NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Conduct disorders in children and young people

Date of Quality Standards Advisory Committee post-consultation meeting:
22 January 2014

2 Introduction

The draft quality standard for Conduct disorders in children and young people was made available on the NICE website for a 4-week public consultation period between 19 November and 17 December 2013. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 12 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the Quality Standards Advisory Committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the Committee as part of the final meeting where the Committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the Committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include overarching outcomes, thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the Committee should read this summary alongside the full set of consultation comments, which are provided in appendices 1 and 2.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

Stakeholders were also invited to respond to the following statement specific questions:

1. For draft quality statement 1: Who would be responsible for identifying classroom populations in need of this intervention?

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- Stakeholders suggested that introductory text on the role of families and carers should be expanded to clarify the importance of the involvement of families and carers in all aspects of care, e.g. participation in group and family programmes, not just in the decision-making process.

- Concerns about representation from the education sector on the advisory committee. Stakeholders suggested that the range of preventative work, support systems and interventions may have not have been addressed due to the composition of the committee.

- Stakeholders recommended the inclusion of a risk and needs focussed approach as part of the statements.

- Stakeholders suggested that it should be made explicit that multiple parents and carers e.g. birth parents and foster parents may be involved in assessments and parenting programmes.

Consultation comments on data collection

- The statements should be measurable.

- In order to determine the denominator for the measures a timeframe would need to be specified.

- Stakeholders suggested that there should be stronger emphasis on effective collaboration between education, health and social care as a significant amount of the data required is already collected but within different systems.

- In order for the measures to be meaningful a definition of high prevalence is required.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

Children aged 3 to 7 years attending school classes that have a high proportion of children identified to be at risk of developing a conduct disorder are offered a classroom-based emotional learning and problem solving programme.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- How would the classroom programmes be implemented i.e. would parents be asked for consent for their child to take part or would the school just build it into the curriculum.
- Some concerns were raised that broad-based school interventions don't effectively reach this group emotionally or socially and that more specialist assessment and interventions are required.
- Concerns that the phrase 'up to 30 sessions' in the definition of the programmes lacks clarity, is too broad and needs to be more specific in order to offer guidance.
- Stakeholders suggested that the person responsible for delivering the programmes should be specified.

Consultation question 3

Stakeholders made the following comments in relation to consultation question 3: Who would be responsible for identifying classroom populations in need of this intervention?

- CAMHS/Community paediatric departments.
- Proxy risk factors such as levels of deprivation could be used.
- Special Educational Needs Co-ordinators (SENCO) employed by schools.
- Teachers.
- Educational psychologists.

- Local authority education departments.
- This could be part of the work of panels implementing single plans, who would be able to monitor the number of children and young people with conduct disorders.

5.2 Draft statement 2

Children and young people with a suspected conduct disorder and their parents or carers have a comprehensive assessment.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- Stakeholders questioned how children and young people should be identified as having a suspected conduct disorder.
- Stakeholders suggested that it would be helpful to acknowledge that it may be difficult to obtain a clear diagnosis of a conduct disorder for certain groups.
- Concerns were raised that the term ‘parenting quality’ is unhelpful and should be replaced with ‘parenting style’.
- Stakeholders suggested that the following outcomes from quality statement 3 can be applied to statement 2: treatment uptake rates; treatment completion rates; did not attend rates.

5.3 Draft statement 3

Children and young people with a conduct disorder who have been referred for treatment and support have a designated professional to oversee their care and facilitate engagement with services.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- Concerns were raised that using the term ‘did not attend’ is not suitable for children and young people and that ‘was not brought’ should be used instead.

- Concerns were raised that the definition of a ‘designated professional’ does not include healthcare staff.

- Stakeholders suggested that the definition of *Oversee care and facilitate engagement* should be amended to refer to people ‘and/or agencies’ as the groups that the designated professional follows up with if initial appointments are not attended.

5.4 Draft statement 4

Parents or carers of children with a conduct disorder aged 3 to 11 years are offered a referral for group or individual parent training programmes.

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- Stakeholders suggested that greater emphasis should be placed on the need for parent training programmes to be evidence-based.

5.5 Draft statement 5

Children and young people with a conduct disorder aged 11 to 17 years, and their parents or carers, are offered a referral for multimodal interventions.

Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

- Stakeholders suggested that greater emphasis should be placed on the need for multi-modal interventions to be evidence-based.

- Stakeholders highlighted that consideration should be given to the subgroup of children and young people who will not respond to multimodal interventions e.g. children and young people who display callous-unemotional traits.

- Stakeholders suggested that under the definition of *Multimodal interventions* it should state that they should be provided by specially trained case managers or health and social care professionals.

5.6 Draft statement 6

Children and young people with a conduct disorder and severely aggressive behaviour who have been prescribed risperidone have a baseline physical and metabolic investigation before starting treatment and the investigation is repeated at regular intervals.

Consultation comments

Stakeholders made the following comments in relation to draft statement 6:

- Concerns were raised about the definition of *Baseline physical and metabolic investigations.* It was suggested that it is not sufficient for the person undertaking the baseline investigations to have expertise in conduct disorder and that it should be a person with expertise in prescribing antipsychotics in children and adolescents for a range of conditions including conduct disorders.

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Increased awareness and more effective and timely action to diagnose differential diagnosis / co-existing conditions.

