Objective: In collaboration with the Social Care Institute of Excellence, to appraise the clinical and cost effectiveness of parent-training/education programmes for the treatment of conduct disorders in children, and to provide guidance to the NHS in England and Wales, which takes account of the multi-agency provision and responsibility for such programmes.

Background: Conduct disorders are characterised by a repetitive and persistent pattern of dissocial, aggressive or defiant conduct. Such behaviour is more severe than ordinary childish mischief or adolescent rebelliousness. Isolated dissocial or criminal acts are not in themselves grounds for the diagnosis, which implies an enduring pattern of behaviour. Oppositional Defiant Disorder (ODD) is an associated but slightly less severe behavioural problem.

Associated factors for conduct disorders include; social disadvantage, homelessness, overcrowding, maternal depression, paternal criminality, exposure to violence, and abuse. Aspects of parenting have also been associated with conduct disorders and include; poor supervision, erratic harsh discipline, parental disharmony, rejection of the child and low parental involvement in the child’s activities.

Suspected conduct disorders are the most common reason for referral of children to mental health services. The prevalence of diagnosed conduct disorders in children between the ages of 5 and 10 is 6.5% for boys and 2.7% for girls (of which 4.8% and 2.1% respectively represent the prevalence of ODD) The prevalence of diagnosed conduct disorders in older children (11-15) is 8.6% for boys and 3.8% for girls (of which 2.8% and 1.3% respectively represent the prevalence of ODD). There is a high prevalence of conduct disorders amongst children in public care.

Conduct disorder and ODD are often seen in association with attention deficit hyperactivity disorder (ADHD). Depression, learning disabilities (particularly dyslexia), substance misuse and less frequently psychosis and autism may also co-exist with conduct disorder.

If un-treated, conduct disorders with on-set in early childhood often persists into adolescence and adulthood. Approximately 40-50% of children with conduct disorder go on to receive a diagnosis of antisocial personality disorder (APD) as adults. Others may be diagnosed with psychiatric disturbances including substance misuse, mania,
schizophrenia, obsessive-compulsive disorder, major depressive disorder and panic disorder. Children with conduct disorders are also at high risk of suffering disadvantage through; school exclusion, poor school achievement, long-term unemployment, juvenile delinquency and crime, all of which have high costs to society.

Social welfare provision for and health care management of conduct disorders varies. Treatments for conduct disorder include; parent-training/education programmes, family therapy, Multi-Systemic Therapy (MST) and Multi Treatment Foster Care (MTFC) and child-based therapies such as; psychotherapy, cognitive-behaviour therapy, social-skill training, play therapy, music/art therapy and occupational therapy.

**The technology:**

Parent-training/education programmes for the treatment of conduct disorders are focussed short-term interventions (varying between 8-22 weeks). They aim to educate parents in improving their relationship with their child, and improve parenting skills, by teaching parents to monitor, discipline and manage child behaviour more effectively. It should be noted that although the term ‘parent’ is used in relation to these programmes, they are not exclusive to biological parents as in certain circumstances the biological parents may not be the main caregiver for the child.

Parent-training/education programmes are most often used with children under the age of 12 years, and two main approaches exist: behavioural and relationship. Behavioural programmes focus on teaching parenting skills to identify the causes of problem behaviour. Relationship programmes aim to help parents understand their own behaviour and to improve communication with their child. However the categories are not exclusive and many contemporary programmes combine elements of both. A range of programmes is available and may be conducted individually or in groups.

Programmes are provided in a variety of formats, including video and written materials, or a combination of the two. Psychiatrists, psychologists and nurses, paediatricians, social workers, family therapists, health visitors, teachers, occupational therapists and primary care workers can all deliver parent-training/education programmes. Often multi-disciplinary teams will provide the service. The programmes are conducted in a variety of settings by a variety of providers including the child’s home, child and adolescent mental health services, schools and by social services and youth offending teams. The appraisal will therefore also consider the use of parent-training/education programmes in settings other than clinical settings.

<table>
<thead>
<tr>
<th>Intervention(s)</th>
<th>Parent-training/education programmes for the treatment of conduct disorders (for example Webster-Stratton programmes, The Triple P – Positive Parenting Program, Mellow Parenting)</th>
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| **Population(s)** | Children diagnosed with conduct disorders (including ODD) aged up to 12 years or with a developmental age of 12 or below

Children with a concurrent diagnosis of ADHD will be included. It should be noted that medication is often the first line of therapy for children with this specific disorder (see Methylphenidate appraisal). |
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<td><strong>Current standard treatments (comparators)</strong></td>
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| **Other considerations** | Reported outcomes include:

**Child**
- changes in child’s behaviour rated by parent/teacher/or independent observer
- changes in child’s problem-solving interaction and communication with peers
- changes in child self-esteem
- school exclusion
- rates of offending

**Parents**
- changes in parental self-esteem
- changes in parental stress, anxiety and depression
- changes in levels of criticism by parents
- rate of parents participation and completion of programmes

**Family**
- extent to which parents learn from the programme and make use of the learning
- changes in parents attitudes and family adjustment
- placement stability

The appraisal will consider the most appropriate evidence from experimental, quasi-experimental, observational and evaluation studies.

If the evidence allows the appraisal will comment on:
- the different models of parent-training/education programmes (e.g. behavioural versus relationship, group)
versus individual), duration of programmes and characteristics of delivery; and
• the impact they may have on different populations (for example children with organic disorders, such as autism, learning disability and psychoses; and parent characteristics, such as teenage parents and lone parents).

A review of NICE Technology Guidance No. 13 on ‘Methylphenidate (Ritalin) for hyperactivity in childhood’ is in progress (for further details see the NICE website www.nice.org.uk).

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i Original remit from the Department of Health “In collaboration with the Social Care Institute of Excellence, to appraise the clinical and cost effectiveness of parent training programmes for the treatment of conduct disorder in children.”


