NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Conduct Disorders

Output: Prioritised quality improvement areas for development.

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Contents

1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for conduct disorders. It provides the Committee with a basis for discussion and prioritising quality improvement areas for developing quality statements and measures, which will be drafted for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the Committee in considering potential statements and measures.

1.2 Development source

The key development source referenced in this briefing paper is:

- Antisocial behaviour and conduct disorders in children and young people. NICE clinical guideline 158 (2013).

2 Overview

2.1 Focus of quality standard

This quality standard will cover the recognition, intervention and management of conduct disorders in children and young people

2.2 Definition

Conduct disorders are characterised by repetitive and persistent patterns of antisocial, aggressive or defiant behaviour that amounts to significant and persistent violations of age appropriate social expectations. The World Health Organization's ICD-10 classification of mental and behavioural disorders divides conduct disorders into;

- socialised conduct disorder
- unsocialised conduct disorder
- conduct disorders confined to the family context
- oppositional defiant disorder

The major distinction between oppositional defiant disorder and the other subtypes of conduct disorder is the extent and severity of the antisocial behaviour.

Oppositional defiant disorder is more common in children aged 10 years or younger; the other subtypes of conduct disorder are more common in those aged over 11 years or older

2.3 Incidence and prevalence

Conduct disorders, and associated antisocial behaviour, are the most common mental and behavioural problems in children and young people. The Office of National Statistics (ONS) surveys of 1999 and 2004 reported that their prevalence was 5% among children and young people aged between 5 and 16 years.

The 1999 ONS survey demonstrated that conduct disorders have a steep social class gradient, with a three- to fourfold increase in prevalence in social classes D and E compared with social class A.

The 2004 survey found that almost 40% of looked-after children, those who had been abused and those on child protection or safeguarding registers had a conduct disorder.

The prevalence of conduct disorders increases throughout childhood and they are more common in boys than girls. For example, 7% of boys and 3% of girls aged 5 to 10 years have conduct disorders; in children aged 11 to 16 years the proportion rises to 8% of boys and 5% of girls.

Conduct disorders commonly coexist with other mental health problems: 46% of boys and 36% of girls have at least 1 coexisting mental health problem. The coexistence of conduct disorders with attention deficit hyperactivity disorder (ADHD) is particularly prevalent and in some groups more than 40% of children and young people with a diagnosis of conduct disorder also have a diagnosis of ADHD.

The prevalence of conduct disorders in the UK varies across ethnic groups; for example, their prevalence is lower than average in children and young people of south Asian family origin and higher than average in children and young people of African-Caribbean family origin.

2.4 Management

Conduct disorders are the most common reason for referral of young children to child and adolescent mental health services (CAMHS). Children with conduct disorders also comprise a considerable proportion of the work of the health and social care system. For example, 30% of a typical GP's child consultations are for behavioural problems, 45% of community child health referrals are for behaviour disturbances and psychiatric disorders are a factor in 28% of all paediatric outpatient referrals. In addition, social care services have significant involvement with children

and young people with conduct disorders, with more vulnerable or disturbed children often being placed with a foster family or, less commonly, in residential care. The demands on the education system are also considerable and include the provision of special-needs education. The criminal justice system also has significant involvement with older children with conduct disorders.

Three themes are common to the main interventions for conduct disorders: a strong focus on working with parents and families, recognition of the importance of the wider social system in enabling effective interventions and a focus on preventing or reducing the escalation of existing problems. These interventions include; parenting programmes typically focused on younger children and multisystemic approaches usually focused on older children.

2.5 National Outcome Frameworks

Tables 1–3 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 The Adult Social Care Outcomes Framework 2013–14

Domain	Overarching and outcome measures
1 Enhancing quality of life for people with care and support needs	***Overarching measure*** 1A Social care-related quality of life* ***Outcome measures*** **People manage their own support as much as they wish, so that are in control of what, how and when support is delivered to match their needs.** 1B Proportion of people who use services who have control over their daily life **People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation.** 1H Proportion of adults in contact with secondary mental health services living independently, with or without support**
3 Ensuring that people have a positive experience of care and support	***Overarching measure*** **People who use social care and their carers are satisfied with their experience of care and support services.** 3A Overall satisfaction of people who use services with their care and support ***Outcome measures*** **People know what choices are available to them locally, what they are entitled to, and who to contact when they need help.** 3D The proportion of people who use services and carers who find it easy to find information about support
Aligning across the health and care system * Indicator complementary ** Indicator shared	

Table 2 NHS Outcomes Framework 2013/14

Domain	Overarching indicators and improvement areas
2 Enhancing quality of life for people with long-term conditions	***Improvement areas*** **Ensuring people feel supported to manage their condition** 2.1 Proportion of people feeling supported to manage their condition**
4 Ensuring that people have a positive experience of care	***Improvement areas*** **Improving the experience of healthcare for people with mental illness** 4.7 Patient experience of community mental health services
Alignment across the health and social care system ** Indicator complementary with Adult Social Care Outcomes Framework (ASCOF)	

Table 3 Public health outcomes framework for England, 2013–2016

Domain	Objectives and indicators
1 Improving the wider determinants of health	***Objective*** Improvements against wider factors that affect health and wellbeing and health inequalities 1.3 Pupil absence 1.4 First-time entrants to the youth justice system 1.5 16–18 year olds not in education, employment or training 1.6 People with mental illness or disability not in settled accommodation** 1.7 People in prison who have a mental illness or significant mental illness 1.8 Employment for those with a long-term health condition including those with a learning difficulty/disability or mental illness
2 Health improvement	***Objective*** People are helped to live health lifestyles, make healthy choices and reduce health inequalities 2.8 Emotional wellbeing of looked-after children
Alignment across the health and social care system ** Indicator complementary with Adult Social Care Outcomes Framework (ASCOF)	

3 Summary of suggestions

3.1 Responses

In total 7 stakeholders responded to the 2-week engagement exercise 19/07/13 – 02/08/13 with 5 suggesting areas for improvement.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table for further consideration by the Committee.

The full detail of the suggestions is provided in appendix 1 for information.

