NICE National Institute for Health and Care Excellence

NICE quality standard

Antisocial behaviour and conduct disorders in children and young people

Quality standard

Published: 17 April 2014
www.nice.org.uk/guidance/qs59

Contents

This standard is based on CG158.

This standard should be read in conjunction with QS39, QS51, QS31, QS88, QS107, QS101, QS154 and QS165.

Introduction

This quality standard covers the recognition and management of antisocial behaviour and 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, and associated antisocial behaviour, are the most common mental and behavioural problems identified in children and young people. 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 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 among children from more deprived households compared with 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. There is evidence to suggest that up to 50% of children and young people with a conduct disorder go on to develop 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.

The quality standard is expected to contribute to improvements in the following outcomes:

- Emotional wellbeing of children and young people.
- Emotional wellbeing of the parents and carers of children and young people.
- Reducing contact with the youth justice system.
- Educational attainment.
- Number of 16–18 year olds in education, employment or training.

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measurable 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 2014–15
- 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 2014–15

Domain	Overarching indicators and improvement areas

4 Ensuring that people have a positive experience of care	*Improvement areas* **Improving children and young people's experience of healthcare** 4.8 Children and young people's experience of outpatient services

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 *Indicators* *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* *1.12 Violent crime (including sexual violence)*
2 Health improvement	*Objective* People are helped to live health lifestyles, make healthy choices and reduce health inequalities *Indicators* *2.8 Emotional wellbeing of looked-after children* *2.10 Self-harm*

Coordinated services

The quality standard for antisocial behaviour and conduct disorders in children and young people specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole antisocial behaviour and conduct disorder care pathway. This is particularly important for this population because local authorities, health services and Child and Adolescent Mental Health Services (CAMHS) share responsibility for recognition, assessment, management and interventions for children and young people with conduct disorders. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to children and young people with a conduct disorder.

Children and young people with conduct disorders may present to a variety of agencies within the health, education, social care and voluntary sectors and the justice system. It is important that agencies work collaboratively so that cases of conduct disorders can be identified early and that they refer appropriately in order for early intervention to occur.

It is important that all relevant agencies recognise that coexisting conditions, for example, attention deficit hyperactivity disorder (ADHD) and post-traumatic stress disorder (PTSD), are common in children and young people with a conduct disorder, and take account of this when working in collaboration with other services.

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 health, public health 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 young people 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, health, public health and social care practitioners should ensure that family members and carers are involved in all aspects of care. This includes involvement in the decision-making process about assessments and any treatment or support options. For children and young people with conduct disorders, health, public health and social care practitioners should be aware that multiple parents and carers may be involved.

[1] Royal College of Psychiatrists. A competency-based curriculum for specialist training in psychiatry [accessed March 2014]

List of quality statements

Statement 1. Children aged 3 to 7 years attending school classes where a high proportion of children are identified as at risk of developing a conduct disorder take part in a classroom-based emotional learning and problem-solving programme.

Statement 2. Children and young people with a suspected conduct disorder and any significant complicating factors have a comprehensive assessment, including an assessment of the child or young person's parents or carers.

Statement 3. Children and young people with a conduct disorder who have been referred for treatment and support have a key worker 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 or carer training programmes.

Statement 5. Children and young people aged 11 to 17 years who have a conduct disorder are offered a referral for multimodal interventions, with the involvement of their parents or carers.

Statement 6. Children and young people with a conduct disorder and severely aggressive behaviour who have been prescribed risperidone have a baseline physical and metabolic investigation and are monitored for efficacy and adverse effects at regular intervals.

Quality statement 1: Early intervention

Quality statement

Children aged 3 to 7 years attending school classes where a high proportion of children are identified as at risk of developing a conduct disorder take part in 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. Given the variety of programmes available, it is important to deliver an evidence-based programme to ensure that this intervention is delivered effectively and appropriately.

Quality measures

Structure

a) Evidence of locally agreed protocols for the identification of school classes where a high proportion of children are at risk of developing a conduct disorder, by individuals or groups with relevant expertise in antisocial behaviour and conduct disorders in children.

b) Evidence of local arrangements for health and social care practitioners, managers and commissioners to work with colleagues in the education sector to design local pathways that include provision of classroom-based interventions for children at risk of developing a conduct disorder.

c) 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

Proportion of school classes (for children aged 3 to 7 years) where a high proportion of children are

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 school classes in the denominator that receive a classroom-based emotional learning and problem-solving programme.

Denominator – the number of school classes (for children aged 3 to 7 years) that have a high proportion of children identified as 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, health and social care and education practitioners, and commissioners

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

Health, social care and education practitioners work in collaboration to identify classroom populations where a high proportion of children are at risk of developing a conduct disorder, and deliver a classroom-based, evidence-based emotional learning and problem-solving programme.

