NICE National Institute for Health and Care Excellence

NICE guideline

Antisocial behaviour and conduct disorders in children and young people: recognition and management

Clinical guideline
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Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the Yellow Card Scheme.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

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This guideline replaces TA102.

This guideline is the basis of QS39 and QS59.

Overview

This guideline covers recognising and managing antisocial behaviour and conduct disorders in children and young people aged under 19. It aims to improve care by identifying children and young people who are at risk and when interventions can prevent conduct disorders from developing. The guideline also makes recommendations on communication, to help professionals build relationships with children and young people and involve them in their own care.

Who is it for?

- Health and social care professionals
- Commissioners and providers
- Children and young people aged under 19 who have or are at risk of antisocial behaviour or conduct disorders, and their families and carers

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Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in NICE's information on making decisions about your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

Health and social care professionals should follow our general guidelines for people delivering care:

- babies, children and young people's experience of healthcare
- decision making and mental capacity (applies to young people aged 16 and over only)
- medicines optimisation
- supporting adult carers
- transition from children's to adults' services.

All recommendations relate to children and young people aged under 18 years unless otherwise specified.

1.1 General principles of care

Working safely and effectively with children and young people

1.1.1 Health and social care professionals working with children and young people who present with behaviour suggestive of a conduct disorder, or who have a conduct

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disorder, should be trained and competent to work with children and young people of all levels of learning ability, cognitive capacity, emotional maturity and development. **[2013]**

1.1.2 When providing assessment or treatment interventions for children and young people, ensure that the nature and content of the intervention is suitable for the child or young person's developmental level. **[2013]**

Establishing relationships with children and young people and their parents or carers

1.1.3 Be aware that many children and young people with a conduct disorder may have had poor or punitive experiences of care and be mistrustful or dismissive of offers of help as a result. **[2013]**

Working with parents and carers

1.1.4 Be aware that parents and carers of children and young people with a conduct disorder might feel blamed for their child's problems or stigmatised by their contact with services. When offering or providing interventions such as parent training programmes, directly address any concerns they have and set out the reasons for and purpose of the intervention. **[2013]**

Culture, ethnicity and social inclusion

1.1.5 When working with children and young people with a conduct disorder and their parents or carers:

- take into account that stigma and discrimination are often associated with using mental health services
- be respectful of and sensitive to children and young people's gender, sexual orientation, socioeconomic status, age, background (including cultural, ethnic and religious background) and any disability

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- be aware of possible variations in the presentation of mental health problems in children and young people of different genders, ages, cultural, ethnic, religious or other diverse backgrounds. **[2013]**

1.1.6 Health and social care professionals working with children and young people with a conduct disorder and their parents or carers should have competence in:

- assessment skills and using explanatory models of conduct disorder for people from different cultural, ethnic, religious or other diverse backgrounds
- explaining the possible causes of different mental health problems, and care, treatment and support options
- addressing cultural, ethnic, religious or other differences in treatment expectations and adherence
- addressing cultural, ethnic, religious or other beliefs about biological, social and familial influences on the possible causes of mental health problems
- conflict management and conflict resolution. **[2013]**

Staff supervision

1.1.7 Health and social care services should ensure that staff supervision is built into the routine working of the service, is properly resourced within local systems and is monitored. Supervision should:

- make use of direct observation (for example, recordings of sessions) and routine outcome measures
- support adherence to the specific intervention
- focus on outcomes
- be regular and apply to the whole caseload. **[2013]**

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Transfer and discharge

1.1.8 Anticipate that withdrawal and ending of treatments or services, and transition from one service to another, may evoke strong emotions and reactions in children and young people with a conduct disorder and their parents or carers. Ensure that:

- such changes, especially discharge and transfer from CAMHS to adult services, are discussed and planned carefully beforehand with the child or young person and their parents or carers, and are structured and phased
- any care plan supports effective collaboration with social care and other care providers during endings and transitions, and includes details of how to access services in times of crisis
- when referring a child or young person for an assessment in other services (including for psychological interventions), they are supported during the referral period and arrangements for support are agreed beforehand with them. **[2013]**

1.1.9 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, such as those who have been looked after or who have limited access to care) refer to NICE's guideline on antisocial personality disorder. For those who have other mental health problems refer to other NICE guidance for the specific mental health problem. **[2013]**

1.2 Selective prevention

In this guideline selective prevention refers to interventions targeted to individuals or to a subgroup of the population whose risk of developing a conduct disorder is significantly higher than average, as evidenced by individual, family and social risk factors. Individual risk factors include low school achievement and impulsiveness; family risk factors include parental contact with the criminal justice system and child abuse; social risk factors include low family income and little education.

