example, the Eyberg Child Behavior Inventory; Child Behavior Checklist; Toddler Temperament Scale; Child Behavior Questionnaire; Parent Daily Reports; Preschool Behavior Questionnaire; Becker/Bipolar Adjective Checklist; Revised Behavior Problems Checklist; Home Situations Questionnaire. *Note*. Outcome data can be collected from children and young people with a conduct disorder, their teachers, parents, peers, and their school records.
• *Important, but not critical outcomes*	• Diagnosis of any conduct disorder • Defined reduction in conduct problems.
• *Study design*	RCT
• *Include unpublished data?*	Unpublished research may be included, but specific searches for grey literature will not be conducted.
• *Restriction by date?*	No
• *Minimum sample size*	N = 10 per arm Excluded studies with >50% attrition from either arm of trial (unless adequate statistical methodology has been applied to account for missing data).
• *Study setting*	• Primary, secondary, tertiary, health and social care and children's services and educational settings (including prisons and forensic services) • Others in which NHS or social care services are funded or provided, or NHS or social care professionals are working in multi-agency teams.
• *Potential sub-group analyses*	– Group interventions. – Intervention target (for example, child symptoms, low family income, parent difficulties). – Intervention length. – Intervention setting.
Exclusion criteria	– Universal prevention programmes (that is, targeted to the general public or to a whole population group that has not been identified on the basis of increased risk).* • Single case study reports. • Studies including participants diagnosed with a conduct disorder (DSM-IV or ICD-10 criteria). • Studies evaluating interventions involving the individualised clinical management or treatment of a conduct disorder. • Studies having a primary outcome focused on suicide prevention, or on mental disorders relating to personality. • Studies evaluating the process of interventions rather than outcomes (for example, uptake of programme). **Note*. Include studies of interventions that were both universal (that is, school-based) and selective or indicated; and include studies which conducted a sub-group analysis of high-risk individuals.
Search strategy	See Appendix 7
Date searched	Inception to June 2012
Searching other resources	Hand-reference searching of retrieved literature.

The review strategy	• The aim is to conduct a separate analysis for each intervention subcategory (see below) versus treatment as usual/attention control or another intervention (*Note*. Studies of children with subaverage IQ, where mean of sample was above 60, will be analysed separately):
	  – sensitivity analyses:
	    o Exclude studies with high risk of bias
	  – comparisons of one intervention category versus another

		intervention category will be conducted if there is sufficient data (five studies had sufficient data, therefore no analysis conducted) – cluster randomised trials – the effective sample size was calculated using the formula: N (effective) = (k x m)/(1+(m-1)*intracluster correlation coefficient, where the intracluster correlation coefficient = 0.02 was used. – For each trial and outcome rater, outcomes with moderate to large baseline differences were excluded from the meta-analysis, unless no other outcome data was suitable, in which case the data were included (sensitivity analyses were conducted). – For each trial and outcome rater, outcomes with high attrition (>50%) were excluded from the meta-analysis.

1.2 ACCESS AND THE ORGANISATION AND DELIVERY OF CARE

Topic	Access and the organisation and delivery of care
Review question(s)	What are the barriers to access that prevent children and young people at risk of, or diagnosed with, conduct disorders from accessing services? (RQ-B1) Do methods designed to remove barriers to services increase the proportion and diversity of children and young people accessing treatment? (RQ-B2) What are the essential elements that assist in the transition into adulthood services for young people with conduct disorders? (RQ-G2) What are the effective ways of monitoring progress in conduct disorders? (RQ-G3) What components of an intervention, or the way in which it is implemented, and by whom are associated with successful outcomes? (RQ-G4) *Note.* Issues to consider: education system (including children in boarding schools) and criminal justice services (for example, issues around 'contact orders').
Chapter	Access to services and the experience of care
Objectives	• To identify barriers relating to the individual child/ parents/ family/ carers, the practitioner, the healthcare/ social care/ other service systems that prevent an individual from accessing services. • To evaluate any methods and models designed to improve access for children and young people, and /or their parents/ family/ carers requiring services. • To evaluate the components and effectiveness of different models for the delivery of care of children and young people with conduct disorders.
Criteria for considering studies for the review	
• *Population*	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. Children and young people identified as being at significant risk of developing conduct disorders. 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.
• *Intervention*	For RQ-B2: • Service developments or changes which are specifically designed to promote access. • Specific models of service delivery (for example, community-based

