Conduct disorders in children and young people

NICE quality standard

Draft for consultation

October 2013

Introduction

This quality standard covers the recognition and management of conduct disorders in children and young people (aged under 18 years). For more information see the conduct disorders in children and young people topic overview.

Why this quality standard is needed

Conduct disorders are the most common mental and behavioural problems identified in children and young people. They 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 11 years or older.

The prevalence of conduct disorders increases throughout childhood and they are more common in boys than girls. Prevalence rates are also linked to deprivation, with

a 3- to 4-fold increase in prevalence amongst children from more deprived households compared to those in the most affluent. Almost 40% of looked after children, those who have been abused and those on child protection and safeguarding registers have been identified as having a conduct disorder.

The behaviour associated with conduct disorders can become more severe and problematic as the child gets older. Many young people with a conduct disorder can go on to have an antisocial personality disorder in adulthood. Selective prevention and early intervention can help to reduce the likelihood of the child developing more complex behavioural problems.

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measureable quality improvements within a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 2 outcomes frameworks published by the Department of Health:

- NHS Outcomes Framework 2013/14
- Improving outcomes and supporting transparency: a public health outcomes framework for England 2013–2016, Part 1 and Part 1A.

Tables 1 and 2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 NHS Outcomes Framework 2013/14

Domain	Overarching indicators and improvement areas
4 Ensuring that people have a positive experience of care	***Improvement areas*** **Children and young people's experience of healthcare** 4.8 Improving children and young people's experience of healthcare.

Table 2 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
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

Coordinated services

The quality standard for conduct disorders in children and young people specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole conduct disorder care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to children and young people with a conduct disorder.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality service for children and young people with a conduct disorder and their families or carers, are listed in ‘Related quality standards’.

Training and competencies

The quality standard should be read in the context of national and local guidelines on training and competencies. All healthcare professionals and social care practitioners involved in assessing, caring for and supporting children and young people with conduct disorders and their families or carers should have sufficient and appropriate training and competencies to deliver the assessments, interventions and other actions described in the quality standard. For psychiatrists, this would include the

specialist training in child and adolescent psychiatry that covers specific competencies in the assessment and management of adolescents with conduct disorders[1]

Role of families and carers

Quality standards recognise the important role families and carers have in supporting children and young people with a conduct disorder. Whenever possible, and if appropriate, healthcare professionals and social care practitioners should ensure that family members and carers are involved in the decision-making process about assessments and any treatment or support options.

List of quality statements

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.

Statement 2 Children and young people with a suspected conduct disorder and their parents or carers have a comprehensive assessment.

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

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

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.

Statement 6 Children and young people with a conduct disorder and severely aggressive behaviour who have been prescribed risperidone have a baseline

[1] Royal College of Psychiatrists. A competency-based curriculum for specialist training in psychiatry [accessed October 2013]

physical and metabolic investigation before starting treatment and the investigation is repeated at regular intervals.

Questions for consultation

Questions about the quality standard

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

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?

Questions about the individual quality statements

Question 3 For draft quality statement 1: Who would be responsible for identifying classroom populations in need of this intervention?

Quality statement 1: Selective prevention

Quality statement

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.

Rationale

A number of social factors increase the risk of a child developing a conduct disorder. Evidence suggests that early intervention can reduce this risk. Classroom-based interventions for populations with a high proportion of children who are at risk of developing a conduct disorder have been shown to be effective in reducing antisocial behaviour in children.

Quality measures

Structure

a) Evidence of local arrangements for health and social care professionals, managers and commissioners to work with schools to design local care pathways that include provision of classroom-based interventions for populations at risk of developing a conduct disorder.

b) Evidence of local arrangements to ensure that children aged 3 to 7 years in classroom populations 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.

Data source: Local data collection.

Process

The proportion of 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 that receive a classroom-based emotional learning and problem solving programme.

Numerator – The number of children in the denominator that receive a classroom-based emotional learning and problem solving programme.

Denominator – The number of 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.

Data source: Local data collection.

Outcome

Rates of antisocial behaviour within a classroom population.

