National Institute for Health and Care Excellence

4-year surveillance (2017) – Antisocial behaviour and conduct disorders in children and young people: recognition and management (2013) NICE guideline CG158

Appendix A: Summary of new evidence from surveillance

General principles of care

158 – 01 What are the essential elements that assist in the transition into adulthood services for young people with conduct disorders?

158 – 02 For children and young people with a conduct disorder, what can be done to improve the experience of the disorder, and the experience of care?

Recommendations derived from these review questions

Working safely and effectively with children and young people

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

1.1.2 Health and social care professionals should ensure that they:

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

1.1.3 Health and social care providers should ensure that children and young people:

- can routinely receive care and treatment from a single team or professional
- are not passed from one team to another unnecessarily
- do not undergo multiple assessments unnecessarily*.

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

1.1.5 Consider children and young people for assessment according to local safeguarding procedures if there are concerns regarding exploitation or self-care, or if they have been in contact with the criminal justice system*.

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

1.1.6 Be aware that many children and young people with a conduct disorder may have had poor or punitive experiences of care and be mistrustful or dismissive of offers of help as a result.

1.1.7 Develop a positive, caring and trusting relationship with the child or young person and their parents or carers to encourage their engagement with services.

1.1.8 Health and social care professionals working with children and young people should be trained and skilled in:

- negotiating and working with parents and carers and

- managing issues relating to information sharing and confidentiality as these apply to children and young people.

1.1.9 If a young person is 'Gillick competent' ask them what information can be shared before discussing their condition with their parents or carers.

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

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

1.1.11 When coordinating care and discussing treatment decisions with children and young people and their parents or carers, ensure that:

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

Working with parents and carers

1.1.12 If parents or carers are involved in the treatment of young people with a conduct disorder, discuss with young people of an appropriate developmental level, emotional maturity and cognitive capacity how they want them to be involved. Such discussions should take place at intervals to take account of any changes in circumstances, including developmental level, and should not happen only once*.

1.1.13 Be aware that parents and carers of children and young people with a conduct disorder might feel blamed for their child's problems or stigmatised by their contact with services. When offering or providing interventions such as parent training programmes, directly address any concerns they have and set out the reasons for and purpose of the intervention.

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

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

Communication and information

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

- take into account the child or young person's developmental level, emotional maturity and cognitive capacity, including any learning disabilities, sight or hearing problems, or delays in language development or social communication difficulties
- use plain language if possible and clearly explain any clinical language; adjust strategies to the person's language ability, for example, breaking up information, checking back, summarising and recapping
- check that the child or young person and their parents or carers understand what is being said
- use communication aids (such as pictures, symbols, large print, braille, different languages or sign language) if needed.

1.1.16 When giving information to children and young people with a conduct disorder and their parents or carers, ensure you are:

- familiar with local and national sources (organisations and websites) of information and/or support for children and young people with a conduct disorder and their parents or carers

- able to discuss and advise how to access these resources
- able to discuss and actively support children and young people and their parents or carers to engage with these resources*.

1.1.17 When communicating with a child or young person use diverse media, including letters, phone calls, emails or text messages, according to their preference*.

Culture, ethnicity and social inclusion

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

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

1.1.19 When working with children and young people and their parents or carers who have difficulties speaking or reading English:

- provide and work proficiently with interpreters if needed
- offer a list of local education providers who can provide English language teaching.

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

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

Staff supervision

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

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

Transfer and discharge

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

- such changes, especially discharge and transfer from CAMHS to adult services, are discussed and planned carefully beforehand with the child or young person and their parents or carers, and are structured and phased

- children and young people and their parents or carers are given comprehensive information about the way adult services work and the nature of any potential interventions provided
- any care plan supports effective collaboration with social care and other care providers during endings and transitions, and includes details of how to access services in times of crisis
- when referring a child or young person for an assessment in other services (including for psychological interventions), they are supported during the referral period and arrangements for support are agreed beforehand with them*.

1.1.23 For young people who continue to exhibit antisocial behaviour or meet criteria for a conduct disorder while in transition to adult services (in particular those who are still vulnerable, such as those who have been looked after or who have limited access to care) refer to Antisocial personality disorder (NICE clinical guideline 77). For those who have other mental health problems refer to other NICE guidance for the specific mental health problem.

* Adapted from Service user experience in adult mental health (NICE clinical guidance 136)

Surveillance decision

These review questions should not be updated.

Experience of disorder and care

2-year surveillance summary

No relevant evidence was identified.

4-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

A committee member highlighted that there is now new legislation in Wales:

- The Social Services and Wellbeing Act came into force from April 2016 and this may impact on how carers are enabled to support service users more effectively.
- The "Together for Children and Young People" Partnership has announced that waiting list targets for CAMHS must be reduced to 48 hours for urgent referrals and 4 weeks for non-urgent referrals.
- Also, the draft "Additional Learning Needs and Education Tribunal (Wales) Bill" may need to be considered.

Impact statement

Feedback from topic experts indicates there is new legislation in Wales regarding the general care of children and young people. However, no studies or legislation specific to a population with conduct disorders was identified. The guideline notes relevant legislation in this area including the Children Act, the Mental Health Act and the Mental Capacity Act and recommends that Health and Social Care professionals should understand how to apply all relevant legislation. As such, no impact on the guideline is anticipated.

New evidence is unlikely to change guideline recommendations.

Selective prevention

158 – 03 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?

158 – 04 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?

Recommendations derived from these review questions

In this guideline selective prevention refers to interventions targeted to individuals or to a subgroup of the population whose risk of developing a conduct disorder is significantly higher than average, as evidenced by individual, family and social risk factors. Individual risk factors include low school achievement and impulsiveness; family risk factors include parental contact with the criminal justice system and child abuse; social risk factors include low family income and little education.

1.2.1 Offer classroom-based emotional learning and problem-solving programmes for children aged typically between 3 and 7 years in schools where classroom populations have a high proportion of children identified to be at risk of developing oppositional defiant disorder or conduct disorder as a result of any of the following factors:

- low socioeconomic status
- low school achievement
- child abuse or parental conflict
- separated or divorced parents
- parental mental health or substance misuse problems
- parental contact with the criminal justice system.

1.2.2 Classroom-based emotional learning and problem-solving programmes should be provided in a positive atmosphere and consist of interventions intended to:

- increase children's awareness of their own and others' emotions
- teach self-control of arousal and behaviour
- promote a positive self-concept and good peer relations
- develop children's problem-solving skills.

Typically the programmes should consist of up to 30 classroom-based sessions over the course of 1 school year.

Surveillance decision

These review questions should not be updated.