Table 1 Summary of suggested quality improvement areas

Suggested area for improvement	**Stakeholder**
Local service pathway - Multiagency and inter-agency working - Access to evidence based interventions	RCPCH, RDSH, SCM 1, SCM 2, SCM 3
Early identification and intervention - Early intervention to prevent development of more problematic disorders - Time between referral and assessment	AFTSP, RDSH, RCPCH, SCM 3.
Comprehensive assessment	AFTSP & SCM 2
Multi systemic therapy	AFTSP, SCM 1, RCPsych,
Treatment contexts / reasonable adjustments	AFTSP, SCM 2, SCM 3, RCPsych
Pharmacological interventions - Short term use of risperidone - Monitoring of physical health and possible side effects	SCM 1, CMHP
Parent training for offending behavioural programmes	SCM 3
Meeting the needs of girls and young women	RCPsych
Workforce training	AFTSP, RDSH, SCM 3
The role of Forensic Child and Adolescent Mental Health Services	RCPsych
Transition	SCM 1

The details of stakeholder organisations who submitted suggestions are provided in table 2.

Table 2 Stakeholder details (abbreviations)

Abbreviation	Full name
AFTSP	Association for Family Therapy and Systemic Practice
CMHP	College of Mental Health Pharmacy
RDSH	Rotherham Doncaster and South Humber NHS FT
RCPCH	Royal College of Paediatrics and Child Health
RCPsych	Royal College of Psychiatrists
SCM	Specialist Committee Member

4 Suggested improvement areas

4.1 Local service pathway

4.1.1 Summary of suggestions

Local service pathway

Stakeholders highlighted the need for a care pathway for children and young people with conduct disorders so health professionals and social care practitioners understand how to access services for children and young people presenting with behaviour that suggests conduct disorders or for those already identified as having a conduct disorder.

Multiagency and inter-agency working

Stakeholders referenced that a number of agencies can be involved in supporting children and young people with conduct disorders. The need for effective multiagency and interagency working was therefore highlighted as a key area for quality improvement to support continuity of care and access to relevant services.

Use of evidence based interventions

Stakeholders emphasised the importance of access for all children and young people with conduct disorders to evidence based interventions. A local service pathway, providing access to relevant specialists for all children and young people with conduct disorders can facilitate access to the most appropriate interventions.

4.1.2 Selected recommendations from the development source

Table 3 below highlights recommendations that have been provisionally selected from the development source(s) which may support potential statement development. These are presented in full below to inform the Committee's discussion.

Table 3 Specific areas for quality improvement

Suggested quality improvement area	NICE CG158 selected recommendations
Local service pathway	**Developing local care pathways** Recommendations 1.7.9 and 1.7.11
Multiagency and inter-agency working	**Developing local care pathways** Recommendations 1.7.16 and 1.7.17

Use of evidence based interventions	This is the purpose of CG158 and the role of the local service pathway

Developing local care pathways

NICE CG158 – Recommendation 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)

NICE CG158 – Recommendation 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

NICE CG158 – Recommendation 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

NICE CG158 – Recommendation 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

4.1.3 Current UK practice

Local service pathway

The full guideline on conduct disorders developed by the National Collaborating Centre for Mental Health[1] reports that despite conduct disorders being the most common of childhood mental health disorders, children and young people with a conduct disorder are under-represented in those in receipt of care from CAMHS and related services. The guideline development group commissioned a focus group with young people who had been identified as having a conduct disorder. They suggested that local service provision should be flexible to meet the different needs and circumstances that people are in.

Multiagency and interagency working

A Health Technology Assessment funded project looked at the effectiveness and cost effectiveness of different parent training and education programmes for the treatment of conduct disorders[2]. The study included a review of service utilisation by

[1] NCCMH 'Antisocial Behaviour and Conduct Disorders in Children and Young People'
[2] HTA (2005) The effectiveness and cost effectiveness of parent / education programmes…

children and young people with conduct disorders and reports findings from a national survey that suggested children and young people with conduct disorders had significantly higher lifetime rates of service utilisation compared to children and young people with other psychiatric diagnoses. The report also highlighted that children and young people with a diagnosis of conduct disorders are likely to come into contact with a range of services, including, special educational needs provision, specialist schools for those with more severe problems and mental health services. This population is also at a higher risk of being in contact with the judicial system and has an increased likelihood of experiencing drug and alcohol problems compared to the rest of the population.

The young people involved in the focus groups carried out during the development of the clinical guideline, also highlighted issues concerning multiagency and interagency working in relation to confidentiality and having to interact with a number of professionals with whom they hadn't built up any sort of a relationship with before. They understood the need for a number of services being involved but that this needs to be managed sensitively.

Access to evidence based practice

Information submitted by the Royal College of Psychiatrists identified access to evidence based interventions is inconsistent across the UK, particularly access to the higher intensity multimodal interventions like multi systemic therapy. This has led to young people not being able to access the treatment and support most appropriate for them.

4.2 Early identification and intervention

4.2.1 Summary of suggestions

Stakeholders highlighted the important of identifying children and young people with possible conduct disorders at the earliest possible opportunity. The evidence suggests that young children who display aggressive and disruptive behaviour are at a much higher risk of going onto develop more problematic behaviour problems as they get older. Stakeholders focused on specific aspects of a child's life where early interventions for conduct disorders can have a significant impact. Improved school attendance, educational attainment, and reduced contact with the criminal justice system are some of the outcomes that can be improved through early identification and early intervention.

One stakeholder emphasised the importance of health professionals and social care practitioners being aware of the risk factors and presenting features of conduct disorder to help facilitate earliest possible identification of children, young people and families who are in need of support.

One stakeholder highlighted the timeliness between referral for assessment, access to treatment and support and review following the start of interventions.

4.2.2 Selected recommendations from the development source

Table 4 below highlights recommendations that have been provisionally selected from the development source(s) which may support potential statement development. These are presented in full below to inform the Committee's discussion.

Table 4 Specific areas for quality improvement

Suggested quality improvement area	NICE CG158 selected recommendations
Early identification and intervention	**Selective prevention** Recommendations 1.2.1 and 1.2.2
Awareness of risk factors and presenting features.	**Identification and assessment** Recommendation 1.3.2

Selective prevention

NICE CG158 – Recommendation 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.