Data source: Local data collection

What the quality statement means for service providers, healthcare professionals, social care practitioners and commissioners

Service providers ensure that they work with partner organisations, including schools, to identify classroom populations with a high proportion of children at risk of developing a conduct disorder, and deliver a classroom-based emotional learning and problem solving programme.

Healthcare professionals and social care practitioners work with colleagues in schools to identify classroom populations with a high proportion of children at risk of developing a conduct disorder, and deliver a classroom-based emotional learning and problem solving programme.

Commissioners ensure that they work with partner organisations, including schools, to design local care pathways that include identification of classroom populations with a high proportion of children at risk of developing a conduct disorder, and deliver a classroom-based emotional learning and problem solving programme.

What the quality statement means for patients, service users and carers

Children in school classes that have a lot of children who are at risk of developing antisocial or aggressive behaviour are offered a programme of activities as part of the class that helps them to learn about managing their emotions and solving problems.

Source guidance

- Antisocial behaviour and conduct disorders in children and young people (NICE clinical guideline 158), recommendations 1.2.1 and 1.2.2.

Definitions of terms used in this quality statement

Children identified to be at risk of developing a conduct disorder

The following factors have been associated with an increased risk of a child or young person developing a conduct disorder:

- 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

[Adapted from Antisocial behaviour and conduct disorders in children and young people (NICE clinical guideline 158), recommendation 1.2.1]

Classroom based emotional learning and problem solving programmes

These programmes should 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 and should involve the teacher in delivering the programme.

[Adapted from Antisocial behaviour and conduct disorders in children and young people (NICE clinical guideline 158), recommendation 1.2.2]

Questions for consultation

Who would be responsible for identifying classroom populations in need of this intervention?

Equality and diversity considerations

The workforce across agencies should, as far as possible, reflect the local community. Practitioners should have training to ensure that they have a good understanding of the culture of families with whom they are working. Interpreters should be provided if no practitioner is available who speaks a language in which the family members can converse fluently. Consideration should be given to the settings in which assessments are conducted to reflect cultural diversity.

Quality statement 2: Comprehensive assessment

Quality statement

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

Rationale

A number of factors can contribute to a child or young person developing a conduct disorder and continuing to have problems. It is important to consider all these factors when looking at possible causes and appropriate interventions. The home environment can be a significant risk factor, as well as one of the best places to target an intervention through working with parents or carers. Therefore, conducting a comprehensive assessment with the child or young person and their parents or carers is important to inform any appropriate interventions and support plans.

Quality measures

Structure

Evidence of local arrangements to ensure that children and young people with a suspected conduct disorder and their parents or carers have a comprehensive assessment.

Data source: Local data collection.

Process

The proportion of children and young people with a suspected conduct disorder and their parents or carers who have a comprehensive assessment.

Numerator – The number of children and young people and their parents or carers in the denominator who have a comprehensive assessment.

Denominator – The number of children and young people with a suspected conduct disorder.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals, social care practitioners and commissioners.

Service providers ensure that staff are trained and competent to carry out comprehensive assessments for suspected conduct disorders, and that when assessing children or young people, they also carry out an assessment of the child or young person's parents or carers.

Healthcare professionals and social care practitioners ensure that when assessing children and young people for a suspected conduct disorder they also carry out an assessment of the child or young person's parents or carers.

Commissioners ensure that they commission services that have staff trained and competent to carry out comprehensive assessments for suspected conduct disorders, and that when assessing children and young people for a suspected conduct disorder they also carry out an assessment of the child or young person's parents or carers

What the quality statement means for patients, service users and carers

Children and young people being assessed for a suspected conduct disorder have an assessment that looks at all the different parts of their life that can affect their behaviour, including their home and school environment and their parents.

Source guidance

Antisocial behaviour and conduct disorders in children and young people (NICE clinical guideline 158), recommendations 1.3.10 and 1.3.15.

Definitions of terms used in this quality statement

Comprehensive assessment of the child or young person

The standard components of a comprehensive assessment of conduct disorders should include, but is not restricted to, 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.

The assessment should take into account and address possible coexisting conditions such as:

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

[Adapted from Antisocial behaviour and conduct disorders in children and young people (NICE clinical guideline 158) recommendation 1.3.10 and 1.3.11]

Comprehensive assessment of the child or young person's parents or carers

A comprehensive assessment of the child or young person's parents or carers 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.

