

# **A Local Authority in the South of England CAMHS**

## **Research and Best Practice**

### **Report**

**June 2008**

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#### **1 Introduction**

The Institute of Public Care (IPC) has been asked to support a project to develop improved services for children and young people with severe challenging behaviour or conduct disorder in a local authority in the South of England. A key element of this project is the identification of key messages from available research and best practice literature about the nature of the problem, how to intervene effectively, and what systems should be in place to ensure the best possible outcomes for this small but 'high risk' group.

This paper has been developed for the Project Steering Group and the wider group of stakeholders. It is hoped that the paper, combined with feedback from stakeholders and further in-depth case analyses, will form the basis of a further final report which, combined with the analysis of local needs and services, will help to shape the direction for change in a local authority in the South of England.

The report comprises the following sections:

**Section 2: Definitions**

**Section 3: Prevalence**

**Section 4: Risk and Resilience Factors**

**Section 5: The Impact of Conduct Disorder and Severe Challenging Behaviour**

**Section 6: Identification and Assessment**

**Section 7: Interventions**

**Section 8: Care Pathways**

#### **2 Definitions**

All children are occasionally badly behaved and disobedient. If bad behaviour continues for several months, or is beyond the normal age period for misbehaviour, or seriously breaks the accepted rules, then there may be a more acute problem which is known as conduct disorder. Conduct disorders affect a child's development and ability to lead a normal life and causes them, their families and their schools considerable distress.

Joint NICE and Social Care Institute for Excellence (SCIE) guidance TA102 (2006) defines conduct disorder and oppositional defiant disorder (ODD) thus:

##### **2.1 Conduct Disorder:**

*'A repetitive and persistent pattern of antisocial aggressive or defiant conduct'.*

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## **2.2 Oppositional Defiant Disorder:**

'Persistently hostile or defiant behaviour outside the normal range, but without aggressive or antisocial behaviour'.

These can be further subdivided into socialised conduct disorder, unsocialised conduct disorder, conduct disorders confined to the family context, and ODD. They consist of a family of symptoms which are best thought of as overlapping and related, with ODD regarded as a less extreme form of conduct disorder. A distinction between childhood onset (before age 10 years) and adolescent onset (10 years or older) is also made (NICE, 2006).

ODD is characterised by temper outbursts, arguing with adults, disobedience, deliberately annoying others, passing on blame, being easily annoyed, and being angry, resentful, spiteful and/or vindictive. Socialised and unsocialised conduct disorders are characterised by telling lies, fighting, bullying, staying out late, running away from home, playing truant, being cruel to animals or people, or serious criminal behaviour such as robbery, rape or using weapons. The difference between these two subtypes lies in the solitary (e.g. running away, playing truant) or group-based nature (e.g. fighting, bullying, and using weapons) of the problem behaviours (Green *et al.*, 2004).

Symptoms of these subtypes of conduct disorders can be further classified along the dimensions of overt/ covert behaviours (e.g. bullying/truancy), and destructive/ non-destructive behaviours (e.g. vandalism/defiance) (Joughin and Morley, 2007).

## **3 Prevalence**

Conduct disorder is the most common form of mental disorder in childhood, and its prevalence around the world is thought to be rising in both genders and in all social classes and family types (Collishaw *et al.*, 2004; Scott, 2007). In Britain, the most recent data shows that conduct disorder occurs in 5.8% of all children and young people. It is more common in boys than girls; boys comprise 69% of those with conduct disorders overall (BMA, 2006). However, there are significant variations in prevalence rates along a number of dimensions outlined below.

### **3.1 Age of Onset**

There are variations in the prevalence of conduct disorder depending on age, particularly according to subtype. Between the ages of 5 and 10, 6.9% of boys and 2.8% of girls in Britain have been found to have a conduct disorder, whereas for adolescents between the ages of 11 and 16 prevalence is more equal (8.1% and 5.1% respectively) (Joughin and Morley, 2007). The prevalence according to age of onset varies by subtype, with ODD the most common type below the age of 11, but the socialised conduct disorder subtype is far higher above this age (Green *et al.*, 2004). There are different developmental pathways for early onset and later onset conduct disorders (Davis *et al.*, 2000) which are considered later in this paper. However, the key message from research is that the likelihood of disordered conduct continuing into adulthood is higher for those with early onset conduct disorder (Moffitt 2003).

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### **3.2 Gender**

The symptoms exhibited by those with conduct disorder vary according to gender also, although boys dominate in all subtypes, tending to show more confrontational behaviour and more persistent symptoms (Green *et al.*, 2004). The onset of conduct disorder symptoms prompting referral to mental health services tends to be later for girls, mainly between the ages of 14 and 16, compared with most commonly between the ages of 8 and 10 for boys. Girls tend to exhibit less aggressive behaviour, and instead tend to show more anxiety-related problems. Consequently it has been suggested that, as girls' difficulties have been less visible to public authorities (for example, through fewer formal exclusions from school, or as young offenders), they tend to have been overlooked, both in terms of research into their mental health needs, and effective practice in interventions to treat or prevent their particular tendency to covert and destructive problem behaviours (Joughin and Morley, 2007).

### **3.3 Refugee and asylum seekers**

Research into prevalence rates of conduct disorders amongst children in this vulnerable group is extremely problematic, not least because of the stigma attached to expressing a mental health need in relation to their immigration status. However, it is known that children in these circumstances have an elevated prevalence overall of mental disorders, and in light of the greater risk of having been subject to multiple and traumatic stressors, are therefore highly likely to be an over-represented group amongst children with conduct disorders, over and above any other predisposing risk factors resulting from their religious or cultural background (BMA, 2006). The mobility of refugees and the unpredictability of future disasters means planning for this group will always be difficult. Initiatives to address their specific needs include services developed by the refugees themselves, including assessment and treatment by refugee doctors.

### **3.4 Looked after children**

Children and young people who are looked after have high prevalence rates of conduct disorder. More than one third of the 5-10 age group, and 40% of those aged 11-15 have some form of conduct disorder, although prevalence rates are higher for some forms of care than others. Those in foster care seem to experience fewer conduct problems than those in residential care (ONS, 2003). Research suggests that specialist mental health services consider changing the care arrangements or education environment of looked after children as possible interventions, in preference to labelling them psychiatrically disordered, and to ensure that residential social workers have the appropriate training to deal with those children with psychiatric disorder. This group's needs are frequently unmet, as it seems that less than 1 in 10 looked after children have positively good mental health (Ford, Vostanis, Meltzer and Goodman, 2007).

### **3.5 Black and Ethnic Minority Children and Young People**

Prevalence of conduct disorder amongst children and young people from black and ethnic minority backgrounds is uncertain (Green *et al.*, 2004) although there is evidence to suggest that prevalence rates may be higher than for white children as a result of greater exposure to important predisposing risk factors such as deprivation, discrimination and poor education (BMA, 2006). It has been

suggested that children from a black or minority ethnic background are less likely than white children to have unsocialised conduct disorder (Green *et al.*, 2004).

There is, however, clear evidence that children and young people from black and ethnic minority backgrounds are less likely to have mental disorders identified, and also that those who access mental health services are more likely to have reached 'crisis point', to access these services through the criminal justice system, and to receive more coercive treatments (Youngminds, 2005). Little is known about how to make early intervention and treatment programmes more sensitised to needs of black and ethnic minority families, an imperative if current poor service uptake and completion rates are to be improved (NICE, 2006).

Differences arising from ethnicity affect a sizeable minority of children, given that children and young people from black and ethnic minority backgrounds make up about 20% of the total population aged under 20, and are also over-represented amongst looked after children, a group at high risk of conduct disorders (Youngminds, 2005). A gap exists in the research literature on conduct disorder (and mental disorders more generally), the influence of ethnicity on the developmental pathways it follows, and also the symptoms experienced (*ibid*).

### **3.6 General Health**

Two thirds of children with conduct disorder have either a physical or developmental problem as well, compared with half of the general population, and their overall health is more far more likely to be reported by their parents as being either fair or bad. Most common problems relative to the general population include bed wetting, speech or language problems, co-ordination difficulties, asthma and eyesight problems (Green *et al.*, 2004).

### **3.7 Young Offenders**

Prevalence of conduct disorder amongst young offenders is likely to be particularly high, with the lowest estimate of prevalence of mental health disorders more generally thought to be 40%, rising to as high as 89% (BMA, 2006). There are however, gaps in the research literature on this group of young people, because of the practical difficulties experienced by researchers in interacting with this group. One recent study showed a prevalence rate of conduct disorder of 32%, with no significant differences between violent and non-violent offenders, although this was based on self-reported data (Anderson *et al.*, 2004).

Additionally, research undertaken by the Youth Justice Board in 2004-2005 found patchy provision by CAMHS services nationally for this group, and few examples of formal and regular contact between Youth Offending teams and CAMHS. It was found that CAMHS staff often felt ill-equipped to deal with young offenders and that there were systematic problems in the identification of those with current mental health needs (Harrington and Bailey, 2005). In addition, there are specific problems attached to treating this group using family and peer group based interventions.