1.2.1 Offer classroom-based emotional learning and problem-solving programmes for

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children aged typically between 3 and 7 years in schools where classroom populations have a high proportion of children identified to be at risk of developing oppositional defiant disorder or conduct disorder as a result of any of the following factors:

- low socioeconomic status
- low school achievement
- child abuse or parental conflict
- separated or divorced parents
- parental mental health or substance misuse problems
- parental contact with the criminal justice system. **[2013]**

1.2.2 Classroom-based emotional learning and problem-solving programmes should be provided in a positive atmosphere and consist of interventions intended to:

- increase children's awareness of their own and others' emotions
- teach self-control of arousal and behaviour
- promote a positive self-concept and good peer relations
- develop children's problem-solving skills.

  Typically, the programmes should consist of up to 30 classroom-based sessions over the course of 1 school year. **[2013]**

1.3 Identification and assessment

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

1.3.1 Adjust delivery of initial assessment methods to:

- the needs of children and young people with a suspected conduct disorder

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and

- the setting in which they are delivered (for example, health and social care, educational settings or the criminal justice system). **[2013]**

1.3.2 Undertake an initial assessment for a suspected conduct disorder if a child or young person's parents or carers, health or social care professionals, school or college, or peer group raise concerns about persistent antisocial behaviour. **[2013]**

1.3.3 Do not regard a history of a neurodevelopmental condition (for example, attention deficit hyperactivity disorder [ADHD]) as a barrier to assessment. **[2013]**

1.3.4 For the initial assessment of a child or young person with a suspected conduct disorder, consider using the Strengths and Difficulties Questionnaire (completed by a parent, carer or teacher). **[2013]**

1.3.5 Assess for the presence of the following significant complicating factors:

- a coexisting mental health problem (for example, depression, post-traumatic stress disorder)
- a neurodevelopmental condition (in particular ADHD and autism)
- a learning disability or difficulty
- substance misuse in young people. **[2013]**

1.3.6 If any significant complicating factors are present refer the child or young person to a specialist CAMHS for a comprehensive assessment. **[2013]**

1.3.7 If no significant complicating factors are present, consider direct referral for an intervention. **[2013]**

Comprehensive assessment

1.3.8 A comprehensive assessment of a child or young person with a suspected

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conduct disorder should be undertaken by a health or social care professional who is competent to undertake the assessment and should:

- offer the child or young person the opportunity to meet the professional on their own
- involve a parent, carer or other third party known to the child or young person who can provide information about current and past behaviour
- if necessary, involve more than 1 health or social care professional to ensure a comprehensive assessment is undertaken. **[2013]**

1.3.9 Before starting a comprehensive assessment, explain to the child or young person how the outcome of the assessment will be communicated to them. Involve a parent, carer or advocate to help explain the outcome. **[2013]**

1.3.10 The standard components of a comprehensive assessment of conduct disorders should include asking about and assessing the following:

- core conduct disorders symptoms including:
  - patterns of negativistic, hostile, or defiant behaviour in children aged under 11 years
  - aggression to people and animals, destruction of property, deceitfulness or theft and serious violations of rules in children aged over 11 years
- current functioning at home, at school or college and with peers
- parenting quality
- history of any past or current mental or physical health problems. **[2013]**

1.3.11 Take into account and address possible coexisting conditions such as:

- learning difficulties or disabilities
- neurodevelopmental conditions such as ADHD and autism
- neurological disorders including epilepsy and motor impairments
- other mental health problems (for example, depression, post-traumatic stress

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disorder and bipolar disorder)

- substance misuse
- communication disorders (for example, speech and language problems). **[2013]**

1.3.12 Consider using formal assessment instruments to aid the diagnosis of coexisting conditions, such as:

- the Child Behavior Checklist for all children and young people
- the Strengths and Difficulties Questionnaire for all children or young people
- the Connors Rating Scales – Revised for a child or young person with suspected ADHD
- a validated measure of autistic behaviour for a child or young person with a suspected autism spectrum disorder (see NICE's guideline on autism spectrum disorder in under 19s)
- a validated measure of cognitive ability for a child or young person with a suspected learning disability
- a validated reading test for a child or young person with a suspected reading difficulty. **[2013]**