This assessment should also include some assessment of parenting/care history, including identification of care in the child or young person's past such as the number of placements within or outside the family.

[Adapted from Antisocial behaviour and conduct disorders in children and young people (NICE clinical guideline 158), recommendation 1.3.15, with additional information based on the expert opinion of specialist committee members]

Equality and diversity considerations

The workforce across agencies should, as far as possible, reflect the local community. Practitioners should have training to ensure that they have a good understanding of the culture of families with whom they are working. Interpreters should be provided if no practitioner is available who speaks a language in which the family members can converse fluently. Consideration should be given to the settings in which assessments are conducted to reflect cultural diversity.

Quality statement 3: Improving access to services

Quality statement

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.

Rationale

Children and young people with a conduct disorder and their families who have been referred for treatment and support have high treatment dropout rates and can sometimes find it difficult to access and engage with services. The identification of a designated professional from one of the services in contact with the child or young person and their family is intended to support coordination of services and facilitate engagement.

Quality measures

Structure

Evidence of local arrangements to ensure that 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.

Data source: Local data collection.

Process

Proportion of children and young people with a conduct disorder referred for treatment and support who have a designated professional.

Numerator – the number of children and young people in the denominator who have a designated professional.

Denominator – the number of children and young people with a conduct disorder who have been referred for treatment and support.

Data source: Local data collection.

Outcome

a) Treatment uptake rates.

b) Treatment completion rates.

c) 'Did not attend' rates for children and young people with conduct disorders and their families.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals, social care practitioners and commissioners

Service providers ensure that they have sufficient resources in place and agreements with local partner agencies for children and young people with a conduct disorder who have been referred for treatment and support to have a designated professional identified to oversee their care and facilitate engagement with services.

Healthcare professionals and social care practitioners ensure that children and young people with a conduct disorder who have been referred for treatment and support have a designated professional identified to oversee their care and facilitate engagement with services.

Commissioners ensure that they commission services that have sufficient resources for children and young people with a conduct disorder who have been referred for treatment and support to have a designated professional identified to oversee their care and facilitate engagement with services.

What the quality statement means for patients, service users and carers

Children and young people with a conduct disorder who have been referred for treatment and support have a member of staff from the service they are in contact with to help coordinate their care and support them to access services.

Source guidance

- Antisocial behaviour and conduct disorders in children and young people (NICE clinical guideline 158) recommendation 1.7.6.

Definitions of terms used in this quality statement

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. The decision about who is the most appropriate professional will depend on what service is best placed to meet the needs of the child or young person – based on the severity and nature of the disorder.

[Adapted from Antisocial behaviour and conduct disorders in children and young people (NICE clinical guideline 158), recommendation 1.7.6]

Oversee care and facilitate engagement

This includes working with children, young people and their families or carers to support engagement (for example, through following up with people if they do not attend initial appointments) and access to services by facilitating:

- 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
- access to services that support engagement (for example, crèche facilities, assistance with travel, interpreters and advocacy services).

[Adapted from Antisocial behaviour and conduct disorders in children and young people (NICE clinical guideline 158), recommendations 1.7.7 and 1.7.8]

Equality and diversity considerations

The workforce across agencies should, as far as possible, reflect the local community. Practitioners should have training to ensure that they have a good understanding of the culture of families with whom they are working. Interpreters should be provided if no practitioner is available who speaks a language in which the family members can converse fluently. Consideration should be given to the settings in which assessments are conducted to reflect cultural diversity.

Quality statement 4: Parent or carer training

Quality statement

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.

Rationale

Parent or carer training is an evidence-based intervention for the management and support of children with a conduct disorder. There is geographical variation in the provision of this intervention.

Quality measures

Structure

Evidence of local arrangements to ensure that 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.

Data source: Local data collection.

Process

The proportion of parents or carers of children with a conduct disorder aged 3 to 11 years who took part in a group or individual parent training programme.

Numerator – the number of parents or carers in the denominator who took part in a group or individual parent training programme.