Selective prevention interventions

2-year surveillance summary

Equine Facilitated Learning Programme

An RCT[1] was identified which examined the effectiveness of an 11 week equine facilitated learning (EFL) programme on social competence and behaviour. Children (n=131) were recruited through referral by school counsellors and schools. They were randomised to either the 11 week EFL programme or to a wait list control group. The EFL programme consisted of individual and team focused activities. The intervention was found to have a moderate treatment effect on social competence. Furthermore, high levels of

intervention attendance were found to predict children's trajectories of observed positive and negative behaviour over the EFL programme.

Parenting intervention

The effectiveness of a brief parenting intervention (Primary Care Triple P) on emotional and behavioural problems in preterm born or asphyxiated term born pre-schoolers was investigated in an RCT[2]. Children (n=67) were randomised to Primary Care Triple P or to a wait list control. Results showed that the intervention was not effective in reducing emotional and behavioural problems in preterm born or term born children with perinatal asphyxia.

Community Based Intervention

An RCT[3] evaluated a Communities that Care (CTC) prevention system. In this study, 24 small towns in 7 states were randomised to CTC or to the control. Follow-up was after 8 years. At follow-up results showed that students in the intervention group were more likely to abstain from drug use, alcohol use, smoking and delinquent behaviour compared to the control. In addition, students in the intervention group were less likely to ever have committed a violent act. However, using the intervention was not found to reduce current levels of risk or the current prevalence of problem behaviour.

4-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

Clinical feedback suggested that causal factors for conduct disorder, in particular attachment difficulties, are not given sufficient consideration in the guideline. Topic experts suggested this could have implications for the interventions recommended although no specific evidence was provided.

Impact statement

The new evidence on EFL found this intervention to have a moderate effect on social competence. CG158 currently recommends (recommendation 1.2.2) that programmes for selective prevention should consist of interventions which develop problem solving skills, increase awareness of the child's own and others emotions, teach self-control of arousal and behaviour and promote positive self-concept and good peer relations. However, the new evidence is limited since the study did not report antisocial behaviour as an outcome and only a moderate effect was reported for social competence. Further research on EFL is needed in order to confirm or refute the benefits of this intervention.

The new evidence on parenting interventions indicated that the Primary Care Triple P intervention was not beneficial. Parent interventions were considered in the evidence base for selective prevention in CG158 but the evidence was inconclusive. As such, no recommendations on this type of intervention were made. This study may not provide enough conclusive evidence to enable a recommendation to be made.

The new evidence on community based interventions is inconclusive as whilst the intervention was found to be beneficial in reducing delinquent behaviours, smoking, and drug and alcohol abuse, it was not beneficial in reducing current levels of risk or the current prevalence of problem behaviour. Currently, CG158 does not make any recommendations about community based interventions. However, before recommendations can be made, further evidence on the effectiveness and cost of community based interventions is needed.

Clinical feedback indicated that causal factors were not given enough consideration in CG158. In particular, attachment issues. However, no evidence of causal factors was identified during the 2 or 4-year surveillance reviews. Furthermore, NICE has developed a guideline on attachment in children and young people who are adopted from care, in care or at high risk of going into care (NG26) which addresses the issue raised by clinical feedback.

New evidence is unlikely to change guideline recommendations.

Identification and assessment

158 – 05 **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 a possible conduct disorder to consider referral for further assessment?**

158 – 06 **What are the most effective methods/instruments for case identification of conduct disorders in children and young people?**

158 – 07 **In children and young people with a possible conduct disorder, what are the key components of, and the most effective structure for, a diagnostic assessment? 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**

158 – 08 **When making a diagnosis of a conduct disorder 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)?**

158 – 09 **What amendments, if any, need to be made to take into account particular cultural or minority ethnic groups or sex?**

158 – 10 **What amendments, if any, need to be made to the agreed methods for case identification to take into account:**

- **Demographics (for example, particular cultural or minority ethnic groups, or girls)**
- **The environment in which case identification takes place (for example, social care, education)?**

Recommendations derived from these review questions

Initial assessment of children and young people with a possible conduct disorder

1.3.1 Adjust delivery of initial assessment methods to:

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

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

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

1.3.4 For the initial assessment of a child or young person with a suspected conduct disorder, consider using the Strengths and Difficulties Questionnaire (completed by a parent, carer or teacher).

1.3.5 Assess for the presence of the following significant complicating factors:

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

1.3.6 If any significant complicating factors are present refer the child or young person to a specialist CAMHS for a comprehensive assessment.

1.3.7 If no significant complicating factors are present consider direct referral for an intervention.

Comprehensive assessment

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

- offer the child or young person the opportunity to meet the professional on their own
- involve a parent, carer or other third party known to the child or young person who can provide information about current and past behaviour
- if necessary involve more than 1 health or social care professional to ensure a comprehensive assessment is undertaken.

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

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

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

1.3.11 Take into account and address possible coexisting conditions such as:

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

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

- the Child Behavior Checklist for all children and young people
- the Strengths and Difficulties Questionnaire for all children or young people
- the Connors Rating Scales – Revised for a child or young person with suspected ADHD
- a validated measure of autistic behaviour for a child or young person with a suspected autism spectrum disorder (see Autism diagnosis in children and young people [NICE clinical guideline 128])
- a validated measure of cognitive ability for a child or young person with a suspected learning disability
- a validated reading test for a child or young person with a suspected reading difficulty.

1.3.13 Assess the risks faced by the child or young person and if needed develop a risk management plan for self-neglect, exploitation by others, self-harm or harm to others.

1.3.14 Assess for the presence or risk of physical, sexual and emotional abuse in line with local protocols for the assessment and management of these problems.

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

- positive and negative aspects of parenting, in particular any use of coercive discipline
- the parent–child relationship
- positive and negative adult relationships within the child or young person's family, including domestic violence
- parental wellbeing, encompassing mental health, substance misuse (including whether alcohol or drugs were used during pregnancy) and criminal behaviour.

1.3.16 Develop a care plan with the child or young person and their parents or carers that includes a profile of their needs, risks to self or others, and any further assessments that may be needed. This should encompass the development and maintenance of the conduct disorder and any associated behavioural problems, any coexisting mental or physical health problems and speech, language and communication difficulties, in the context of:

- any personal, social, occupational, housing or educational needs
- the needs of parents or carers
- the strengths of the child or young person and their parents or carers.

Surveillance decision

These review questions should not be updated.

Case identification

2-year surveillance summary

No relevant evidence was identified.

4-year surveillance summary

A meta-analysis[4] (n=13 studies) found that youths with conduct problems had significantly reduced grey matter volumes in the left amygdala, right insula, left medial superior frontal gyrus, and left fusiform gyrus compared to typically developing youths.

Topic expert feedback

No relevant evidence was identified.