1.3.13 Assess the risks faced by the child or young person and if needed develop a risk management plan for self-neglect, exploitation by others, self-harm or harm to others. **[2013]**

1.3.14 Assess for the presence or risk of physical, sexual and emotional abuse in line with local protocols for the assessment and management of these problems. **[2013]**

1.3.15 Conduct a comprehensive assessment of the child or young person's parents or carers, which should cover:

- positive and negative aspects of parenting, in particular any use of coercive discipline

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- 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. **[2013]**

1.3.16 Develop a care plan with the child or young person and their parents or carers that includes a profile of their needs, risks to self or others, and any further assessments that may be needed. This should encompass the development and maintenance of the conduct disorder and any associated behavioural problems, any coexisting mental or physical health problems and speech, language and communication difficulties, in the context of:

- any personal, social, occupational, housing or educational needs
- the needs of parents or carers
- the strengths of the child or young person and their parents or carers. **[2013]**

1.4 Identifying effective treatment and care options

1.4.1 When discussing treatment or care interventions with a child or young person with a conduct disorder and, if appropriate, their parents or carers, take account of:

- their past and current experience of the disorder
- their experience of, and response to, previous interventions and services
- the nature, severity and duration of the problems
- the impact of the disorder on educational performance
- any chronic physical health problem
- any social or family factors that may have a role in the development or

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maintenance of the identified problems

- any coexisting conditions. **[2013]**

1.4.2 When discussing treatment or care interventions with a child or young person and, if appropriate, their parents or carers, provide information about:

- the nature, content and duration of any proposed intervention
- the acceptability and tolerability of any proposed intervention
- the possible impact on interventions for any other behavioural or mental health problem
- the implications for the continuing provision of any current interventions. **[2013]**

1.4.3 When making a referral for treatment or care interventions for a conduct disorder, take account of the preferences of the child or young person and, if appropriate, their parents or carers when choosing from a range of evidence-based interventions. **[2013]**

1.5 Psychosocial interventions – treatment and indicated prevention

In this guideline indicated prevention refers to interventions targeted to high-risk individuals who are identified as having detectable signs or symptoms that may lead to the development of conduct disorders but who do not meet diagnostic criteria for conduct disorders when offered an intervention.

The interventions in recommendations 1.5.1 to 1.5.12 are suitable for children and young people who have a diagnosis of oppositional defiant disorder or 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).

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Parent training programmes

1.5.1 Offer a group parent training programme to the parents of children and young people aged between 3 and 11 years who:

- have been identified as being at high risk of developing oppositional defiant disorder or conduct disorder **or**
- have oppositional defiant disorder or conduct disorder **or**
- are in contact with the criminal justice system because of antisocial behaviour. **[2013]**

1.5.2 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 (the manual should have been positively evaluated in a randomised controlled trial). **[2013]**

1.5.3 Offer an individual parent training programme to the parents of children and young people aged between 3 and 11 years who are not able to participate in a group parent training programme and whose child:

- has been identified as being at high risk of developing oppositional defiant disorder or conduct disorder **or**
- has oppositional defiant disorder or conduct disorder **or**
- is in contact with the criminal justice system because of antisocial behaviour. **[2013]**

1.5.4 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:

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- 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 (the manual should have been positively evaluated in a randomised controlled trial). **[2013]**

Parent and child training programmes for children with complex needs

1.5.5 Offer individual parent and child training programmes to children and young people aged between 3 and 11 years if their problems are severe and complex and they:

- have been identified as being at high risk of developing oppositional defiant disorder or conduct disorder **or**
- have oppositional defiant disorder or conduct disorder **or**
- are in contact with the criminal justice system because of antisocial behaviour. **[2013]**

1.5.6 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 (the manual should have been positively evaluated in a randomised controlled trial). **[2013]**

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Foster carer/guardian training programmes

1.5.7 Offer a group foster carer/guardian training programme to foster carers and guardians of children and young people aged between 3 and 11 years who:

- have been identified as being at high risk of developing oppositional defiant disorder or conduct disorder **or**
- have oppositional defiant disorder or conduct disorder **or**
- are in contact with the criminal justice system because of antisocial behaviour. **[2013]**