NICE CG158 Recommendation 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

Identification and assessment

NICE CG158 Recommendation 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

4.2.3 Current UK practice

In an overview of conduct disorders published by the Royal College of Psychiatry[3] they reference evidence that children who became violent as adolescents can be identified with almost 50% reliability as early as age 7, as a result of their aggressive and disruptive behaviour at home and at school. Evidence is also referenced that shows that approximately 40–50% of children with conduct disorder go on to develop antisocial personality disorder as adults.

[3] RCPsych (2002) - www.rcpsych.ac.uk/files/samplechapter/80_3.pdf

The full guideline on conduct disorders [4] reports that not all children displaying behaviour linked to future conduct disorder go onto develop more severe forms of behaviour . However, there is an increased risk of future problems in this group as they are far more likely to display the most severe symptoms in adolescence, and to persist in their antisocial tendencies into adulthood. The most antisocial 5% of children aged 7 years are 500 to 1000% more likely to display' indices of serious life failure' at 25 years, for example drug dependency, criminality, unwanted teenage pregnancy, leaving school with no qualifications, unemployment, and so on. Follow-back studies show that most children and young people with conduct disorder had prior oppositional defiant disorder and most (if not all) adults with antisocial personality disorder had prior conduct disorder. Likewise about 90% of severe, recurrent adolescent offenders showed marked antisocial behaviour in early childhood.

[4] National Collaborating Centre for Mental Health
http://www.nccmh.org.uk/downloads/CD/CG158FullCG.pdf

4.3 Comprehensive assessment

4.3.1 Summary of suggestions

One stakeholder and a specialist committee member highlighted the importance of assessments for conduct disorders being comprehensive considering a range of issues including the family circumstances, the strengths of the family and the child or young person and risks and vulnerability. The need for other co-existing conditions being taken into consideration was also highlighted by the specialist committee member. The importance of the assessment being conducted by someone with suitable expertise and experience was also highlighted.

4.3.2 Selected recommendations from the development source

Table 5 below highlights recommendations that have been provisionally selected from the development source(s) which may support potential statement development. These are presented in full below to inform the Committee's discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	NICE CG158 selected recommendations
Comprehensive assessment	**Comprehensive assessment** Recommendations 1.3.8, 1.3.10 and 1.3.15

Comprehensive assessment

NICE CG158 – Recommendation 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.

NICE CG158 – recommendation 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

NICE CG158 – Recommendation 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

4.3.3 Current UK Practice

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience

4.4 Multi systemic therapy

4.4.1 Summary of suggestions

Two stakeholders and a specialist committee member highlighted increasing access to multi systemic therapy for children and young people with conduct disorders and their families as an area for quality improvement. The evidence of the effectiveness of multi systemic therapy for helping children and young people with conduct disorders and their families is referenced alongside the fact that there is not universal / equal access to this support in all geographical areas.

4.4.2 Selected recommendations from the development source

Table 6 below highlights recommendations that have been provisionally selected from the development source(s) which may support potential statement development. These are presented in full below to inform the Committee's discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	NICE CG158 selected recommendations
Multi systemic therapy	**Multimodal interventions** Recommendation 1.5.13

Multimodal interventions

NICE CG158 - Recommendation 1.5.13

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

4.4.3 Current UK Practice

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience

4.5 Treatment contexts and reasonable adjustments

4.5.1 Summary of suggestions

Stakeholders and two specialist committee members identified the need for services to be delivered in a way that facilitates and encourages engagement from children, young people and their families. A number of factors were identified that can have an impact on whether people engage with services or not and where reasonable adjustments could be made that would improve engagement. Some suggestions included, meeting with children and families in their own home or at other non-stigmatising venues as chosen by the family. Cultural sensitivities were also referenced, including taking into account any language barriers. One stakeholder highlighted the need for children and young people with conduct disorders who are living in secure settings being given equal access to interventions and support.

4.5.2 Selected recommendations from the development source

Table 7 below highlights recommendations that have been provisionally selected from the development source(s) which may support potential statement development. These are presented in full below to inform the Committee's discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	NICE CG158 selected recommendations
Treatment contexts and reasonable adjustments	**Improving access to services** Recommendations 1.7.3, 1.7.4, 1.7.5, 1.7.6, 1.7.7 and 1.7.8

Improving access to services

NICE CG158 – Recommendation 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

NICE CG158 – Recommendation 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.

NICE CG158 – Recommendation 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)

NICE CG158 – Recommendation 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

NICE CG158 – Recommendation 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

4.5.3 Current UK Practice

Current practice information reported in the full clinical guideline for conduct disorders highlights the importance of engagement of families in treatment and support for conduct disorders. For children and young people with conduct disorders, dropout rates from treatment are high, at around 30-40%. The guideline also describes how any of the parents or children with conduct disorder may themselves have difficulty with authority, and be very sensitive to criticism. This is highlighted as another issue that has effected engagement, and something that needs to be considered when delivering support and interventions to these families.

4.6 Pharmacological interventions

4.6.1 Summary of suggestions

Short term use of risperidone

One specialist committee member identified the short term use of risperidone for the management of severe aggression in young people with conduct disorders as an area for quality improvement.

Monitoring of physical health and possible side effects

One stakeholder prioritised improving monitoring of physical health and side effects in those who were being given antipsychotics for their behaviour, as an area of quality improvement. They also referenced the need to improve blood pressure and height and weight monitoring when stimulant medication is prescribed.

4.6.2 Selected recommendations from the evidence source

Table 8 below highlights recommendations that have been provisionally selected from the development source(s) which may support potential statement development. These are presented in full below to inform the Committee's discussion.

Table 8 Specific areas for quality improvement

Suggested quality improvement area	NICE CG158 selected recommendations
Short term use of risperidone	**Pharmacological interventions** Recommendation 1.6.3
Monitoring of physical health and possible side effects.	**Pharmacological interventions** Recommendation 1.6.6 and 1.6.7

Pharmacological interventions

NICE CG158 Recommendation 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

NICE CG158 Recommendation 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, HbA_{1c}, 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.

NICE CG158 Recommendation 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.

4.6.3 Current UK practice

A regional survey conducted in the former Trent region in England[5] looked at antipsychotic prescribing amongst all child and adolescent psychiatrists and community paediatricians during a 12 month period.