Impact statement

A meta-analysis found differences in grey matter volumes between youths with and without conduct problems. However, this is preliminary data in an area with little evidence and is currently unlikely to impact on recommendations.

New evidence is unlikely to change guideline recommendations.

Identifying effective treatment and care options

158 – 11 For children and young people with a conduct disorder, 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 cultural or minority ethnic groups, or sex)?

Recommendations derived from this review question

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

- their past and current experience of the disorder
- their experience of, and response to, previous interventions and services
- the nature, severity and duration of the problem(s)
- the impact of the disorder on educational performance
- any chronic physical health problem
- any social or family factors that may have a role in the development or maintenance of the identified problem(s)
- any coexisting conditions**.

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

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

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

** Adapted from Common mental health disorders (NICE clinical guideline 123)

Surveillance decision

No new information was identified at any surveillance review.

This review question should not be updated.

Psychosocial interventions – treatment and indicated prevention

158 – 12 **For children and young people with a conduct disorder, what are the benefits and potential harms associated with individual and group psychosocial interventions?**

158 – 13 **For children and young people with a conduct disorder, what are the benefits and potential harms associated with parenting and family interventions?**

158 – 14 **For children and young people with a conduct disorder, what are the benefits and potential harms associated with multi-modal/ multiple interventions?**

158 – 15 **For children and young people with a conduct disorder, what are the benefits and potential harms associated with school behaviour management?**

Recommendations derived from these review questions

In this guideline indicated prevention refers to interventions targeted to high-risk individuals who are identified as having detectable signs or symptoms that may lead to the development of conduct disorders but who do not meet diagnostic criteria for conduct disorders when offered an intervention.

The interventions in recommendations 1.5.1–1.5.12 are suitable for children and young people who have a diagnosis of oppositional defiant disorder or conduct disorder, are in contact with the criminal justice system for antisocial behaviour, or have been identified as being at high risk of a conduct disorder using established rating scales of antisocial behaviour (for example, the Child Behavior Checklist and the Eyberg Child Behavior Inventory).

Parent training programmes

1.5.1 Offer a group parent training programme to the parents of children and young people aged between 3 and 11 years who:

- have been identified as being at high risk of developing oppositional defiant disorder or conduct disorder or
- have oppositional defiant disorder or conduct disorder or
- are in contact with the criminal justice system because of antisocial behaviour.

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

- typically have between 10 and 12 parents in a group
- be based on a social learning model, using modelling, rehearsal and feedback to improve parenting skills
- typically consist of 10 to 16 meetings of 90 to 120 minutes' duration
- adhere to a developer's manual† and employ all of the necessary materials to ensure consistent implementation of the programme.

1.5.3 Offer an individual parent training programme to the parents of children and young people aged between 3 and 11 years who are not able to participate in a group parent training programme and whose child:

- has been identified as being at high risk of developing oppositional defiant disorder or conduct disorder or
- has oppositional defiant disorder or conduct disorder or
- is in contact with the criminal justice system because of antisocial behaviour.

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

- be based on a social learning model using modelling, rehearsal and feedback to improve parenting skills
- typically consist of 8 to 10 meetings of 60 to 90 minutes' duration
- adhere to a developer's manual† and employ all of the necessary materials to ensure consistent implementation of the programme.

Parent and child training programmes for children with complex needs

1.5.5 Offer individual parent and child training programmes to children and young people aged between 3 and 11 years if their problems are severe and complex and they:

- have been identified as being at high risk of developing oppositional defiant disorder or conduct disorder or
- have oppositional defiant disorder or conduct disorder or
- are in contact with the criminal justice system because of antisocial behaviour.

1.5.6 Individual parent and child training programmes should involve both parents, foster carers or guardians if this is possible and in the best interests of the child or young person, and should:

- be based on a social learning model using modelling, rehearsal and feedback to improve parenting skills
- consist of up to 10 meetings of 60 minutes' duration
- adhere to a developer's manual† and employ all of the necessary materials to ensure consistent implementation of the programme.

Foster carer/guardian training programmes

1.5.7 Offer a group foster carer/guardian training programme to foster carers and guardians of children and young people aged between 3 and 11 years who:

- have been identified as being at high risk of developing oppositional defiant disorder or conduct disorder or
- have oppositional defiant disorder or conduct disorder or
- are in contact with the criminal justice system because of antisocial behaviour.

1.5.8 Group foster carer/guardian training programmes should involve both of the foster carers or guardians if this is possible and in the best interests of the child or young person, and should:

- modify the intervention to take account of the care setting in which the child is living
- typically have between 8 and 12 foster carers or guardians in a group
- be based on a social learning model using modelling, rehearsal and feedback to improve parenting skills
- typically consist of between 12 and 16 meetings of 90 to 120 minutes' duration
- adhere to a developer's manual† and employ all of the necessary materials to ensure consistent implementation of the programme.

1.5.9 Offer an individual foster carer/guardian training programme to the foster carers or guardians of children and young people aged between 3 and 11 years who are not able to participate in a group programme and whose child:

- has been identified as being at high risk of developing oppositional defiant disorder or conduct disorder or
- has oppositional defiant disorder or conduct disorder or
- is in contact with the criminal justice system because of antisocial behaviour.

1.5.10 Individual foster carer/guardian training programmes should involve both of the foster carers if this is possible and in the best interests of the child or young person, and should:

- modify the intervention to take account of the care setting in which the child is living

- be based on a social learning model using modelling, rehearsal and feedback to improve parenting skills
- consist of up to 10 meetings of 60 minutes' duration
- adhere to a developer's manual† and employ all of the necessary materials to ensure consistent implementation of the programme.

Child-focused programmes

1.5.11 Offer group social and cognitive problem-solving programmes to children and young people aged between 9 and 14 years who:

- have been identified as being at high risk of developing oppositional defiant disorder or conduct disorder or
- have oppositional defiant disorder or conduct disorder or
- are in contact with the criminal justice system because of antisocial behaviour.

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

- be based on a cognitive–behavioural problem-solving model
- use modelling, rehearsal and feedback to improve skills
- typically consist of 10 to 18 weekly meetings of 2 hours' duration
- adhere to a developer's manual† and employ all of the necessary materials to ensure consistent implementation of the programme.

Multimodal interventions

1.5.13 Offer multimodal interventions, for example, multisystemic therapy, to children and young people aged between 11 and 17 years for the treatment of conduct disorder.

1.5.14 Multimodal interventions should involve the child or young person and their parents and carers and should:

- have an explicit and supportive family focus
- be based on a social learning model with interventions provided at individual, family, school, criminal justice and community levels
- be provided by specially trained case managers
- typically consist of 3 to 4 meetings per week over a 3- to 5-month period
- adhere to a developer's manual† and employ all of the necessary materials to ensure consistent implementation of the programme.