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### **3.8 Substance Misuse**

Research indicates a clear association between conduct disorder, use of illicit drugs and violent antisocial behaviour by boys. In particular, recent research of self reported mental disorders amongst young offenders showed a high level of co morbidity between conduct problems and substance misuse (Anderson *et al.*, 2004). This research showed that those engaged in substance misuse were less likely to engage with treatment services, and of those who did, substance misuse problems tended to be treated in isolation from conduct problems. The need to address ways of engaging and preparing young people for engagement with specialist services was highlighted, as was the need for specialist mental health services to develop and communicate clear operational and referral criteria.

### **3.9 Family and Household Characteristics**

Conduct disorders are more prevalent amongst those who live in single parent households, large families, with other step children, with poorly educated and/or unemployed carers, in low socio-economic households and communities, or with someone who is disabled. Conduct disorders are also more prevalent amongst those who are living with a mentally-ill parent, a parent who has experienced a major stressful life event, or a family who have poor relationships (Green *et al.*, 2004). The high prevalence of conduct disorders amongst children and young people living in these circumstances reflects the difficulties of growing up in poverty and in hard-pressed families and neighbourhoods.

### **3.10 Co morbidity**

Children with conduct disorder are more likely than the rest of the child population to experience physical and developmental problems (Green *et al.*, 2004). In addition, around half of children with conduct disorder also have some other form of mental disorder, with ADHD, depression and hyperactivity being the most common combinations (Joughin and Morley, 2007; Richardson and Joughin, 2002). Those with multiple problems are more likely to be boys (ONS, 2004). Those with early-onset conduct disorder are particularly likely to have ADHD and anxiety disorders and those with adolescent-onset post traumatic stress disorder, alcohol and substance misuse problems, and multiple (+6 diagnoses lifetime) co morbidity (Connor *et al.*, 2007). Those with multiple disorders are also far more likely than those with conduct disorder alone to experience physical and developmental problems (ONS, 2004).

As with age of onset and variations in subtype, there are gender variations in co morbid problems also, with girls tending to present more frequently with anxiety, substance misuse or eating disorders than boys (Langsford, Houghton, Douglas and Whiting, 2007). The co morbidity of conduct disorder with other disorders also varies according to subtype of conduct disorder, with the unsocialised subtype showing the highest co morbidity rates (Green *et al.*, 2004) Those with multiple disorders are also more likely than those with conduct disorder alone to be at greater risk of suffering more serious symptoms (BMA, 2006). Thus, there is great variability between children or young people's experience of symptoms, and consequently, those with multiple problems account for approximately one third of those using specialist mental health services (BMA, 2006).

### **3.11 Learning Disabilities**

About 0.3% of children have moderate or severe learning disabilities caused by a range of factors, from brain injury at birth to genetic disorders. Within this group, around 50% have significant mental health problems, and amongst these, aggressive behaviours are common (around 40%). It is recognised that challenging behaviour of this kind is often learned and can be considered as a form of communication (Joughin and Morley, 2007).

### **3.12 Persistence of and Developmental Pathways for Conduct Disorder**

There are additional differences both in conduct disorder symptoms and outcomes for individuals which depend upon the age of onset. Significant repeated 'in flows' and 'outflows' of individuals take place, with fewer than half of those identified with conduct disorder in early childhood becoming adolescents with a conduct disorder (Utting, Montiero and Ghate, 2007). Early onset conduct disorder tends to be the more persistent and associated with ODD compared with adolescent onset disorder. However, of those with adolescent onset conduct disorder, only between 3% and 5% exhibited symptoms in early childhood, and these include significant numbers of girls (Joughin and Morley, 2007).

Although early onset ODD has the poorest lifetime prognosis, with persistence estimated as 10%, a majority of those whose ODD desists go on to develop other serious forms of emotional or conduct disorders. The overwhelming majority of individuals with early onset ODD have other co morbid disorders, and ODD tends to have preceded the development of these other disorders. This early onset ODD with co morbidity is difficult to treat once adolescence is reached (Nock, Kazdin, Alan, Hirpi, Kessler and Ronald, 2007). Those with the most persistent conduct disorder also tend to have special educational needs.

This persistent form of early starter conduct disorder seems to follow a clear developmental pathway beginning with oppositional and defiant disorders in the preschool years, progressing to aggressive and non-aggressive symptoms in middle childhood, and develops into the most serious symptoms by adolescence including violence. Additionally, there is an expansion in the number of settings across which the symptoms take place, from home to preschool, then to school and finally the broader community. ODD is therefore a sensitive predictor of subsequent conduct disorder and is the primary developmental pathway for delinquency in adolescence and for conduct disorder in adulthood (Davis *et al.*, 2000)

The persistence of conduct disorder is not thought to be linked to either gender or physical illness, but rather is related to a number of family, household and social characteristics. Conduct disorder tends to persist more for those children living in single parent households, in rented accommodation, in low income households, and / or with a mother in poor health (Meltzer, 2003).

It is well-established that between 40 and 50% of individuals who have had any form of conduct disorder as children go on to develop antisocial personality disorder as adults. Furthermore, those who do not go on to develop antisocial personality disorder as adults frequently experience a range of other psychiatric disturbances or antisocial behaviours including schizophrenia, obsessive-compulsive disorder, violence, substance abuse and theft (Richardson and

Joughin, 2002; Utting, Montiero and Ghatte, 2007). Research suggests that it is possible to identify those adolescents who go on to become violent with almost 50% reliability as a result of conduct disorder exhibited at the age of 7 (*ibid*). Therefore, despite the risk of obtaining 'false positives' in identification of young children and with careful attention to avoid stigmatisation of individuals, there seems to be a good case on behalf of both public services and individuals for early interventions for those most at risk, and this is the case particularly for boys.

### **3.13 Service Users**

It is estimated that only 10% of children with mental disorders in general are in contact with specialist mental health services (Payne and Butler, 2003). Rates of diagnosis of conduct disorder in particular are low (estimated at less than 50%), leading to reduced referral rates and children with complex needs missing out on individual therapies (George, 2007). Furthermore, it has been estimated that only a quarter of children diagnosed with conduct disorder receive specialist treatment and that there are fewer than 1000 practitioners trained within NICE guidelines nationally (Scott, 2007). Other non-specialist practitioners may also lack appropriate training (BMA, 2006). A recent large national survey showed that almost a third of parents of children with behavioural and emotional disorders did not seek help because they felt stigmatised, and almost a fifth did not do so because they did not know where to go for help (*ibid*). Such low rates of diagnosis and subsequent treatment of individuals for a disorder with high prevalence in the general population indicates a sizeable potential unfulfilled need.

## **4 Risk and resilience factors**

### **4.1 Risk**

Recent research has demonstrated that conduct disorders have a strong genetic component (Woolgar and Scott, 2005). However, there is also a strong socially-promulgated component to conduct disorders. The theoretical case for viewing conduct disorder as essentially preventable is endorsed by half a century of longitudinal large-scale studies in a variety of countries including the UK (BMA, 2006).

According to the NICE guidelines (*ibid*), pre-disposing risk factors for conduct disorder, as for a number of poor child outcomes, can be divided into three groups:

- Family factors.
- Individual factors.
- Environmental factors.

Alternatively, risk factors can be grouped according to those present in individuals, those due to schooling, and those present in communities. Either way, poor or abusive parenting practices where parents exhibit few positive behaviours appears to be a major cause of conduct disorder (Richardson and Joughin, 2002), as does parental mental ill health, with depression particularly predictive of conduct disorder (BMA, 2006; Harrington *et al.*, 2000). Educational



factors, such as low scholastic achievement, and schooling in an environment where there are low levels of teacher satisfaction, poor cooperation and poorly defined and enforced rules, are also linked with conduct disorder, as is living in the circumstances associated with low socio-economic status, particularly the experience of poverty. Children with cognitive deficits or developmental delays, in some cases associated with brain damage, chronic illness or temperamental difficulties are also at high risk of developing conduct disorder (Richardson and Joughin, 2002).

Factors combine to increase the risk of developing conduct disorder and anti-social behaviour (Utting *et al.*, 2007). The relative importance of these factors to each other changes with age, with early onset disorders more likely to be linked to individual and family-based factors. The hypothesised developmental pathways of the most serious and persistent forms of conduct disorder suggest that these factors can combine at critical points or transition phases so that there are no single causes or appropriate treatments, but rather 'windows of opportunity' in which different interventions may prevent potential problems occurring (Davis *et al.*, 2000).

## **4.2 Resilience**

Some children appear to have a number of risk factors associated with an increased risk of developing behavioural problems, yet do not develop conduct disorders. Resilience refers to the ability to withstand or recover quickly from difficulties. Stress and resilience are therefore potentially complementary. Both stress and resilience can be characteristics of individuals, as well as families and communities. Critically, these characteristics can be inter-dependent. However, research into the cultural context of stress and resilience is lacking in both the UK and the US (Parrot *et al.*, 2008)

The bulk of research into mental health problems has in the past focused on individual or child factors. This has more recently been challenged by researchers who suggest that the key unit of analysis should be the family. It is also known that inequality and poverty are significant contributory stressors in families with mental health problems. A recent analysis undertaken on behalf of the SCIE of the relative impacts of different stressors suggested that resilience or mediating factors comprise three sets:

- Biological influences on the child.
- Relational influences in the mother-child discipline, child attachment, and positive modelling behaviour by parents.
- Factors indirectly affecting maternal and child functioning, such as income and social resources (Parrot *et al.*, 2008).