Appendix 1: Quality standard consultation comments table

Comment ID	Stakeholder	Statement no.	Comment
1	Association of School and College Leaders	General	ASCL welcomes the proposed new quality standard. This may help a condition to be addressed that has often been masked by other conditions, or elided with more general behavioural issues.
2	Royal College of Paediatrics and Child Health	General	These standards seem appropriate and should be measurable.
3	AFT, the Association for Family Therapy and Systemic Practice	General	This response is submitted by AFT, the Association for Family Therapy and Systemic Practice (www.aft.org.uk). AFT is committed to supporting developments in practice, research, training and delivery of high quality therapeutic services for families and other caring groups, and is the UK's leading organisation for professionals working systemically with individuals, couples, families and other networks of care across the lifespan. AFT's membership is multi-disciplinary and includes Family and Systemic Psychotherapists (aka family therapists), clinical psychologists, psychiatrists, GPs, nurses, social workers, teachers, occupational therapists, health visitors, PMHWs, CPNs and others committed to developing their systemic practice skills and understandings.
4	AFT, the Association for Family Therapy and Systemic Practice	General	Adjusting language to reduce stigma and invite engagement. AFT notes the quality standards are currently framed in terms of children 'having a conduct disorder' or being at risk of developing a conduct disorder. It can be unhelpful to identify children in these terms, which many families experience as stigmatising. Instead, the statements could be framed in a way which leaves the question of diagnosis open (as in the NICE guidelines) – something like 'children and young people with conduct difficulties of a severity which is likely to limit their progress and life opportunities'. This language would be more inclusive and more likely to be embraced by families and professionals working in the field.

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5	AFT, the Association for Family Therapy and Systemic Practice	General	Training: Don't we need to start with a quality statement about the delivery of training in early recognition and interventions for conduct problems in primary schools? Then we could have some degree of optimism that children experiencing conduct problems would be identified and referred to agencies delivering comprehensive assessments.
6	Royal Pharmaceutical Society	General	The Royal Pharmaceutical Society welcomes the quality standard for conduct disorders in children and young people and agrees with the draft quality statements.
7	British Association for Adoption and Fostering	General	This response is being submitted on behalf of the BAAF Health Group, which is also a special interest group of the Royal College of Paediatrics and Child Health (RCPCH). The Health Group was formed to support health professionals working with children in the care system, through training, the provision of practice guidance and lobbying to promote the health of these children. With over 500 members UK-wide, an elected Health Group Advisory Committee with representation from community paediatricians working as medical advisers for looked after children and adoption panels, specialist nurses for looked after children, psychologists and psychiatrists, the Health Group has considerable expertise and a wide sphere of influence. Our area of concern is the particularly vulnerable group comprised of looked after and adopted children and young people.

Comment ID	Stakeholder	Statement no.	Comment
8	Faculty of Forensic and Legal Medicine	General	The FFLM welcomes this standard, especially early intervention and a multidisciplinary approach. It also welcomes the call for appropriate training for all healthcare professionals involved in seeing this group of children and young people with complex needs. These cases will often first present to services in police custody and it is important that all children and young people in police custody receive a detailed health and psychosocial assessment by appropriately skilled healthcare staff. This does not currently happen nationally. This allows early identification of cases of possible conduct disorder and referral onwards in the hope that early intervention can prevent further offending behaviour. The FFLM's members will be involved in assessing these cases in police custody and it is important that rapid access to appropriate health services can be secured for this group if they are not already receiving interventions. The FFLM is aware that health services in Youth Offending Teams (YOT) often vary in availability and also that an opportunity for intervention for some of these cases will be missed if they are not referred to the YOTs.
9	British Association for Adoption and Fostering	General	In order to determine the denominator, a time frame would need to be specified.
10	College of Occupational Therapists	Introduction	Include references for statements 'the prevalence of conduct disorders increases throughout childhood and they are more common in boys than girls' 'Almost 40% of looked after children, those who have been abused and those on child protections and safeguarding registers have been identified as having a conduct disorder'
11	AFT, the Association for Family Therapy and Systemic Practice	Introduction	Role of families and carers. The phrasing of this important section could be revised for clarity. At present, some have read the statement 'that family members and carers are involved in the decision-making process about assessments and any treatment or support options' as meaning they are involved in decision making only. As is made clear in other parts of this draft QS, working with parents and carers is one of the most effective interventions, and the evidence is strong for the

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			inclusion and active participation of parents and carers in group and individual family programmes (such as Incredible Years) for treatment and selective prevention. This needs to be made crystal clear in this introductory section.
12	British Association for Adoption and Fostering	Introduction	We welcome the acknowledgement that services should be delivered by professionals with sufficient and appropriate training and competencies. Our members constantly tell us that psychiatrists and other CAMHS professionals do not understand the complex needs of looked after and adopted children and their carers, so much workforce training and development are needed to address this. CAMHS professionals need specialist training encompassing conduct disorders, autism, ADHD, attachment difficulties, FASD, etc, so that they can unpick complex behaviours in assessing individual children and determining appropriate interventions. The specialised needs of this population should also be addressed in this section.
13	British Association for Adoption and Fostering	Introduction	We fully support this statement. It would strengthen the quality standard if it was made explicit that the local authority, health services and CAMHS shared responsibility for recognition, assessment, management and interventions for children with conduct disorders.
14	Association of School and College Leaders	Briefing paper	The Department for Education (DfE) seems to be removing 'behaviour' from its definition of special educational need. This would make it harder for schools and colleges to play a full part in addressing conduct disorders. It might be worthwhile for NICE to address this question directly with the DfE,
15	Association of School and College Leaders	Briefing paper	ASCL is always in favour or partnerships and in particular of multi-agency working.
16	Association of School and College Leaders	Briefing paper	The inclusion of the idea of an agreed programme of support for young people with conduct disorder is welcome, but would make the point that educational budgets do not, in practice, allow for such support, which may be still more difficult under the new SEN code proposed by the DfE.
17	Association of School and College Leaders	Briefing paper	ASCL supports the idea of a single professional but would stress that steps need to be taken to ensure that there is stability in personnel so that a child is not shifted from social worker to social worker, destroying confidence in the interventions being attempted.
18	Association of School and College Leaders	Briefing paper	It would be helpful for there to be more research into the effectiveness of different kinds of classroom interventions and management.
19	Association of School and College Leaders	Briefing paper	ASCL welcomes the proposed protocols and checks on the use of risperidone. We would also welcome some indication that if prescribed, if possible, it should be possible to avoid administration, in particular self-administration, in school, to avoid difficulties with sharing substances, overdosing