† The manual should have been positively evaluated in a randomised controlled trial

Surveillance decision

These review questions should not be updated.

Individual and group psychosocial interventions

2-year surveillance summary

Narrative Exposure Therapy

An RCT[5] was identified which randomised 32 males (17 years old) scoring highly in appetitive aggression to either forensic offender rehabilitation narrative exposure therapy (FORNET) or to treatment as usual. At follow-up (4 to 7 months) significantly fewer offences were committed by those in the intervention group.

Psychodynamic Therapy

An RCT[6] randomised 66 adolescents diagnosed with mixed disorders of conduct and emotion to manualised in-patient psychodynamic therapy (PDT) or a waiting list/treatment as usual. Results showed that those in the PDT group had higher rates of

remission and had significantly better outcomes on the Strength and Difficulties questionnaire. Furthermore, PDT was found to further necessary preconditions for long-term stabilisation.

Child-centred Play Therapy

A pilot RCT[7] assessed Child-centred Play Therapy (CCPT) in 54 children with disruptive behaviour. Children were randomised to CCPT or to reading mentoring (RM). Results showed a statistically significant decrease in disruptive behaviour in the CCPT group compared to the control. Furthermore, the CCPT group showed statistically significant decreases in aggression and attention problems.

Williams LifeSkills Training

In an RCT[8] 66 Chinese young male violent offenders were randomised to routine intervention alone or to routine intervention plus Williams LifeSkills Training (WLST). Results showed that WLST may be effective in reducing overt aggression in this population.

Collaborative Care

The efficacy of collaborative care for behaviour problems was investigated in a cluster RCT[9] in which 321 children and their caregivers in paediatric primary care were randomised to Doctor Office Collaborative Care (DOCC) or an enhanced version of usual care. Overall, it was found that DOCC was associated with higher rates of completion, treatment initiation, improvement in behaviour problems, hyperactivity and internalising behaviour, parental stress, remission in behaviour and internalising behaviour, goal improvement, treatment response and consumer satisfaction.

Guided self-change

The effectiveness of a guided self-change intervention in minority adolescents was investigated in an RCT[10]. In this study, 514 high school students reporting substance use and perpetrating aggression were randomised to Guided Self-change (GSC), involving a brief motivational intervention and cognitive behavioural therapy (CBT), or standard care. GSC led to significant reductions in the total number of alcohol use days, drug use days and aggressive behaviour incidents when compared to the control.

4-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

Clinical feedback indicated that trials of Multisystemic therapy (MST) and family focused therapy (FFT) for conduct disorder are currently ongoing.

Impact statement

The evidence on narrative exposure therapy shows this intervention to be beneficial. Currently, CG158 does not provide any recommendations on the use of narrative exposure therapy. However, the evidence identified during this 2 year surveillance review is limited. This is because the study was small and results may not be generalisable to the guideline population since participants were 17 year olds in the criminal justice system. As such, this evidence is unlikely to be sufficient to warrant an update of CG158. Further evidence on the effectiveness of narrative exposure therapy is needed before the potential impact on recommendations can be established.

Limited evidence also found psychodynamic therapy to be beneficial. Currently, CG158 does not provide recommendations on psychodynamic therapy. However, the evidence identified during this 2 year surveillance review is limited to one small study in a mixed disorder population. Further large studies in children and adolescents with antisocial behaviour and conduct disorders are needed before the impact on recommendations can be assessed.

The new evidence concerning child-centred play indicates that this intervention is beneficial in reducing disruptive behaviour, aggression and attention problems. Child focussed interventions are included in this guidance but CG158 does not make specific recommendations on child-centred play. However, the evidence identified during this 2 year surveillance review is limited to a pilot study. As such, more evidence is required on the effectiveness of this intervention before the potential impact on guideline recommendations can be established.

Limited new evidence on WLST shows this intervention to be effective in Chinese young male offenders. At present, CG158 does not make any recommendations on the use of WLST and no studies involving this intervention were included in the development of the original guideline. However, the evidence identified in this 2 year surveillance review is limited to one small study which may be

insufficient to warrant an update at this time. Further RCTs investigating the effectiveness of WLST are needed before consideration for inclusion in CG158.

The evidence on collaborative care indicates that it is beneficial. Currently, CG158 does not make any recommendations about collaborative care in a paediatric primary care population. However, the study identified is unlikely to impact on CG158 since the findings may not be generalisable to a conduct disorder population. This is because the study population included children with behavioural problems, attention-deficit hyperactivity disorder (ADHD) or anxiety. Further evidence investigating collaborative care in children with antisocial behaviour and conduct disorders is required before any potential impact on guideline recommendations can be assessed.

The new evidence on GSC also shows this intervention to be beneficial for minority adolescents. This evidence is consistent with guideline recommendations 1.5.11 and 1.5.12 which recommend group and problem solving programmes based on cognitive –behavioural problem solving models. This is because the GSC programme is based on a cognitive-behavioural model.

Clinical feedback states that trials of Multisystemic therapy and Family Focused therapy are due to report. However, no further details of these studies were provided and no new evidence on these interventions was identified during the surveillance reviews. These areas will be examined further at the next surveillance review of the guideline.

New evidence is unlikely to change guideline recommendations.

Parenting and family interventions

2-year surveillance summary

Parenting Matters

An RCT[11] was identified in which parents (n=178) with concerns about their 2 to 5 year old's discipline problems were randomised to usual care or to the Parenting Matters intervention combined with usual care. The intervention involved a self-help booklet with telephone calls to a coach and follow-up was after 6 months. Behavioural problems were found to decrease significantly more in the intervention group compared to the control. Furthermore, greater improvements were found in psychopathology with the intervention but no differences were found between the two groups in parenting.

Incredible Years programme

The effectiveness of the Incredible Years Programme was investigated in an RCT[12] of 150 parents of toddlers (aged 2 to 4 years) with disruptive behaviours in a paediatric primary care setting. Parents were randomised to the Incredible Years Programme or to a wait list control. The intervention was found to lead to greater improvements in child disruptive behaviours and parenting practices.

Another RCT[13] was identified which randomised 154 families with children with ODD, conduct disorder and/or ADHD to either the BASIC Incredible years parenting intervention or to a waiting list control. The intervention was found to reduce parent reported disruptive child behaviour and teacher reported hyperactive and inattentive child behaviour and increase parent reported use of praise and incentives. However, it was found to have no effect on parent reported hyperactive and inattentive child behaviour, teacher reported child conduct problems and parent reported use of appropriate discipline techniques, clear expectations, parenting stress and physical punishment.

