National Institute for Health and Clinical Excellence

Name of guideline Conduct Disorders
Guideline Consultation Comments Table
15th August – 26th September 2012

No	Type	Stakeholder	Order No	Document	Section No	Page No	Line No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
39	SH	Aneurin Bevan Health Board	1	Full	2.1.1	15	5	The Child Psychologists within our service are concerned about the medicalisation of emotional and behavioural presentations that, from our experience and training, represent a child's expression of distress. Whilst of course the guidelines acknowledge the role of context and trauma throughout, the use of the term conduct disorder and oppositional defiant disorder implies that the problem resides within the child. This promotes and reinforces a view within society that the problem is located within the child, and that there is somehow a medical validity in this.	Thank you for this comment. To address it, under section 2.2 in the introduction we now clarify that giving a diagnosis of conduct disorder does not imply that the problem resides within the child, and in some cases may purely be due to harsh inconsistent parenting or traumatic experiences.
140	SH	Aneurin Bevan Health Board	2	Full	6.4.1.8 (NICE rec 1.3.7)	185	21	We advocate for a more prominent role of formulation in the process, developed with the young person and their carers/parents. This would provide an understanding of the child's behaviours as an expression of distress in the context of their past and current life experiences. This would bring a normalising, non-stigmatising framework of understanding for the child and those working with him or her. Formulations would also facilitate planning in terms of which interventions would be most helpful for a specific child, young person and system.	Thank you but we do not specify or prescribe roles or formulate the process.
3	SH	Association For Family Therapy and Systemic Practice (AFT)	2	Full		General		AFT welcomes this document's recognition of gaps in the 'evidence base', and the statement (p8 line 18) that evidence from 'clinical experience' will also be included in the development of these guidelines. AFT will include evidence from clinical experience and 'service user' feedback in this response.	Thank you for your comments and helpful suggestion regarding systemic family therapy. However, the literature searches conducted would have identified randomised controlled trials (RCTs) for this intervention and

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								Although RCTs involving systemic family therapy remain relatively rare, the evidence base for systemic family therapy in relation to conduct disorders is strong (Carr, 2009a), and forms the basis for the most intensive family based interventions such as MST and FFT. (Hengeller, 2002; Alexander et al, 2002). Systemic Family Therapy also forms the basis for new methods for targeting change in safeguarding services (Goodman & Trowler, 2012). It has also been shown to be highly cost-effective (Crane, 2008). • Carr, A. (2009a) The effectiveness of family therapy and systemic interventions for child-focused problems. *Journal of Family Therapy*, 31: 3–45. • Henggeler, S. W., & Sheidow, A. J. (2002). Conduct disorder and delinquency. In D. H. Sprenkle (Ed.), *Effectiveness research in marriage and family therapy* (pp. 27-51). Washington, DC: AAMFT. • Alexander, J.F. & Sexton, T.L (2002) Functional Family Therapy: A model for treating high risk, acting out youth in J Lebow *Comprehensive Handbook of Psychotherapy, Vol 4 Integrative/Eclectic* (pp111-132) New York: Wiley • Crane, D.R. (2008) The cost effectiveness of family therapy: A summary and progress report. *Journal of Family Therapy*, 30: 399-410. Crane D.R. & Christenson, J.D. (2008) The Medical Offset Effect: Patterns in Outpatient Services Reduction for High Utilizers of Health Care	as none were found we feel that it would not be appropriate to consider lower levels of evidence for one intervention above others as this would introduce a risk of bias. Therefore, after reviewing, where available, the publications you list, we can find no further RCT evidence to add to the meta-analysis.
4	SH	Association For Family Therapy and Systemic Practice (AFT)	4	Full		General		AFT notes the draft guidance comment that: 'We now need research on clinical proposals of what to do with those who do not respond (to parent management training).' (p32, line 16) Although there is well established evidence that parenting programmes are helpful for families and children with less complex difficulties, AFT members' clinical experience also suggests they are not enough to help families and children with complex needs.	Thank you for raising this issue. The GDG have considered the evidence you provide. Please see our responses below.

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								Service offers to children and young people with 'conduct disorder' have traditionally fallen between two extremes; on the one hand programmes such as MST, effective, but targeting a limited number of families particularly in start-up, and parenting programmes which may not equipped to deal with the complexities thrown up by many families. A middle path has been developed by a number of family therapy services around the UK, which AFT would urge the GDC to consider:	
5	SH	Association For Family Therapy and Systemic Practice (AFT)	4 (cont)					• Outreach Systemic Family Therapy and systemic parenting approaches for families with complex needs, developed by Newham CFCS/CAMHS. From 2002-2010 Newham CFCS targeted systemic family therapists, dual-trained in validated parenting techniques, in the Sure Start zones. CFCS also created the award-winning Reframe Team (RFT) from Children's Fund monies. The tasks of this team were to engage with those families whose children had severe conduct disorder and were not engaging in multi-agency services. Many of the children and young people that the RFT worked with had histories of school exclusion and children's social care safeguarding interventions. The majority of this team were systemic family therapists, dual trained in validated parenting techniques. The work of this team has resulted in peer-reviewed publication (Aggett et al, 2011; 2012). The team received good feedback from service users who traditionally did not engage with services, and also were able to engage with 98% of service users. The team delivered systemic family therapy and complex parenting packages on an outreach basis, most often in the home setting. *Aggett P. et al (2011) 'Seeking Permission: an interviewing stance for finding connection with hard to reach families' Journal of Family Therapy http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1467-6427/earlyview*	Thank you for these references, however, neither meet eligibility criteria for the review. Steve: Ty – but as you see for the comment above the focus for evidence of effectiveness was on RCTs (in line with the NICE technical manual)