1.5.8 Group foster carer or 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 (the manual should have been positively evaluated in a randomised controlled trial). **[2013]**

1.5.9 Offer an individual foster carer/guardian training programme to the foster carers or guardians of children and young people aged between 3 and 11 years who are not able to participate in a group programme and whose child:

- has been identified as being at high risk of developing oppositional defiant disorder or conduct disorder **or**
- has oppositional defiant disorder or conduct disorder **or**

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- is in contact with the criminal justice system because of antisocial behaviour. **[2013]**

1.5.10 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 (the manual should have been positively evaluated in a randomised controlled trial). **[2013]**

Child-focused programmes

1.5.11 Offer group social and cognitive problem-solving programmes to children and young people aged between 9 and 14 years who:

- have been identified as being at high risk of developing oppositional defiant disorder or conduct disorder **or**
- have oppositional defiant disorder or conduct disorder **or**
- are in contact with the criminal justice system because of antisocial behaviour. **[2013]**

1.5.12 Group social and cognitive problem-solving programmes should be adapted to the children's or young people's developmental level and should:

- be based on a cognitive–behavioural problem-solving model
- use modelling, rehearsal and feedback to improve skills

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- typically consist of 10 to 18 weekly meetings of 2 hours' duration
- adhere to a developer's manual and employ all of the necessary materials to ensure consistent implementation of the programme (the manual should have been positively evaluated in a randomised controlled trial). **[2013]**

Multimodal interventions

1.5.13 Offer multimodal interventions, for example, multisystemic therapy, to children and young people aged between 11 and 17 years for the treatment of conduct disorder. **[2013]**

1.5.14 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 (the manual should have been positively evaluated in a randomised controlled trial). **[2013]**

1.6 Pharmacological interventions

1.6.1 Do not offer pharmacological interventions for the routine management of behavioural problems in children and young people with oppositional defiant disorder or conduct disorder. **[2013]**

1.6.2 Offer methylphenidate or atomoxetine, within their licensed indications, for the management of ADHD in children and young people with oppositional defiant

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disorder or conduct disorder, in line with NICE's guideline on attention deficit hyperactivity disorder. **[2013]**

1.6.3 Consider risperidone for the short-term management of severely aggressive behaviour in young people with a conduct disorder who have problems with explosive anger and severe emotional dysregulation and who have not responded to psychosocial interventions.

In March 2013, this was an off-label use of some preparations of risperidone in young people, and of all preparations of risperidone in children under 5. See NICE's information on prescribing medicines. **[2013]**

1.6.4 Provide young people and their parents or carers with age-appropriate information and discuss the likely benefits and possible side effects of risperidone including:

- metabolic (including weight gain and diabetes)
- extrapyramidal (including akathisia, dyskinesia and dystonia)
- cardiovascular (including prolonging the QT interval)
- hormonal (including increasing plasma prolactin)
- other (including unpleasant subjective experiences).

In March 2013, this was an off-label use of some preparations of risperidone in young people, and of all preparations of risperidone in children under 5. See NICE's information on prescribing medicines. **[2013]**

1.6.5 Risperidone should be started by an appropriately qualified healthcare professional with expertise in conduct disorders and should be based on a comprehensive assessment and diagnosis. The healthcare professional 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

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- fasting blood glucose or glycosylated haemoglobin (HbA1c)
- blood lipid and prolactin levels
- assessment of any movement disorders
- assessment of nutritional status, diet and level of physical activity.

In March 2013, this was an off-label use of some preparations of risperidone in young people, and of all preparations of risperidone in children under 5. See NICE's information on prescribing medicines. **[2013, amended 2021]**

1.6.6 Treatment with risperidone should be carefully evaluated, and include the following:

- Record the indications and expected benefits and risks, and the expected time for a change in symptoms and appearance of side effects.
- At the start of treatment give a dose at the lower end of the licensed range and slowly titrate upwards within the dose range given in the British national formulary for children (BNFC) or the summary of product characteristics (SPC).
- Justify and record reasons for dosages above the range given in the BNFC or SPC.
- Monitor and record systematically throughout treatment, but especially during titration:
  - efficacy, including changes in symptoms and behaviour
  - the emergence of movement disorders
  - weight and height (weekly)
  - fasting blood glucose or HbA1c
  - blood lipid and prolactin levels
  - adherence to medication
  - physical health, including warning parents or carers and the young

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person about symptoms and signs of neuroleptic malignant syndrome.