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

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), recommendation 1.2.1.

Definitions of terms used in this quality statement

Children identified as 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. [Adapted from Antisocial behaviour and conduct disorders in children and young

people (NICE clinical guideline 158), recommendation 1.2.2]

High proportion of children identified as being at risk of developing a conduct disorder

This should be defined locally by individuals and/or groups with relevant expertise in antisocial behaviour and conduct disorders in children, and knowledge of the risk factors associated with an increased risk of a child developing a conduct disorder. These individuals and groups may include:

- special educational needs coordinators (SENCO)
- teachers
- educational psychologists
- local education authority departments.
- Child and Adolescent Mental Health Services (CAMHS) departments
- community paediatric departments. [Developed from expert consensus]

Equality and diversity considerations

It is important that schools have local protocols in place to ensure that parents and carers are made aware that their child will take part in a classroom-based emotional learning and problem-solving programme.

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 any significant complicating factors have a comprehensive assessment, including an assessment of the child or young person's parents or carers.

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. Where significant complicating factors are identified as part of initial assessment, a comprehensive assessment should be conducted. This should take into account the home environment which 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 an assessment of 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 any significant complicating factors have a comprehensive assessment, including an assessment of their parents or carers.

Data source: Local data collection.

Process

a) The proportion of children and young people with a suspected conduct disorder and any significant complicating factors who have a comprehensive assessment.

Numerator – the number of children and young people in the denominator who have a comprehensive assessment.

Denominator – the number of children and young people with a suspected conduct disorder and any significant complicating factors.

b) The proportion of parents or carers of children and young people with a suspected conduct disorder and any significant complicating factors who have a comprehensive assessment.

Numerator – the number of parents or carers in the denominator who have a comprehensive assessment.

Denominator – the number of parents or carers of children and young people with a suspected conduct disorder and any significant complicating factors.

Data source: Local data collection.

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

Service providers ensure that staff are trained and competent to carry out comprehensive assessments for children and young people with a suspected conduct disorder and significant complicating factors, and also to carry out and assessment of their parents or carers.

Health and social care practitioners ensure thatthey complete a comprehensive assessment for children and young people with a suspected conduct disorder and any significant complicating factors, and also carry out an assessment of their parents or carers.

Commissioners ensure that they commission services that have staff trained and competent to carry out comprehensive assessments for children and young people with a suspected conduct disorder and any significant complicating factors, and also to carry out an assessment of their parents or carers.

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

Children and young people who are suspected to have a conduct disorder and who have other conditions (for example, problems with learning, communication or substance misuse, mental health problems, or conditions such as epilepsy and autism) 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 1.3.6, 1.3.8 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 style
- history of any past or current mental or physical health problems
- the presence or risk of physical, sexual and emotional abuse in line with local protocols for the assessment and management of these 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).

When diagnosing coexisting conditions, it may be appropriate to use formal assessment instruments, such as the Strengths and Difficulties Questionnaire, for all children or young people

to aid the diagnosis. [Adapted from Antisocial behaviour and conduct disorders in children and young people (NICE clinical guideline 158) recommendations 1.3.10, 1.3.11, 1.3.12 and 1.3.14 and expert consensus]

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, parental learning disability, 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 and expert consensus]

Significant complicating factors

Significant complicating factors assessed as part of the initial assessment of children and young people with a possible conduct disorder include:

- 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. [Antisocial behaviour and conduct disorders in children and young people (NICE clinical guideline 158) recommendation 1.3.5]

Suspected conduct disorder

Children and young people are considered to have a suspected conduct disorder if their parents or carers, health or social care professionals, school or college, or peer group, raise concerns about persistent antisocial behaviour. [Adapted from Antisocial behaviour and conduct disorders in

children and young people (NICE clinical guideline 158), recommendation 1.3.2]

Equality and diversity considerations

Practitioners should support access to services and the uptake of interventions by children and young people, and their parents and carers, by being flexible in relation to settings and offering a range of support services. Recommendations 1.7.7 and 1.7.8 provide examples of settings and support services.

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 specific needs of:

- girls and young women with conduct disorders
- looked-after and adopted children and young people.

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 key worker 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 key worker 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 key worker 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 key worker.

Numerator – the number of children and young people in the denominator who have a key worker.

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, health and 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 key worker who will oversee their care and facilitate engagement with services.