Resilience in relation to these areas is explored below.

### **4.2.1 Promoting child-focused resilience: control and optimism**

Resilience appears to be enhanced by knowledge and understanding of positive steps that can be taken to overcome stressors. The ability to engage in self-help tends to develop a positive sense of self and a feeling of control. This is reflected

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in the emphasis within the best practice literature on cognitive behavioural approaches to conduct disorder.

### **Resilience Research in Children: The Penn Resiliency Project (Gillham & Reivich, 2007)**

The Penn Resiliency Program (PRP) is a school-based intervention curriculum designed to build resilience, promote adaptive coping skills, and teach effective problem-solving. It aims to promote optimism, helping children and adolescents to respond to the daily challenges and problems that are encountered during their secondary school years. The skills taught in the programme are generic, and can be applied to many contexts of life, including relationships with peers and family members as well as achievement in academics or other activities. The programme has been found to be effective in helping to buffer children against the effects of stress, including more serious levels of stress such as anxiety and depression.

The PRP is a manual-based intervention comprising twelve 90-minute group sessions. The curriculum teaches cognitive-behavioural and social problem-solving skills and is based in part on cognitive-behavioural theories of depression by Beck, Ellis and Seligman. Students are encouraged to identify and challenge negative beliefs, use evidence to make more accurate appraisals of situations and events, and to use effective coping mechanisms when faced with adversity. In addition to the cognitive-behavioural component, students learn techniques for assertiveness, negotiation, decision-making, and relaxation.

The PRP (also known as the Penn Optimism Program, or POP, and the Penn Depression Prevention Program) has been tested extensively in various American settings and with diverse samples of participants. It has been shown to be effective at reducing depressive symptoms.

A new parent program designed to accompany the adolescent intervention is currently being developed at Penn University. In the parent program, parents learn to use the PRP skills in their own lives and to encourage their children's use of these skills. The expectation is that parents will model the PRP skills at home long after the school-based intervention groups have ended. In addition, adolescents and parents attend several booster sessions in the years following the intervention. The booster sessions review the critical concepts covered in the initial intervention. It is hoped that these new additions to the PRP will produce longer lasting intervention effects. Unlike the core programme, these additions are, as yet, unevaluated.

This 'PRP' programme is now being trialled in the UK as part of the UK Resilience Programme sponsored by the DCSF. The trial will end in December 2010. Manchester, Hertfordshire and South Tyneside are trialling the PRP with their Year 7 students as part of a Local Wellbeing Project, seeking to reduce problems such as depression and anxiety. The PRP is the first of six strands of the wellbeing project; the others will seek to promote resilience in other parts of the 3 local communities in question. For example, two of the strands will seek to enhance resilience by encouraging neighbourliness, and by working with elderly people.

#### **4.2.2 Parental factors in resilience, particularly parental mental health**

Not all children whose parents have mental health problems are adversely affected. However, parental bonding is affected by parental mental ill-health and good parental bonding is a foundation of resilience. It is estimated that 2 million children live in a household where at least one parent has a mental health problem, resulting from two policy changes in recent decades; adults with mental health problems now tend to live in the community, and child care practice now focuses on keeping birth families together. Mutual stressors experienced by both child and parent tend to have a cumulative effect. Child disruptive behaviour can result from parenting which is sometimes either withdrawn, or too intrusive, as a result of the parents' depression. Children can experience this as a loss, even though the parent is still present. Reaction to the loss can be exhibited as anger towards the parent. This tends to create a negative spiral of interactions; the anger prompts further withdrawal or intrusion by parents. Children may also experience fear for the long term. Paternal depression particularly promotes negative familial interactions, because of the increase in paternal irritability and cynicism (Parrot et al., 2008).

The research literature on promoting parental mental health and positive parenting is indicated in the earlier paper and is very wide-ranging. Of note is the absence of evidence-based approaches to promoting positive parenting among families who are already dysfunctional and whose children are presenting at Tiers 3 and 4. However, the recent review of innovative practice relating to NSF implementation of standards relating to emotional health and wellbeing (CSIP 2008) identified that parenting programmes such as The Incredible Years (Webster Stratton) can engage and work very effectively with harder to reach families (including fathers) presenting at Tier 3 where significant emphasis is placed on engagement and flexible hours of service delivery.

#### **4.2.3 Community factors in resilience**

##### **Schools**

Schooling that provides a secure base and opportunities to develop social networks and self-esteem improves resilience. There is a wealth of best practice literature on how to promote healthy schools, including emotional health and wellbeing, to the benefit of the full range of pupils (from Tier 1 to 4). The recent research on resilience seems to suggest that addressing the 'whole school' environment is important even for children and young people whose needs take them beyond whole school approaches. Some of the key in-school initiatives are outlined below:

Social and Emotional Aspects of Learning (SEAL) is a universal primary school curriculum programme currently operating in 30% of primary schools nationally, aiming to promote calm, empathetic relationships between pupils. Development of similar materials for use in secondary schools is currently underway (SEBS). There are also similar plans in the Further Education sector. Learning from the National CAMHS Support Service (Rees, 2007) suggests that CAMHS engagement in the delivery of emotional health and wellbeing training to all school staff is desirable through these approaches. The Bristol Healthy Schools toolkit offers a good example of putting such health promotion into action – see below (Shears and Young, 2006).

However, these approaches address on individual classrooms, rather than the school environment as a whole. Comprehensive research for OFSTED (Visser, 2003) demonstrated that other issues were the most critical to providing a secure base and opportunities to develop social networks. Schools with the following features had far fewer students exhibiting conduct and other emotional and behavioural difficulties:

- Stability of school teaching staff.
- An attractive physical environment.
- A positive and supportive school ethos.
- Positive attachments formed between students and teachers (particularly in tutor time).
- A positive approach to school inclusion (children attending the same school rather than moving between schools).

It follows from the above that schools possessing these attributes can help to promote resilience through providing a secure base and opportunities to develop social networks for vulnerable students.

### **Culture**

An individual's ability to cope effectively with stressors is shaped by the values, beliefs and everyday practices of the culture in which they live. Such values, beliefs and practices should be assessed for their ability to contribute to resilience or to hinder it. A culture that values maintaining social networks and having interests outside the family tends to foster resilience, as having these provides a sense of security, self-worth and imparts a feeling of control over the immediate environment. Professionals' interventions should therefore focus on an individual's and a family's strengths, as well as their needs. They should seek to provide opportunities for an individual to experience multiple social roles. (Parrot et al., 2008).

### **Social support**

Having and giving assistance conveys empathy and positive regard for others, which contributes to resilience. Giving and receiving effective help is reciprocal, whether practical or emotional, and promotes positive relationships and self-esteem. Opportunities to experience this reciprocity should be sought by professionals, perhaps involving community organisations, or more informally at home and school.

## **5 The impact of conduct disorder and severe challenging behaviour**

The cost of conduct disorders, both in terms of quality of life of those who have a conduct disorder (as well as those in their family or community) and in terms of the resources required to counteract the effects is high. Treatments and services therefore need to be both effective and cost-effective.

### **5.1 Impact on public resources**

The economic implications of severe behavioural problems in childhood are serious. It has been estimated that the total annual cost of treating conduct

disorder, including the resources spent by local authority services, the NHS and education services, and the costs incurred by the family, amounts to around £15,000 per child (RCP, 2006). The costs of publicly resourced services for those aged 28 who had conduct disorder in childhood are estimated to be 10 times higher (£70 019) than for those with no behavioural problems (£7423) (Edwards and Hughes, 2007).

Children and young people with conduct disorders who appear out of control or with challenging behaviour during a mental health crisis present a specific challenge to service professionals called upon to provide help on an emergency or crisis basis. Recent research conducted on behalf of Young Minds and the Mental Health Foundation found that young people presented themselves or were taken to a range of settings during an emergency, including accident and emergency, police custody and other areas of the youth justice system, where staff were required to make a mental health assessment. The research highlighted poor crisis response because of frequent mismatches between CAMHS and other services in perceptions of when the emergency constituted a psychiatric problem requiring mental health professionals, and when it could be handled by the referring service. Additionally, the research found that many crises were preventable, as prior deterioration had often been observed by those involved in day to day care.

The research suggests that there is scope for improving the efficiency of public care responses to conduct disorder mental health emergencies specifically by CAMHS providing training to partner agencies to help encourage early identification, better assessment of need and using a multi-agency response for some. For example, in pilots where training had been provided by CAMHS to staff in foster placement teams and care homes, this had helped to encourage the early identification of potential problems and reduced the need for emergency interventions for looked after children. Those CAMHS which reported assisting other professionals in social care, the criminal justice system and A&E departments with training and development of assessment tools to assist in decision making around the need to call a substance misuse worker, the emergency duty team or a mental health professional, reported that this led to more efficient and appropriate management of patients with severe conduct problems (Storey and Statham, 2007).