	outreach clinics, clinics or services in non-health settings). • Methods designed to remove barriers to access (including stigma (both cultural and self and stigmatisation), misinformation or cultural beliefs about the nature of mental disorder).
• *Comparison*	For RQ–B2: Treatment as usual
• *Critical outcomes*	For RQ–B1 and B2: • proportion of people from the target group who access services • uptake of services • data on the diversity of the group who access or are retained in services/ interventions.
• *Important, but not critical outcomes*	For RQ–B1 and B2: • satisfaction, preference • anxiety about treatment • experience of care • number leaving the study early.
• *Study design*	Systematic reviews and qualitative reviews
• *Include unpublished data?*	Unpublished research may be included, but specific searches for grey literature will not be conducted.
• *Restriction by date?*	No
• *Minimum sample size*	No
• *Study setting*	• Primary, secondary, tertiary, health and social care and children's services and educational settings (including prisons and forensic services). • Others in which NHS or social care services are funded or provided, or NHS or social care professionals are working in multi-agency teams.
Search strategy	See Appendix 7
Searching other resources	Hand-reference searching of retrieved literature
The review strategy	• For the questions about access, the literature will be presented via a narrative synthesis of the available evidence taking into account access to services: – for the child – for the parents/families/carers. • For questions about the organisation and delivery of care, high order principles from existing guidelines (for example, common mental health disorders) will be reviewed by the GDG to determine whether these can be incorporated or adapted for conduct disorder. In particular, the following sources of information will be used to make this decision: – GDG experience – systematic reviews identified during the general search for secondary evidence – experience of care chapter.

1.3 CASE IDENTIFICATION AND ASSESSMENT

<table>
<tr><th>Topic</th><th>Case identification and assessment</th></tr>
<tr><td>Review question(s)</td><td>What concerns and behaviours (as expressed by the carer or exhibited by the child) should prompt any professional who comes into contact with a child or young person with possible conduct disorders to consider referral for further assessment? (RQ-C1)

What are the most appropriate methods/instruments for case identification of conduct disorders in children and young people? (RQ-C2)

What amendments, if any, need to be made to the agreed methods for case identification to take into account: (RQ-C3)
demographics (for example, particular cultural or minority ethnic groups, or girls)
the environment in which case identification takes place (for example, social care, education)?
In children and young people with possible conduct disorders, what are the key components of, and the most appropriate structure for, a diagnostic assessment? (RQ-D1)

To answer this question, consideration should be given to:
the nature and content of the interview and observation, which should both include an early developmental history where possible
formal diagnostic methods/psychological instruments for the assessment of core features of conduct disorders
the assessment of risk
the assessment of need
the setting(s) in which the assessment takes place
the role of the any informants
gathering of independent and accurate information from informants.
When making a diagnosis of conduct disorders in children and young people, what amendments (if any) need to be made to take into account coexisting conditions (such as ADHD, depression, anxiety disorders and attachment insecurity)? (RQ-D2)