4-year surveillance summary

Child Adult Relationship Enhancement in Primary Care (PriCARE)

An RCT[14] (n=120) found that a 6-session training group for parents of children (aged 2 to 6 years) with behaviour problems significantly reduced problem behaviours in children and improved parents' positive attitudes compared with controls. The outcomes were measured at baseline, 9-week treatment completion and follow-up at 16 weeks.

Strongest Families Smart Website

An RCT[15] (n=464 parents) found that an 11-week internet-assisted parent training programme significantly improved scores on externalising, internalising, aggression, sleep, withdrawal, anxiety, emotional problem, and

callousness in 4-year old children with disruptive behavioural problems. The intervention also significantly improved self-reported parenting skills compared with controls. The outcomes were measured at 12-month follow-up.

Topic expert feedback

An ongoing study is investigating the effect of parenting programmes on child antisocial behaviour and social inequalities.

Impact statement

The new evidence on parenting interventions suggests that they are beneficial in some outcomes. Currently, CG158 recommends parent training interventions (1.5.1 to 1.5.4) but is not specific on which parent training interventions to use. Further evidence is necessary on the effectiveness of parenting interventions, particularly focusing on the components of the intervention and short and medium-term outcomes over at least 18 months to confirm any definite impact on guideline recommendations.

When published, the results of the ongoing study on parenting programmes may provide further data on the populations for whom these programmes are most effective. This study will be considered at the next surveillance review following publication of results.

New evidence is unlikely to change guideline recommendations.

Multi-modal / multiple interventions

2-year surveillance summary

No relevant evidence was identified.

4-year surveillance summary

A systematic review and meta-analysis[16] consisting of 17 RCTs compared 19 psychological treatments for conduct disorders. The analysis found that psychological treatments significantly improved conduct disorder related outcomes as reported by parents, teachers and blinded observers. Self-reported outcomes by children and adolescents were not significantly different. However, the abstract does not note the individual treatments analysed, the comparators within studies or the specific outcomes measured.

An RCT[17] (n=891) investigated the effectiveness of a 10-year intervention to prevent psychopathology, crime and improve wellbeing in children with conduct disorders. The intervention consisted of a combination of social skills training, parent behaviour management training, peer coaching, reading tutorials, and classroom social-emotional curricula. The study found that significantly fewer participants in the intervention group experienced externalising, internalising or substance abuse problems compared with those in the control group.

A meta-analysis[18] (n=28 studies) found that psychosocial treatments which include the child, parent or multiple components improved outcomes in children with disruptive behaviour disorders compared to controls. The largest effects were found for interventions that included at least the parent component in the treatment.

Topic expert feedback

No relevant evidence was identified.

Impact statement

The evidence for the effectiveness of multiple psychological interventions shows improvements in some outcomes relevant to conduct disorders. Currently, CG158 recommends multimodal treatments and only specifies multisystemic therapy as an example. Further evidence which includes specific combinations of interventions is necessary to determine any impact on guideline recommendations.

New evidence is unlikely to change guideline recommendations.

School behaviour management

2-year surveillance summary

Incredible Years Training

A cluster RCT[19] investigated the effectiveness of the Incredible Years Teacher Training intervention in 24 community pre –schools for children with reported conduct problems. Schools were randomised to either the Incredible Years Teacher Training intervention or to a control group. Children in the intervention group were found to show significant reductions in conduct problems and significant decreases in teacher and parent reported behavioural difficulties.

Cognitive Behavioural Therapy

Another RCT[20] investigated a child-focussed CBT programme introduced into schools. In total, 173 children with disruptive behaviour aged 8 to 12 years were randomised to CBT with active teacher support (ATS), CBT plus educational teacher support (ETS) or to a wait-list control. Results showed positive post treatment effects for both CBT groups compared to the control on disruptive behaviour. Whilst no consistent effect of teacher type was found between the two CBT groups at post treatment, at 3 month follow up children in the ETS group had significantly better outcomes.

4-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

No relevant evidence was identified.

Impact statement

The new evidence on classroom based interventions shows these interventions to be beneficial. Currently CG158 does not make any recommendations on classroom-based interventions as the topic experts felt that the evidence did not support a recommendation for interventions given separately to teachers or to classroom-based interventions. This was because the evidence on the effectiveness of these interventions was inconclusive and none of the included studies reported any follow-up data. Whilst the two identified studies identified through surveillance add to the evidence base, more conclusive evidence on the effectiveness and cost effectiveness of both classroom and teacher based interventions is needed before they can be considered for inclusion in the guideline.

New evidence is unlikely to change guideline recommendations.

Pharmacological interventions

158 – 16 For children and young people with a conduct disorder, what are the benefits and potential harms associated with pharmacological interventions?

158 – 17 For children and young people with a conduct disorder, what are the benefits and potential harms associated with physical interventions (for example, diet)?

Recommendations derived from these review questions

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

1.6.2 Offer methylphenidate or atomoxetine, within their licensed indications, for the management of ADHD in children and young people with oppositional defiant disorder or conduct disorder, in line with Attention deficit hyperactivity disorder (NICE clinical guideline 72).

1.6.3 Consider risperidone†† for the short-term management of severely aggressive behaviour in young people with a conduct disorder who have problems with explosive anger and severe emotional dysregulation and who have not responded to psychosocial interventions.

1.6.4 Provide young people and their parents or carers with age-appropriate information and discuss the likely benefits and possible side effects of risperidone†† including:

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

1.6.5 Risperidone†† should be started by an appropriately qualified healthcare professional with expertise in conduct disorders and should be based on a comprehensive assessment and diagnosis. The healthcare professional should undertake and record the following baseline investigations:

- weight and height (both plotted on a growth chart)
- waist and hip measurements
- pulse and blood pressure
- fasting blood glucose, glycosylated haemoglobin (HbA1c), blood lipid and prolactin levels
- assessment of any movement disorders
- assessment of nutritional status, diet and level of physical activity.

1.6.6 Treatment with risperidone‡ should be carefully evaluated, and include the following:

- Record the indications and expected benefits and risks, and the expected time for a change in symptoms and appearance of side effects.
- At the start of treatment give a dose at the lower end of the licensed range and slowly titrate upwards within the dose range given in the British national formulary for children (BNFC) or the summary of product characteristics (SPC).
- Justify and record reasons for dosages above the range given in the BNFC or SPC.
- Monitor and record systematically throughout treatment, but especially during titration:
  - efficacy, including changes in symptoms and behaviour
  - the emergence of movement disorders
  - weight and height (weekly)
  - fasting blood glucose, HbA1c, blood lipid and prolactin levels
  - adherence to medication
  - physical health, including warning parents or carers and the young person about symptoms and signs of neuroleptic malignant syndrome.
- Record the rationale for continuing or stopping treatment and the effects of these decisions††.