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

Commissioners ensure that they commission services that can provide children and young people with a conduct disorder who have been referred for treatment and support with a key worker 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 one of the services 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

Key worker

This can include a member of staff from Child and Adolescent Mental Health Services (CAMHS), or a member of staff from a relevant social care, education or healthcare 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

Practitioners should support access to services and the uptake of interventions by children and young people, and their parents and carers, by being flexible in relation to settings and offering a range of support services. Recommendations 1.7.7 and 1.7.8 provide examples of settings and support services.

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 specific needs of:

- girls and young women with conduct disorders
- looked-after and adopted children and young people.

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 or carer training programmes.

Rationale

Parent or carer training is an intervention to help people gain the skills needed to support children with a conduct disorder. Given the variety of training programmes available, it is important to offer this group an evidence-based programme to ensure that this intervention is delivered effectively and appropriately.

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 or carer training programmes.

Data source: Local data collection.

Process

a) Proportion of parents or carers of children with a conduct disorder aged 3 to 11 years who are offered a referral for a group or individual parent or carer training programme.

Numerator – the number of parents or carers in the denominator who are offered a referral for a group or individual parent or carer training programme.

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

b) Proportion of parents or carers of children with a conduct disorder aged 3 to 11 years who attend a group or individual parent or carer training programme.

Numerator – the number of parents or carers in the denominator who attend a group or individual

parent or carer training programme.

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

c) Proportion of parents or carers of children with a conduct disorder aged 3 to 11 years who complete a group or individual parent or carer training programme.

Numerator – the number of parents or carers in the denominator who complete a group or individual parent or carer 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, health and social care practitioners, and commissioners

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

Health 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 or carer training programmes.

Commissioners ensure that they commission services that provide group or individual parent or carer training programmes that adhere to an evidence-based model 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, 1.5.5, 1.5.7 and 1.5.9.

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). Where possible, a group parent or carer training programme should be offered. However, parents of children with severe or complex problems should be referred for individual training programmes. These interventions should be evidence-based and adhere to a developer's manual to ensure that care is effective, person-centred and individualised.

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]

Individual parent and child training programmes

Individual parent and child training programmes should involve both parents, foster carers or guardians 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
- 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 1.5.6]

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

Practitioners should support access to services and the uptake of interventions by children and young people, and their parents and carers, by being flexible in relation to settings and offering a range of support services. Recommendations 1.7.7 and 1.7.8 provide examples of settings and support services.

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

Quality statement 5: Multimodal interventions

Quality statement

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

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. Parental participation is an important part of the intervention because the focus is on changing the environment around the young person, which can then help to change the young person's behaviour. Given the variety of interventions available, it is important to offer evidence-based multimodal interventions to ensure that the intervention is delivered effectively and appropriately.

Quality measures

Structure

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

Data source: Local data collection.

Process

a) Proportion of children and young people aged 11 to 17 years who have a conduct disorder who take part in multimodal interventions.

Numerator – the number of children and young people in the denominator who take part in multimodal interventions.

Denominator – the number of children and young people aged 11 to 17 years who have a conduct disorder.

b) Proportion of parents or carers of children and young people aged 11 to 17 years who have a conduct disorder who are involved in multimodal interventions.

Numerator – the number of parents or carers in the denominator who are involved in multimodal interventions.

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

Data source: Local data collection.

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

Service providers ensure that they provide multimodal interventions that adhere to an evidence-based model and involve parents or carers for children and young people aged 11 to 17 years who have a conduct disorder.

Health and social care practitioners ensure that they offer multimodal interventions to children and young people aged 11 to 17 years who have a conduct disorder and involve their parents or carers in the intervention.

Commissioners ensure that they commission services that provide multimodal interventions that adhere to an evidence-based model and involve parents or carers for children and young people aged 11 to 17 years who have a conduct disorder.

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

Children and young people aged 11 to 17 yearswho have a conduct disorder take part in a programme of support, which involves their parents or carers and is 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 and 1.5.14.

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, those in contact with the criminal justice system for antisocial behaviour, or those who 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 manualand 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]

Equality and diversity considerations

Practitioners should support access to services and the uptake of interventions by children and young people, and their parents and carers, by being flexible in relation to settings and offering a range of support services. Recommendations 1.7.7 and 1.7.8 provide examples of settings and support services.

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 specific needs of:

- girls and young women with conduct disorders

- looked-after and adopted children and young people.

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 and are monitored for efficacy and adverse effects at regular intervals.

Rationale

Pharmacological interventions should not be offered for the routine management of behavioural problems in children and young people with a conduct disorder. Risperidone may be considered for the short-term management of severely aggressive behaviour in children and young people with a conduct disorder who have problems with explosive anger and severe emotional dysregulation and which has not responded to psychosocial interventions. 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 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 and are monitored for efficacy and adverse effects 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 and recorded 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 and recorded 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 physical and metabolic investigations repeated and recorded at regular intervals.