The majority (88%) of child psychiatrists and 33% of paediatricians had prescribed atypical antipsychotics, most commonly risperidone. Challenging behaviour in developmental disorders was the most common indication for atypicals. Both child psychiatrists and paediatricians prescribed atypicals for non-psychotic

[5] Otasowie et al (2010) Antipsychotic prescribing practice among child psychiatrists and community paediatricians

developmental disorders, whereas prescribing for psychosis occurred almost exclusively among psychiatrists. Height, weight and blood pressure were routinely monitored, but waist circumference was rarely measured and there was wide variation in the monitoring of other parameters such as blood glucose, prolactin and extrapyramidal side-effects. Three-quarters of the participants felt there was a need for guidance on prescribing and monitoring atypical antipsychotic therapy

The Prescribing Observatory for Mental Health (POHM) conducted an audit[6] concerning practice in relation to prescribing antipsychotics for children and adolescents in 2012. The audit looked at the level of screening for possible side effects in children and young people being prescribed antipsychotics. The audit found there was no evidence of baseline screening for full blood count, renal function, liver function and thyroid function in around 30% or young people prescribed an antipsychotic.

A similar result was found for monitoring of body weight, BP, pulse, blood glucose, lipid profile, and ECG.

The audit standard expected that physical health screening be conducted at least every six months. Again wide variations in practice wide noted with regard to meeting this standard.

[6] POMH-UK (2012) Topic 10b Prescribing antipsychotics for children and adolescents.

4.7 Parent training for offending behavioural programmes

4.7.1 Summary of suggestions

One specialist committee member identified the need for specialised training for parents and care givers regarding offending behavioural programmes, as a priority for quality improvement.

4.7.2 Selected recommendations from the evidence source

Table 9 below highlights recommendations that have been provisionally selected from the development source(s) which may support potential statement development. These are presented in full below to inform the Committee's discussion.

Table 9 Specific areas for quality improvement

Suggested quality improvement area	NICE CG158 selected recommendations
Parent training for offending behavioural programmes	**Parent and child training programmes for children with complex needs** Recommendation 1.5.5

Parent and child training programmes for children with complex needs

CG158 Recommendation 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.

4.7.3 Current UK practice

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on specialist committee member knowledge and experience.

4.8 Meeting the needs of girls and young women

4.8.1 Summary of suggestions

One stakeholder suggested that not enough attention has been paid to whether girls and young women with conduct disorder have specific and possibly different needs and whether they respond differently to interventions.

4.8.2 Selected recommendations from the evidence source

Table 10 below highlights recommendations that have been provisionally selected from the development source(s) which may support potential statement development. These are presented in full below to inform the Committee's discussion.

Table 10 Specific areas for quality improvement

Suggested quality improvement area	NICE CG158 selected recommendations
Meeting the needs of girls and young women	**Improving access to services** Recommendation 1.7.5

Improving access to services

NICE CG158 Recommendation 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

4.8.3 Current UK practice

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on the stakeholder's knowledge and experience. They did reference anecdotal / unpublished work that suggests that girls have been shown to respond much better and faster to multi systemic treatment than boys.

4.9 Other suggested areas for quality improvement

A summary of other suggested improvement areas deemed not appropriate for quality statement development or covered by other areas is provided below.

i. Trained workforce

Two stakeholders and 1 specialist committee member suggested improving workforce training and awareness of what conduct disorders is, how to identify young people with possible conduct disorders and providing more specialist with training in interventions for conduct disorders. The need for a suitably trained and skilled workforce to deliver high quality care is a generic issue across all topics and is therefore referenced in the introductory section of all quality standards. This issue would also be implicit in any statements concerning the development of any local pathways or actions to help support earliest possible identification and interventions.

ii. The role of Forensic Child and Adolescent Mental Health Services

One stakeholder suggested that one area for quality improvement could be the better utilisation of forensic child and adolescent mental health services in treating children and young people with more complex conduct disorders and severe behavioural issues. There were no recommendations supporting this point and it was agreed that this is a structural issue that would depend on local service configurations. Therefore this has not been suggested as an area for further development.

iii. Transition

Stakeholders highlighted transition to adult services as an area for quality improvement. This is an important area but will be covered in a specific quality standard that has been referred for development by NICE in the future.

Appendix 1: Key priorities for implementation (CG158)

Recommendations that are key priorities for implementation in the source guideline and which have been referred to in the main body of this report are highlighted in grey.

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

- 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).
- 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.

Comprehensive assessment

- 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.

Parent training programmes

- 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.

Foster carer/guardian training programmes

- 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.

Child-focused programmes

- 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.

Multimodal interventions

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

Pharmacological interventions

- 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).

Improving access to services

- 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

Appendix 2: Suggestions from stakeholder engagement exercise

ID	*Stakeholder*	*Key area for quality improvement*	Why is this important?	Why is this a key area for quality improvement?	Supporting information
001	Association for Family Therapy and Systemic Practice	Key area for quality improvement 1 Accessible systemic family therapy interventions for families with a child or young person exhibiting conduct disorder symptoms	Systemic Family Therapy has been demonstrated to be an effective intervention for child and adolescent conduct disorders. Various systemic family therapy approaches are recommended by NICE. These include FFT (Functional Family Therapy) and MST (Multi Systemic Therapy) These approaches are generally time limited and intensive. Their core approaches can be adapted for the CAMHS/Children and Young Peoples Service population of families and for practitioners sufficiently trained in core systemic skills and understandings.	Provision of systemic therapeutic services for CYP+ families affected by conduct disorders remains patchy. Availability is seriously limited in many areas, with symptoms escalating and/or families reaching crisis point before they are offered skilled supports. Parenting programmes are helpful for families and children with less complex difficulties but are not enough to help families and children with complex needs. Intensive programmes such as MST and FFT target a limited number of families. The importance of systemic family therapy 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 + families affected by conduct disorders. 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	The evidence base for systemic family therapy in relation to conduct disorders is strong (Carr, 2009a), and forms the basis for the most intensive family based interventions such as MST and FFT. (Hengeller, 2002; Alexander et al, 2002). The draft CYP IAPT curriculum for systemic working with families (inc conduct disorders) is available to view at http://www.iapt.nhs.uk/silo/files/curricula-for-systemic-work-with-families-.pdf . Final curricula will be released after the final date for submission to this Topic Overview consultation, but can be accessed via the IAPT web pages A number of trials of systemic approaches to conduct disorder are currently being undertaken in the UK. These include: SAFE study, National Academy for Parenting Practitioners at the Institute of Psychiatry, Brighton & Hove Youth Offending Services (YOS), Targeted Youth Support Services, Anti-Social Behaviour Team and West Sussex YOS Families Changing Families: An Evaluation of the Marlborough Multi-Family Model in an Education Context, Marlborough Family Service, Central and North West London NHS Trust Carr, A. (2009a) The effectiveness of family therapy and systemic interventions for child-

