National Institute for Health and Clinical Excellence

Conduct disorders in children and young people
Stakeholder Comments

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Stakeholder Organisation:	Association of Child Psychotherapists, 120 West Heath Road, London NW3 7TU. Tel: 020 8458 1609 www.childpsychotherapy.org.uk			
Name of commentator:	Biddy Youell, ACP chair			
Order number *(For internal use only)*	**Document** Indicate if you are referring to the **Full** version or the **Appendices**	**Page Number** **Number only** (do not write the word 'page/pg'). Alternatively write **'general'** if your comment relates to the whole document.	**Line Number** **Number only** (do not write the word 'line'). See example in cell below	**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.**
Example	Full	16	45	Our comments are as follows ……
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1	Full	General		The draft conduct disorder guidelines contain much to be welcomed. They stress the impact of conduct disorder upon life chances, citing findings of Fergusson et al. (2005) that the most antisocial 5% of seven-year-old children are 500 to 1000% more likely to display indices of serious life failure at 25. The terms of reference are broad, including a wide range of studies, and practical guidance is measured and thoughtful. The guidance is strong on the benefits of long term care, on continuity of care, and on the qualities of the experience of care, as opposed to the particular content.
2	Full	26	2	However, the report begins with a consideration of aetiology which is disappointingly inconclusive. The authors suggest that "a low resting pulse rate or slow heart rate has been found consistently to be associated with antisocial behaviour". They do not delve into the neurobiology which might illuminate this interesting fact, presumably because it was outside their brief, and so leave unexplored an important and relevant finding that might have shed light on necessary prevention and/or treatment.
3	Full	27	19	There are also tentative links made in this respect with child attachment: "Although it seems obvious that poor parent-child relations in general predict conduct problems, it has yet to be established whether

				attachment difficulties as measured by observational paradigms have an independent causal role in the development of behaviour problems". Here again, readily available and long-established neurobiology in this field may have helped establish more firmly the connection between attachment difficulties and later conduct disorder. The draft guidance does acknowledge the strong contribution of harsh, inconsistent parenting, though, and the witnessing of domestic violence among other family problems. These factors indicate a relational basis for conduct disorders. It is our view that the child is a social being, whose behaviour, however disordered, makes sense in the social context in which his or her mind developed. Interestingly, studies of parent-rated interventions found less improvement than teacher- or self-rated studies. This seems to suggest that people outside the family see the most change. It is possible that in child-focused work, the change has not happened in the family but has happened in relation to other people in the world outside the family. It does not follow that the intervention is ineffective, only that family-focused work may also be needed for the changes to be experienced in the family. This seems to point to a relational variable, which, in our view, was under-addressed in the report. It is apparent in the evidence and touched on in the guidance, but perhaps not sufficiently emphasized. One reason for this may be an understandable concern about blaming or stigmatizing parents; the importance of respecting parents is tactfully stressed.
4	Full	119		However, the corollary can be that children with conduct disorder are themselves stigmatized. The authors address this in their further recommendations, reminding health and social care professionals that "many children and young people with a conduct disorder may have had substandard or punitive experiences of care from both family members or statutory services and therefore may be mistrustful or dismissive of offers of help". This is where broadening the remit to include neuroscience could help, explaining without blame the experience-dependent nature of the brain's wiring in early childhood. Professionals and service users alike are thus helped to understand better how those parents and children who have experienced abuse or neglect are liable to act these out in later life, and how best to respond.
5	Full	92		A related area of concern is that the consultation document does not, in our view, take sufficient account of the communicative function of behaviour. This strikes us as important omission. In our experience, over many years' work with disturbed children, disordered conduct is a communication about a child's disordered emotional state, which the child does not yet have the language to convey verbally, The attempt to understand what the child is communicating through his or her behaviour seems to be the curative factor, provided it happens within a relationship with qualities identified in the guidelines: "emotional support, empathy and respect".
6	Full	98		We welcome the authors' emphasis on establishing a relationship of trust with the service-provider as the most significant consideration, necessitating "an identified professional or worker who remained constant in their lives over time".

7	Full	95		The highlighting of the need for a “weaning process” as things become more settled and need for care diminishes is welcome too. In this context, the advice for a very vulnerable group, those in the process of leaving care, strikes us as being in need of strengthening. It simply advocates “adequate attention” being given to support for children and young people when they are on the verge of leaving care and living independently. Given that most 18-year-olds struggle to establish independent living, especially in the current gloomy economic climate, it would seem necessary to build in more rigorous guidelines for those whose lives have been troubled, and who have not had the support of an intact family. Conduct disorders of significant expense to society are a particular risk for careleavers. Some recommendations, although welcome, will be a challenge for multi-agency working in the context of potential payment by results; for example, keeping assessment to a minimum, tailoring services to individual families’ needs, respect for confidentiality and greater clarity about the sharing of information, not passing children from one team to another unnecessarily, practical support in maintaining engagement with services, increased knowledge on the part of staff concerned with the delivery of service, and improved continuity of service provision. This is not to call into question the principles of the guidance, but instead to highlight some of the implications of the system of payment by results as presently envisaged. These implications are also apparent in the search for independent causal factors. Guidelines in relation to outcome measurement, for example in educational settings, raise similar questions.
8	Full	General		Finally, it is our understanding that the authors’ recommend that benefits of medication are generally unlikely to outweigh the potential harm, except where there is particularly explosive anger. We are not qualified to comment on this, but it would fit with our conception of the relational nature of this disorder. In summary, in our view the draft conduct disorder guidelines are **strong on**: benefits of intensive, long term care for the most vulnerable; continuity of person delivering care; need to involve family with caveats for adolescents; experience of qualities of care over particular content; professional morale and expertise. The guidelines are **less strong on**: relational nature of aetiology and implications for treatment; awareness of behaviour as communication; specific guidelines for work with some groups e.g. careleavers; coherent approach to complexity of the problem versus outcome measures. The guidance seems to raise questions about the design of any payment by results system, which as currently envisaged, necessitates fragmentation of services into separate, specialist clinics. This conflicts with the underlying principles of the guidelines and also the specific guidance advocated.
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Closing date: 5pm on 26.09.12

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