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# Prompt interventions improve outcomes in conduct disorders



Dr Clare Taylor, and Professors Stephen Pilling and Stephen Scott explain the importance of early identification and care of children and young people with conduct disorders

Antisocial behaviour and conduct disorders are common, affecting 5% of the total child and adolescent population in Britain, with around double the rate in boys compared with girls, and several times the rate in families who are socioeconomically disadvantaged.<sup>1</sup> They present a significant challenge across healthcare and social care services, with approximately one-third of a typical GP's child consultations involving behavioural problems.<sup>2</sup> Healthcare professionals in primary care can have a major role in influencing outcomes,<sup>3</sup> which are very poor if the child remains untreated. The following are 5- to 10-fold higher in children with a conduct disorder than in controls:<sup>4</sup>

- ▶ criminality
- ▶ domestic violence
- ▶ serious drug and alcohol misuse
- ▶ teenage pregnancy
- ▶ leaving school with no qualifications
- ▶ unemployment.

## Risk factors

Risk factors for antisocial behaviour and conduct disorders include:<sup>8</sup>

- ▶ genetic predisposition (often indicated by parents in contact with the criminal justice system, or with an alcohol-use disorder)



NICE Clinical Guideline 158 on *Antisocial behaviour and conduct disorders in children and young people: recognition, intervention and management* has been awarded the NICE Accreditation Mark.

This Mark identifies the most robustly produced guidance available. See [evidence.nhs.uk/accreditation](http://evidence.nhs.uk/accreditation) for further details.

- ▶ symptoms of attention deficit hyperactivity disorder (ADHD):
  - motor overactivity
  - impulsiveness
  - short attention span
- ▶ poor parenting:
  - harsh, inconsistent discipline
  - low levels of parental warmth
  - lack of parental involvement and joint activities.

## Recognising antisocial behaviour

Antisocial behaviour is not difficult to recognise as concerned parents will often disclose to their GP that their child is:

- ▶ disobedient
- ▶ rude
- ▶ aggressive
- ▶ destructive
- ▶ often lies or steals.

If this behaviour continues for longer than 6 months, it is quite likely that the child or young person will have a conduct disorder (typically oppositional defiant disorder if the child is under 10 years of age). If the behavioural problems are short-lived and do not interfere with school or family life, it is reasonable for GPs to wait a month or two to see if the problems change. However, if they are more persistent or severe, then referral to a specialist service will become necessary.

▲

**Conduct disorders present a significant challenge across healthcare and social care services**

▼

## Clinical Guideline 158

NICE Clinical Guideline (CG) 158 on *Antisocial behaviour and conduct disorders in children and young people: recognition, intervention and management* was developed by the National Collaborating Centre for Mental Health (NCCMH) and the Social Care Institute for Excellence. NICE CG158 states that 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.’<sup>2</sup>

This article summarises the key recommendations from NICE CG158 that are relevant to GPs and other primary care healthcare professionals.

### Working safely and effectively with children and young people

NICE CG158 makes several recommendations to improve competency in professionals who come into contact with children and young people with a conduct disorder, and their parents and carers. Children and young people with conduct disorders represent all levels of learning ability, cognitive capacity, emotional maturity, and development. Clinicians should be able to:

- ▶ assess the child or young person’s capacity to understand information and make decisions
- ▶ apply relevant legislation such as the Children Act (1989),<sup>5</sup> Mental Health Act (2007),<sup>6</sup> and Mental Capacity Act (2005).<sup>7</sup>

### Establishing relationships

The Guideline Development Group (GDG) for NICE CG158 was aware that many children and young people with a conduct disorder have poor or punitive experiences of care and

therefore might not trust, or might dismiss, offers of help. It was therefore keen to promote a positive and trusting relationship between professionals and the child or young person (and their parents and carers, if involved). The qualitative evidence reviewed in NICE CG158<sup>8</sup> demonstrated that issues of confidentiality and privacy were of prime importance to children and young people with a conduct disorder. NICE CG158 makes several recommendations to help improve the way negotiations are handled with regard to information that is shared with other professionals, parents or carers. If parents or carers are involved in a young person’s care or treatment, CG158 recommends that professionals should periodically discuss the form that this involvement should take (i.e. which aspects of care the child or young person wants the parents/carers to be involved in, and to what extent). The guideline also recognises the needs of parents and carers, and recommends that they are offered:<sup>2</sup>

- ▶ personal, social, and emotional support
- ▶ help to carry out their caring role (including advice on emergency plans)
- ▶ advice on practical matters (e.g. housing, finances, and the care of any other dependent children).