- Record the rationale for continuing or stopping treatment and the effects of these decisions.

  In March 2013, this was an off-label use of some preparations of risperidone in young people, and of all preparations of risperidone in children under 5. See NICE's information on prescribing medicines. **[2013, amended 2021]**

1.6.7 Review the effects of risperidone after 3 to 4 weeks and discontinue it if there is no indication of a clinically important response at 6 weeks.

In March 2013, this was an off-label use of some preparations of risperidone in young people, and of all preparations of risperidone in children under 5. See NICE's information on prescribing medicines. **[2013]**

1.7 Organisation and delivery of care

Improving access to services

1.7.1 Health and social care professionals, managers and commissioners should collaborate with colleagues in educational settings to develop local care pathways that promote access to services for children and young people with a conduct disorder and their parents and carers by:

- supporting the integrated delivery of services across all care settings
- having clear and explicit criteria for entry to the service
- focusing on entry and not exclusion criteria
- having multiple means (including self-referral) of access to the service
- providing 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. **[2013]**

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1.7.2 Provide information about the services and interventions that constitute the local care pathway, including the:

- processes by which a child or young person moves through the pathway
- means by which progress and outcomes are assessed
- delivery of care in related health and social care services. **[2013]**

1.7.3 When providing information about local care pathways for children and young people with a conduct disorder and their parents and carers, take into account the person's knowledge and understanding of conduct disorders and their care and treatment. **[2013]**

1.7.4 Health and social care professionals, managers and commissioners should collaborate with colleagues in educational settings to develop local care pathways that promote access for a range of groups at risk of under-utilising services, including:

- girls and young women
- black and minority ethnic groups
- people with a coexisting condition (such as ADHD or autism). **[2013]**

1.7.5 Support access to services and increase the uptake of interventions by:

- ensuring systems are in place to provide for the overall coordination and continuity of care
- designating a professional to oversee the whole period of care (for example, a staff member in a CAMHS or social care setting). **[2013]**

1.7.6 Support access to services and increase the uptake of interventions by providing services for children and young people with a conduct disorder and their parents and carers, in a variety of settings. Use an assessment of local needs as a basis for the structure and distribution of services, which should typically include delivery of:

- assessment and interventions outside normal working hours

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- 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. **[2013]**

1.7.7 Health and social care professionals, managers and commissioners should collaborate with colleagues in educational settings to look at a range of services to support access to and uptake of services. These could include crèche facilities and assistance with travel. **[2013]**

Developing local care pathways

1.7.8 Local care pathways should be developed to promote implementation of key principles of good care. Pathways should be:

- negotiable, workable and understandable for children and young people with a conduct disorder and their parents and carers as well as professionals
- accessible and acceptable to all people in need of the services served by the pathway
- responsive to the needs of children and young people with a conduct disorder and their parents and carers
- integrated so that there are no barriers to movement between different levels of the pathway
- focused on outcomes (including measures of quality, service user experience and harm). **[2013]**

1.7.9 Responsibility for the development, management and evaluation of local care pathways should lie with a designated leadership team, which should include health and social care professionals, managers and commissioners. The

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leadership team should work in collaboration with colleagues in educational settings and take particular responsibility for:

- developing clear policy and protocols for the operation of the pathway
- providing training and support on the operation of the pathway
- auditing and reviewing the performance of the pathway. **[2013]**

1.7.10 Health and social care professionals, managers and commissioners should work with colleagues in educational settings to design local care pathways that promote a model of service delivery that:

- has clear and explicit criteria for the thresholds determining access to and movement between the different levels of the pathway
- does not use single criteria such as symptom severity or functional impairment to determine movement within the pathway
- monitors progress and outcomes to ensure the most effective interventions are delivered. **[2013]**

1.7.11 Health and social care professionals, managers and commissioners should work with colleagues in educational settings to design local care pathways that promote a range of evidence-based interventions in the pathway and support children and young people with a conduct disorder and their parents and carers in their choice of interventions. **[2013]**

1.7.12 Health and social care professionals, managers and commissioners should work with colleagues in educational settings to design local care pathways that promote the active engagement of all populations served by the pathway. Pathways should:

- offer prompt assessments and interventions that are appropriately adapted to the cultural, gender, age and communication needs of children and young people with a conduct disorder and their parents and carers
- keep to a minimum the number of assessments needed to access interventions. **[2013]**

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1.7.13 Health and social care professionals, managers and commissioners should work with colleagues in educational settings to design local care pathways that respond promptly and effectively to the changing needs of all populations served by the pathways. Pathways should have in place:

- clear and agreed goals for the services offered to children and young people with a conduct disorder and their parents and carers
- robust and effective means for measuring and evaluating the outcomes associated with the agreed goals
- clear and agreed mechanisms for responding promptly to changes in individual needs. **[2013]**

1.7.14 Health and social care professionals, managers and commissioners should work with colleagues in educational settings to design local care pathways that provide an integrated programme of care across all care settings. Pathways should:

- minimise the need for transition between different services or providers
- allow services to be built around the pathway and not the pathway around the services
- establish clear links (including access and entry points) to other care pathways (including those for physical healthcare needs)
- have designated staff who are responsible for the coordination of people's engagement with the pathway. **[2013]**

1.7.15 Health and social care professionals, managers and commissioners should work with colleagues in educational settings to ensure effective communication about the functioning of the local care pathway. There should be protocols for:

- sharing information with children and young people with a conduct disorder, and their parents and carers, about their care
- sharing and communicating information about the care of children and young people with other professionals (including GPs)
- communicating information between the services provided within the

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pathway

- communicating information to services outside the pathway. **[2013]**

1.7.16 Health and social care professionals, managers and commissioners should work with colleagues in educational settings to design local care pathways that have robust systems for outcome measurement in place, which should be used to inform all involved in a pathway about its effectiveness. This should include providing:

- individual routine outcome measurement systems
- effective electronic systems for the routine reporting and aggregation of outcome measures
- effective systems for the audit and review of the overall clinical and cost effectiveness of the pathway. **[2013]**

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Recommendations for research

The guideline committee has made the following recommendation for research.

1 Parent training programmes for children aged 12 years and over with a conduct disorder

What is the effectiveness of parent training programmes for conduct disorders in children and young people aged 12 years and over?

Why this is important

The evidence for parent training programmes is well established for children with conduct disorders aged 11 years and younger, with well-developed models for the delivery of care. In contrast there is little evidence for these programmes in older children despite the recognition that parenting problems continue to play a part in the development and maintenance of conduct disorders.

This question should be answered using a randomised controlled trial (RCT) design reporting short- and medium-term outcomes, including cost effectiveness, over at least 18 months. Attention should be paid to the adaptation of parent training programmes to older children, and to training and supervision of staff delivering the programmes to ensure robust and generalisable results. The outcomes and acceptability of the intervention should be rated by parents, teachers and independent observers. The study needs to be large enough to determine the presence of clinically important effects, and mediators and moderators of response should also be investigated.

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Context

Conduct disorders, and associated antisocial behaviour, are the most common mental and behavioural problems in children and young people. The Office of National Statistics (ONS) surveys of 1999 and 2004 reported that their prevalence was 5% among children and young people aged between 5 and 16 years. Conduct disorders nearly always have a significant impact on functioning and quality of life. The 1999 ONS survey demonstrated that conduct disorders have a steep social class gradient, with a three- to fourfold increase in prevalence in social classes D and E compared with social class A. The 2004 survey found that almost 40% of looked-after children, those who had been abused and those on child protection or safeguarding registers had a conduct disorder.

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 and 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. Isolated antisocial or criminal acts are not sufficient to support a diagnosis of conduct disorder or oppositional defiant disorder. Oppositional defiant disorder is more common in children aged 10 years or younger; the other subtypes of conduct disorder are more common in those aged over 11 years or older.

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

Conduct disorders commonly coexist with other mental health problems: 46% of boys and 36% of girls have at least 1 coexisting mental health problem. The coexistence of conduct disorders with attention deficit hyperactivity disorder (ADHD) is particularly prevalent and in some groups more than 40% of children and young people with a diagnosis of conduct disorder also have a diagnosis of ADHD. Conduct disorders in childhood are also associated with a significantly increased rate of mental health problems in adult life, including antisocial personality disorder – up to 50% of children and young people with a conduct disorder go on to develop antisocial personality disorder. The prevalence of

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

A diagnosis of a conduct disorder is strongly associated with poor educational performance, social isolation and, in adolescence, substance misuse and increased contact with the criminal justice system. This association continues into adult life with poorer educational and occupational outcomes, involvement with the criminal justice system (as high as 50% in some groups) and a high level of mental health problems (at some point in their lives 90% of people with antisocial personality disorder will have another mental health problem).