Denominator – the number of parents or carers of children with a conduct disorder aged 3 to 11 years.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals, social care practitioners and commissioners

Service providers ensure that they provide group or individual parent training programmes for any parents or carers of children with a conduct disorder aged 3 to 11 years.

Healthcare professionals and social care practitioners ensure that they offer parents or carers of children with a conduct disorder aged 3 to 11 years the opportunity to take part in group or individual parent training programmes.

Commissioners ensure that they commission services that provide group or individual parent training programmes for parents or carers of children with a conduct disorder aged 3 to 11 years.

What the quality statement means for patients, service users and carers

Parents or carers of children with a conduct disorder aged 3 to 11 years are offered the opportunity to take part in a training programme (either on their own or as part of group) to help them develop skills to manage and improve their child's behaviour.

Source guidance

Antisocial behaviour and conduct disorders in children and young people (NICE clinical guideline 158) recommendations 1.5.1, 1.5.3, 1.5.4, 1.5.7, 1.5.9 and 1.5.10.

Definitions of terms used in this quality statement

Individual and group parent or carer training programmes

These interventions are suitable for the parents or carers of children and young people who have a conduct disorder, are in contact with the criminal justice system for antisocial behaviour, or have been identified as being at high risk of a conduct disorder using established rating scales of antisocial behaviour (for example, the Child Behavior Checklist and the Eyberg Child Behavior Inventory). Children with severe or complex problems should be referred for individual training programmes.

Group parent training programme

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

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

[Adapted from Antisocial behaviour and conduct disorders in children and young people (NICE clinical guideline 158), recommendation 1.5.2]

Individual parent training programmes

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

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

[Adapted from Antisocial behaviour and conduct disorders in children and young people (NICE clinical guideline 158), recommendation 1.5.4]

Group foster carer/guardian training programmes

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

- modify the intervention to take account of the care setting in which the child is living
- typically have between 8 and 12 foster carers or guardians in a group

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

[Adapted from Antisocial behaviour and conduct disorders in children and young people (NICE clinical guideline 158), recommendation 1.5.8]

Individual foster carer/guardian training programmes

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

- modify the intervention to take account of the care setting in which the child is living
- be based on a social learning model using modelling, rehearsal and feedback to improve parenting skills
- consist of up to 10 meetings of 60 minutes' duration
- adhere to a developer's manual and employ all of the necessary materials to ensure consistent implementation of the programme.

[Adapted from Antisocial behaviour and conduct disorders in children and young people (NICE clinical guideline 158), recommendation 1.5.10]

Equality and diversity considerations

Consideration will need to be given to representation of family units and recognising that family units can vary between cultures. Where possible, programme materials should be made available in different languages.

Quality statement 5: Multimodal interventions

Quality statement

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.

Rationale

Multimodal interventions have been shown to be effective in helping older children and young people with a conduct disorder to manage their behaviour in different social settings. There is a high level of geographical variation in the provision of this intervention.

Quality measures

Structure

Evidence of local arrangements to ensure that children and young people identified with a conduct disorder aged 11 to 17 years, and their parents or carers, are referred for multimodal interventions.

Data source: Local data collection.

Process

The proportion of children and young people with a conduct disorder aged 11 to 17 years who, with their parents or carers, take part in multimodal interventions.

Numerator – the number of young people and their parents or carers, in the denominator who take part in multimodal interventions.

Denominator – the number of children and young people with a conduct disorder aged 11 to 17 years and their parents or carers.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals, social care practitioners and commissioners

Service providers ensure that they provide multimodal interventions for children and young people with a conduct disorder aged 11 to 17 years, and their parents or carers.

Healthcare professionals and social care practitioners ensure that they offer children and young people with a conduct disorder aged 11 to 17 years, and their parents or carers, multimodal interventions.

Commissioners ensure that they commission services that provide multimodal interventions for children and young people with a conduct disorder aged 11 to 17 years, and their parents or carers.

What the quality statement means for patients, service users and carers

Children and young people with a conduct disorder who are aged 11 to 17 years take part in a programme of support focused on helping them to improve how they interact with their family, when they are at school and in other settings within their community.

Source guidance

Antisocial behaviour and conduct disorders in children and young people (NICE clinical guideline 158), recommendation 1.5.13.