## **5.2 Impact on Families and Communities**

The costs for both individuals and their families or communities are similarly high. It is estimated that 40-50% of children with conduct disorder go on to develop anti-social personality disorder as adults, and those who do not are at increased risk of developing a range of other psychiatric disturbances, including substance misuse, mania, schizophrenia, obsessive-compulsive disorder, major depressive conditions and panic disorder. These adults are at higher risk of violent death, and of participating in a range of other undesirable activities such as theft, violence to others and to property, drunk driving, use of illegal drugs, and carrying and using weapons, all of which carry significant costs to society (RCP, 2006). Conduct disorder has been shown to lead to poor personal relationships, including family break up, failure to complete schooling and joblessness and those with conduct disorder are also more likely to abuse the next generation of children and thus to increase the risk that they too will develop conduct disorder (*ibid*).

There is also evidence to suggest that the bulk of the financial costs are currently borne by the family in the form of extra house repairs due to the child or young person's destructiveness, and days off work because of their behaviour. By contrast, in the region of £10 per head per year is spent on child and adolescent mental health, with conduct disorder being seen as a 'social problem' rather than a disorder with serious consequences including high morbidity rates (Romeo, Knapp and Scott, 2006)

## **6 Identification and Assessment**

### **6.1 Context**

The Common Assessment Framework for children was recently introduced for all professionals working with children aged 0-18 and is designed to facilitate a universal means of identifying children with 'additional needs' or 'complex needs' who are those at risk of poor outcomes as defined by the Every Child Matters Agenda (be healthy, stay safe, enjoy and achieve, make a positive contribution and achieve economic well-being). It is intended to enable early intervention, and to reduce the need for specialist assessment. However, in itself, CAF lacks a common standard for identifying need and referring children and families to support services, so the potential for early intervention is constrained. It does not have a formal scoring system, but scope exists to develop a scoring system for children at risk of conduct disorders and anti social personality disorder as a further 'filter' once children's additional or complex needs have been determined (Utting *et al* 2007).

It is known that factors such as type and severity of disorder, parental perceptions, child age and gender, and family and social background factors determine which children with mental health problems gain access to diagnosis and treatment, and overall only up to one third of children with mental disorders receive services for these problems.

The research also shows that the two most important barriers to service access are parental perceptions of the appropriateness of expressing concern about their child's behaviour in a primary care setting, and the lack of training and specialist support for primary care services to enhance the ability of these settings to provide care (Sayal, 2006). For example, the Royal College of Psychiatry has identified that it is particularly important to provide training to GPs on early identification of mental disorders more generally, as behavioural aspects of paediatrics are not covered in training (BMA, 2006).

A large-scale national study identified that school-based access to mental health services may be effective for those parents who do not receive help through other service routes, as parents are most likely to decide to seek help for conduct problems from teachers. A successful approach to improving a school's ability to provide this sort of pastoral support lies in nominating and training particular support staff whose core responsibilities lies in this area.

## 6.2 Identification / Diagnostic Tools Used by CAMH Services

There are currently no practice guidelines from NICE for the overall assessment and treatment of conduct disorder (Scott, 2007). However, NICE guidelines for the 'treatment' of conduct disorder through the use of parenting programmes for children aged 0 – 11 years do exist. These guidelines state that:

- ICD-10/DSM-IV defines conduct disorder according to at least three of its given criteria (see below). ODD is a sub section of conduct disorder within ICD-10 (WHO, 1996).
- Professional assessment should be by at least one of the following: child and adolescent psychiatrist, a paediatrician, a child clinical psychologist specialist in behavioural disorders, or other professional with appropriate competencies using checklists to rate symptoms based on observation and interviews (e.g. the child behavioural checklist. The guidance specifies that a child with conduct disorder would be expected to score over 65 using this tool).
- Conduct disorders are often present in association with other conditions such as attention deficit disorder, depression, substance misuse, learning disabilities and autism.

The ICD 10 criteria state that a diagnosis of conduct disorder is given if a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months:

1. Aggression to people and animals
  1. often bullies people, threatens, or intimidates others
  2. often initiates physical fights
  3. has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)
  4. has been physically cruel to people
  5. has been physically cruel to animals
  6. has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
  7. has forced someone into sexual activity
2. Destruction of property
  1. has deliberately engaged in fire setting with the intention of causing serious damage.
  2. has deliberately destroyed others' property (other than by fire).
3. Deceitfulness or theft
  1. has broken into someone else's house, building, or car
  2. often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)

3. has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)
4. Serious violations of rules
  1. often stays out at night despite parental prohibitions, beginning before age 13 years
  2. has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)
  3. is often truant from school, beginning before age 13 years

Assessment for conduct disorder requires the collection of data from a number of 'informants' (professional and family) in multiple settings using multiple methods. The assessment process is significant, and other conditions need to be ruled out before a CD or ODD diagnosis can be made (Richardson and Joughin, 2002). A wide variety of assessment / diagnostic tools are in use by various professionals and within professions, but some of the most common are:

- The Child Behaviour Checklist (CBCL) (Achenbach and Edelbrock, 1991)
- This can be used to measure a child's change in behaviour over time or following treatment and exists in teacher, youth self-report and direct observation forms. One version is used for children aged 11/2 to 5, and another for children aged 6-18.
- The Eyberg Child behaviour Inventory (Eyberg, 1992)
- The Conner's Parent-teacher Rating Scales (Conners, 1989; Conners et al, 1998 a, b) (taken from Richardson and Joughin, 2002)
- The Aberrant Behaviour Scale
- The Goodman checklist (Visser, 2003)
- The strengths and difficulties questionnaire (SDQ)
- This is a brief behavioural screening questionnaire about 3-16 year olds which exists in various versions for use by researchers, clinicians and educationalists and takes approximately 5 minutes to complete. There is a self-report version for 11-16 year olds (Youthinmind, 2007).

Assessment using any of these tools can be problematic, because all procedures are prone to errors of measurement and represent a child's status as seen by a particular informant at a particular point in time (Visser, 2003). Creating discrete categories of conduct disorders using such diagnoses can therefore be seen as a commendable attempt to bring order out of chaotic patterns, and acting to 'medicalise' difficulties, many of whose components are social and cultural in origin (Visser, 2003). However, the fact remains that sizeable numbers of children have conduct disorders, which despite their complex origins, are often preventable and treatable.



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## **6.3 Other Service-Specific Assessment / Diagnostic Tools**

### **6.3.1 Early Years and Education Settings**

Schools are a key arena for early identification of conduct problems, although identification within other services can also assist in preventing conduct problems from escalating in severity. Potentially, those working in early years settings have a key role in assessment and prevention. However, the identification of mental health needs more generally across universal services is a complex picture.

Children with conduct disorder may be assessed for and classified as having Emotional and Behavioural Difficulties (EBD). They may subsequently be given a statement of special educational need (SEN) by SEN specialist teachers according to a national code of conduct (Joughin and Morley, 2007). However, EBD is a broad term, and a wide variety of assessment tools are known to be use across school settings.

The research generally points towards the need for a debate between CAMHS professionals and education professionals in particular to agree common understanding of definitions, criteria for assessment, and a common language to avoid ambiguity and to minimise misunderstanding.

Currently, schools tend to rely on educational psychologists for help in identifying the type of mental health difficulty a pupil is experiencing, often to find that that educational psychologists themselves do not have specific expertise in mental health issues. The ability to refer directly to a CAMHS professional is seen as positive, as is knowledge within schools of what CAMHS can offer, and guidance from CAMHS to schools. A 'triage' system of applying prioritisation has been suggested to allow those in greatest need to be seen with minimal delay, whilst still assisting with expert opinion in early recognition.

### **6.3.2 Youth Justice Services**

The youth justice system uses the ASSET screening tool, where a score of 2 or more on section 8 'Emotional and Mental Health' should trigger the use of a further (short) mental health screening tool delivered by a suitably trained youth justice practitioner. There is a third more in depth screening stage carried out ideally by a health worker. Youth justice staff are urged to clearly understand the mechanisms for accessing substance misuse services, as problems with substance misuse frequently co-occur with mental health problems. However, conduct disorder is not formally included as one of the disorders for which the SIfA and SQIfA screening tools are designed to identify (Youth Justice Board, 2003).

### **6.3.3 Substance Misuse Services**

Substance misuse services have an important part to play in both identifying and treating those with conduct disorders, given the high level of co morbidity between drug misuse, conduct disorder and violent behaviour particularly by adolescent boys. Identification and treatment of parents with substance misuse problems is also important in early intervention strategies to prevent development or escalation of conduct problems in their children.

Research conducted in 2005 found that, in around 65% of areas, local substance misuse services or Drug Action teams (DATs) had developed a formalised screening process for universal services around substance-misuse related need, but that the methods and screening tools used varied. Even where screening processes had been integrated into services, more than three quarters of areas reported that they experienced problems with late or inappropriate referrals where substance misuse problems by young people had escalated to problematic levels. It was found that the ability to self-screen and self refer by young people was highly effective.

In addition to those young people engaged in heaviest drug use identified as being vulnerable to mental health need, children of substance misusers were also identified as a vulnerable group in need of targeted provision. New guidance issued last year indicates that specialist assessment by drug misuse services should form part of a holistic assessment unless self referral takes place, and that a variety of tools might be used to accomplish this.