1.6.7 Review the effects of risperidone†† after 3–4 weeks and discontinue it if there is no indication of a clinically important response at 6 weeks.

†† At the time of publication (March 2013) some preparations of risperidone did not have a UK marketing authorisation for this indication in young people and no preparations were authorised for use in children aged under 5 years. The prescriber should consult the summary of product characteristics for the individual risperidone and follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Good practice in prescribing and managing medicines and devices for further information.

‡ Adapted from Schizophrenia (NICE clinical guideline 82)

Surveillance decision

These review questions should not be updated.

Pharmacological interventions

2-year surveillance summary

No relevant evidence was identified.

4-year surveillance summary

A secondary analysis[21] of the Treatment of Severe Childhood Aggression (TOSCA) study (n=168) investigated the effect of adding risperidone to stimulant and parent training for children with severe aggression, disruptive behaviour disorder and ADHD. The study found that the child's anxiety, schizophrenia symptoms and global impairment, as rated by their teacher and associated with disruptive behaviour, significantly improved with risperidone compared with placebo. However, there were no significant improvements in depression, manic or autism symptoms as rated by teachers. There were no significant improvements in any of the parent rated outcomes, which in addition to the 6 teacher outcomes also included; separation anxiety, enuresis/encopresis, and eating disorders.

Topic expert feedback

Feedback suggests that guanfacine extended release and Lisdexamfetamine are now approved for ADHD. These medications may have a beneficial effect against oppositional and aggressive or emotional dysregulation symptoms.

Further feedback suggests that aripiprazole for conduct disorders is often used as a preferred option to risperidone because of reduced side effects. However, risperidone has potential as a pharmacological treatment for aggression in conduct disorders.

A NICE evidence summary on clonidine published in 2013. This evidence summary relates to ADHD. However, the summary notes that weak evidence was found which suggests clonidine improves symptoms of conduct disorder.

Impact statement

Evidence from the surveillance review and topic expert feedback suggests that risperidone may reduce aggression in conduct disorders. This is in line with recommendation 1.6.3 in CG158.

Further topic expert feedback suggests that guanfacine extended release, Lisdexamfetamine and aripiprazole may have beneficial effects for conduct disorders. However, there is currently no further evidence on their effectiveness in in children and young people with oppositional defiant disorder or conduct disorder to impact guideline recommendations at this time.

The NICE evidence summary suggests clonidine improves symptoms of conduct disorder. However, as the evidence was derived from 2 small trials with short-term follow-up, further evidence is required to determine the efficacy in children with conduct disorders and is unlikely to impact recommendations in CG158 at this time.

New evidence is unlikely to change guideline recommendations.

Physical interventions

2-year surveillance summary

Omega 3 supplementation

A crossover RCT[22] randomised 21 children with disruptive behaviour disorders and impulsive aggression to either fish oil capsules or placebo. Results showed that fish oil did not improve aggression in this population.

4-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

No relevant evidence was identified.

Impact statement

The new evidence on omega 3 supplementation showed this supplementation to not be beneficial for disruptive behaviour disorders or impulsive aggression. Currently, CG158 does not make any recommendations concerning diet and supplementation. As the study showed no benefit and had a small sample size it is unlikely to be sufficient new evidence to warrant an update of CG158.

New evidence is unlikely to change guideline recommendations.

Organisation and delivery of care

158 – 18 What are the barriers to access that prevent children and young people at risk of or diagnosed with a conduct disorder from accessing services?

158 – 19 Do methods designed to remove barriers to services increase the proportion and diversity of children and young people accessing treatment?

158 – 20 What are the effective models for the delivery of care to children and young people with a conduct disorder including:

- **The structure and design of care pathways (for example, primary care, education, social services, private and voluntary organisations, and the criminal justice system)**
- **Systems for the delivery of care (for example, case management)**
- **Specialist teams?**

158 – 21 What are the effective ways of monitoring progress in conduct disorders?

158 – 22 What components of an intervention, or the way in which it is implemented, and by whom are associated with successful outcomes?

Recommendations derived from these review questions

Improving access to services

1.7.1 Health and social care professionals, managers and commissioners should collaborate with colleagues in educational settings to develop local care pathways that promote access to services for children and young people with a conduct disorder and their parents and carers by:

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

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

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

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

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

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

1.7.5 Health and social care professionals, managers and commissioners should collaborate with colleagues in educational settings to develop local care pathways that promote access for a range of groups at risk of under-utilising services, including:

- girls and young women
- black and minority ethnic groups
- people with a coexisting condition (such as ADHD or autism)**.

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

- ensuring systems are in place to provide for the overall coordination and continuity of care
- designating a professional to oversee the whole period of care (for example, a staff member in a CAMHS or social care setting)**.

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

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

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

- crèche facilities
- assistance with travel
- advocacy services**.

Developing local care pathways

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

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

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

- developing clear policy and protocols for the operation of the pathway
- providing training and support on the operation of the pathway

- auditing and reviewing the performance of the pathway**.

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

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

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

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

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

1.7.14 Health and social care professionals, managers and commissioners should work with colleagues in educational settings to design local care pathways that promote the active engagement of all populations served by the pathway. Pathways should:

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

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

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

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

- minimise the need for transition between different services or providers
- allow services to be built around the pathway and not the pathway around the services
- establish clear links (including access and entry points) to other care pathways (including those for physical healthcare needs)
- have designated staff who are responsible for the coordination of people's engagement with the pathway**.

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

- sharing information with children and young people with a conduct disorder, and their parents and carers, about their care
- sharing and communicating information about the care of children and young people with other professionals (including GPs)

- communicating information between the services provided within the pathway
- communicating information to services outside the pathway**.

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

- individual routine outcome measurement systems
- effective electronic systems for the routine reporting and aggregation of outcome measures
- effective systems for the audit and review of the overall clinical and cost effectiveness of the pathway**.

** Adapted from Common mental health disorders (NICE clinical guideline 123)

⌗⌗ From Common mental health disorders (NICE clinical guideline 123)

Surveillance decision

These review questions should not be updated.

Barriers to access

2-year surveillance summary

No relevant evidence was identified.

4-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

Clinical feedback stated that many children with conduct disorder are excluded from child and adolescent mental health services. As such, there is a large issue about enabling access to this group who are notably disabled in terms of current social functioning and future life prospects.

It was also highlighted that Pupil Premium, Adoption Support Fund and the NICE Children's attachment Guidelines may impact on how mental health services for children and young people are delivered in the future.

Lastly, clinical feedback stated that there are safety concerns regarding referral, treatment time, intervention and practice. It was stated that whilst the guideline sets criteria and time guidance for service users this is not the case in actual practice.