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			or theft.
20	British Psychological Society	Questions about the quality standard. Question 1	Does the draft QS accurately reflect the key areas for quality improvement? The Society has concerns regarding the lack of education representation in the advisory committee may have led to the range of preventative work, support systems or interventions for children at risk of either developing challenging behaviour or who have already been identified with challenging behaviour that is in place within schools, being overlooked. As has already been noted to be effective in meeting the needs of young people at risk of developing conduct disorder and those causing more significant concern; the knowledge and skills, across sectors and 'tiers' should be brought together. The Society also believes that the current Children and Young People's Improving Access to Psychological Therapies (IAPT) initiative, which includes evidence-based parent training, should be referenced within the standard. It is frequently the case that children, young people and families needing more intensive or longer-term support struggle to access the right level of provision. There is no clear statement about how availability of provision or low levels of capacity for provision will be captured within the standard.
21	Royal College of Psychiatrists	Questions about the quality standard. Question 1	In our opinion this quality standard accurately reflects the key areas for quality improvement.

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22	College of Occupational Therapists	Questions about the Quality Standard. Question 1	Key areas of quality improvement should include increased awareness and more effective and timely action to diagnose differential diagnosis / co-existing conditions. CAMHs teams are less likely to have expertise of conditions such as DCD and other motor/ sensory/ coordination disorders which can have severe and detrimental effects on behaviour and requires specific intervention, differing from that detailed here. Children with these conditions are more often referred to Child Development Teams and not to CAMHs, where occupational therapists have a central role in their assessment and diagnosis. Occupational Therapists are the AHP profession most likely to be involved in the assessment and diagnosis of Developmental Coordination Disorder and have a core role in offering expert advice to schools and parents. It is important that all differential diagnoses are routinely considered and the multi disciplinary team is in place to deliver the necessary range of assessments and subsequent interventions. Commissioners have a role to play in ensuring that multi disciplinary teams are in place within CAMHS both to address the additional diagnoses as stated above and to address the intervention needs of those with conduct disorder. Occupational therapists asses the child in the context in which they live and learn and assess the barriers to participation and every day activity. Given the emphasis within the quality standard on context based assessment and on every day activity occupational therapists should be a key part of the multi disciplinary team and commissioners should ensure they are in place within CAMHS teams.
23	Rotherham Doncaster and South Humber NHS Foundation Trust	Questions about the Quality Standard. Question 1	We agreed this does accurately reflect the key areas.
24	Rotherham Doncaster and South Humber NHS Foundation Trust	Questions about the Quality Standard. Question 2	Yes - with full commitment from all agencies

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25	British Psychological Society	Questions about the quality standard. Question 2	If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures? We believe that there is a need for a stronger emphasis on effective collaboration between education, health and social care. Much of the data is already collected but within different systems. For example, within education departments the SEN database should prove helpful. It would be crucial to ensure an evidence base for the proposed work and therefore building in the processes for collecting the proposed data should be implicit in the planning of service delivery. One of the key problems identified by prominent authors in the area such as Alan Kazdin (2000) and Richard Tremblay (2003) is that the diagnostic threshold for conduct disorder is both over and under-inclusive. This means that there are young people who need support who do not meet the diagnostic criteria, and young people within the diagnostic criteria who do not require significant support and for whom behavioural difficulties may be resolved through time without intervention. A diagnostic categorisation of an individual with conduct disorder can cause problems in that it can stigmatise an individual without any benefit, and does not accurately direct intervention to the needs of the individual. Evidence based practise would favour focussing on a risk and needs assessment models where individual risk factors can be highlighted and addressed to reduce behavioural dysfunction. This can focus on the appearance of risk factors in different domains of an individual's life, education, home and community. So poor school attainment can be addressed through educational support, gang based offending can be addressed through structured leisure activities etc. This method of assessment and intervention is broadly favoured over diagnostic categorisation as a means to assess and gauge difficulties (Borum and Verhagen, 2006, Farrington and Welsh, 2007). Effective risk and needs assessment should involve practitioner psychologists, not to complete all assessments, but to ensure systems are functioning effectively in directing intervention and evaluating change in young people who meet diagnostic criteria for conduct disorder. The Society would recommend the inclusion of a risk and needs focussed approach as part of the recommendations. The majority of treatments with demonstrated efficacy in treating those with conduct disorder are psychological (e.g. social skills training, functional family therapy and mindfulness). The Society

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			would support the guidance in focussing on structured interventions and the descriptions of interventions used, as this is consistent with the key principles of effective intervention (Lipsey, M. W. (1995), Hollin, C. R. (2001). However, in addition we would recommend that although these treatments do not need to be completed by a psychologist, a psychologist should be involved in oversight of psychologically based treatment regimes. A consistent finding of effective intervention is that it is monitored and evaluated, indeed there is evidence to suggest that treatments that allow drift in treatment integrity and move to non-evidence based approaches increase risk and cause harm (Lilienfeld 2007). As such it would be advised that oversight by a practitioner psychologist of psychological treatment is advised within treatment and assessment regimes. References: Borum, R, and Verhagen, D. (2006) Assessing and managing violence risk in juveniles. New York. NY: Guildford Press Farrington, D. P. and Welsh, B. C. (2007) Saving children from a life of crime: Early risk factors and effective interventions. Oxford: Oxford University Press Hollin, C. R. (2001) The role of the consultant in developing effective correctional programmes In G. A Bernfeld, D. P. Farringto and A W Leschied Offender Rehabilitation in Practice: Implementing and Evaluating Effective Programs. Wiley 269-283 Kazdin, A. E. (2000) – Psychotherapy for Children and Adolescents: Directions for Research and Practice. New York: Oxford University Press Lipsey, M. W. (1995). What do we learn from 400 research studies on the effectiveness of treatment with juvenile delinquents. In J. McGuire (ed.). What Works: Reducing reoffending. Chichester: John Wiley and Sons Lilienfeld, S. O. (2007). Psychological treatments that cause harm. Perspectives on psychological