Numerator – the number of children and young people in the denominator who have physical and metabolic investigations repeated and recorded at regular intervals.

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 are taking risperidone who have changes in their symptoms and behaviour monitored and recorded at regular intervals.

Numerator – the number of children and young people in the denominator who have changes in their symptoms and behaviour monitored and recorded at regular intervals.

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

Data source: Local data collection.

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 have a baseline physical and metabolic investigation and to be monitored for efficacy and adverse effects at regular intervals.

Healthcare professionals 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 and are monitored for efficacy and adverse effects 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 have a baseline physical and metabolic investigation and be monitored for efficacy and adverse effects 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 have a number of physical checks carried out before they start treatment, and are regularly monitored to check whether the treatment is working and whether there are any unwanted side effects.

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 prescribing antipsychotics in children and young people for a range of conditions including 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. [Adapted from Antisocial behaviour and conduct disorders in children and young people (NICE clinical guideline 158), recommendation 1.6.5 and expert consensus]

Regular intervals

Advice on the frequency of monitoring is provided in table 1 of Psychosis and schizophrenia in

children and young people (NICE clinical guideline 155) and should be read in conjunction with the British national formulary (BNF), British national formulary for children (BNFC) and summary of product characteristics.

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]

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 alongside the documents listed in development sources.

Information for commissioners

NICE has produced support for commissioning that considers the commissioning implications and potential resource impact of this quality standard. This is available on the NICE website.

Information for the public

NICE has produced information for the public about this quality standard. Patients, service users and carers can use it to find out about the quality of care they should expect to receive; as a basis for asking questions about their care, and to help make choices between providers of social care services.

Diversity, equality and language

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

Good communication between health, public health 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

- Psychosis and schizophrenia in children and young people. NICE clinical guideline 155 (2013).

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).

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:

- Transition from children's to adult services.
- Personality disorder (children and young people).
- Transition between social care and health care services.

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:

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

Dr 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

Matthew Fay
General Practitioner, West Yorkshire

Dr Malcolm Fisk
Co-Director, Ageing Society Grand Challenge Initiative, Coventry University

Margaret Goose
Lay member

Ms Julia Hickling
Director, Advancing Quality Alliance

Dr Raymond Jankowski
Deputy Director of Public Health, NHS Hertfordshire

Mrs Geeta Kumar
Clinical Director – Women's services, Betsi Cadwaladr University Health Board (East)

Mrs Rhian Last
Clinical Lead, Education for Health

Ms Ann Nevinson
Lay member

Dr Jane O'Grady
Director of Public Health, Buckinghamshire County Council

Professor Gillian Parker
Professor of Social Policy Research and Director, Social Policy Research Unit, University of York

Mr David Pugh
Mental Capacity Act and Mental Health Act Implementation Manager, Gloucestershire County Council

Dr Eve Scott
Head of Safety and Risk, Christie NHS Foundation Trust

Dr Jim Stephenson
Consultant Medical Microbiologist, Epsom and St Helier NHS Trust

Mr Darryl Thompson
Psychosocial Interventions Development Lead, South West Yorkshire Partnership NHS Foundation Trust

Mrs Julia Thompson
Strategic Commissioning Manager, Sheffield City Council

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

Mrs Maria Brewster
Lay member

Dr Daphne Keen
Consultant Paediatrician, St George's Hospital, London

Dr Moira Doolan
Consultant Systemic Psychotherapist, Child and Adolescent Mental Health Services (CAMHS), South London and Maudsley NHS Foundation Trust

Mr Paul Mitchell
Clinical Lead, Hindley Young Offender Institution (YOI) Mental Health, Greater Manchester West NHS Trust

Dr Anne Taylor
Consultant Child and Adolescent Psychiatrist, Head2Head Team, Nottinghamshire Healthcare NHS Trust

NICE project team

Dylan Jones
Associate Director

Shirley Crawshaw
Consultant Clinical Adviser

Michael Mellors
Consultant Social Care Adviser

Rachel Neary
Programme Manager

Terence Lacey
Technical Adviser

Julie Kennedy
Lead Technical Analyst

Brian Bennett
Technical Analyst

Esther Clifford
Project Manager

Lee Berry
Coordinator

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.

This quality standard has been incorporated into the NICE pathway for antisocial behaviour and conduct disorders in children and young people.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Changes after publication

April 2015: minor maintenance

Copyright

ISBN: 978-1-4731-0536-2

Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social

Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- College of Mental Health Pharmacy
- Royal College of Occupational Therapists
- Royal College of Psychiatrists
- Royal College of General Practitioners
- Royal College of Paediatrics and Child Health