### **6.3.4 General Practice**

A study from the mid-90s found at least 77 different guidelines in relations to mental health in use by English and Welsh Health visitors (Utting *et al.*, 2007).

## **6.4 Specific Screening Tools for Conduct Disorder**

Research has been conducted into the efficacy of specific mass screening programmes for conduct disorder. One large scale national study has demonstrated that the SDQ is highly effective and reliable as a mass-screening tool for diagnosing child psychiatric disorders including conduct disorder in children and young people aged 5-15. The SDQ is multi-informant and is completed by parents, teachers and older children. However, no economic evaluation was carried out, and no account was taken of the need to further screen for 'false positives' (Goodman *et al.*, 2000). It has been shown that parents of low-risk families in screening programmes tend to prefer the SDQ over the CBCL as the screening instrument, although both are considered to be equally effective at identifying conduct problems (Goodman and Scott, 1999).

Research has indicated that different subtypes of conduct disorder may be associated with different developmental pathways, and can be predicted by different pre-school behavioural problems. Preschool behaviours assessed by parents such as hot temper, disobedience, bossiness were associated with later development of ODD and preschool bullying was predictive of later CD (Emond *et al.*, 2007), suggestive that scope exists for screening for these behaviours in preschool settings. Early Assessment of Risk Lists (EARLs) have been devised separately for boys and girls in Canada as a way of assessing individual risks for offending, and it has been suggested to the Department of Health and the Cabinet Office that this merits further investigation.

The refinement of existing tools for early risk assessment remains complicated, not least because of the sensitivity needed in relation to children at the start of their lives whose exposure to risk may not justify stigmatising them as the anti-social adults of the future (Utting *et al.*, 2007). Whatever tools are used, the research suggests that caution should be exercised, as there is a risk of misclassification, particularly 'false' positives (Szmatmari, 1999).

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## **6.5 Risks attached to screening, including early labelling**

Whatever screening instrument is used, there are risks inherent in the instrument design. The outcomes of such screening depend on the values and skills of the person(s) making an assessment. For example, despite many years developing the CBCL, Achenbach (1991) noted that there was no well-validated criterion for categorically distinguishing between children who are 'normal' and those who are 'abnormal' and that with respect to mental health syndromes, 'children are continually changing' (p45). He warned that:

'All assessment procedures are subject to errors of measurement and other limitations. No single score precisely indicates a child's status. Instead, a child's score on a syndrome scale should be considered an approximation of the child's status as seen by a particular informant at the time the informant completes the CBCL.' (p45-6).

Other academics and commentators have expressed doubts about identification and screening in both the EBD and mental health literature. There is a continuing debate among psychiatrists about the relevance of the diagnostic model and particularly the use of diagnoses such as 'conduct disorder', which may 'medicalise' difficulties. The Canadian psychiatrist Barker (1996) suggested that:

'Efforts to create categories within what is a heterogeneous and wide-ranging collection of patterns are commendable attempts to bring order out of chaos; yet they are essentially both arbitrary and artificial and have serious limitations, particularly as guides to treatment and prognosis. In reality the disorders of childhood and adolescence are a very mixed bag of social-behavioural-emotional disorders, which usually have multiple causes. A comprehensive formulation of each case is more important than the assigning of a diagnostic label.' (p13)

The key message appears to be that, to avoid inaccurate diagnoses and false positives, screening and diagnosis activities should be undertaken using a range of evidence-based tools and informants. Furthermore, a diagnosis of conduct disorder should be a trigger for a holistic set of interventions that impact on the child, family and wider community, rather than for a strictly CAMHS-focused response.

In addition, research evidence shows that, although some pupils, usually those with cognitive as well as behaviour difficulties, are quite at ease with the presence of an LSA beside them to support their behavioural and emotional difficulties, other pupils dislike their presence, seeing it as a highly visible stigma. Such a label can sometimes negatively affect the practice of staff working with individual 'difficult' children.

## **7 Interventions**

The recent 'Research in Practice' summary of messages from best practice is clear that effective intervention with children and young people with conduct disorder must address multiple domains in a co-ordinated manner and over a period of time. The report suggests that even some milder forms of challenging behaviour require co-ordinated interventions, such as parent training (for carers), social skills problem training for the child, as well as school-based

interventions. Chronic conduct disorder, which is usually childhood onset, requires early intervention, intensive treatment in multiple domains, and long-term follow up designed in particular to strengthen parent-child attachments and positive parenting practice (Research in Practice 2007). Although established patterns of behaviour (by adolescence) are more resistant to change, there is also a growing range of (multi-modal) interventions that may help older children and young people with conduct disorder. There is still, however, a dearth of research evidence on effective interventions with girls (particularly adolescent girls) specifically. Although a sizeable number of girls exhibit severe challenging behaviour as adolescents, resources still tend to be targeted at boys.

Interventions have tended divide themselves mainly into those targeting the child, or the carer, or the family as a whole. Child-focused interventions include: behavioural therapy, cognitive therapy, social skills training, play therapy, music/art therapy and school-based interventions. Parent-focused interventions have included mainly parenting education/training programmes. Whole-family interventions have included family therapy and, more recently, 'multi-systemic' or multi-agency interventions which have been identified by recent research as effective if tightly applied to model specifications and implemented by skilled therapists (Woolgar and Scott, 2005). However, currently, only a quarter of children with conduct disorder appear to receive some form of specialist treatment (Scott, 2007).

The key interventions are explored below:

### **7.1 Community-Based Interventions for Early Years**

These are interventions typically delivered by health visitor or other community-based health services, and can include some group-based interventions such as parenting classes, as well as individual family support delivered in the child's own home.

The Nurse-Family Partnership home visiting programme has achieved good results in the UK, as has the evaluated Child Development Programme. The Family Partnership Model is also promising for early behaviour problems where there is marital discord (BMA, 2006). These nurse or health visitor- home visiting programmes provide effective and cost effective support for teenage parents, single mothers, and those who live in poverty. They are not, however, universally effective across all family types, and so require appropriate targeting particularly for harder to reach families (Utting *et al.*, 2007).

**In Leeds, the 'Baby Bonding' Early Attachment Project** is coordinated by a consultant clinical psychologist and consists of health visitors, midwives and a nursery nurse. There are links with CAMHS, social services and adult mental health services. The work is based in Sure Start and family Centres, with much work completed in home visits. Pre natal engagement is established by targeting first time mothers and also women at risk of relationship difficulties due to mental health issues or histories of personal abuse. In these cases, therapeutic help is offered, before and after the birth where necessary, sometimes through referral to adult mental health services. The health visitor uses tailored materials to facilitate discussion around good quality parent-child interaction. Assessment and feedback is also given using video and the NCAST tool.

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## 7.2 Parent Training or Parenting Programmes

Parent education/training programmes have been around for 30 years and are therefore amongst the best researched interventions (Woolgar and Scott, 2005). They have been evaluated as both clinically and cost effective in the short term, and have led to the production of NICE guidelines in this area. Most of the cost savings from effective interventions identified in the guidance accrued to health and education services, although the potential cost savings to youth justice and adult healthcare were not considered (NICE, 2006).

For children with early onset conduct disorder, early intervention with family training to provide effective, non-aversive discipline and communication with their children has been evaluated as effective in prevention of the long term developmental consequences. It appears to work by preventing the later development, once schooling begins, of peer rejection, of a 'bad' reputation, and of academic failure (Davis *et al.*, 2000).

A wide range of mostly commercial parenting programmes are available in the UK and their content and approach varies widely, as does the expertise of the staff running them (Joughin and Morley, 2007). NICE Guidance suggests that group-based parent training/education programmes are recommended in the management of children aged 12 years or younger with conduct disorders in most cases. Individual-based parent training/education programmes are recommended in the management of children with conduct disorders only in situations where there are particular difficulties in engaging with the parents, or where the family's needs are too complex to be met by group-based programmes (NICE 2006).

Research shows that those which are effective include:

### Content

- Structured sequence of topics introduced in a set order over 8-12 weeks
- Subjects such as infant nutrition, play, praise, incentives, setting limits, health and safety, and discipline
- Emphasis on calm parenting and promoting sociable, self-reliant child behaviour
- Makes use of parent's own experience and possibly predicaments
- Basis in empirical research is made explicit to practitioners
- Has a detailed manual available to ensure model fidelity

### Delivery

- Collaborative approach acknowledging parent's feeling difficulties normalised, humour and fun encouraged and beliefs respected
- Parents practise new approaches in sessions and through homework
- Contains individual family work
- Crèche, good quality refreshments and transport provided if necessary
- Practitioners supervised to ensure model fidelity and to develop expertise

Commercial programmes which have been evaluated as effective include Parent Child Interaction Therapy, and The Incredible Years or Webster Stratton Programme (Woolgar and Scott, 2007). The Incredible Years can be effective with diverse ethnic groups, and amongst hard to reach and disadvantaged groups, although there is usually quite a high level of 'drop-out'. Some parenting programmes are now also teaching parents to read with their children, with the most recent research evidence showing that this treatment is relatively inexpensive using parents only as the vehicle for treatment, yet targets a number of the risk factors for developing conduct disorder (Scott, 2008).