What amendments, if any, need to be made to take into account particular cultural or minority ethnic groups or gender? (RQ-D3)</td></tr>
<tr><td>Chapter</td><td>Case identification and assessment</td></tr>
<tr><td>Objectives</td><td>For case identification:
To identify the concerns and behaviours (as expressed by carers and exhibited by the child) that would prompt referral for further assessment.
To identify and evaluate the most effective instruments for case identification of conduct disorders in children and young people.
To identify which amendments need to be made to the agreed methods for case identification to take into consideration demographics and the environment in which case identification takes place.
For assessment:
To identify the key components of a comprehensive assessment.
To identify what amendments, if any, need to be made to take into</td></tr>
</table>

	account particular cultural and/or minority ethnic groups or sex.
Criteria for considering studies for the review	
• *Population*	Children and young people (aged 18 years and younger) with a suspected conduct disorder, including looked-after children and those in contact with the criminal justice system.
• *Intervention*	Any case identification instrument considered suitable for use
• *Comparison*	Gold standard: DSM-IV or ICD-10 of conduct disorder Other assessment instruments or strategies
• *Critical outcomes*	**Sensitivity**: the proportion of true positives of all cases diagnosed with conduct disorder in the population. **Specificity**: the proportion of true negatives of all cases not-diagnosed with conduct disorder in the population.
• *Important, but not critical outcomes*	**Positive predictive value**: the proportion of patients with positive test results who are correctly diagnosed. **Negative predictive value**: the proportion of patients with negative test results who are correctly diagnosed. **Area under the curve:** are constructed by plotting the true positive rate as a function of the false positive rate for each threshold.
• *Other outcomes*	**Reliability** (for example, inter-rater, test-retest). **Validity** (for example, construct, content).
• *Study design*	RCTs, cross-sectional studies
• *Include unpublished data?*	Unpublished research may be included, but specific searches for grey literature will not be conducted.
• *Restriction by date?*	No
• *Minimum sample size*	No
• *Study setting*	• Primary, secondary, tertiary, health and social care and children's services and educational settings (including prisons and forensic services). • Other residential settings such as those provided by fostering services and to looked-after children. • Others in which NHS or social care services are funded or provided, or NHS or social care professionals are working in multi-agency teams.
Search strategy	See Appendix 7
Searching other resources	Hand-reference searching of retrieved literature.
The review strategy	For case identification: • To conduct pooled diagnostic accuracy meta-analyses on the sensitivity and specificity of case identification instruments. This is dependent on available data from the literature. In the absence of this, a narrative review of case identification instruments with be conducted and guided by a pre-defined list of consensus-based criteria (for example, the clinical utility of the tool, administrative characteristics, and psychometric data evaluating its sensitivity and specificity). For assessment: • To provide a GDG consensus-based narrative identifying the key components of an effective assessment for conduct disorder (considering possible amendments due to the presence of individual variation), children and young people with conduct disorders and coexisting conditions, from particular cultural and minority ethnic

	groups, girls, looked-after children and those in contact with the criminal justice system.