ID	*Stakeholder*	*Key area for quality improvement*	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				important contribution to the development and maintenance of the therapeutic alliance.' The curricula comprises a basic systemic module and specialist modules including working with conduct disorder. It is now widely acknowledged that increasing access to effective systemic interventions for children, young people and families, delivered by adequately trained practitioners, will transform lives and makes social and economic sense.	focused problems. Journal of Family Therapy, 31: 3–45. Henggeler, S. W., & Sheidow, A. J. (2002). Conduct disorder and delinquency. In D. H. Sprenkle (Ed.), Effectiveness research in marriage and family therapy (pp. 27-51). Washington, DC: AAMFT. Alexander, J.F. & Sexton, T.L (2002) Functional Family Therapy: A model for treating high risk, acting out youth in J Lebow Comprehensive Handbook of Psychotherapy, Vol 4 Integrative/Eclectic (pp111-132) New York: Wiley
001	Association for Family Therapy and Systemic Practice	Key area for quality improvement 2 Workforce trainings	Systemic approaches to working with young people with conduct disorders and their families seek to tackle the complex interlocking problems that such families experience; for example, parental self-esteem and mental ill-health, parental relationship difficulties, parenting style, partner violence, poverty, child behaviour, sibling antisocial behaviour, youth offending, educational attainment and social competence are linked in complex causal and/or maintaining loops. Systemic Family Psychotherapists provide interventions that address the different and interlocking	Phase 2 CYP IAPT (Improving Access to Psychological Therapies) 'Working Systemically with Families' programme is to be welcomed, but will offer only a limited number of training places to CAMHS practitioners, including those working with Conduct Disorders.	The draft CYP IAPT curriculum for systemic working with families (inc conduct disorders) is available to view at http://www.iapt.nhs.uk/silo/files/curricula-for-systemic-work-with-families-.pdf . Final curricula will be released after the final date for submission to this Topic Overview consultation, but will be published soon on the CYP IAPT web pages

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			problems experienced by the family, so the capacity for change is increased and the resources of the family and network are utilised. They can offer supervision and consultation to practitioners with lower levels of training. Outcomes of practitioner trainings in systemic family therapy approaches to conduct disorders include: o Engaging and motivating young people and families o Building pro-social, family based behavioural skills that fit the family and alleviate the presenting problems o Generalize treatment and prevent subsequent relapse o Managing complex clinical situations whilst retaining a relational systemic focus o Identifying the relational processes that maintain or precipitate conduct disorders o Creating shared relational treatment goals with families o Monitoring progress to agreed goals collaboratively o Demonstrating cultural competence in systemic family therapy for conduct disorders		
001	Association for Family Therapy	Key area for quality improvement 3	Accurate assessments, including systemic assessment of individual	The importance of high level systemic family working in assessing risk and	The Munro Review of Child Protection (2011)

ID	*Stakeholder*	*Key area for quality improvement*	**Why is this important?**	**Why is this a key area for quality improvement?**	**Supporting information**
	and Systemic Practice	Assessment	and family strengths, resources, risks and vulnerabilities, are key to safe and effective services. These need to be conducted by practitioners with adequate trainings and skills. Current assessment focuses on parent-child and adult relationships. Important information about risks and resources may be missed without a systemic, 3-generational (minimum) overview. The comprehensive assessment could better support clients and practitioners when children and young people are experiencing complex and/or converging symptoms, through clear guidance on when and how to seek further specialist assessment. For example, the comprehensive assessment uses language that restricts symptom description as 'core conduct disorder'. An alternative wording could be: "symptoms indicating possible disorders such as conduct, attachment, and anxiety may converge within an individual and/or require further specialist assessment to differentiate which if any one of these diagnosis matches the symptoms recorded.'	responding effectively to the needs of vulnerable children and families was highlighted in The Munro Review of Child Protection (2011) Without systemic trainings, skills and understandings in engaging with families and supporting the child/young person and family in talking about difficult issues in their lives, important relational and contextual factors impacting on a child or young person's behaviour and mental health (including violence, abuse and parental mental health difficulties) may remain hidden. Assessments are sometimes undertaken by unqualified staff with little or no training.	
001	Association for Family Therapy	Key area for quality improvement 4	The clinical evidence is strong that systemic family therapy	There is good evidence that a large proportion of children and young people	Carr, A. (2009) The effectiveness of family therapy and systemic interventions for child-

ID	*Stakeholder*	*Key area for quality improvement*	**Why is this important?**	**Why is this a key area for quality improvement?**	**Supporting information**
	and Systemic Practice	Early intervention	approaches in health, social care and education services can support families in resolving their difficulties before they escalate sufficient to trigger serious conduct disorders in vulnerable children and young people. (Carr, 2009). Left undetected or unresolved, difficulties can embed over time and cascade through generations. Early identification and intervention can transform lives, and makes sense socially and economically.	experiencing conduct disorders who do not access effective help for themselves and their families 'will go on to be antisocial adults with impoverished and destructive lifestyles, especially if the conduct problems develop early.' (Piling et al, 2013) When children's difficulties escalate, they require greater resources from statutory services (council children's and education services, police and health) with diminishing effectiveness. The earlier the skilled intervention to support young person and family, the better the outcome.	focused problems. Journal of Family Therapy, 31: 3–45. Pilling S, Gould N, Whittington C et al Recognition, intervention, and management of antisocial behaviour and conduct disorders in children and young people: summary of NICE-SCIE guidance. BMJ, 2013, Vol 346, Issue 7902, p33 – 35
001	Association for Family Therapy and Systemic Practice	Key area for quality improvement 5 Treatment contexts	There is strong and growing evidence that mental health and social work outreach teams, including and supported by professionals with high-level systemic training, are successfully engaging with children, young people and families unable or unlikely to attend mainstream clinic based services. Many vulnerable children and young people experiencing or at risk of developing conduct disorders will not be supported by their parents and carers in attending clinic appointments. Outreach services that can meet with children and families in their own homes or at other non-stigmatising venues of their choice	A significant number of young people and families in this client group are unable or unlikely to attend mainstream clinic-based services. NICE guidelines have previously cited only Multi-Systemic Therapy as an effective multi-modal therapy. The Topic Overview and Quality Standards give opportunity to cite other effective and accessible systemic approaches being developed and evaluated in the UK.	Systemic Multi-Family Therapy groups in schools http://marlborough.thedigitalacademy.com/asset/286/Marlborough%20Model%20Brochure.pdf). Families Changing Families: An Evaluation of the Marlborough Multi-Family Model in an Education Context, Marlborough Family Service, Central and North West London NHS Trust Asen, E. (2002). Multiple family therapy: an overview. Journal of Family Therapy, 24, 3-16. Functional Family Therapy SAFE study, National Academy for Parenting Practitioners at the Institute of Psychiatry, Brighton & Hove Youth Offending Services (YOS),