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			science, 2, 1, 53-69 Tremblay, R. E. (2003) Why Socialization Fails: The Case of Chronic Physical Aggression In B. B. Lahey, T. E. Moffitt & A. Caspi (eds.). Causes of conduct disorder and juvenile delinquency, 182-224. London: The Guildford Press).
26	Royal College of Psychiatrists	Questions About The Quality Standard. Question 2	It should be possible to collect data of the proposed quality measures provided systems and structures were in place
27	Royal College of Paediatrics and Child Health	Quality statement 1	Question1: Whilst we feel most key areas are covered, having discussed the standards with psychologists, we believe that that those localities with a high proportion of children with CD should also be top priority to be targeted with a relationship based antenatal course (not just parentcraft) and a relationship based evidence based parenting course and access to evidence based online parenting courses arranged for the partners of parents (often Dads) who can't attend a face to face to group and for those who won't attend a face to group. Access in such areas before the child is 3 would be ideal. Question 2: If the quality measures are to be taken seriously, a definition of high prevalence is needed- otherwise no real way of holding to account Question 3: identifying high prevalence areas could be part of the work of panels implementing single plans, who would be able to monitor the number of CYP with conduct disorder. Alternatively CAMHS / Community paeds departments, this would represent a new exercise for them but would be achievable. Easiest in coterminous au authorities of course! Otherwise proxy risk factors such as levels of deprivation, which are already collected, could be used.
28	British Association for Adoption and Fostering	Quality statement 1	Following on from our last comment, often broad-based school interventions don't effectively reach this group emotionally/socially, and they may need more specialist assessment and interventions designed to meet their complex needs.

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29	Royal College of Psychiatrists	Quality Statement 1	See comment above; in this regard the role of the SENCO in schools should be strengthened.
30	British Psychological Society	Quality statement 1	In order to achieve the goal of identifying children at risk of developing conduct disorder, a key source of information will be information from parents/carers about behavioural difficulties as they may or may not be apparent within education. A second key area of evidence will be the number of children needing additional services because of their behaviour problems within school as opposed to in the home. The Society believes that the phrase "Up to 30 sessions" on page 8- is too broad and requires more specific guidance. It is unclear whether the quality standard would therefore be met by one such session being delivered. It is also unclear how this delivery will be evidenced and quality assured. It isn't clear how schools will know about the guidance. One of the key programmes in the area is Aggression Replacement Training (Glick and Gibbs 2011: Research Press: Champaign. IL.) This does run for thirty sessions, but it would be rare for a programme to be completed without assessment, cancellations, or missed meetings. It should be recognised within the standard that historically there have been several initiatives delivered within education which have included work intervening with children at risk of demonstrating challenging behaviour within school, e.g. Social and Emotional Aspects of Learning (SEAL) and Targeted Adolescent Mental Health (TAMHs). It is crucial as we progress towards the EHC Plans that there is stronger collaboration between Education, Health and Social Care. There is a risk of duplication of interventions in schools, where such needs are identified, unless healthy working collaborations exist. Also there is the converse risk of schools assuming that an existing intervention addresses this standard. There may be opportunities to extend or augment interventions, including cross agency collaborations. There is a need for integrated training opportunities and more collaborative working between professionals in education, health and social care and better systems for sharing data in order to map local needs accurately. It is of critical importance to understand the systems and provision already in place within schools

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			and communities to ensure that any additional input is culturally appropriate. Additional input should offer something both distinct and sympathetic to the policies and practices of the education based professionals already working within schools, but also are willing to challenge them collaboratively to improve outcomes for children and share skills. It will be important therefore, that the proposed classroom based emotional learning and problem solving programmes are clearly described within the standards.
31	Association of School and College Leaders	Quality statement 1	Who would be responsible for identifying classroom populations in need of this intervention is a key question. It is doubtful that education staff could develop the expertise to do so, beyond referring likely cases to other agencies, notably educational psychologists. If this was part of a comprehensive CAMHS commissioned by Health, it would be of real benefit to these young people. We would not want to see this as a further charge upon educational budgets, nor that additional burdens be placed on schools and colleges in relation to data collection.
32	Royal College of Paediatrics and Child Health	Quality statement 1	Response to question 3 that relates to standard 1 (who should be responsible for identifying which classroom populations with a high proportion of children at risk of developing conduct disorders and therefore in need of a classroom-based emotional learning and problem solving programme?): Rather than assign this responsibility to an individual or individuals in each school or locality, this intervention programme should be offered in all the early year classes of those schools that have catchment areas showing the highest rates of socio-economic hardship (one measure of which could be the prevalence of entitlement to free school meals although there are various other indicators including the local 'deprivation index').
33	AFT, the Association for Family Therapy and Systemic Practice	Quality statement 1	AFT agrees with the 'question for consultation' - that clarity is needed as to who would be responsible for identifying classroom populations in need of this intervention. Who is to say when a class has a high proportion of pupils at risk of developing conduct problems, and how is this to be estimated? What counts as a high proportion? Wouldn't it be simpler to say that young people between these ages identified as at risk of developing conduct problems get this support? To be maintained over time, these emotional learning and problem-solving skills will need to be supported by other teachers as the children progress through school. These teachers will need relevant training.