1.4 TREATMENT INTERVENTIONS

1.4.1 Psychological/psychosocial treatment interventions

Topic	Psychological/psychosocial treatment interventions
Review question(s)	For children and young people with conduct disorders, what are the benefits and potential harms associated with individual and group psychosocial interventions? (RQ-E1) For children and young people with conduct disorders, what are the benefits and potential harms associated with parenting and family interventions? (RQ-E2) For children and young people with conduct disorders, what are the benefits and potential harms associated with multi-modal/multiple interventions? (RQ-E3) For children and young people with conduct disorders, what are the benefits and potential harms associated with classroom based interventions? (RQ-E6) For children and young people with conduct disorders, should interventions found to be safe and effective be modified in any way in light of coexisting conditions (such as ADHD, depression, anxiety disorders, attachment insecurity) or demographics (such as age, particular black and minority ethnic groups, or sex)? (RQ-E7)
Chapter	Psychological/psychosocial interventions
Objectives	– To evaluate the clinical effectiveness and safety of individual, group, family, multi-modal and parental/carer interventions for conduct disorders. – To evaluate if any modifications should be made to interventions to take into account co-existing conditions or demographic variation.
Criteria for considering studies for the review	
• *Types of participants*	Children and young people (aged 18 years and younger), including looked-after children and those in contact with the criminal justice system, diagnosed with a conduct disorder, including oppositional defiant disorder, or with persistent offending behaviour or symptoms of conduct problems. (Conduct disorder and oppositional defiant disorder 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). Referral by healthcare professionals for conduct problems or self-referral by parents because of their child's conduct problems was taken as evidence of conduct disorder for the purposes of the review. Studies of children with subaverage IQ, where mean of sample was above 60, will be included, but analysed separately. 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 problems/issues) • 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.
• *Intervention*	• **Child-focused** (for example, social skills training). • **Parent-focused** (for example, Incredible Years Parent Training; Triple P). • **Foster carer focused** (for example, Keeping Foster Parents Trained and Supported). • **Parent–child-based** (for example, Incredible Years Parent Training + Incredible Years Dina Dinosaur Child Training). • **Parent–teacher-based** (for example, the early impact intervention for parents and for teachers). • **Family-focused** (for example, functional family therapy). • **Multi-modal** (for example, multisystemic therapy). • **Multi-component** (for example, Incredible Years – Teacher Classroom Management Program + Incredible Years Parent Training + Incredible Years Dina Dinosaur Child Training). • **Classroom-based** (for example, Incredible Years – Teacher Classroom Management Program).
• *Comparison*	Treatment as usual, no treatment, wait-list control, active control, other active interventions
• *Critical outcomes*	**Child outcomes:** • agency contact (for example, residential care, criminal justice system) • antisocial behaviour (at home, at school, in the community)* • drug/alcohol use • educational attainment (that is, the highest level of education completed) • offending behaviour • school exclusion due to antisocial behaviour. *Measured with, for example, the Eyberg Child Behavior Inventory; Child Behavior Checklist; Toddler Temperament Scale; Child Behavior Questionnaire; Parent Daily Reports; Preschool Behavior Questionnaire; Becker/Bipolar Adjective Checklist; Revised Behavior Problems Checklist; Home Situations Questionnaire. *Note*. Outcome data can be collected from children and young people with conduct disorder, their teachers, parents, peers, and their school records.
• *Important, but not critical outcomes*	**Child outcomes:** • anxiety/depression • harms and side effects • impulsivity • no longer meeting criteria for a conduct disorder • out-of-school placement • outcomes for coexisting conditions • pregnancy • self-esteem • self-harm • self-reported delinquent behaviour • sexual behaviour • social functioning/quality of life. **Parent/carer outcomes:** • domestic violence • drug/alcohol use • family/parental functioning • harms and side effects • outcomes for coexisting conditions • parenting skills • self-esteem