Parent training for carers of older children (aged 10 years and older) has shown smaller effects than for younger children (Research in Practice 2007), although some programmes such as 'Triple P' are being trialled in the United Kingdom, and have shown 'early signs' of success (BMA, 2006). For this older age group, whole family and multi-modal approaches appear to be more successful (see below).

NICE has noted that more research is needed about how to make parenting programmes more sensitised to the needs of socially excluded families and those of black and ethnic minority background as attendance is a problem (NICE, 2006). Up to half of parents with antisocial children will not attend parent training. It has been shown that attendance can be improved if the modality in which the treatment is delivered is non-stigmatising and there is a pre-treatment motivational interview to align parental expectations and expected outcomes of the training programmes (Woolgar and Scott, 2007). It does not appear to matter whether these parent education programmes are community or hospital based, but is more important that the services are appropriate and address parental mental health issues in addition to the child's problems (Harrington *et al.*, 2000) Although effective in the shorter term, little is known also about how lasting the effects of these programmes might be on child behaviour, educational achievement and criminality (NICE, 2006).

### **7.3 Child/Young Person Behaviour Interventions**

Amongst the promising types of treatments that have been applied to children and conduct disordered youths are psychotherapy (for younger children), cognitive therapy, social skills training, problem-solving skills training, and anger management (Woolgar and Scott, 2007). A cautionary note is sounded by recent research evidence that suggests some group-based treatments for conduct disorders in adolescents may actually lead to an increase in their behavioural problems, and also that the use of many of these interventions in isolation is unlikely to be effective for children and young people with more chronic or severe problems (Research in Practice 2007).

Problem-solving skills training (as a cognitive behavioural approach) combined with parent training seems to be emerging as the 'treatment of choice' for severe conduct problems in children aged 8 to 12 years. However, there can be a problem with large drop-out rates. For this reason, a 'Barriers to Treatment' Measure has been designed, offering the potential to tailor programmes to the specific needs (and engagement issues) of individual families (Research in Practice 2007).

For adolescents with conduct disorder or severe challenging behaviour, schemes encompassing cognitive behavioural therapy techniques have been found to be particularly effective in youth offending (particularly serious offenders) but also some other contexts (Fongay and Kurtz 2002). Shorter and more intensive programmes have been found to have poorer results than longer less intensive interventions. Social skills training and training in academic skills, when applied to low educational achievers, have also been found to be ineffective in improving conduct problems (Richardson and Joughin 2002).

**Dialectical Behaviour Therapy Service** – A local authority in the South of England

This service is reported in the national review of NSF implementation (CSIP 2008). It describes a community-based treatment which uses the principles of cognitive behavioural therapy combined with meditation skills to help young people take hold of, and control, their mind and thoughts, rather than their thoughts controlling them. The service was designed to manage and contain a group of high risk and disaffected young people from the looked after system who have complex needs and who would not usually engage with CAMHS. Hard to reach young people were engaged through outreach techniques, group work and residential activities. The initial evaluation identified reductions in young person depression, hopelessness, and self-harm. However, there was a high level of drop out by young people who had an 'avoidant attachment style'. The service is reported to have merged with the existing CAMHS Assertive Outreach Service in April 2007.

#### **7.4 School-Based Interventions**

School-based programmes for children and young people with a range of behaviour issues include classroom based behaviour management programmes and curriculum approaches to teaching children to recognise, express and regulate their emotions through teaching self-control and problem solving (Davis *et al.* 2000). The High/Scope Pre-school Curriculum appears promising, as does the PATHS (Promoting Alternative Thinking Strategies) classroom curriculum for 7-11 year olds. There are also several well-evaluated whole-school prevention initiatives in the US that have not (yet) been transferred to the UK (BMA, 2006). Adequate training of staff and ongoing supervision and support appears to be crucial for successful implementation.

School-based interventions for children and young people with conduct disorder or severe challenging behaviour include 'contingency management plans' in particular (using methods such as behavioural contracts, reinforcement for work completed, and physical reorganisation of classrooms). Although these methods have been shown to have the potential to impact on child behaviour at school, behavioural changes have been found not to generalise to other settings (Ibid). Cognitive behavioural treatments and social competence training delivered out of class but in-school settings have produced significant positive change for children from primary school age upwards (Ibid). Research indicates that more in-class guidance from CAMHS specialists on techniques to employ to support young people with conduct disorder-related difficulties is also desired by teachers (Rothi *et al.*, 2005).

Although clearly more in-school support is available for children and young people with conduct disorder or severe challenging behaviour, research from 2002 suggests that in the past what has been provided didn't link well or was inconsistent with intervention strategies directed at the home setting (Fongay and Kurtz 2002). Multi-professional Behaviour and Education Support Teams (BESTs) have been created in many parts of the United Kingdom to develop a more holistic response to the needs of children and young people with a range of emotional and behavioural needs. However, it may be that this criticism is still pertinent to services being provided in 2008.

**In North Tyneside**, CAMHS runs a joint tier 2/3 service which is split over two sites and is multidisciplinary. Tier 4 services are run in specialist units. They work mostly through BASS (Behaviour and Attendance Support Service), a multi agency managed group, with Community Psychiatric Nurses (CPN) seconded from CAMHS to BASS. Referrals are made from schools to BASS, and the BASS team may decide to pass the referral to the CPN. The CPN conducts a range of interventions, mostly in school settings, although some are in the home. The interventions are both individual and group-based, and include cognitive behaviour therapy, counselling and work on self esteem. They also conduct home visits jointly with educational welfare officers.

Parent groups have been set up in schools and are run jointly with school nurses. Special support assistants and learning mentors have been trained and supervised to run small children's groups in schools. School nurses and nursery nurses have also been trained to provide cognitive behavioural therapy. It is notable that this area has recently witnessed an increase in the number of asylum seekers, many of whom have experienced serious trauma (a key predisposing risk factor for conduct and other mental disorders), yet are unaware of or do not know how to access services. Successful outreach meetings have been conducted with refugee groups.

## 7.5 Targeted Youth Support Interventions

14 pathfinder areas have been established as a result of the *Youth Matters* green paper published in 2005, and are intended to improve the five outcomes identified for young people in the paper. These areas provide coordinated help from a range of agencies to vulnerable teenagers, thus addressing many of the factors that contribute cumulatively to later challenging behaviour problems. Agencies to be included are:

- youth services;
- schools;
- health services;
- social services;
- voluntary and community services;
- teenage parent support workers;
- special educational needs coordinators;
- CAMHS;
- counselling services;
- information services;
- housing and housing support services;



- youth offending services; and
- The police.

Targeted support seeks to address the risk factors to avert poor outcomes by building resilience to a range of problems that can be experienced across the full 0-19 age range. It is built on seven key delivery elements, based on the learning from several existing youth programmes:

- Increasing the influence of vulnerable young people, their families and communities
- Early identification
- Clear shared assessment based on CAF
- Early support given in universal settings
- Personalised packages of support in including support for their parents or carers
- Support across transitions
- Accessible and attractive services

Multi-agency teams are usually based in community settings and they support the identification of need and early intervention by universal staff in these settings. They allocate a lead professional, provide drop-in and outreach, and draw on more specialist support, possibly from a higher level panel or board. The panels generally receive complex cases from locality-based teams, and can also act as the first point of contact for agencies that are not linked directly to a locality based team. For example, some less central services are linked to these teams by providing practitioners to form a team around the young person as needed. This is supported by formal protocols, joint training and other techniques to develop working relationships, such as hot-desking. Of particular interest are the following innovations:

- Gateshead have established schools as the initial 'spotters' and assessors of need, and multi-agency staff (including CAMHS) are being redeployed into teams around schools to provide training to staff and more effective support.
- In Knowsley, there is a Risk and Resilience Team, which focuses on transition, individual mental health resilience, health promotion, and parental and family support.

## **7.6 Functional Family Therapy (FFT)**

Functional Family Therapy is a highly structured prevention programme for young people aged 11-18 years who have challenging behaviour including offending, violence, substance misuse, DD or ODD.

FFT places an emphasis on enhancing protective factors and reducing risk factors, including in particular improving family communication and supportiveness and decreasing family negativity. Research from the United States indicates that this may be an effective treatment for young people with conduct disorder and severe challenging behaviour. However, effective delivery of this intervention requires considerable training and supervision, and the suggestion from the best practice literature is that more UK-based research would be required before this approach could be widely implemented.

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## 7.7 Multi-Systemic Therapy (MST)

MST is another intensive treatment programme that emanates from the United States, and aims to work with young people with complex clinical, social and educational problems (e.g. violence, drug abuse, school expulsion), and their parents to:

- Reduce criminal activity.
- Reduce other types of anti-social behaviour such as drug abuse and sexual offending.
- Reducing the need for care or incarceration.