Impact statement

Clinical feedback indicates that some children with conduct disorder are excluded from mental health services and suggests that there is an issue around enabling access to this group. In addition, it is indicated that there are safety concerns surrounding some areas of the guideline and that whilst CG158 sets criteria and time guidance about the recognition and management of conduct disorders for service users these are not used in practice. However, no data about the uptake of the guideline is currently available to highlight the extent of these issues.

Clinical feedback also highlights that certain guidelines may impact on how mental health services for children and young people are delivered in the future. As such, the impact of these in-development guidelines will be evaluated at the next surveillance review of the guideline.

New evidence is unlikely to change guideline recommendations.

Efficacy of methods designed to remove barriers to services

2-year surveillance summary

No relevant evidence was identified.

4-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

Clinical feedback suggested that there is currently a joint NHS England Youth Justice Board initiative to support young people in the secure estate with complex needs/challenging behaviours. “Secure Stairs” provides the framework for a multidisciplinary approach (principally between immediate carers such as prison officers/residential workers, and mental health practitioners) based on psychologically informed care and the use of formulation. The initiative is intended to be rolled out at all sites in the secure estate in England. A formal evaluation of the initiative is being commissioned and data is not yet available.

Impact statement

Topic expert feedback highlighted the Secure Stairs initiative to support young people with complex needs or challenging behaviours in secure settings. As no data is currently available from the evaluation of the initiative, the relevance for a population with conduct disorders is unclear. It is unlikely to impact on the guideline at this time but will be monitored in future surveillance reviews.

New evidence is unlikely to change guideline recommendations.

Models for the delivery of care

2-year surveillance summary

No relevant evidence was identified.

4-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

Clinical feedback suggested that the guideline should have made more explicit reference to pathways and interventions within the youth justice contexts.

It was also suggested that at most 30% of children with conduct disorder receive mental health services. It was stated that adolescent males are least likely to access help and that there may be significant issues related to care pathways which mean that certain ethnic groups are less likely to access support.

Clinical feedback also indicated that Child and Adolescent Mental Health Services (CAMHS) are being transformed in England by NHS England (NHSE). It was suggested that guidance needs to be aligned with integrated services across social care, health and education. Service delivery models were not systematically considered in the guideline.

Impact statement

Clinical feedback indicates that the guideline should make more explicit reference to pathways and interventions in the youth justice contexts. The Guideline Committee ran a focus group with User voice during the development of CG158 to explore the experiences of young people who have a conduct disorder and who have been involved in the youth justice services. The focus group explored access to care, interventions, and delivery and coordination of care. Information gathered from this focus group helped to inform CG158. However, no further evidence was provided and no new evidence in youth justice contexts was identified during the surveillance reviews.

Clinical feedback also indicates that few children with conduct disorder receive mental health services and suggests that certain groups are less likely to access support. However, no further evidence was provided and no new evidence on this issue was identified during the surveillance reviews. Furthermore, no data on the uptake of this guidance is currently available to highlight the extent of this issue.

The feedback from the topic experts indicates that guidance needs to be aligned with integrated services across social care, health and education and further suggests that service delivery models were not systematically considered in the guideline. However, no further details were provided and no new evidence on service delivery models was identified during the surveillance reviews.

New evidence is unlikely to change guideline recommendations.

Editorial and factual corrections

During surveillance of the guideline we identified the following issue with the NICE version of the guideline that should be corrected:

- Footnote number 7 in NICE guideline CG158 contains a link to NICE guideline CG82 schizophrenia. NICE guideline CG82 schizophrenia has been replaced by NICE guideline CG178 psychosis and schizophrenia in adults. The link is to be amended so that it directs to NICE guideline CG178 psychosis and schizophrenia in adults.

Research recommendations

Prioritised research recommendations

At 4-year and 8-year surveillance reviews of guidelines published after 2011, we assess progress made against prioritised research recommendations. We may then propose to remove research recommendations from the NICE version of the guideline and the NICE database for research recommendations. The research recommendations will remain in the full versions of the guideline. See NICE's research recommendations process and methods guide 2015 for more information.

These research recommendations were deemed priority areas for research by the Guideline Committee; therefore, at this 4-year surveillance review time point a decision **will** be taken on whether to retain the research recommendations or stand them down.

We applied the following approach:

- New evidence relevant to the research recommendation was found and an update of the related review question is planned.
  - The research recommendation will be removed from the NICE version of the guideline and the NICE research recommendations database. If needed, a new research recommendation may be made as part of the update process.
- New evidence relevant to the research recommendation was found but an update of the related review question is not planned because the new evidence is insufficient to trigger an update.
  - The research recommendation will be retained because there is evidence of research activity in this area.
- New evidence relevant to the research recommendation was found but an update of the related review question is not planned because evidence supports current recommendations.
  - The research recommendation will be removed from the NICE version of the guideline and the NICE research recommendations database because further research is unlikely to impact on the guideline.
- Ongoing research relevant to the research recommendation was found.
  - The research recommendation will be retained and evidence from the ongoing research will be considered when results are published.
- No new evidence relevant to the research recommendation was found and no ongoing studies were identified.
  - The research recommendation will be removed from the NICE version of guideline and the NICE research recommendations database because there is no evidence of research activity in this area.
- The research recommendation would be answered by a study design that was not included in the search (usually systematic reviews or randomised controlled trials).
  - The research recommendation will be retained in the NICE version of the guideline and the NICE research recommendations database.
- The new research recommendation was made during a recent update of the guideline.
  - The research recommendation will be retained in the NICE version of the guideline and the NICE research recommendations database.

RR – 01 What is the effectiveness of parent training programmes for conduct disorders in children and young people aged 12 years and over?

No new evidence relevant to the research recommendation was found and no ongoing studies were identified. New evidence for parent training programmes was found and included under question 158-13. However, this evidence only included children under the age of 12 and would not be directly relevant to the research recommendation. Comments from stakeholder consultation suggested this research recommendation should be retained.

Surveillance decision

Comments from stakeholder consultation disagreed with the surveillance decision to remove this research recommendation. The amended surveillance decision is that this research recommendation will be considered again at the next surveillance point.

RR – 02 What strategies are effective in improving uptake of and engagement with interventions for conduct disorder?

No new evidence relevant to the research recommendation was found and no ongoing studies were identified. Topic expert feedback regarding the barriers to access treatment is included under questions 158-18 and 158-19. However, these comments do not specifically address the research recommendation which concerns the strategies to improve uptake and engagement.

Surveillance decision

The research recommendation will be removed from the NICE version of guideline and the NICE research recommendations database because there is no evidence of research activity in this area.

RR – 03 What is the effectiveness of interventions to maintain the benefits of treatment and prevent relapse after successful treatment for conduct disorder?