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			(such as schools, Key Stages 1-4.) are essential if children and families are to access skilled and effective supports when and where they need them. Examples of accessible, high quality systemic services for families affected by conduct disorders include: Functional Family Therapy (FFT) - a systemic, intensive home based intervention that aims to assist young people and their families to make meaningful changes in their lives. Systemic Multi-Family therapy groups in schools – proving effective in supporting children and families experiencing conduct disorder and other emotional, behavioural and social difficulties Outreach Systemic Family Therapy, such as that developed by Newham CFCS/CAMHS. From 2002-2010, CFCS created the award-winning Reframe Team (RFT) from Children's Fund monies. The tasks of this team were to engage with those families whose children had severe conduct disorder and were not engaging in multi-agency services (Aggett et al, 2011; 2012). Many of the children and young people that the RFT worked with had histories of school exclusion and children's		Targeted Youth Support Services, Anti-Social Behaviour Team and West Sussex YOS 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 **CAMHS: Good practice example Non-Violent Resistance (NVR)** Lavi-Levavi, I., (2010). Improvement in systemic intra- familial variables by "Non-Violent Resistance" treatment for parents of children and adolescents with behavioral problems, PhD dissertation, Tel- Aviv University, Tel Aviv.

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			social care safeguarding interventions. The majority of this team were systemic family therapists. The team received good feedback from service users who traditionally did not engage with services, and also were able to engage with 98% of service users. The team delivered systemic family therapy and complex parenting packages on an outreach basis, most often in the home setting. Non –Violent Resistance: A number of Family and Systemic Psychotherapists (for example, teams in Oxleas NHS Foundation Trust) are developing ways of working with families affected by conduct disorders using Non Violent Resistance (NVR). An emerging evidence base for NVR demonstrates behavioral improvement in young people and in parents, an over 90% retention rate in therapy, reduced parental helplessness, improved parent mental health and improved perception of social support in parents compared to controls.		
002	Rotherham Doncaster and South Humber NHS Foundation Trust	Key area for quality improvement 1	Skilled staff - Early identification of conduct disorder.	It is important to give early interventions for these children and their families. The interventions should help reduce poor school attendance and attainment, the potential of reduced contact with the criminal justice system, reduction of future presentation to mental health services and potential risk of	Public Health England: Targeted Mental Health in Schools (TaMHS) http://www.chimat.org.uk/camhs/schools/tamhs

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				exploitation.	
002	Rotherham Doncaster and South Humber NHS Foundation Trust	Key area for quality improvement 2	Multi agency and inter-agency working. To provide seamless services to meet the needs of the child and family	Provides a safer information sharing network, for agencies and families to promote positive outcomes. This would be at least a CAF, child in need, SEN meetings	Early intervention: The Next Steps The Allen Report. http://www.dwp.gov.uk/docs/early-intervention-next-steps.pdf
002	Rotherham Doncaster and South Humber NHS Foundation Trust	Key area for quality improvement 3	Specialist trained staff to provide psycho social intervention. To provide timely and appropriate specialist interventions.	To provide evidence based treatments, monitoring of progression of approaches and clinical outcomes.	Various NICE CG's Depression in children and young people. Self Harm
003	Royal College of Paediatrics and Child Health	Key area for quality improvement 1: Awareness of the risk factors and presenting features of Conduct Disorder	Evidence suggests that possible Conduct Disorder is a common presentation in Paediatric Outpatients, Community Child Health and General Practice consultations	Improved recognition particularly in high risk groups would lead to earlier referral with a higher chance of a positive outcome	
003	Royal College of Paediatrics and Child Health	Key area for quality improvement 2: Improved coordination of services across different groups of Health Professionals and across agencies	Treatment in complex family and social systems needs a high level of clear communication between involved professionals. Referring professionals working closely with CAMH or other specialist assessments optimises the chance of good information sharing and appropriate parental and family involvement	This is key to ensure a sustained and comprehensive intervention programme	
003	Royal College of Paediatrics and Child Health	Key area for quality improvement 3: Clear local referral pathways	All professionals aware of the treatment options and levels of care	Avoidance of multiple referrals and duplication of service involvement. Improved follow through to successful outcome, depending on level of severity and complexity of the problem.	
004	College of Mental Health Pharmacy	Improved Monitoring of Physical Health and the presence of	Antipsychotics can cause serious metabolic side effects that can have significant long term cardiovascular consequences.	Audits of Documentation of physical Health Monitoring Conducted by the Prescribing Observatory for Mental Health (POMH) show sub optimal levels	POMH-UK Topic 10b Prescribing antipsychotics for children and adolescents. (2012) This audit found there was no evidence of