	• social functioning/quality of life.
• *Other outcomes*	• Acceptability. • Attrition. • Compliance. • Satisfaction (child/young person and parental).
• *Study design*	• RCT
• *Include unpublished data?*	Unpublished research may be included, but specific searches for grey literature will not be conducted.
• *Restriction by date?*	No
• *Minimum sample size*	N = 10 per arm. Exclude studies with > 50% attrition from either arm of trial (unless adequate statistical methodology has been applied to account for missing data).
• *Study setting*	• Primary, secondary, tertiary, health and social care and children's services and educational settings (including criminal justice and forensic services), children's services and educational settings. • Residential settings such as those provided by fostering services and those provided to 'looked-after children'. • Others in which NHS or social care services are funded or provided, or NHS or social care professionals are working in multi-agency teams.
• *Potential sub-group analyses*	• The presence of co-existing conditions (such as ADHD, depression, anxiety disorders, attachment insecurity). • Age (<11, 11+ years). • Other demographics (such as particular black and minority ethnic groups, or sex).
Exclusion criteria	• Single case study reports. • Studies evaluating prevention interventions. • Studies evaluating the process of interventions rather than outcomes (for example, uptake of programme).
Search strategy	See Appendix 7
Date searched	Inception to June 2012
Searching other resources	Hand reference searching of: • Furlong M, McGilloway S, Bywater T, Hutchings J, Smith SM, Donnelly M. Behavioural and cognitive-behavioural group-based parenting programmes for early-onset conduct problems in children aged 3 to 12 years. Cochrane Database of Systematic Reviews. 2012;15 Feb;2:Art No.: CD008225. DOI: 10.1002/14651858.CD008225.pub2. • Littell JH, Campbell M, Green S, Toews B. Multisystemic Therapy for social, emotional, and behavioral problems in youth aged 10-17. Cochrane Database of Systematic Reviews. 2005;Issue 4:Art. No.: CD004797. DOI: 10.1002/14651858.CD004797.pub4. • Montgomery P, Bjornstad GJ, Dennis JA. Media-based behavioural treatments for behavioural problems in children. Cochrane Database of Systematic Reviews. 2006;Issue 1:Art. No.: CD002206. DOI: 10.1002/14651858.CD002206.pub3. • NCCMH. Chapter 5: Interventions in children and adolescents for the prevention of antisocial personality disorder. In: NCCMH, Antisocial Personality Disorder: Treatment, Management and Prevention. Clinical guideline 77). London: The British Psychological Society and The Royal College of Psychiatrists, 2009. • NICE. Parent-Training/Education Programmes in the Management of Children with Conduct Disorders. NICE technology appraisal guidance 102. London: NICE/SCIE, 2006. • Woolfenden S, Williams KJ, Peat J. Family and parenting interventions in children and adolescents with conduct disorder and delinquency aged

	10-17. Cochrane Database of Systematic Reviews. 2001;Issue 2:Art. No.: CD003015. DOI: 10.1002/14651858.CD003015.
The review strategy	• The initial aim is to conduct a meta-analysis evaluating the clinical effectiveness of the interventions. However, in the absence of adequate data, the available evidence will be synthesised using narrative methods. • Consideration will be made to whether any amendments due to common mental health disorders are needed. • Studies of children with subaverage IQ (where mean of sample was above 60) will be analysed separately.
Meta-analysis	• The aim was to conduct a separate analysis for each intervention subcategory (see below) versus treatment as usual/attention control or another intervention:* – For each trial and outcome rater, outcomes with moderate to large baseline differences were excluded from the meta-analysis, unless no other outcome data was suitable, in which case the data were included (sensitivity analyses were conducted). – For each trial and outcome rater, outcomes with high attrition (>50%) were excluded from the meta-analysis. – Where few trials reported offending behaviour, these were combined in the meta-analysis with antisocial behaviour. – Where few trials reported composite outcomes, these were combined with researcher/clinician rated outcomes (rationale is that composite outcomes are likely to provide better measurement than a single rater; composite constructed by researcher). *Note*. Studies of children with subaverage IQ, where mean of sample was above 60, will be analysed separately.
Review registration	PROSPERO: Reg. No. CRD42011001748

1.4.2 Pharmacological and physical interventions

Topic	**Pharmacological and physical interventions**
Review question(s)	For children and young people with conduct disorders, what are the benefits and potential harms associated with pharmacological interventions? (RQ-E4) For children and young people with conduct disorders, what are the benefits and potential harms associated with physical interventions (for example, diet)? (RQ-E5) For children and young people with conduct disorders, should interventions found to be safe and effective be modified in any way in light of coexisting conditions (such as ADHD, depression, anxiety disorders, attachment insecurity) or demographics (such as age, particular black and minority ethnic groups, or sex)? (RQ-E7)
Chapter	Pharmacological and physical interventions
Objectives	• To evaluate the clinical effectiveness and safety of pharmacological and physical interventions for conduct disorders • To evaluate if any modifications should be made to interventions to take into account co-existing conditions or demographic variation

