NICE Clinical Guideline

Conduct Disorders in children and young people stakeholder consultation workshop

30 November 2010

All groups responded positively to the scope, reporting that they were happy with its general direction. Suggestions for how the scope could be improved were principally focussed on early identification and prevention of conduct disorder, and the coordination of health, social and educational services.

1. The scope covers a wide range of organisations and professions - balancing representation and comprehensiveness will be challenging. Do think the current composition will enable us to achieve that?

Group A

The group noted the importance of a range of service user experience being represented in some form. Suggestions for gaining input were:

- Inviting older adolescents or young adults, with relatively recent personal experience of being a service user
- Young people at different points in the care pathway could be consulted
- Focus groups, for example those that assess services on behalf of NHS trusts or royal colleges, might have some general evidence about the experience of young mental health service users
- It would be useful to consult with young people who have tried multiple treatment options
- The GDG could be flexible with methods so that young people can be involved.

Group B

The group suggested that someone from a specialist educational background should be included in the GDG membership.

Group C

The group suggested the following roles should be included in the GDG constituency:

- Systemic psychotherapist
- Probation/youth offending team member
- Children and Young People psychotherapist
- Speech and language therapist.

The group suggested that service users could be engaged by:

- Holding consultation with SCIE (as the Looked After Children project did)
- Have young people (20-22) on GDG.

The group asserted the importance of engaging with these groups and recognised the challenges in doing so.

Group D

The group did not suggest any changes to the current composition of the GDG group.

2. Scope - Are we on the right track? Have we struck an appropriate balance between the need to keep the scope manageable and covering the most important issues?

Group A
The group though that the scope was appropriate and welcomed the range and depth of it.

Group B
The group were generally happy with the direction and emphasis of the scope, and the discussion was mainly focussed on details.

The group suggested that the title should be changed to "Conduct disorder and *persistent* anti-social behaviour" in order to broaden the population the guideline hopes to reach.

The group also suggested that the guideline should try and capture the difficulties faced during the transition period between childhood and adulthood, in terms of access to services.

The group suggested the following alteration be made to 4.1.1 (a):
"Children and young people with *persistent anti-social behaviour, which may meet the criteria of conduct disorder…*"

The group also suggested that covering individuals who are in contact with the criminal justice system may be too specific. There was discussion about whether to include lower lever agencies, which may be in contact with this group before they reach the criminal justice system.

4.1.2: The group suggested the following alterations be made:
- 4.1.2 (b) "Children and young people with *significant* autism spectrum conditions"
- 4.1.2 (d) "Children and young people with significant learning disabilities (IQ<*60*)"

The group were also concerned about the exclusion of speech and language difficulties and drug and alcohol problems. It was felt that these should be moved to the inclusion group in 4.1.1b.

4.2 (a): "Primary, secondary and tertiary health care, *and children's services* (including the criminal justice system and forensic services), and education settings (*including those who have dropped out of education*)"

4.5: The group queried whether QALYs were a good enough measure of quality of life for this group.

Group C
Comments on 4.1.1

b) The group asserted that there should be a specific focus on girls as they are often not identified, can be at greater risk to themselves, and can often have emerging Borderline Personality Disorder.

Comments on 4.1.2
The group was concerned with the exclusion of primary drug and alcohol problems, children and young people with learning disabilities, and speech and language difficulties. They asserted that these are often hard to separate out in the diagnosis of people with conduct disorders, particularly in the case of drug and alcohol problems. The group felt the comorbidity is so high that all these problems should be looked at in relation to conduct disorders.

Group D
The group were generally happy with the scope, agreeing that was on the right track and that it included the most relevant issues.

3. Do the topics listed in the scope (section 4.3.1) cover the most important areas? Are there any omissions or any topics on the list that should be deleted?

Group A
The group did not think there was anything that should be deleted from the scope.

It was suggested that the scope should include public health and the organisation of services.

Group B
The group suggested the following alterations be made to 4.3.1 (b):
- "the structure of assessment, including naming areas that will be assessed"
- "the diagnostic thresholds taking a tiered/stepped approach"
- "the assessment of risk to others and from others"

4.31 (f): The group felt that some consideration of therapists' skills, including their access to support and training in intervention delivery, should be captured within this bullet point.

Group C
The group agreed that all important areas were covered by 4.3.1.

Group D
The group were generally happy however suggested the following additions/ alterations could be made:
- 4.1.1 b) "Consideration will be given to…children and young people with coexisting conditions (such as ADHD... *and attachment disorders*)"
- 4.3.1 c) iv. "multi-systemic interventions (involving work with peer groups, social care, educational, community, *special educational needs, and vocational settings*)"
- 4.3.1 c) Psychosocial interventions should be ordered according to priority, with an acknowledgement that this is subject to change in individual circumstances, as follows:

"Parenting and family interventions…"
"Multi-systemic interventions…"
"Social care…"
"Individual and group interventions"

- 4.3.1 e) "Physical interventions, such as diet *and exercise*"

4. Suggested key areas – ask the group the following general questions in order to agree/prioritise their selection.

Group A
It can be difficult to assess the efficacy of long-term treatments and there is a lack of evidence for commonly offered treatments, such as counselling, which are often offered as a matter of course. This has the potential to be harmful, as well as wasteful, as young people can feel disincentivised to try new treatments if previous treatments have been unsuccessful. This can also reinforce parents' worries that nothing can be done to change their children's behaviour.