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		Extrapyramidal Side effects when antipsychotics are prescribed	Extrapyramidal side effects are unpleasant, can be stigmatising and reduce adherence to treatment	of recording details of physical health checks and assessment for presence of EPSE	baseline screening for full blood count, renal function, LFT and TFTs in around 30% or young people prescribed an antipsychotic. A similar result was found for monitoring of body weight, BP, pulse, Blood glucose, lipid profile, and ECG. The audit standard expected that physical health screening be conducted at least every six months. Again wide variations in practice wide noted with regard to meeting this standard.
004	College of Mental Health Pharmacy	Improved monitoring of BP and height/weight when stimulant medication is prescribed	The use of stimulant medication such as amphetamines and atomoxetine is associated with changes in blood pressure and potential growth retardation	As outlined above, audits or physical health monitoring for other medicines is sub-optimal. It is probable that a similar picture will be found with stimulant medication	POMH have conducted an audit of recording of monitoring relevant parameters for young people prescribed stimulant medication for ADHD. The result of this audit will be available in September 2013
005	NHS England	I wish to confirm that NHS England has no substantive comments to make regarding this consultation			
006	Royal College of Nursing	This is to inform you that the Royal College of Nursing has no comments to submit to inform on the topic engagement for the conduct disorders in children and young people quality standard at this time.			
007	SCM 1	Multisystemic therapy for conduct disorder	There is evidence to support the use of multisystemic therapy in improving outcomes for young people with conduct disorders	At present multi-systemic therapy is not widely available in CAMHS and its use is currently being evaluated (START Trial)	Cochrane review: Family and parenting interventions in children and adolescents with conduct disorder aged 10-17 for a systematic review of family and parenting

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			(reduced time in institutions, reduced rates of arrest) and provide cost saving to society. (NICE Clinical Guidance158; Antisocial behaviour and conduct disorders in children and young people; Costing Report, 2013)		interventionshttp://summaries.cochrane.org/CD003015/family-and-parenting-interventions-in-children-and-adolescents-with-conduct-disorder-and-delinquency-aged-10-17 START Trial (UCL, UK) multicentre trial evaluating outcome of multi-systemic therapy in adolescents (ongoing): http://www.ucl.ac.uk/start/index.php
007	SCM 1	Pharmacological interventions	There is some evidence to support the short-term use of risperidone for the management of severe aggression in young people with conduct disorder	Likely variation in use of pharmacological interventions and need to standardise monitoring of adverse effects of anti-psychotic medication e.g. risperidone in view of potential for development of metabolic adverse effects	Evidence base regarding antipsychotic side effects in children and young people: summary of relevant published data (POMH-UK/Royal college of psychiatrists, 2012) Cochrane review ; Atypical antipsychotics for disruptive behaviour disorders in children and youths (2012)
007	SCM 1	Access to services	Many different models of CAMHS –relating to entry criteria, settings in which interventions for conduct disorder are delivered.	Impact of service model on access to and uptake of services by individuals with conduct disorder, in particular for those socially excluded young people who may be least likely to attend traditional clinic- based service	NICE Clinical guidance 158
007	SCM 1	Transition of young people with conduct disorder from CAMHS to adult services	Poorly planned transition to adult mental health services is a risk factor for disengagement from services	Clear guidance re appropriate service pathways for transitional care can inform current reviews of both CAMHS and adult mental health services.	Working at the CAMHS/Adult Interface: Good practice guidance for the provision of psychiatric services to adolescents/young adults. A joint paper from the Interfaculty working group of the Child and Adolescent Faculty and the General and Community Faculty of the Royal College of Psychiatrists, May 2008. Royal college of psychiatrists report: 147 Developing services to improve the quality of life of young people with neurodevelopmental disorders, emotional/neurotic disorders and emerging personality disorder

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					Transition from CAMHS to Adult Mental Health Services (TRACK): A Study of Service Organisation, Policies, Process and User and Carer Perspectives Report for the National Institute for Health Research Service Delivery and Organisation programme January 2010
008	SCM 2	Key area for quality improvement 1	NICE guidelines recommend that: "" 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."	Effective treatments for Conduct Problems are evidence based programmes, including parenting programmes. Delivering these programmes successfully requires service development and provisions of aspects of service (e.g. crèches, transport for parents) which are often atypical for services. Without proper service development including provision of appropriately qualified staff, proper time allocation, provision of adequate supervision and training and adequate resources interventions will not be effective. Research on implementation has shown that good service development at senior level is vital to successful implementation.	Please see: Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M. & Wallace, F. (2005). Implementation Research: A Synthesis of the Literature. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231) http://nirn.fpg.unc.edu/sites/nirn.fpg.unc.edu/files/resources/NIRN-MonographFull-01-2005.pdf Asmussen, K.A, Matthews,T., Weizel,K., Bebiroglu, N. and Scott, S Research Report DFE-RR186 Evaluation of the National Academy of Parenting Practitioners' Training Offer in evidence based parenting programmes https://www.gov.uk/government/publications/evaluation-of-the-national-academy-of-

ID	*Stakeholder*	*Key area for quality improvement*	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					parenting-practitioners-training-offer-in-evidence-based-parenting-programmes
008	SCM 2	Key area for quality improvement 2	NICE guidelines state: "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."	The term "evidence based" can be used quite generally and it is important that programmes and interventions have been shown to be effective, as stated clearly in the definition below. "In the health care field, evidence-based practice (or practices), also called EBP or EBPs, generally refers to approaches to prevention or treatment that are validated by some form of documented scientific evidence." ….. "Evidence-based practice stands in contrast to approaches that are based on tradition, convention, belief, or anecdotal evidence." (SAMHSA, What is Evidence Based?) It is therefore vital that managers and commissioners are assisted to recognize the importance of choosing a programme or intervention with a strong scientific evidence base which is appropriate to their target population, otherwise the intervention is unlikely to be effective and that a portfolio of programmes is chosen that meet a range of needs	For an assessment of parenting programmes and evidence based interventions which carefully considers the level of evidence and the target population see: http://www.education.gov.uk/commissioning-toolkit and http://www.blueprintsprograms.com/ For a guide to choosing programmes appropriately see: http://dartington.org.uk/wp-content/uploads/2013/07/Design-and-Refine-guide.pdf
008	SCM 2	Key area for quality improvement 3	NICE guidelines state: "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 "Assess for the presence of the	Although conduct problems are the most common referral problem across services, there is an increasing trend for child behavioural problems to be seen as a social problem and for the complexity and seriousness of conduct problems to be overlooked. The need for skilled and competent assessment which takes account of co-morbid conditions is vital.	The article below shows that conduct disorder with comorbid conditions is under diagnosed and therefore undertreated. https://kclpure.kcl.ac.uk/portal/en/publications/service-utilisation-by-children-with-conduct-disorders--findings-from-the-gb-national-study(5c81c7e1-1685-4d35-815b-151096c79f11).html