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34	College of Occupational Therapists	Quality statement 1	Special Educational Needs Co-ordinators employed by schools would be best placed to be responsible for identifying classroom populations in need of this intervention.
35	Rotherham Doncaster and South Humber NHS Foundation Trust	Quality statement 1	Teachers/SENCO and educational psychologists.
36	British Psychological Society	Quality statement 1	Who would be responsible for identifying classroom populations in need of this intervention? The starting point here is clearly schools. Educational Psychologists can play a key role in assisting schools to identifying populations at 'risk of developing a conduct disorder'. Although local arrangements differ as to how this input is accessed, the current position is that there is an Educational Psychologist attached to every maintained school, both special and mainstream. School management teams can choose to access such psychological expertise to aid identification and understanding within education, through regular consultation. It will be important that all partner agencies collaborate with a school to inform an understanding of the risk factors within the community to help to identify the classes and groups of pupils at highest risk, some of this knowledge will already be held within education, some through professionals working in health or social care or in the voluntary sector. In particular information from professionals working in the community, regardless of sector, will be vital to inform this need assessment.
37	British Association for Adoption and Fostering	Quality statement 1	The QS should also specify who is responsible for delivering, monitoring and evaluating classroom interventions
38	Royal College of Psychiatrists	Quality Statement 1	In relation to identifying classroom populations in need of intervention schools should be given a key role. The special educational needs coordinator (SENCO), for example, could easily identify the population at risk. In our experience these children are usually on the radar for learning and/or behavioural problems, some already receiving intervention via school action plus measures, some will have free school meals etc. The SENCO should be assigned a key role.

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39	Paediatric Mental Health Association (previously BPMHG)	Quality statement 1	The question of what level of risk is 'high' is not addressed, therefore giving commissioners a good excuse to ignore this standard. Joint commissioning should make this standard easier to acheive, but since NICE have no justidiction over schools, widespread adoption is unlikely. Identification would most likely be at the level of suitable schools, on the basis of catchment demographic. This is best done by Local authority Education departments.
40	College of Occupational Therapists	Quality statement 1	Change wording to 'The classroom based sessions should be delivered by an occupational therapist or other qualified health care professional trained to deliver these programmes with the teacher's involvement.'
41	AFT, the Association for Family Therapy and Systemic Practice	Quality statement 2	This begs the questions as to how young people should be identified as having a suspected conduct problem (see our 'General' point on training, above), what constitutes a comprehensive assessment and who should be delivering these. What will support early identification of children with conduct difficulties NOT in those areas identified as having a high proportion of children at risk of developing conduct problems? Staff training for comprehensive assessment needs to include high level skills in engaging and talking with parents and carers in ways that open up conversations about difficult issues effectively and safely. Consideration of conduct problems needs to be included in assessments for commonly co-morbid conditions (such as emotional problems inc depression, PTSD; ADHD; other neurodevelopmental problems eg autism; learning disabilities; substance misuse), just as consideration of co-morbid conditions needs to be included in assessments for conduct problems.
42	Paediatric Mental Health Association (previously BPMHG)	Quality statement 2	From the guidance, it appears that any child with persistent anti-social behaviour will need this assessment, which is very onerous, and given the resource implications, unlikely to be commissioned. In the guidance it is implied that specialist CAMHS would not be taking on this work unless significant complicating factors exist - so who will? Paediatricians often do, but have little access to assistance and intervention.

Comment ID	Stakeholder	Statement no.	Comment
43	British Psychological Society	Quality statement 2	The standard notes highlights the need to look at a range factors which impact on parenting capacity 'wellbeing' which the Society welcomes (encompassing mental health, substance misuse and criminal behaviour) - on the basis that we suggest that parental learning disability should also be included. However, it will be important that such an assessment does not make assumptions about the links between parental mental health difficulties and conduct disorder that perpetuate stigma. It may be helpful within the statement to reinforce the breadth of what is meant by parental mental health to avoid this. The Society believes that the term 'Parenting quality' is unhelpful. We believe that 'parenting style' is more appropriate and it would be helpful to be clear that certain style of parenting associated with Conduct Disorder (e.g. papers below) rather than poor parenting per se. The guidelines make reference to "coercive parenting" later in the document. Morrell, J. and Murray, L. (2003), Parenting and the development of conduct disorder and hyperactive symptoms in childhood: a prospective longitudinal study from 2 months to 8 years. Journal of Child Psychology and Psychiatry, 44, 489–508. Aunola, K. and Nurmi, J.-E. (2005), The Role of Parenting Styles in Children's Problem Behavior. Child Development, 76, 1144–1159. It is the experience of practitioner psychologists working with such families that parents are often hard to engage and frequently DNA appointments. Consideration needs to be given to this in terms of this standard as parents merely 'being offered' an appropriate parenting intervention is unlikely to be an adequate outcome. A greater emphasis at this stage needs to be made on demonstrating active engagement with parents to encourage and assist them to access such interventions. It is hoped that the provision of a designated professional as noted in qs 3 would assist in this. Given the research literature noting the significance of complex developmental trauma, the Society recommends that specific mention of this should be included as part of a comprehensive assessment. e.g. Ford, D., et al (1999)

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			Developmental trauma also has links to attachment and the Society would like to recommend that a comprehensive assessment should include an understanding of a young person's attachment. This significantly adds to a clinician's understanding. Many of the parenting characteristics associated with aggressive and violent behaviour are also linked with insecure attachment in young children and adolescents e.g. Doyle, A. B., & Markiewicz, D. (2005). In line with the literature, the Society would strongly support that that risk and needs assessment should be a guiding principle e.g. Lipsey, M. W. (1995), Tremblay, R. E. (2003). The Society believes that it would be helpful to have a description of what is meant by 'coercive discipline' within the standard. The standard could consider reviewing the inclusion of "parental mental health" as a criterion. Although it would be recognised that parental functioning is a factor in the development of conduct disorder there would be concern about the stigmatising all parents with mental health difficulties. We believe that the following outcomes within QS3 could be applied to QS2 outcomes a) Treatment uptake rates. b) Treatment completion rates. c) 'Did not attend' rates for children and young people with conduct disorders and their families. References: Doyle, A. B., & Markiewicz, D. (2005). Parenting, marital conflict and adjustment from early- to mid-adolescence: mediated by adolescent attachment style? Journal of Youth and Adolescence, 34(2), 97–110. Ford, D., Racusin, R, Daviss, B., Ellis, G., Thomas, Rogers., Reiser, , Schiffman, ., Sengupta (1999) Trauma exposure among children with oppositional defiant disorder and attention deficit–hyperactivity disorder. Journal of Consulting and Clinical Psychology, 67(5), 786-789.