### Communication and information

NICE CG158 recommends that professionals become familiar with local and national sources of information relating to conduct disorders and are able to discuss these and actively support children and young people, and their parents or carers, in engaging with them.<sup>2</sup>

In order to effectively engage children and young people with a conduct disorder in treatment, it is important they are given information that is appropriate to their developmental, cognitive, and intellectual level. This principle extends to all forms of communication, and the guideline advises the use of plain language and communication aids if necessary (e.g.

pictures, symbols, large print, Braille, different languages, or sign language). Diverse forms of media (e.g. email and text messaging) should also be used.<sup>2</sup>

### Selective prevention

Given the proportion of children and young people presenting to primary care with behavioural problems, GPs and other primary care healthcare professionals are in a prime position to prevent such problems from developing into a conduct disorder by identifying risk factors early on. NICE CG158 makes several recommendations to this end, advising that interventions should be targeted at those children and young people whose risk of developing a conduct disorder (as described in the introduction above) is significantly higher than average. This process is called ‘selective prevention’. The guideline recommends that emotional learning and problem-solving programmes, for children aged typically between 3 and 7 years, should be provided in schools where classroom populations have a high proportion of children identified as being at risk of developing a conduct disorder. The aim of these programmes is to:<sup>2</sup>

- ▶ 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
- ▶ help develop problem-solving skills.

### Identification and assessment

If a child or young person’s parents, carers, or school/college raise concerns about persistent antisocial behaviour, GPs and primary care healthcare professionals may be able to identify established or suspected conduct disorders early on, which, in turn, will ease access to children and adolescent mental health services (CAMHS).<sup>9</sup> NICE CG158 recommends considering the use of the Strengths and Difficulties Questionnaire (SDQ),<sup>10</sup> which should be completed by a parent, carer, or teacher during the initial

## NICE implementation tools

NICE has developed the following tools to support implementation of Clinical Guideline 158 (CG158) on *Conduct disorders in children and young people*:

- ▶ costing report
- ▶ costing template
- ▶ clinical audit tool
- ▶ baseline assessment tool
- ▶ podcast.

The tools are now available to download from the NICE website:  
[www.nice.org.uk/CG158](http://www.nice.org.uk/CG158)

assessment of a child or young person with a suspected conduct disorder. While the evidence suggests that the sensitivity of the SDQ improves from moderate to excellent when more than one person completes it,<sup>11</sup> the GDG recognised that for use in a primary care setting, this would not normally be feasible.

The GP or primary care healthcare professional has an important part to play in ascertaining the nature of the parenting style (assessment according to local safeguarding procedures should be made if the relationship is exploitative or abusive), and whether there are concerns about the parents' mental health, such as depression or drug misuse, or partner violence that may impact on the child or young person.

NICE CG158 recommends that the presence of other mental health problems (e.g. depression, post-traumatic stress disorder) and neurodevelopmental conditions (e.g. ADHD, autism) in children and young people with a conduct disorder should be assessed, along with learning disabilities or difficulties, and substance misuse. (Indeed, the GDG was keen to emphasise that a neurodevelopmental condition should not be a barrier to assessment.) If any of these problems are present, the child or young person should be referred to specialist CAMHS for comprehensive assessment.<sup>2</sup>

If the problem is primarily a conduct disorder, the guideline advises that a direct referral for an intervention, such as a parent-training programme, can be made.<sup>2</sup>

## Discussing the options

The guideline recognises the importance of a full discussion about the recommended interventions with the child or young person (and, if appropriate, their parents or carers), before making a referral. Such discussions should be predicated on the:<sup>2</sup>

- ▶ child or young person's past and current experience of conduct disorder
- ▶ child or young person's experience of, and response to, previous interventions and services
- ▶ nature, severity, and duration of the problem
- ▶ impact of the disorder on educational performance
- ▶ social or family factors that may have a role in the development or maintenance of the identified problem
- ▶ any coexisting conditions, including chronic physical health problems.

The child or young person's preferences, or that of their parent or carer, should also be taken into account.<sup>2</sup>

All those involved in the discussion should be given information about the nature, content, duration, acceptability, and tolerability of any proposed intervention, its possible impact on treatments for any other behavioural or mental health problem, and the implications for continuing with any current interventions.<sup>2</sup>

## Interventions

### Psychosocial interventions

There are a number of recommended psychosocial interventions that 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
- ▶ 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<sup>12</sup> and the Eyberg Child Behavior Inventory<sup>13</sup>).

These interventions include:<sup>2</sup>

- ▶ for children aged between 3 and 11 years:
  - parent-training programmes (group and individual)
  - parent and child training programmes for children with complex needs
  - foster carer/guardian training programmes (group and individual)
- ▶ For children aged between 9 and 14 years:
  - child-focused social and cognitive problem-solving programmes (group).

In addition, for young people aged 11–17 years with a diagnosed conduct disorder, multimodal interventions (e.g. multisystemic therapy), are recommended. Interventions should be provided by specially trained case managers and are very intensive. They should involve the young person and their parents and carers, and should have an explicit and supportive family focus with interventions provided at the following levels:<sup>2</sup>

- ▶ individual
- ▶ family
- ▶ school
- ▶ criminal justice
- ▶ community.