It is an example of a successfully evaluated programme that works with parents and families on an individual basis, rather than within the context of a group-based programme. Over a period of three to six months, MST is delivered in homes, neighbourhoods, schools and communities by a team of professionals with low caseloads. A crucial aspect of MST is its emphasis on promoting behaviour change in the young person's natural environment. Initial family sessions identify the strengths and weaknesses of the young person, the family, and their interactions with peers, friends, school, and parental workplace. Identified problems throughout the family are explicitly targeted for change, and the strengths of each system are used to facilitate such change. Examples areas for specific intervention include:

- Improved parental discipline practices
- Increased family affection
- Decreased association with deviant peers
- Increased association with pro-social peers
- Improved school / vocational performance
- Engagement in positive recreational activities
- Improved family – community relations
- Empowerment of the family to solve future difficulties

The Department for Education and Skills and Department of Health are in the process of piloting MST in six local authority areas across England to identify the extent to which its success in The United States can be replicated in the United Kingdom. The available research suggests that it is highly effective (for example in reducing offending, improving family functioning and reducing the need for care) for adolescents provided that practitioners are highly trained and closely supervised (Woolgar and Scott, 2007). It is equally effective across differing economic and cultural backgrounds, and is especially useful as an intervention for those children who have been active offenders from a young age (Utting et al., 2007)

The review of learning from NSF implementation (CSIP 2008) included an intensive intervention service for families with complex needs, including young people with complex disorders and hard to engage families. The programme is based on multi-systemic treatment approaches and includes intensive treatment delivered by professionals with low caseloads. It comprises four components:

- 
- An assessment strategy
  - A formulation and treatment plan
  - Goal-setting for treatment
  - Evaluation at three and six months

This programme is one of the better evaluated pilots which identified that all young people presenting with violent behaviour stayed in borough, as did 4 of 6 young people with sexualised behaviour. All of the young people using the service were in school or training at the end of the intervention and evaluation period (8 of the 15 young people had been excluded from school at the commencement of the evaluation). Key learning points from the overall evaluation were:

- Key objectives can be met through the team having small caseloads, an active and assertive approach to engagement, and a resilient and tenacious approach to establishing a realistic programme of work with the family.
- A high level of clinical experience within the team is likely to be a key reason for success in engagement and outcome. No families dropped out of treatment.

The project was considered to be good value for money in that it enabled many of the young people to remain in borough (with treatment costs estimated at £20,000 per young person compared to £93,6000 average cost per annum for an out of area placement).

## **7.8 Multidimensional Treatment Foster Care**

Closely allied to MST, this treatment is particularly relevant to young people who need to be looked after by the local authority, in many cases young people who have become looked after in their late childhood or adolescence because their families can no longer cope with their behaviour. It is also known variably as treatment foster care, therapeutic foster care and specialist or 'wrap around' foster care. Specially trained foster parents care for adolescents for between 6 and 9 months, and act as the key worker for the young person during this time. The treatment comprises different elements of individual therapy, family therapy, and close monitoring by foster carers in the home and school to take into account different problems and learning styles. There are particular features which make treatment foster care distinct from traditional foster care:

- An above-average level of support, training and remuneration of carers.
- Often a teenage user group with challenging behaviour.
- A coordinated method of working that aims to address behaviours in the home, school, and community.
- Clinical staff, including psychiatrists, available to support the placement.
- A specified length of stay.

The Maudsley Hospital was one of the pioneers of treatment foster care programmes, and was funded by the DfES to pilot and evaluate this approach which has been effective in the USA for looked after children aged 11-16 years. The programme works directly against known risk factors and builds resilience and is designed to reduce rejection from adults and peers. It provides a

wraparound multi-level programme for young people in a single placement over a 9-12 month period with a daily behavioural management programme based on social learning theory. Foster carers receive tailored training and support, and there is also a clinical team to work with the young person and the family of origin. Evaluations undertaken to date have indicated increased placement and educational stability for young people coming onto the programme for whom more conventional approaches would not offer an effective solution.

North Yorkshire is one of the nineteen councils piloting treatment foster care. Prior to the pilot, the Council had already been running a specialist fostering scheme involving full time, fee-paid foster carers. However, treatment foster care is reported to have addressed some of the weaknesses of their specialist scheme in that it provides carers with training, clinical input, and directional support.

Multidimensional Treatment Foster Care has been evaluated as effective, and is particularly promising as an intervention for children who have a history of abuse and neglect, borderline intellectual functioning, young offenders, and youths with mental health problems (Utting *et al.*, 2007). The treatment is considered to be particularly effective in reducing violent offending rates for adolescents (Woolgar and Scott, 2007).

## **7.9 Social Pedagogy Model**

This model refers to the approach taken with children in residential care in Denmark and Germany, where such children have a better quality of life and outcomes than their counterparts in the UK (it should be noted that the social contexts of these countries are quite different to the UK, and therefore it is difficult to conclude on the basis of the preceding evidence alone that the social pedagogue model is the reason for these improved outcomes). As a term, it is also used to refer to more general childcare practice in Sweden and various other European countries. In particular, it relates to the overall support for children's development, and ultimately, parents are the primary pedagogues. Social pedagogy, therefore, is pedagogy undertaken on behalf of society.

The social pedagogue works with the whole child and supports their all-round development. Having undertaken 3, 4 or even 5 year degree courses, they employ theories, professional knowledge and creative and practical skills with groups and on an individual basis. The model has parallels with therapeutic communities in the UK, such as Steiner and Montessori schools. However, the bulk of practice in the UK still tends to be more oriented towards damaged children having the most daily contact with workers with relatively poor levels of education, despite government policy to increase the numbers of graduate-level workers.

A recent study (Cameron, 2007) found that the social pedagogy model is underpinned by three principles:

- Supporting children to develop their own self in relation to others by building relationships and attachments
- Meeting the holistic needs of individuals
- An attachment to an adult to provide emotional security

These principles echo the domains in which resilience can be promoted which were listed above, offering the potential to prevent the development of challenging behaviour in looked after children, a group which has high prevalence of conduct disorder problems. Also, the study highlights the similarities between these principles and those outlined in the *Care Matters* green paper.

A possible response to this model in a UK setting might involve linking a higher education institution with children's sector employees in a particular area in order to develop pedagogic practice. This would focus on the theories of practice, and the teaching of 'being together', learning and working in groups, sharing 'life space', and 'being present for children'. Potentially, groups of staff, or particular suitable individuals could be encouraged and financed to study at foundation degree level and beyond. Training sessions for staff groups could be provided by pedagogy-informed bespoke consultancy from the higher education institution. This could be enhanced by a study tour of pedagogic projects in another country. Thus, a more generalist, harmonised, approach to the training of the children's workforce would be taken, with workers sharing common values, theoretic understandings, skills and practice principles. This could be enhanced with workers taking specialist options to further the objectives in their respective disciplines (Petrie *et al.*, 2005).

The social pedagogy form of practice is becoming increasingly appropriate in England as a result of many recent changes to the structure and practice of the children's workforce, the drivers of which were detailed above. Increasingly, children are being viewed as individuals, rather than problems to be managed, and organisational barriers are being reshaped across agencies and workforces. The appropriateness of this approach to the UK is enhanced by the newly developed guidance referred to above, which particularly emphasises the need to reduce the gap in outcomes between looked after children and others, and by the imminent publication by the DCSF of Building Brighter Futures: next steps for the children's workforce action plan, which will detail how integrated professional working will take place through Children's Trusts.

## **7.10 Combination Treatments**

As evidenced by some of the multi-component interventions illustrated above, the research suggests that combination treatments aiming to influence child, family, and wider-based community issues produce better outcomes than just a single treatment component.

For example, combining parent training with a child training component produces lasting improvements for children with ODD, although these improvements do not always generalise to the school setting. However, there is some evidence to suggest that adding in a teacher training component does improve child behaviour in the school setting, at least in the short term. Equally, combining child and teacher training only is effective, but the improvements in problem behaviours do not generalize to the home setting. For parents experiencing stressful life events, such as divorce or bereavement, combining a problem solving component with parent training produces greater improvements than parent training alone, although does not necessarily reduce stress levels (Woolgar and Scott, 2005).

In addition to MST and other such treatments, research indicates that interventions targeting other poor outcomes, such as substance misuse can also impact on the behaviour of young people. For example, early targeted intervention aimed at strengthen families to prevent or reduce substance misuse in the USA has resulted in reducing the prevalence of conduct related problem behaviours, which are lasting in their effects. This is a promising approach, and there is further support for combining a parent-based approach with broader, school-based prevention approaches (Joughin and Morley, 2007).

**A team in South Tyneside** brings together staff from the youth service, Connexions, youth offending service, substance misuse, looked after children, children with disabilities, Sure Start, CAMHS, the children's fund, the behaviour improvement programme, schools and staff involved in CAF, the lead professional and information sharing. Identified gaps in engagement between agencies lead to involvement of CAMHS, health, and school staff initially in the substance misuse assessments and panels, and youth inclusion and support panels. The intention is to create a new comprehensive panel, and to allow self-referral to the new panel through proactive identification and support.

In Sefton, CAMHS has provided training for the Lead Behaviour Professional who works in school with the collaboration of social care and educational psychology services around child protection issues, working with families, parenting courses and identifying needs as social as well as educational. Additionally, educational psychology services undertook training around managing challenging behaviours and emotional literacy. A Behaviour and Education Support Team across all 22 schools in the area has been created and Home/School Liaison Workers have been employed. There is also a Learning Development Manager who runs provision for excluded children. This has resulted in improving attendance rates and a reduction in exclusions.