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			Lipsey, M. W. (1995). What do we learn from 400 research studies on the effectiveness of treatment with juvenile delinquents. In J. McGuire (ed.). What Works: Reducing reoffending. Chichester: John Wiley and Sons. Tremblay, R. E. (2003) Why Socialization Fails: The Case of Chronic Physical Aggression In B. B. Lahey, T. E. Moffitt & A. Caspi (eds.). Causes of conduct disorder and juvenile delinquency, 182-224. London: The Guildford Press
44	British Association for Adoption and Fostering	Quality statement 2	We fully support this statement however, following on from our previous comment, we are concerned that it may be difficult to obtain a clear diagnosis, and it would be helpful to acknowledge this. We are concerned about at risk, looked after and adopted children's behaviours being simply classified as 'conduct disorder' as a 'catch all' diagnosis, when we know that their methods of relating can be part of far more complex attachment strategies and/or related to developmental trauma, and these should be explored using a systems approach. Developmental trauma and attachment difficulties should be included under the definition of comprehensive assessment. These children need more specialist assessment and interventions designed to meet their complex needs.
45	British Association for Adoption and Fostering	Quality statement 2	There should be an acknowledgment in the QS that carrying out these assessments is complex and time consuming, involving a variety of professionals, and that issues of capacity must be addressed by commissioners, particularly given current economic restraints.

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46	Royal College of Psychiatrists	Quality Statement 2	In our opinion the high comorbidity between ADHD and Conduct disorder needs special consideration and should be emphasised given that evidence based and highly effective treatment with a quick positive response is available for ADHD. It requires a huge cultural shift within CAMHS to actually diagnose children and young people who fulfil the criteria for conduct disorder. Currently the practice of diagnosing varies considerably within CAMHS. The reason is mainly around concerns stigmatising or labelling children and young people. This is particularly relevant for conduct disorder because traditionally conduct disordered children were not seen in CAMHS although they might have been screened for comorbidities. The other aspect that needs consideration is emerging evidence of the high comorbidity between conduct disorder and emotional disorders (anxiety, panic disorders, depression, social phobia, PTSD etc), particularly in girls. This is based on a preliminary analysis of (unpublished) data of the START trial (large UK multicentre trial of MST in conduct disordered children and young people).
47	British Association for Adoption and Fostering	Quality statement 2	Given the high prevalence of conduct disorder in looked after children, and the significant numbers of children who return home then return later to care, it should be made explicit that birth parents will need to be part of the assessment – and part of the interventions in QS 4 and 5 – and that assessment and parenting programmes may also involve multiple foster carers for a given child. The impact of this on capacity issues should also be acknowledged.
48	British Association for Adoption and Fostering	Quality statements 3, 4 and 5	Use of the term 'designated' professional is confusing, as this is an established term in other contexts, including safeguarding and for looked after children. Perhaps 'lead professional' or 'key worker' would be better. While having such a worker may be helpful, this alone will not be sufficient. All involved will need to consider ways to promote better engagement and funding should be made available for projects to facilitate and evaluate what improves engagement. Commissioners need to work with professionals to provide services that are accessible, have sufficient capacity to provide timely assessments and offer appropriate interventions as well as ongoing support if needed. Professionals must understand this group and have relevant competencies so that children and families feel they are understood and helped. The capacity issues inherent in delivering this must be addressed!

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49	Royal College of Psychiatrists	Quality Statement 3	We agree that identification of a designated professional, usually from CAMHS or social care, would be helpful in coordinating the care of the child or young person. One issue is that depending on local arrangements children and young people with ADHD (a substantial proportion with comorbid conduct disorder) will be either seen by paediatricians and/or CAMHS. In order to avoid fragmentation of care local arrangements to transfer the care to one agency might be helpful, e.g. a child with conduct disorder and ADHD requiring specific intervention for conduct disorder delivered by CAMHS. In these cases it would make sense for CAMHS also to oversee the ADHD treatment.
50	British Psychological Society	Quality statement 3	It is recommended that to ease understanding this Quality statement uses the recognised phrase 'assertive outreach' this appears to be the model of service provision that the guidelines are working to. Provided that this is consistent with the "close to home principle" which is one of four principles from the meta-analysis in Guerra, N. G., Kim, T. E., and Boxer, P. (2008),. the Society would support this provision as well as the other three principles identified by these authors of; • Rehabilitation and not punishment focus • Evidence-based principle • Risk-focussed / Strength –Based References: Guerra, N. G., Kim, T. E., and Boxer, P. (2008). What works: Best practices with juvenile offenders? In R. D. Hoge, N. G. Guerra & P. Boxer (eds.). Treating the juvenile offender, 33-53, London: Guildford Press.
51	Royal College of Paediatrics and Child Health	Quality statement 3	We would prefer the term was" not brought" to" did not attend"- the latter is suitable for adult healthcare but can be misleading in paediatrics, implying a fault in the CYP themselves, blinding us to neglect and leading to "professional neglect" (Michael Roe, BMJ 2010; 341:c6332.)
52	Paediatric Mental Health Association (previously BPMHG)	Quality statement 3	The designated professional is stated here to be either a CAMHS member of staff or social worker. Why not a paediatrician? And if the designated professional is from CAMHS, should not CAMHS be doing the assessment?