Criteria for considering studies for the review	
• *Types of participants*	Children and young people (aged 18 years and younger), including looked-after children and those in contact with the criminal justice system, diagnosed with a conduct disorder, including oppositional defiant disorder or persistent offending/symptoms of conduct problems (conduct disorder and oppositional defiant disorder 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). Studies of children with subaverage IQ, where mean of sample was above 60, will be included, but analysed separately. 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 problems/issues) • 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.
• *Intervention*	• **Pharmacological interventions** (for example, antipsychotics). • **Physical interventions** (for example, diet).
• *Comparison*	Treatment as usual, placebo, other active interventions.
• *Critical outcomes*	**Child outcomes:** • antisocial behaviour (at home, at school, in the community)* • offending behaviour • school exclusion due to antisocial behaviour • educational attainment (that is, the highest level of education completed) • agency contact (for example, residential care, criminal justice system) • sexual behaviour • drug/alcohol use. * Measured with, for example, the Eyberg Child Behaviour Inventory; Child Behaviour Checklist; Toddler Temperament Scale; Child Behaviour Questionnaire; Parent Daily Reports; Preschool Behavior Questionnaire; Becker/Bipolar Adjective Checklist; Revised Behaviour Problems Checklist; Home Situations Questionnaire. *Note*. Outcome data can be collected from children and young people with conduct disorder, their teachers, parents, peers, and their school records.
• *Important, but not critical outcomes*	**Child outcomes:** • self-reported delinquent behaviour • no longer meeting criteria for a conduct disorder • out-of-school placement • social functioning/ quality of life • impulsivity • anxiety, mood • self-harm • pregnancy • self-esteem • harms and side effects (including extrapyramidal side effects, weight gain, sedation/fatigue, sexual dysfunction, diabetes/disturbance of

	glucose homeostasis, increased prolactin, cardiotoxicity, suicide, depression) • outcomes for coexisting conditions. **Parent/carer outcomes:** • parenting skills • social functioning/quality of life • agency contact (for example, residential care, criminal justice system) • outcomes for coexisting conditions • family/parental functioning • self-esteem • drug/alcohol use • domestic violence • harms and side effects.
• *Other outcomes*	• Satisfaction (child/young person and parental). • Acceptability. • Attrition. • Compliance.
• *Study design*	• RCT
• *Include unpublished data?*	Unpublished research may be included, but specific searches for grey literature will not be conducted.
• *Restriction by date?*	No
• *Minimum sample size*	N = 10 per arm. Exclude studies with >50% attrition from either arm of trial (unless adequate statistical methodology has been applied to account for missing data).
• *Study setting*	• Primary, secondary, tertiary, health and social care, children's services and educational settings (including criminal justice and forensic services). • Residential settings, such as those provided by fostering services and those provided to 'looked-after children'. • Others in which NHS or social care services are funded or provided, or NHS or social care professionals are working in multi-agency teams.
• *Potential sub-group analyses*	• The presence of co-existing conditions (such as ADHD, depression, anxiety disorders, attachment insecurity). • Age (<11, 11+ years). • Other demographics (such as particular black and minority ethnic groups, or sex).
Exclusion criteria	• Single case study reports. • Studies evaluating prevention interventions. • Studies evaluating the process of interventions rather than outcomes (for example, uptake of programme).
Search strategy	See Appendix 7
Date searched	Inception to June 2012
Searching other resources	Hand-reference searching of: • Loy JH, Merry SN, Hetrick SE, Stasiak K. Atypical antipsychotics for disruptive behaviour disorders in children and youths. Cochrane Database of Systematic Reviews. 2012;Issue 9:Art. No.: CD008559. DOI: 10.1002/14651858.CD008559.pub2.
The review strategy	• The initial aim is to conduct a meta-analysis evaluating the clinical effectiveness of the interventions. However, in the absence of adequate data, the available evidence will be synthesised using narrative methods. • Consideration will be made to whether any amendments due to common mental health disorders are needed. • Studies of children with subaverage IQ (where mean of sample was