### Pharmacological interventions

Pharmacological interventions are not recommended for the routine management of behavioural problems in children and young people.<sup>2</sup>

However for those who also have ADHD, the guideline advises use of methylphenidate or atomoxetine, within their licensed indications, in line with NICE Clinical Guideline 72,

## Key points

- ▶ Antisocial behaviour and conduct disorders affect 5% of children and young people in Britain
- ▶ Around 33% of a GP's child consultations can relate to behavioural problems
- ▶ Less than one-quarter of children and young people with a conduct disorder receive specialist assessment or treatment
- ▶ Untreated conduct disorder can lead to poor outcomes, and GPs have a role in improving these outcomes
- ▶ Selective prevention interventions in schools can help to prevent at-risk children from developing a conduct disorder
- ▶ GPs can make direct referrals to parent-training programmes if there are no significant problems in addition to the conduct disorder.

*Attention deficit hyperactivity disorder.*<sup>14</sup> (Methylphenidate and atomoxetine do not have UK marketing authorisation for use in children younger than 6 years. Informed consent should be obtained and documented.) The antipsychotic risperidone can be considered for a young person exhibiting the following, but only if they have not responded to psychosocial interventions:

- ▶ severely aggressive behaviour
- ▶ explosive anger
- ▶ severe emotional dysregulation.

Risperidone should be started only by an appropriately qualified healthcare professional with expertise in conduct disorders (usually a child and adolescent psychiatrist).<sup>2</sup> At the time of publication of NICE CG158 (March 2013), some preparations of risperidone did not have a UK marketing authorisation for this indication in young people and no preparations were authorised for use in children aged under 5 years. The prescriber should consult the summary of product characteristics for the individual risperidone and follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented.

## Transfer and future care

For children and young people with a conduct disorder, withdrawal and

ending of treatments or services, and transition from one service to another, may evoke strong emotions and reactions. To ease this transition as much as possible, the guideline recommends careful planning beforehand so that any changes are structured and phased. Children and young people, and their parents or carers, should be given comprehensive information about the way adult services work and the nature of any potential interventions proposed. When a child or young person is referred for assessment by other services (including for psychosocial interventions), they should be supported during the referral period and arrangements for support agreed beforehand.<sup>2</sup>

For young people who continue to exhibit antisocial behaviour, or meet criteria for a conduct disorder while in transition to adult services (in particular those who are still vulnerable, e.g. those who have been looked after, or who have limited access to care), professionals should refer to NICE CG77 on *Antisocial personality disorder*.<sup>2,15</sup>

## Implementing NICE CG158 on antisocial behaviour and conduct disorders

Less than 25% of children and young people with a conduct disorder receive

assessment or treatment in specialist services,<sup>16</sup> and this is partly because of a lack of awareness among professionals and the wider public that conduct disorder is not mere naughtiness but a diagnosable condition with psychological and biological causes, which can be effectively treated by a range of evidence-based interventions (e.g. parent-training programmes).

In order to ensure that these interventions are accessible, they need to be:<sup>2</sup>

- ▶ available at times when parents can attend, including outside normal working hours
- ▶ provided in the person's home or other residential setting (where needed)
- ▶ delivered by trained staff who have regular supervision.

## Local care pathways

In line with previous NICE guidance on common mental health disorders,<sup>17</sup> the guideline on conduct disorders<sup>2</sup> recommends that healthcare professionals (including those in primary care), 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, their parents, and carers. Such pathways should have multiple means of accessing the service (including self-referral), and multiple points of access that facilitate links with the wider care system, including educational and social care services and the community in which the service is located. There should also be protocols for sharing and communicating information about the care of children and young people with other professionals (including GPs) and communicating information between the services provided within the pathway.

More widely, service delivery needs to be highly organised and coordinated across agencies, including youth offending teams.

## GP commissioning take home messages for England

written by Dr David Jenner, NHS Alliance GMS contract/PBC Lead

- ▶ NICE recommends that local commissioners work with local providers of children's services and education to design local care pathways that demonstrate available services (NB these services should have multiple access and referral points, including for self referral)
- ▶ Commissioners will need to consider how they can engage 'free schools and academies' in this process as local councils no longer have accountability for these services
- ▶ Health visitors and education services can assist GPs in the assessment and referral process by completing the Strengths and Difficulties Questionnaire<sup>10</sup> prior to GP consultations
- ▶ Commissioners should look to identify any gaps in recommended service provision as part of the pathway process and to commission services to meet unmet need
- ▶ The mental health tariff is complex and not as precise as the general Payment by Results tariff;<sup>a</sup> commissioners should seek to agree prices for the commissioned services recognising that some may be a joint commissioning responsibility with social services.

<sup>a</sup>[www.gov.uk/government/publications/payment-by-results-pbr-operational-guidance-and-tariffs](http://www.gov.uk/government/publications/payment-by-results-pbr-operational-guidance-and-tariffs)

## Conclusion

Primary care can play an important role in the early identification of problems that might lead to development of a conduct disorder, and in the recognition of established conduct disorder. This is crucial in helping to prevent antisocial behaviours becoming entrenched and developing into antisocial personality disorder in adulthood. Prompt interventions are key to relieving the substantial burden that these problems place on the individual, their family, and wider society.

**Key points are available on p.20 and commissioning messages are above.**

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