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53	College of Occupational Therapists	Quality statement 3	Designated professional 'This can include a member of staff from Child and Adolescent Mental Health Services or a member of staff from a relevant social care setting'. Consider adding the word 'health or' before 'social care setting.'
54	College of Occupational Therapists	Quality statement 3	Oversee care and facilitate engagement Add the words and / or agencies after the word 'people' in line two.
55	Royal College of Paediatrics and Child Health	Quality statement 4	Special parent training for those whose child also has a comorbid diagnosis of ADHD should be added to this: the lack of such provision is perhaps more keenly felt in clinical practice with these families than any other.
56	College of Occupational Therapists	Quality statement 4	Ensure consistency in the terms parent / carer. Carer is not included in some instances on pages 18, 19 and 20.
57	British Psychological Society	Quality statement 4	We believe that throughout this statement e.g. in the structure and process sections, the wording should be strengthened indicate need for 'evidenced based' parent training programmes with behavioural outcomes monitored, not solely parent satisfaction. The Society welcomes the recognition of the psychological theoretical basis for such parent training programmes draws heavily on social learning theory however given the noted importance of attachment in understanding conduct disorder and effective intervention, it would be helpful if the developing evidence base for attachment-based treatment programmes was noted, (e.g. Obsuth, Moretti, Holland, Braber, & Cross, 2006). The Society suggests that a minimum figure should be given to the foster carer/ guardian training programmes, rather than simply "up to 10 meetings". References: Obsuth, I., Moretti, M. M., Holland, R., Braber, C., & Cross, S. (2006). Conduct disorder: new directions in promoting effective parenting and strengthening parent-adolescent relationships. Canadian Child

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58	British Association for Adoption and Fostering	Quality statement 4	Social learning groups for carers and adoptive parents can be effective but it should be noted that they may also need to access specialist support via professionals specifically trained to help children with other issues which may co-exist or complicate the diagnosis, such as attachment difficulties/disorders, and developmental trauma.
59	Royal College of Psychiatrists	Quality Statement 4	No comment.
60	British Association for Adoption and Fostering	Quality statement 4	We do not agree with the recommendation that individual parent/foster carers/guardians should receive fewer sessions of the training programmes as it is the experience of our members that this group often needs very specialised intervention and that this may need to be repeated at intervals throughout the course of childhood and adolescence to be effective.
61	AFT, the Association for Family Therapy and Systemic Practice	Quality statement 5	Multi modal interventions such as MST and FFT target a limited number of families. AFT wonders what the QS document can signpost for those young people aged 11-17 who do not engage in or do not respond to multi modal interventions or who live in areas where multi-modal interventions are not available (see 'service options', below)? The evidence base for multi-modal interventions indicates their effectiveness. This is to be warmly welcomed. However, the research shows that they work for many young people, not how they work. The branding and promotion of these interventions suggests they are distinct, and have to be purchased and followed as a manualised treatment 'package'. Yet they overlap considerably. Further research into how such treatments work, and which elements of them make a difference to young people and families, may in the long run support wider dissemination of effective treatments earlier to more young people and families. Service options to support young people with conduct difficulties and their families include: CYP IAPT services for young people with conduct problems and their families. The importance of systemic family practice in relation to conduct disorders is reflected in its inclusion of Phase 2 of Children and Young People's 'Improving Access to Psychological Therapies' (CYP IAPT) programme. This includes training for practitioners working with CYP with 'conduct disorders' and their families.

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			The CYP IAPT curricula for systemic work with families states: 'Work with families is a significant component of treatment in CAMHS and other child focused mental health settings. There is growing evidence for positive outcomes from family interventions. In addition, work with families often accompanies other interventions and can make an important contribution to the development and maintenance of the therapeutic alliance.' The curriculum comprises a basic systemic module and specialist modules including working with conduct disorder. • Outreach Systemic Family Therapy and systemic parenting approaches for families with complex needs, such as that developed by Newham CFCS/CAMHS. From 2002-2010 Newham CFCS targeted systemic family therapists, dual-trained in validated parenting techniques, in the Sure Start zones. CFCS also created the award-winning Reframe Team (RFT) from Children's Fund monies. The tasks of this team was to engage with those families whose children had severe conduct disorder and were not engaging in multi-agency services. The team engaged with 98% of service users, delivering systemic family therapy and complex parenting packages on an outreach basis, most often in the home setting. Aggett P. et al (2011) 'Seeking Permission: an interviewing stance for finding connection with hard to reach families' Journal of Family Therapy http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1467-6427/earlyview Aggett P. (2012) Responsiveness, Permission-Seeking and Risk in Context 04/12 AFT • Systemic Multi-Family Therapy groups in schools are proving highly effective in supporting children and families experiencing emotional, behavioural and social problems http://marlborough.thedigitalacademy.com/asset/286/Marlborough%20Model%20Brochure.pdf). This model is currently being evaluated http://www.uel-ftsrc.org/ongoing_research.htm