	above 60) will be analysed separately.
Meta-analysis	• Separate analysis for each treatment subcategory (anticonvulsant drugs, antihypertensive drugs, antimanic drugs, antipsychotic drugs, central nervous system stimulant drugs, norepinephrine reuptake inhibitor drugs) versus placebo or another treatment intervention (studies of children with subaverage IQ, where mean of sample was above 60, will be analysed separately): – Sub-group analyses (where sufficient data): o intervention type o age category (<11, 11+, both) o rater (teacher, parent, observer/researcher, self) o time point (post-treatment, longest follow-up) o diagnosis (conduct disorder/oppositional defiant disorder or behavioural problems) o coexisting conditions (such as ADHD, depression, anxiety disorders and attachment problems/issues). – For each trial and outcome rater, outcomes with moderate to large baseline differences will be excluded from the meta-analysis, unless no other outcome data was suitable, in which case the data were included (sensitivity analyses were conducted). – For each trial and outcome rater, outcomes with high attrition (>50%) will be excluded from the meta-analysis.
Review registration	PROSPERO: Reg. No. CRD42011001786

1.5 EXPERIENCE OF CARE

Topic	Experience of care
Review question(s)	For children and young people with conduct disorders, what can be done to improve the experience of the disorder, and the experience of care?* Consider this: What information and day-to-day support do families and carers need: (RQ-F1) • during the initial period of assessment and diagnosis? • when treatment and care is provided (for example, telephone helpline, information packs, advocates or respite care, interpreters and other language instruments)? • if initial treatment fails? • If adequate resources are not available? • during periods of crisis? * The question will be structured using the matrix of service user experience, which includes support for families and carers (see Table 1).
Chapter	Access to services and experience of care
Objectives	• To identify the experiences of having the disorder, access to services and treatment on children and young people. • To identify the experiences of support that parents and carers of children and young people with conduct disorders receive.
Criteria for considering studies for the review	
• *Types of participants*	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. Children and young people identified as being at significant risk of developing conduct disorders. 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 in contact with the criminal justice system.
• *Intervention*	Not applicable
• *Comparison*	Not applicable
• *Critical outcomes*	Not applicable
• *Important, but not critical outcomes*	Not applicable
• *Other outcomes*	Not applicable

• *Study design*	Qualitative research and quantitative (for example, surveys and observational studies).
• *Include unpublished data?*	Yes
• *Restriction by date?*	Not applicable
• *Dosage*	Not applicable
• *Minimum sample size*	Not applicable
• *Study setting*	• Primary, secondary, tertiary, health and social care and children's services and educational settings (including prisons and forensic services). • Other residential settings such as those provided by fostering services and to looked-after children. • Others in which NHS or social care services are funded or provided, or NHS or social care professionals are working in multi-agency teams.
Search strategy	See Appendix 7
The review strategy	The following evidence will be narratively synthesised, extracting themes using a matrix of service user experience (see Table 1 systematic reviews of qualitative research • a qualitative analysis of transcripts of people with or at risk of conduct disorders from resources found online (primarily healthtalkonline and/or youthhealthtalk) • experience surveys.

Table 1: Matrix of service user experience

Dimensions of person-centred care (adapted from Picker Institute Europe[3])		**Key points on the pathway of care**			
		Access	**Assessment**	**Treatment**	**Education**
Experience of the disorder					
The relationship between individual service users and professionals	Involvement in decisions and respect for preferences				
	Clear, comprehensible information and support for self-care				
	Emotional support, empathy and respect				
The way that services and systems work	Fast access to reliable health advice				
	Effective treatment delivered by trusted professionals				
	Attention to physical and environmental needs				
	Involvement of, and support for, family and carers				
	Continuity of care and smooth transitions				
Other themes					

[3] www.pickereurope.org/patientcentred