National Institute for Health and Clinical Excellence

Conduct disorders in children and young people

Stakeholder Comments – Draft scope

Please enter the name of your registered stakeholder organisation below. **NICE is unable to accept comments from non-registered organisation or individuals. If you wish your comments to be considered please register via the NICE website or contact the registered stakeholder organisation that most closely represents your interests and pass your comments to them.**	
Stakeholder organisation:	**Association of Child Psychotherapists** 120 West Heath Road, London NW3 7TU Tel: 020 8458 1609 www.childpsychotherapy.org.uk
Name of commentator:	**Beverley Tydeman** Chair

Comment No.	Section number Indicate **number** or **'general'** if your comment relates to the whole document	Comments Please insert each new comment in a new row. Please do not paste other tables into this table, as your comments could get lost – type directly into this table
1	3.1 (a)	We feel the scope needs to include greater clarification and discussion of the differences between Conduct Disorder (CD) and Oppositional Defiance Disorder (ODD).
2	3.1 (b)	In our view it is difficult to diagnose a "pure" conduct disorder, which renders the statement "conduct disorders are the most common mental health disorder in children and young people" potentially misleading. Vanderkolk is trying to get developmental traumas which affect conduct written into the ICD-10 and the DSMIV – the link between developmental trauma and conduct disorders seems key but is not mentioned in the scope.
3	3.1 (c)	We wonder whether the figures for those females diagnosed with CD are up to date? There is anecdotal evidence in a number of CAMHS clinics of growing numbers of young females presenting with CD-type presentations. Statistics are available for self harm in females, which is not unconnected in terms of destructive behaviours and CD and drop-out from school (3.1e).
4	3.1 (d)	We welcome the scope's recognition that CD commonly co-exists with other mental health disorders. As well as links with ADHD, the presence of attachment disorders is also key. (*Morality, Disruptive behaviour….Fonagy, Target, et al., 1997)* We feel care needs to be taken within this diagnostic category to provide greater distinction, where possible, between CD and ADHD where there is not a co-existence of the two disorders. In our experience there is a tendency in some settings to give a primary diagnosis of ADHD where a diagnosis of CD may be more appropriate. This can lead to a preponderance of treatment involving medication more likely to target ADHD.

5	3.2 (c)	We are in agreement that negative parenting styles and exposure to parental conflict, including domestic violence, can impact on the child's behaviour. A great deal of evidence points towards young males in particular identifying with an adult (often male) who demonstrates dominance, power and control in the parental relationship (*Jaffe, Wolfe and Wilson, 1990; Rosenbaum and O'Leary, 1981; Glaser, 2000).* We welcome the scope's emphasis on parent training. We consider this crucial, along with psycho-educational programmes for parents. Interventions such as Family Nurse Practitioners (FNP) attempt to help parents to understand behaviour as a communication (*Gunner. M, 1998: Quality of early care and buffering of neuroendocrine stress reactions: Potential effects on the human brain).* We also support the scope's emphasis on early intervention programmes, which could include early observation of behaviours in nursery or school reception settings as well as presentation of CD behaviours in the home environment. The presentation of CD behaviours in the home, school and the community must be linked, and highlighting the resilience of the child and young person is key. More detail may need to be provided in terms of treatment options for those children and young people diagnosed with CD. Psychoanalytic/psychodynamic child and adolescent psychotherapists in CAMHS work successfully with children and young people with diagnoses of CD or ADHD and their wider networks in conjunction with colleagues from other disciplines. Psychoanalytically-based child psychotherapy can focus on developing a reflective capacity in the young person and thereby lessen aspects of the impulsivity which is a common component of CD.
6	4.1.1 (a)	We believe that adopted children should be among the groups specifically covered by the guidance. In our experience CD is prevalent in children and young people who have been adopted, linked to significant attachment difficulties including early trauma and losses. Children demonstrating CD traits in educational settings, often linked with low educational attainment and poor engagement with learning, might also be considered.
7	4.1.1 (c)	We welcome the inclusion of "attachment insecurity" (first bullet point) but wonder whether the term is a little vague. We wonder whether replacing this with the more widely used and understood term "attachment disorders" might offer greater clarity.
8	4.3.1 (c)	Clinicians with an in-depth training are likely to be able to provide a containing function to the child or young person and to have the capacity to consider the impact of their difficulties on the wider network around them i.e. the family, the school, the community, social services where relevant. Interventions with a psychoanalytic/psychodynamic child and adolescent psychotherapy component are valuable in terms of managing high levels of stress, being trained in understanding parent-infant interactions and their impact on behaviour and also in working with aggression and complexities in the system.
9	4.3.2 (a)	We would advocate greater consideration of the link between CD and trauma. There is a great deal of research exploring the impact on children of witnessing domestic violence, experiencing physical abuse and identifying with an aggressor. Experiencing such trauma can be linked with developing disorders such as CD. *(Anda, Felitti, Bremner et al, 2006; Cleaver et al, 1999; Gorin, 2006; Vanderkolk, 2009; Fonagy & Higgit, 2000; Bremner et al, 2006; CD and poverty: Halpern, 1993)*

10	4.4 (a)	Greater clarification is needed about what is meant by 'anti-social behaviour' at home and at school.
11	4.4 (b)	Despite the scope's reference to educational tools and input, we note that work in educational settings will not be considered in this guidance. Perhaps the guidance should consider quantitative measurement tools for professionals working with children across a range of settings. These could be in the form of questionnaires, for example.
12	General Comments	We are impressed by the scope's recognition of the aetiology of children and young people who appear to use behaviour as their primary method of communication and of the 'bigger picture' around CD, including the issues for the family, education services and the wider network around the child. We also welcome the scope's emphasis on early intervention and treatment.
13	General Comments	We would like to reiterate that the scope needs to give far greater consideration to the impact of developmental trauma and attachment difficulties on the developing brain and therefore on the conduct of children and adolescents.

Please add extra rows as needed

Please email this form to: ConductDisorders@nice.org.uk

Closing date: 5pm on 9th February 2011

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