Definitions of terms used in this quality statement

Multimodal interventions

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

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

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

[Adapted from Antisocial behaviour and conduct disorders in children and young people (NICE clinical guideline 158), recommendation 1.5.14]

Quality statement 6: Monitoring adverse effects of pharmacological interventions

Quality statement

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 that is repeated at regular intervals.

Rationale

For some children and young people whose severely aggressive behaviour has not responded to psychosocial interventions alone, atypical antipsychotics (most commonly risperidone) may also be needed in the short term. This medication can have significant physical effects and, in some cases, significant adverse effects. Current practice information suggests that there is variation in the baseline investigations and monitoring of adverse effects carried out in children and young people taking risperidone.

Quality measures

Structure

Evidence of local arrangements to ensure that children and young people with a conduct disorder and severely aggressive behaviour who have been prescribed risperidone have a baseline physical and metabolic investigation carried out before starting treatment that is repeated at regular intervals.

Data source: Local data collection.

Process

a) The proportion of children and young people with a conduct disorder and severely aggressive behaviour who have been prescribed risperidone who have a baseline physical and metabolic investigation carried out before the start of treatment.

Numerator – the number of children and young people in the denominator who have a baseline physical and metabolic investigation carried out at before the start of treatment.

Denominator – the number of children and young people with a conduct disorder and severely aggressive behaviour who have been prescribed risperidone.

b) 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

Numerator – the number of children and young people in the denominator who have had their height and weight measured and recorded at each appointment

Denominator – the number of children and young people with a conduct disorder and severely aggressive behaviour who are taking risperidone.

c) The proportion of children and young people with a conduct disorder and severely aggressive behaviour who have been prescribed risperidone who have had a metabolic investigation carried out no later than 3 months after the baseline investigation and then at least every 3 months afterwards until treatment is stopped.

Numerator – the number of children and young people in the denominator who have a metabolic investigation carried out no later than 3 months after the baseline investigation and then at least every 3 months afterwards until treatment is stopped.

Denominator – the number of children and young people with a conduct disorder and severely aggressive behaviour that have been prescribed risperidone.

Data source: The Royal College of Psychiatrists Prescribing Observatory for Mental Health (2012) National audit of antipsychotic prescribing (2012) topic 10b: prescribing antipsychotics for children and adolescents.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers ensure that there are protocols in place for all children and young people with a conduct disorder and severely aggressive behaviour who have been prescribed risperidone to be monitored for adverse effects and have a baseline physical and metabolic investigation carried out before the start of treatment that is repeated at regular intervals.

Healthcare professionals ensure that children and young people with a conduct disorder and severely aggressive behaviour who have been prescribed risperidone are monitored for adverse effects and have a baseline physical and metabolic investigation carried out before the start of treatment that is repeated at regular intervals.

Commissioners ensure that they commission services that have protocols in place for all children and young people with a conduct disorder and severely aggressive behaviour that have been prescribed risperidone to be monitored for adverse effects and have a baseline physical and metabolic investigation carried out before the start of treatment that is repeated at regular intervals.

What the quality statement means for patients, service users and carers

Children and young people who are taking risperidone to help treat their conduct disorder and aggressive behaviour are monitored for any unwanted side effects and have a number of physical checks carried out before they start treatment that are repeated regularly to monitor the effects of the treatment.

Source guidance

Antisocial behaviour and conduct disorders in children and young people (NICE clinical guideline 158), recommendations 1.6.5 and 1.6.6.

Definitions of terms used in this quality statement

Baseline physical and metabolic investigation

At the start of treatment, a suitably qualified healthcare professional with expertise in conduct disorders should undertake and record the following baseline investigations:

- weight and height (both plotted on a growth chart)
- waist and hip measurements
- pulse and blood pressure
- fasting blood glucose, glycosylated haemoglobin (HbA_{1c}), blood lipid and prolactin levels
- assessment of any movement disorders

- assessment of nutritional status, diet and level of physical activity.

Regular intervals

Weight and height should be recorded at each appointment and blood testing should occur at least every 3 months.

[Adapted from the The Maudsley Prescribing Guidelines 11th edition)

Severely aggressive behaviour

This refers to the behaviour of children and young people with a conduct disorder who have problems with explosive anger and severe emotional dysregulation.