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			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.		
008	SCM 2	Key area for quality improvement 4	Given the association with social disadvantage, children with conduct problems and their parents may be hard to engage in treatment because of anxiety about stigma and blame and scarce resources. The Nice Guidelines indicate that improving access to service and improving engagement requires a range of measures which take account of cultural diversity and language, including: • Multiple access points • Offering programmes at times families can attend • A supportive and non blaming approach • Resources in multiple languages	Unless families and children can be successfully engaged, there can be no treatment and research on the life course of conduct problems suggests that problems are likely to get worse. Thus placing an emphasis on services that can be proactive in engagement and are designed to meet service user needs is vital.	Papers discussing issues for engagement: Webster-Stratton, C. (1998)Parent Training with Low-income Families: Promoting parental engagement through a collaborative approach In J. R. Lutzker (Ed.), Handbook of child abuse research and treatment. NY: Plenum Press. Spoth, R and Redmond C. (2000) Research on Family Engagement in Preventive Interventions: Toward Improved Use of Scientific Findings in Primary Prevention Practice *The Journal of Primary Prevention,* Vol. 21, No. 2,
009	SCM 3	Compulsory specialised training for all educational staff in both	the amount of teaching and ancillary staff that I have contact with repeatedly inform me that they have no		

ID	*Stakeholder*	*Key area for quality improvement*	**Why is this important?**	**Why is this a key area for quality improvement?**	**Supporting information**
		,primary and secondary educational settings	idea/understanding/empathy of conduct disorders and have never been offered support, guidance or training related to oppositional behaviours.		
009	SCM 3	Specialised training for parents and care givers regarding offending behavioural programmes	to enable parents and carers to work through the enduring stress, hostility, verbal aggression and perplexing behaviours challenging them 24/7		
009	SCM 3	Continuity of care from health and social care for all service users	From my own personal experience and speaking to other families a big obstacle is the amount of different professionals that service users are expected to work with. Service users become very agitated and feel less valued by being passed around from team to team and consultant to consultant		
009	SCM 3	Time limits	Time limits, between the length of time acceptable to service users from referral to assessments, treatments and regular reviews.		
009	SCM3	Reasonable adjustments	Services must be adapted so that service users gain access to outpatient services specialising in the treatment conduct disorders.		
010	The Royal College of Psychiatrists	Evidence based treatment should not exclude Looked After Children	Where intensive multimodal treatments like MST, are available they have strict inclusion criteria. This means, for example, that Looked after Children, e.g. those living in children's homes or in a foster home, are usually excluded. Given that MST has the best evidence for effectiveness in conduct disorder and the high rate of this disorder in the LAC population, they are specifically disadvantaged. These strict inclusion criteria are understandable during the research phase of the MST pilot but this has come now to an end and we argue that LAC children should not be excluded		

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010	The Royal College of Psychiatrists	Evidence based treatment should be available for children and young people in the secure estate	A high rate of those children and young people who are incarcerated because of criminal offences have conduct disorder. This could be an opportunity for intervention, e.g. if staff were trained to deliver evidence based treatment modules.		
010	The Royal College of Psychiatrists	The role of Forensic Child and Adolescent Mental Health Services	A small proportion of children and young people with conduct disorder display behaviours that are extremely worrying, e.g. severe aggression and violence, serious harmful sexual behaviour, repeated severe fire setting, cruelty to animals, etc. Some of these young people show traits of emerging severe personality disorder and psychopathy. These complex children and young people usually do not respond to the short term intervention methods recommended for the treatment of conduct disorder. A forensic child and adolescent mental health service would be well positioned to offer consultation, assessment (including risk assessment) and treatment. But there are nationally very few forensic child and adolescent mental health services commissioned.		
010	The Royal College of Psychiatrists	Evidence based treatment should be available for all children and young people with conduct disorder	NICE guidance (CG 158) recommends a variety of evidenced based treatments for children and young people with conduct disorder. These include parent training programmes, parent and child training programmes for children with complex needs, child-focused programmes and multimodal interventions	These programmes are not widely available in the UK. There are well established programmes (Webster-Stratton, Triple P, Strengthening Families) with good evidence bases but these are inconsistently available throughout the UK. Whilst CYP-IAPT Phase 2 will include parent training this again is not available throughout England. Appropriate assessment and treatment of ADHD and co-morbidities should also be considered as part of a range of strategies to prevent children developing conduct disorder. There are particular difficulties in accessing the higher intensity multimodal interventions like multisystemic therapy (MST). Effectively this means that a 16 year old	• Incredible Years (Webster Stratton). • Triple P (Positive Parenting Program). • Strengthening Families Programme 10-14 (Oxford Brookes). • Strengthening Families, Strengthening Communities

ID	*Stakeholder*	*Key area for quality improvement*	**Why is this important?**	**Why is this a key area for quality improvement?**	**Supporting information**
				with conduct disorder for whom MST might be the treatment of choice cannot access it in most places in UK.	
010	The Royal College of Psychiatrists	Gender issues	Little attention has been paid so far whether girls and young women with conduct disorder have specific and possibly different needs and whether they respond differently to intervention.	Preliminary data from the MST trial show that girls with conduct disorder respond better and faster than boys to any treatment modality and particularly MST (Stephen Butler et al 2012, unpublished data, personal communication). Do we need to depart from the notion that early onset conduct disorder, i.e. lifetime persistent CD, has a particularly bad trajectory for both genders if we consider the findings that most girls with CD have an age of onset in middle childhood (Pittsburgh Girls Study) and they might respond better to any treatment, particularly MST.	The Pittsburgh Girls Study (Keenan et al 2010), a longitudinal, community–based study of 2,451 girls showed that 3.5% and 4.7% of girls aged 5-8 had ODD, 5–9% had CD across ages 7 to 14 years of age. Interestingly 90% had an age of onset for CD before the age of 10. The authors conclude that their "data indicate that the age at which conduct problems and depression emerge and signal a poor developmental trajectory for girls is during middle childhood and the preadolescent period, not adolescence. This means that prevention efforts need to be targeted during early childhood, prior to the onset of sub-syndromal or sub-threshold manifestations of disorders."