The group thought it would be very useful if the guideline could clarify the evidence for pharmacological treatments for conduct disorder, including the prescription of drugs off-label.

a. Is there sufficient emphasis on recognition and identification in the guideline?

Group A:
The group felt that a lack of assessment and identification, often resulting from health and social care professionals being reluctant to stigmatise children and young people, was a barrier to uptake. It was also noted that diagnosis is vital for service user/carer education and enabling service users/carers to form organisations.

Group B
This was not discussed by the group.

Group C
No further changes were suggested by the group.

Group D
The group discussed the importance of ensuring that those working with children in educational, social care and other settings have the appropriate training and skills to be able to recognise signs and symptoms of conduct disorder.

Additionally the group felt that it was important to take family history into account when making a diagnostic assessment and to make special arrangements for children with parents with learning disabilities and/or drug/alcohol problems.

b. How available/accessible are these services and should we set out appropriate care pathways? How might the care pathway be designed to take in these issues?

Group A

It was noted that it might be difficult for the guideline developers to attempt to fully specify care pathways, beyond general principles, as the entry points to care pathways would vary widely in the case of conduct disorder. The group thought that it might be worth looking at closer links between services and schools.

Group B
This was not discussed by the group.

Group C
This was not discussed by the group.

Group D
It was noted that children are currently assessed separately by multiple agencies and that there was a need for a more comprehensive, multi-agency approach.

The group suggested that existing assessment tools already in use could help encourage multi-agency participation, such as the Common Assessment Framework, the safeguarding triangle and the '2-year review' (Healthy Child Programme).

c. Does the scope capture the appropriate range and nature of social and educational services?

Group A
Poor coordination of health/social/education services, and the differing language used by professional working in those services, are potential barriers to the development of effective care pathways. Information sharing between services is also poor.

The group felt the role of teachers was very important, as they are well-placed to observe behaviour but may not always recognise or report possible cases of conduct disorder. Multi-agency assessments might be a useful, for example by using pre-emptive questionnaires.

Group B
The group felt that "lower level" services which deal with children and young people who display suspected but not diagnosed conduct disorder and/or anti-social behaviour which is not at a criminal level should be included. This would enable the guideline to capture information about preventative interventions.

Group C
No further changes were suggested by the group

Group D
See point ii) for question 2.

d. To what extent should we consider early interventions in health, social care and education services i.e. the evidence on likely pre-conditions and effective interventions at those stages?

Group A

A focus on early intervention was welcomed by the group. One member of the group noted that it might be useful if the guideline looked at both general and specific pre-natal indicators.

Individual tailoring of treatment/education/social engagement is important. It is not always easy to engage young people with traditional therapies such as CBT or psychoanalysis; alternative therapies, such as drama /art therapy, and mentoring schemes can be more successful.

Group B
See previous comment.

Group C
The group asserted that attachment disorders should be covered in the scope as they are often the pre-conditions to conduct disorders.

Group D
The group recognised the need for detection of early warning signs of conduct disorder. It was discussed that as the impact of the child's behaviour on their environment currently drives referral and assessment, the stage at which the child receives 'early intervention' is dependent on social norms, geography and access to services.

e. What are the key outcomes to be considered (see also section 4.4 of the draft scope)?

Group A
Outcomes measures should include:
- Anti-social behaviour, including at home and school
- Attendance at and exclusion from school

Group B
The group suggested the following alterations be made:
- (a) "Improvements in social behaviour (including reduction in *anti-social behaviour*)"
- 4.4 (b) "Improvements in the psychological, education, social and *vocational* functioning…"

Group C
The group suggested the following outcomes:
- Greater social inclusion
- No increase in challenging behaviour
- Proxy indicators

Group D
The group did not discuss any additional key outcomes.

5. Equalities – how do inequalities impact on the provision of care for children and young people with conduct disorders? Should any particular subgroups of the population be considered within the guideline?

Group A

The group advised that looked after children are at risk of not being diagnosed with conduct disorder.

Group B

There was some discussion within the group regarding whether it is stigmatising to isolate BME groups for special consideration. It was felt that if there are particular barriers to access or different treatment recommendations depending on BME group, the separation is appropriate.

There was also some discussion about whether girls should be included as a group for special consideration.

Group C

The group agreed the importance at looking at BME groups and girls.

Group D

The group agreed that BME groups and girls should be given special consideration in the guideline.