[Adapted from Antisocial behaviour and conduct disorders in children and young people (NICE clinical guideline 158), recommendation 1.6.3]

Status of this quality standard

This is the draft quality standard released for consultation from 19 November 2013 to 17 December 2013. It is not NICE's final quality standard on conduct disorders. The statements and measures presented in this document are provisional and may change after consultation with stakeholders.

Comments on the content of the draft standard must be submitted by 5pm on 17 December 2013. All eligible comments received during consultation will be reviewed by the Quality Standards Advisory Committee and the quality statements and measures will be refined in line with the Quality Standards Advisory Committee's considerations. The final quality standard will be available on the NICE website from April 2014.

Using the quality standard

Quality measures

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

We have indicated if current national indicators exist that could be used to measure the quality statements. These include indicators developed by the Health and Social Care Information Centre through its Indicators for Quality Improvement Programme. If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

See NICE's What makes up a NICE quality standard? for further information, including advice on using quality measures.

Levels of achievement

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of

100% should be aspired to (or 0% if the quality statement states that something should not be done). However, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

Using other national guidance and policy documents

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered by commissioners, providers, healthcare professionals and social care practitioners, patients, service users and carers alongside the documents listed in 'Development sources'.

Diversity, equality and language

During the development of this quality standard, equality issues have been considered and equality assessments are available.

Good communication between healthcare professionals and social care practitioners and children and young people with a conduct disorder, and their parents or carers (if appropriate), is essential. Treatment, care and support, and the information given about it, should be both age-appropriate and culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. Children and young people with a conduct disorder and their parents or carers (if appropriate) should have access to an interpreter or advocate if needed.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

Development sources

Further explanation of the methodology used can be found in the quality standards Process guide on the NICE website.

Evidence sources

The documents below contain recommendations from NICE guidance or other NICE-accredited recommendations that were used by the Quality Standards Advisory Committee to develop the quality standard statements and measures.

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

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

- Department of Health (2012) No health without mental health: implementation framework..
- Department of Health (2011) A guide to working with offenders with personality disorders..
- Department of Health (2011) Children and young people's emotional wellbeing and mental health national support team – the learning: 'What good looks like'.
- Department of Health (2011) No health without mental health: a cross-government mental health outcomes strategy for people of all ages.

Definitions and data sources for the quality measures

- The Royal College of Psychiatrists Prescribing Observatory for Mental Health (2012) National audit of antipsychotic prescribing (2012) topic 10b: prescribing antipsychotics for children and adolescents.

Related NICE quality standards

Published

- Attention deficit hyperactivity disorder. NICE quality standard 39 (2013).
- Health and wellbeing of looked-after children and young people. NICE quality standard 31 (2013).

- Patient experience in adult NHS services. NICE quality standard 15 (2012).
- Service user experience in adult mental health. NICE quality standard 14 (2011).

Future quality standards

This quality standard has been developed in the context of all quality standards referred to NICE, including the following topics scheduled for future development:

- Managing the transition from children's to adult services.
- Personality disorder (children and young people).

Quality Standards Advisory Committee and NICE project team

Quality Standards Advisory Committee

This quality standard has been developed by Quality Standards Advisory Committee 3.

Membership of this committee is as follows:

Hugh McIntyre (Chair)
Consultant Physician, East Sussex Healthcare Trust

Alastair Bradley
General Medical Practitioner, Tramways Medical Centre/ Academic Unit of Primary Medical Care, University of Sheffield

Jan Dawson
Public Health Nutrition Lead, Manchester City Council

Lisa Edwards
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Malcolm Frisk
Co-Director, Ageing Society Grand Challenge Initiative, Coventry University

Margaret Goose

Lay member

Julia Hickling

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Ann Nevinson

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Eve Scott

Head of Safety & Risk, Christie NHS Foundation Trust.

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Julia Thompson

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The following specialist members joined the committee to develop this quality standard:

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Lay member

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Consultant Paediatrician, St George's Hospital, London

Moira Doolan

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About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

The methods and processes for developing NICE quality standards are described in the quality standards process guide.

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