### **7.11 Interventions specific to girls**

A recent comprehensive review on behalf of the Research in Practice organisation into conduct disorder in older children examined gender differences specifically and noted that although it is well established that conduct disorder is three to four times more common in boys, there is 'very little evidence to guide practice on interventions for girls' (Joughin and Morley, 2007; q.4). A comprehensive scoping review of research into antisocial personality disorder that included conduct problems undertaken for the Home Office offers further evidence that the existence and nature of gender differences are well-established, but that antisocial behaviour (and associated conduct problems) in girls is a 'relatively under-studied area', and that there is 'still much that needs to be researched', despite increasing academic interest (Morgan and Hagell, 2001). Visser, (2003) studying challenging behaviour in education, notes that 'very little has been published' on gender specific treatment and approaches, and that there are 'no clear answers' to the question 'what is effective for girls?' (p.63). The existence of gender differences and the dearth of understanding of the processes underlying these differences and ways to address them is further backed by a recent international expert paper on child and adolescent antisocial behaviour produced by the NHS Forensic Mental Health Programme. It notes that 'little is known why this trend [in differences] has occurred' and 'research is lagging behind' with regard to girls' problematic behaviour and its relationship to difficulties experienced in adulthood (Bailey *et al.*, 2007).

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What is known can be summarised as follows:

- Boys become increasingly more aggressive during primary school years, but gender differences start to diminish in adolescence.
- Girls develop late-onset non-aggressive conduct problems at a greater rate than boys.
- Girls have greater likelihood of developing co-morbid symptoms (particularly ADHD; also problems with drug misuse and teenage pregnancy) and internalising disorders (particularly anxiety and depression -(Loebler, 2000))
- Girls tend to exhibit more covert behaviours (Loebler, 2000).
- Girls with co morbid ADHD tend to have more persistent CD.
- Girls appear to be more vulnerable to informal and unofficial school exclusions, and the invisibility of girls' problems can have serious consequences for their ability to get help.

Although there is little formal research, many explanations for the existence of these differences have been offered. Socio-cultural explanations have included observations that in the West, as in most countries, girls are socialised differently from boys. Right from infancy males are played with more vigorously than girls, are allowed to engage in more active play, and have behavioural patterns that are tolerated differently when they occur than if they occur in females. Research seems to indicate that only one factor accounts for the difference in how fathers parent children as opposed to mothers-the amount of physical play they engage in with their children. Fathers tend to play more vigorously with children than mothers, and play more vigorously with their male children than their female children. This implies that boys are therefore more likely from a cultural perspective to acquire problems with aggressive conduct problems.

Furthermore, since there is no generally agreed definition of what constitutes challenging behaviour, it follows that there can be great variation in what is identified as challenging, by whom it is identified, and from whom it is manifested. All behaviour is relative to a context be it social, environmental, cultural, or historical. What is challenging in one context can be perceived as quite normal in another. The contextual nature of human behaviour makes it difficult to be certain what is appropriate or inappropriate (Carey, 2007). The implication is that girls' behaviour is perceived differently from boys' behaviour by observers (including themselves) and thus they might be rated differently in the diagnostic process for conduct disorder, with the consequence that the observed gender differences are generated.

There are also biological explanations offered for gender differences in challenging behaviour. There is research that seems to indicate that the male sex hormone plays a role in the development of aggressive behaviour in boys. A definitive answer to these contrasting explanations and their interaction in these gender issues has yet to be arrived at.

It was noted in the first paper produced by IPC on conduct disorder that expert opinion in a variety of fields and national contexts agree that interventions more generally should be tailored to the specific functional impairments of each individual, and their circumstances. This is to be understood as comprising the domains of their family, their schooling and community, their peers and their age. It can therefore be concluded that, despite a lack of definitive answers as

to what works specifically for girls, interventions in each of the above domains could be tailored to take into account the tendencies highlighted above.

In light of this conclusion, it is worth noting that there is evidence to suggest that particular problems may arise for authorities seeking to intervene in the peer, school and community domains for girls with conduct problems in ensuring that they have a suitable peer group. This problem is most likely to arise if they attend a 'mixed' EBD school where there are often gender imbalances (Visser, 2003), or if they are placed in a mainstream school with poor gender ratios, mostly likely to occur in under-performing schools serving socio-economically deprived communities. Also in the domain of schools, communities and/or peers, individual education and/or care plans that address both the pupil's short and long-term affective and educational needs are likely to be useful, particularly those which allow space and time for *respite*, *relationships* and *resignification* (Visser, 2003). Time for talking and listening in one-to-one and small group situations might also be particularly appropriate for those with co-morbid anxiety problems.

### **7.12 Intervention principles**

Scott has identified some key principles for intervening with children and young people with conduct disorders, and their carers as follows:

- Engage the family using practical measures, such as help with travel, childcare and providing sessions in the evenings, and ensure the therapist clearly understands their viewpoint, and builds a good quality alliance.
- Select the treatment and who should deliver it so that interventions specifically address each context.
- Develop strengths by encouraging abilities and prosocial activities.
- Treat co morbid conditions, particularly depression, ADHD and post traumatic stress disorder.
- Promote social and scholastic learning, so that positive behaviours are taught.
- Use guidelines, such as NICE (2006).
- Treat the child in their natural environment so that gains are maintained.

(Scott 2008)

Services provided need to be flexible and innovative in order to reach young people, with a diverse range of venues and styles of service to reflect the differing needs of the individual and nature of their conduct-disordered difficulties. On a practical level, it can be helpful to combine CAMHS with others services aimed at young people such as general medical and sexual healthcare, and to provide drop-in, 'un-badged', or telephone access to services. At a social and psychological level, it is critical that both children and parents are made aware of the nature of conduct disorder as treatable to reduce the construction of negative stereotypes which act as barriers to treatment. Confidentiality and support also needs to be maintained through treatment, combined with communication about what can realistically be provided by CAMHS and realistically achieved (BMA, 2006).



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## 8 Care pathways

Research in both medical and social intervention settings has demonstrated the value of developing clear and if possible multi-disciplinary care pathways for services to particular groups of the population who require treatment or intervention from public care services.

Multi disciplinary care pathways are currently being developed from within a range of policy domains, as a result of various national drivers. These include:

- Every Child Matters, 2004, specifying five outcomes for children
- The Children Act, 2004, creating a legal duty for agencies to work in partnership i.e. creating Children's Trust arrangements
- National Service Framework for Children, Young People and Maternity Services, 2004, specifying 11 standards
- CAMHS NSF Standard and Public Service Agreement
- Common Assessment Framework, 2005, for all children's services
- The Children and Young Peoples' Plan, a requirement for all local authorities
- Joint Area Reviews, assessing how well local services work together
- Youth Matters: Next Steps, 2006, increasing funding and young people's voice
- RESPECT Agenda, 2006, an Action Plan with six main strands covering individuals, families and communities
- Revised National Outcomes Framework, April 2008, new guidance for inter agency cooperation to guide children's trusts over the next 10 years

The recently published guidance on children's trusts (DCSF 2008) states that:

*"There should be clear processes and pathways for engaging and working with more specialist services where additional needs are identified, and accessible multi-agency arrangements for allocating resource and delivering joined up services to address these needs".*

The national review of NSF standards implementation relating to psychological well being and mental health (CSIP 2008) reported that poorly cited care pathways is a significant factor in children and young people experiencing difficulties in accessing CAMHS.

An example care pathway is for ADHD. This pathway was developed in response to the need for multi-disciplinary input into the diagnosis and management of the disorder in Cheshire, and is based on nationally accepted quality standards. The pathway starts with teacher identification of possible ADHD and completion of an initial assessment in the form of questionnaires for the teacher and parents. The initial assessment is forwarded to a specified arm of the CAMH service to complete a more in-depth assessment where required. The pathway includes prompts to consider a range of interventions and settings, including family and school-based. It also addresses the importance of the wider-school context by ensuring not only that schools are informed of the diagnosis, but also that they are prompted to take advantage of wider training and interventions offered by the CAMH service. All child-related documentation, including the community

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clinic, psychiatric review, parent and school questionnaires and growth charts are contained in a parent-held record.

Sheffield is also in the process of developing an early intervention care pathway for younger children experiencing behavioural problems with the aim of ensuring improved co-ordination at Tiers 1 and 2, and appropriate referral to Tier 3 services (CSIP 2008).

For the purposes of this project, IPC has attempted to identify a pre-existing care pathway for:

- Younger children with early onset conduct disorder; and
- Older children and young people with late onset conduct disorder or severe challenging behaviour (with a distinction between girls and boys perhaps).

As there does not appear to be a pre-existing care pathway of this nature, it is likely that, in seeking to establish new ways of working with children with conduct disorder and their families, A local authority in the South of England will have to develop a 'for purpose' pathway of its own. This might include any or all of the following elements:

- An indication of the key stages of the journey through care services, from the child and family perspective (from identification through care planning, intervention, and review).
- A set of standards that show the minimum requirements to deliver effective services to children and young people across the pathway.
- Supplementary tools to support effective interventions throughout the pathway, for example:
  - A tool to support the early identification of potential conduct disorder or severe challenging behaviour in schools and other settings.
  - A decision support tool for use in care planning and in managing interventions to ensure evidence based practice across these key stages of the pathway.
  - Guidance on child and family engagement techniques.

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