No new evidence relevant to the research recommendation was found and no ongoing studies were identified. New evidence on psychological interventions was found and is included under questions 158-12 to 158-15. However, these studies only include relatively short follow-up periods and do not investigate relapse as an outcome.

Surveillance decision

The research recommendation will be removed from the NICE version of guideline and the NICE research recommendations database because there is no evidence of research activity in this area.

RR – 04 What is the efficacy of combining treatment for mental health problems in parents with treatment for conduct disorders in their children?

No new evidence relevant to the research recommendation was found and no ongoing studies were identified. New evidence on psychological treatments that include a parent component was found and included under question 158-13. However, this evidence does not include treatment of parental mental health as required by the research recommendation.

Surveillance decision

The research recommendation will be removed from the NICE version of guideline and the NICE research recommendations database because there is no evidence of research activity in this area.

RR – 05 What is the efficacy of classroom-based interventions for conduct disorders?

No new evidence relevant to the research recommendation was found and no ongoing studies were identified. New evidence on selective prevention interventions was identified and included under questions 158-03 and 158-04. However, this evidence does not include classroom-based interventions as required by the research recommendation.

Surveillance decision

The research recommendation will be removed from the NICE version of guideline and the NICE research recommendations database because there is no evidence of research activity in this area.

Other research recommendations

The following research recommendation was not deemed as priority areas for research by the guideline committee.

RR – 06 **For children and young people with a conduct disorder and coexisting depression, are selective serotonin reuptake inhibitor antidepressant drugs when used in combination with a psychosocial intervention for conduct disorders effective and cost-effective at reducing antisocial behaviour?**

No new evidence relevant to the research recommendation was found and no ongoing studies were identified. New evidence on the pharmacological treatment of aggression in conduct disorders was found and included under question 158-16. However, this evidence does not include a population with coexisting depression or use of SSRI antidepressants as required by the research recommendation.

Surveillance decision

This research recommendation will be considered again at the next surveillance point.

References

1. Pendry P, Carr AM, Smith AN et al. (2014) Improving adolescent social competence and behavior: a randomized trial of an 11-week equine facilitated learning prevention program. Journal of Primary Prevention 35:281-293.
2. Schappin R, Wijnroks L, Uniken VM et al. (2013) Brief parenting intervention for parents of NICU graduates: a randomized, clinical trial of Primary Care Triple P. BMC Pediatrics 13:69.
3. Hawkins JD, Oesterle S, Brown EC et al. (2014) Youth problem behaviors 8 years after implementing the communities that care prevention system: a community-randomized trial. JAMA Pediatrics 168:122-129.
4. Rogers JC and De Brito SA. (2016) Cortical and Subcortical Gray Matter Volume in Youths With Conduct Problems: A Meta-analysis. JAMA Psychiatry 73:64-72.
5. Crombach A and Elbert T. (2015) Controlling offensive behavior using narrative exposure therapy: A randomized controlled trial of former street children. [References]. Clinical Psychological Science 3:270-282.
6. Salzer S, Cropp C, Jaeger U et al. (2014) Psychodynamic therapy for adolescents suffering from co-morbid disorders of conduct and emotions in an in-patient setting: A randomized controlled trial. [References]. Psychological Medicine 44:2213-2222.
7. Bratton SC, Ceballos PL, Sheely-Moore AI et al. (2013) Head start early mental health intervention: Effects of child-centered play therapy on disruptive behaviors. [References]. International Journal of Play Therapy 22:28-42.
8. Chen C, Li C, Wang H et al. (2014) Cognitive behavioral therapy to reduce overt aggression behavior in Chinese young male violent offenders. Aggressive Behavior 40:329-336.
9. Kolko DJ, Campo J, Kilbourne AM et al. (2014) Collaborative care outcomes for pediatric behavioral health problems: a cluster randomized trial. Pediatrics 133:e981-e992.
10. Wagner EF, Hospital MM, Graziano JN et al. (2014) A randomized controlled trial of guided self-change with minority adolescents. Journal of Consulting & Clinical Psychology 82:1128-1139.
11. Reid GJ, Stewart M, Vingilis E et al. (2013) Randomized trial of distance-based treatment for young children with discipline problems seen in primary health care. Family Practice 30:14-24.
12. Perrin EC, Sheldrick RC, McMenamy JM et al. (2014) Improving parenting skills for families of young children in pediatric settings: a randomized clinical trial. JAMA Pediatrics 168:16-24.
13. Leijten P, Raaijmakers MAJ, and Orobio de Castro B et al. (2015) Effectiveness of the Incredible Years Parenting Program for Families with Socioeconomically Disadvantaged and Ethnic Minority Backgrounds. Journal of Clinical Child & Adolescent Psychology 1-15.
14. Schilling S, French B, Berkowitz SJ et al. (25-6-2016) Child-Adult Relationship Enhancement in Primary Care (PriCARE): A Randomized Trial of a Parent Training for Child Behavior Problems. Acad Pediatr .
15. Sourander A, McGrath PJ, Ristkari T et al. (2016) Internet-Assisted Parent Training Intervention for Disruptive Behavior in 4-Year-Old Children: A Randomized Clinical Trial. JAMA Psychiatry 73:378-387.
16. Bakker MJ, Greven CU, Buitelaar JK et al. (2017) Practitioner Review: Psychological treatments for children and adolescents with conduct disorder problems - a systematic review and meta-analysis. J Child Psychol Psychiatry 58:4-18.
17. Dodge KA, Bierman KL, Coie JD et al. (2015) Impact of early intervention on psychopathology, crime, and well-being at age 25. Am J Psychiatry 172:59-70.
18. Epstein RA, Fonnesbeck C, Potter S et al. (2015) Psychosocial Interventions for Child Disruptive Behaviors: A Meta-analysis. Pediatrics 136:947-960.
19. Baker-Henningham H, Scott S, Jones K et al. (2012) Reducing child conduct problems and promoting social skills in a middle-income country: cluster randomised controlled trial. British Journal of Psychiatry 201:101-108.
20. Liber JM, De Boo GM, Huizenga H et al. (2013) School-based intervention for childhood disruptive behavior in disadvantaged settings: a randomized controlled trial with and without active teacher support. Journal of Consulting & Clinical Psychology 81:975-987.

21. Arnold LE, Gadow KD, Farmer CA et al. (2015) Comorbid anxiety and social avoidance in treatment of severe childhood aggression: response to adding risperidone to stimulant and parent training; mediation of disruptive symptom response. J Child Adolesc. Psychopharmacol. 25:203-212.

22. Dean AJ, Bor W, Adam K et al. (2014) A randomized, controlled, crossover trial of fish oil treatment for impulsive aggression in children and adolescents with disruptive behavior disorders. Journal of Child & Adolescent Psychopharmacology 24:140-148.