Conduct disorders are the most common reason for referral of young children to child and adolescent mental health services (CAMHS). Children with conduct disorders also comprise a considerable proportion of the work of the health and social care system. For example, 30% of a typical GP's child consultations are for behavioural problems, 45% of community child health referrals are for behaviour disturbances and psychiatric disorders are a factor in 28% of all paediatric outpatient referrals. In addition, social care services have significant involvement with children and young people with conduct disorders, with more vulnerable or disturbed children often being placed with a foster family or, less commonly, in residential care. The demands on the educational system are also considerable and include the provision of special-needs education. The criminal justice system also has significant involvement with older children with conduct disorders.

Multiple agencies may be involved in the care and treatment of children with conduct disorders, which presents a major challenge for services in the effective coordination of care across agencies.

Several interventions have been developed for children with conduct disorder and related problems, such as parenting programmes typically focused on younger children and multisystemic approaches usually focused on older children. Other interventions focused on prevention, such as the Nurse Family Partnership (known as the Family Nurse Partnership in the UK), have recently been implemented in the UK and are currently being evaluated. Three themes are common to these interventions: a strong focus on working with parents and families, recognition of the importance of the wider social system in enabling effective interventions and a focus on preventing or reducing the escalation of existing problems.

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Uptake of these interventions and the outcomes achieved vary across England and Wales. Parenting programmes are the best established; implementation of multisystemic approaches and early intervention programmes is more variable. In addition to the programmes developed specifically for children with a conduct disorder, a number of children (and their parents or carers) are treated by both specialist CAMHS teams and general community-based services such as Sure Start.

Identifying which interventions and agencies are the most appropriate is challenging, especially for non-specialist health, social care and educational services. Further challenges arise when considering the use of preventive and early intervention programmes and identifying which vulnerable groups stand to gain from such interventions. Factors that may be associated with a higher risk of developing conduct disorders include parental factors such as harsh and inconsistent parenting style and parental mental health problems (for example depression, antisocial personality disorder and substance misuse), environmental factors such as poverty and being looked after, and individual factors such as low educational attainment and the presence of other mental health problems.

The guideline covers a range of interventions including treatment, indicated prevention and selective prevention (but not universal prevention), adapting definitions developed by the Institute of Medicine. For a description of the criteria used to determine whether an intervention was judged to be selective or indicated prevention see chapter 5 of the full guideline. (In this guideline selective prevention refers to interventions targeted to individuals or to a subgroup of the population whose risk of developing a conduct disorder is significantly higher than average, as evidenced by individual, family and social risk factors. Individual risk factors include low school achievement and impulsiveness; family risk factors include parental contact with the criminal justice system and child abuse; social risk factors include low family income and little education.)

Some recommendations in this guideline have been adapted from recommendations in other NICE clinical guidance. In these cases the Guideline Development Group was careful to preserve the meaning and intent of the original recommendations. Changes to wording or structure were made to fit the recommendations into this guideline.

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Finding more information and committee details

To find NICE guidance on related topics, including guidance in development, see the NICE topic page on children's social care.

For full details of the evidence and the guideline committee's discussions, see the full guideline. You can also find information about how the guideline was developed, including details of the committee.

NICE has produced tools and resources to help you put this guideline into practice. For general help and advice on putting our guidelines into practice, see resources to help you put NICE guidance into practice.

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Update information

December 2021: Following a surveillance review we have updated recommendations 1.6.5 and 1.6.6 to say that either glycosylated haemoglobin (HbA1c) or fasting blood glucose may be used to test for diabetes in people taking antipsychotic medication. These recommendations last had an evidence review in 2013, and we updated them without an evidence review in 2021. The recommendations are marked **[2013, amended 2021]**.

April 2017: Four research recommendations were identified as out of date in a 2017 surveillance review, and have been deleted.

Minor changes since publication

May 2024: We have simplified the guideline by removing recommendations on general principles of care that are covered in other NICE guidelines (for example, the NICE guideline on service user experience in adult mental health). This is a presentational change only, and no changes to practice are intended.

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