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			• Non Violent Resistance is a therapeutic intervention working with parents who feel helpless and overwhelmed by the child's situation. It can be offered to parents in individual families or in groups, and is proving especially useful in engagement of parents of adolescents. Groups of family therapists in the UK have adapted the approach and won awards for their parents' groups (for example, Oxleas NHS Trust's Bexley and Greenwich CAMHS Non Violent Resistance Project - http://www.oxleas.nhs.uk/news/2011/12/nvr-project-comes-out-tops/). An emerging evidence base for NVR demonstrates not only behavioral improvement in young people, but also behavioural improvement in parents. In addition to behavioural improvement and a 90%+ retention rate in therapy even for families of adolescents, Weinblatt and Omer (2008) found the approach led to reduced parental helplessness, improved parent mental health and improved perception of social support in parents compared to controls. A German study compared NVR for 11-18 year old young people who were showing oppositional, aggressive and anti-social behaviour with TEEN Triple-P and a waiting list control group (Ollefs, 2009). The study demonstrated significant improvement in parental presence, improved parenting behaviour, reduced parental helplessness and reduced parental depression for both treatment groups. NVR was superior to TEEN Triple-P by showing significant improvement in child externalising behaviour on Achenbach's CBCL. Ollefs, B., Von Schlippe, A., Omer, H., and Kriz, J. (2009) Adolescents showing externalising problem behaviour. Effects of parent coaching (German). Familiendynamik, 3: 256-265.
62	British Psychological Society	Quality Statement 5	The Society welcomes the acknowledgment that there is a high level of geographical variation in the provision of this Intervention and the emphasis on the need for such provision to be available. However, this statement should emphasise that the multi-modal provision should be an evidenced-based model, drawing on a broad range of psychological knowledge and theory. Such provision is specialist and will necessarily require input from practitioner psychologists to ensure some oversight of the application of psychological knowledge and skills. It would be recommended that the psychologist be skilled in assessment and intervention with adults and young people to inform and deliver effective multimodal psychological formulation driven interventions that reduce the risk of later-life antisocial behaviour.

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			In addition to the multimodal interventions for young people living within their families, there are several examples of multiple professional teams working with looked after children and foster carers and we suggest that this should be mentioned within the explanatory text. The Society would also wish to highlight the needs of children on the edge of care and recently adopted children and their carers; these are also highly vulnerable groups who would benefit from rapid access to services to prevent any behavioural difficulties escalating. The Society recognises the value in demonstrating intervention treatment integrity and this is a key principle of effective treatment and that do treatments not including this provision run the risk of negative effects. However there are limits to the degree of conformity to a manual. Whilst the research supports structured treatments however, to be effective these must be adaptable to focus on specific skill deficits. To this end the input of practitioner psychologists, will have key role in adapting and individualising treatments. These specialists will be able tailor a formulation driven intervention plan directing treatment to focus on specific critical risk factors, working through and with other professionals,. E.g. Lipsey, M. W. (1995). Hollin, C. R. (2001). References: Lipsey, M. W. (1995). What do we learn from 400 research studies on the effectiveness of treatment with juvenile delinquents. In J. McGuire (ed.). What Works: Reducing reoffending. Chichester: John Wiley and Sons; Hollin, C. R. (2001) The role of the consultant in developing effective correctional programmes In G. A Bernfeld, D. P. Farrington and A W Leschied Offender Rehabilitation in Practice: Implementing and Evaluating Effective Programs. Wiley 269-283

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63	Royal College of Psychiatrists	Quality statement 5	While the majority of conduct disordered children will respond to multimodal interventions there is a subgroup that will not. This group displays callous-unemotional traits and may be less responsive to typical parental socialization practices than other children with conduct problems (Hipwell et al., 2007; Oxford, Cavell, & Hughes, 2003: Wootton, Frick, Shelton, & Silver-thorn, 1997), In a study by Hawes and Dudds children with callous-unemotional traits did not benefit from punishment-oriented behaviour modification programs such as 'time-out,' which were effective for other conduct disordered children (Hawes & Dadds, 2005). It is known that callous-unemotional traits predict more severe antisocial acts, delinquency, and higher rates of recidivism for adolescent offenders. Consideration should be given to mention this group and the potential role of highly specialist forensic CAMH services in offering consultation and possible intervention (where they exist).
64	College of Occupational Therapists	Quality statement 5	Consider adding 'or health and social care professional' after the word managers.
65	Royal College of Paediatrics and Child Health	Quality statement 6	We would like to ask what is the evidence for the value of regular blood tests at the start and throughout antipsychotic treatment?
66	British Psychological Society	Quality statement 6	The Society believes that the need to ensure that challenging behaviour should be conceptualised using a biopsychosocial model and that interventions are focused at each level and medication is not seen as an intervention in its own right without accompanying therapeutic and context based support. We believe that feedback from within Education should be included in the monitoring and reviewing of medication interventions. The society supports the quality statement in principle.
67	Royal College of Psychiatrists	Quality statement 6	In our opinion Risperidone should be initiated and the side effects monitored by a healthcare professional who is competent in prescribing antipsychotics in children and adolescents and has expertise in assessing and diagnosing conduct disorder including consideration of all relevant differential diagnoses and comorbidities (ADHD, emotional disorders, etc). The relevant paragraph in NICE guidelines (para 1.6.5) : "Risperidone[should be started by an appropriately qualified healthcare professional with expertise in conduct disorders and should be based on a

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			comprehensive assessment and diagnosis." We think that expertise in conduct disorder is not sufficient for a license to prescribe antipsychotics in children and adolescents. It should be expertise in prescribing antipsychotics in children and adolescents for a whole range of conditions including conduct disorder. Page 26, first complete paragraph stipulates: The proportion of children and young people with a conduct disorder and severely aggressive behaviour who are taking risperidone who have had their height and weight measured and recorded at each appointment" We are querying whether this should be rephrased to : The proportion of children and young people with a conduct disorder and severely aggressive behaviour who are taking risperidone who have had their height and weight measured and recorded monthly or quarterly and when clinically indicated. This is to avoid taking unnecessary height and weight measurements, e.g when the young person is reviewed at a high frequency.
68	College of Occupational Therapists	Quality statement 6	Reword the bold test so it reads 'Health and Social Care Professionals'.
69	Royal Pharmaceutical Society	Quality statement 6	The Royal Pharmaceutical Society would like to highlight the role of pharmacists. As experts in medicines, pharmacists provide advice on how to take medicines, adverse effects, monitoring, possible interactions and cautions, to raise patients' and their carers' awareness of these and increase their understanding of their condition and therapy. Community pharmacies are accessible, open long hours and present in communities across the country, including areas of deprivation.