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								Aggett P. (2012) Responsiveness, Permission-Seeking and Risk in Context 04/12 AFT	
6	SH	Association For Family Therapy and Systemic Practice (AFT)	4 (cont)					• Systemic Multi-Family Therapy groups in schools are proving effective in supporting children and families experiencing emotional, behavioural and social problems http://marlborough.thedigitalacademy.com/asset/286/Marlborough%20Model%20Brochure.pdf). This model is currently being evaluated http://www.uel-ftsrc.org/ongoing_research.htm	Thank you for providing this link, however the focus for evidence of effectiveness was on Randomised Control Trials (in line with the NICE technical manual). The evidence you cite does not include RCTs and therefore does not meet the eligibility criteria. But we do have evidence from other RCTs for school based interventions.
7	SH	Association For Family Therapy and Systemic Practice (AFT)	4 (cont)					• Non Violent Resistance is a therapeutic intervention now used across different settings and countries, working with parents who feel helpless and overwhelmed by the child's situation. It can be offered to parents in individual families or in groups, and is proving especially useful in engagement of parents of adolescents. Groups of family therapists in the UK have adapted the approach and won awards for their parents' groups (for example, Oxleas NHS Trust's Bexley and Greenwich CAMHS Non Violent Resistance Project - http://www.oxleas.nhs.uk/news/2011/12/nvr-project-comes-out-tops/). An emerging evidence base for NVR demonstrates not only behavioral improvement in young people, but also behavioural improvement in parents. In addition to behavioural improvement and a 90%+ retention rate in therapy even for families of adolescents, Weinblatt and Omer (2008) found the approach led to reduced parental helplessness, improved parent mental health and improved perception of social support in parents compared to controls. A German study compared NVR for 11-18 year old young people who were showing oppositional, aggressive and anti-social behaviour with TEEN Triple-P and a waiting list control group (Ollefs, 2009). The study demonstrated significant improvement in	Thank you for providing these references. The GDG reconsidered whether NVR should be included in the review and agree that NVR should be included and have searched for interventions accordingly. We were able to obtain and extract data from one RCT (Weinblatt and Omer, 2008) and the review has been updated accordingly. With regard to the other studies you have cited, the study in German was not picked up as we limit our evidence base to English-Language papers. We do not have access to the Lavi-Levavi dissertation. Although the findings from the one small study are positive, the GDG decided not to make a recommendation at this stage because they did not think that the evidence was strong enough to support a recommendation.

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								parental presence, improved parenting behaviour, reduced parental helplessness and reduced parental depression for both treatment groups. NVR was superior to TEEN Triple-P by showing significant improvement in child externalising behaviour on Achenbach's CBCL. Improvement from therapy using NVR has further been demonstrated on a variety of systemic variables, which included reduced parental submission, increase in parental supervision, less dominant thinking, fewer power struggles and reduced negative emotions, as well as improvement in child behaviour (Lavi-Levavi, 2010). *Ollefs, B., Von Schlippe, A., Omer, H., and Kriz, J. (2009) Adolescents showing externalising problem behaviour. Effects of parent coaching (German). Familiendynamik, 3: 256-265.* *Lavi-Levavi, I., (2010). Improvement in systemic intra- familial variables by "Non- Violent Resistance" treatment for parents of children and adolescents with behavioral problems, PhD dissertation, Tel- Aviv University, Tel Aviv*.	
8	SH	Association For Family Therapy and Systemic Practice (AFT)	4 (cont)					• The Reclaiming Social Work model in Hackney. This social work model is transferrable to health and multi agency, multi disciplinary teams. In RSW, small teams of appropriately skilled staff attempt to change the way family members interact with one another by challenging the problem at a number of different levels systemically (Goodman & Trowler, 2012). Goodman S and Trowler I (2012) *Social Work Reclaimed* Jessica Kingsley	Thank you for this comment. The focus of the guideline was on prevention and treatment interventions, using evidence from randomised controlled trials. In addition, we have taken account of the social work perspective both in membership of the GDG and in the guideline joint development with SCIE.
9	SH	Association For Family Therapy and Systemic Practice (AFT)	5	Full		General		Prevention: AFT agrees that: 'Much is known about the risk factors leading to conduct disorders and effective treatments exist. The challenge is to make these available on a wider scale, and to develop approaches to selective prevention which are effective and can be put into practice at a community level.' (p37, line 42 on)	Thank you for your comment. We agree with the point that prevention is important, which is why we have specific chapters on this. It does not seem to us that either treating severe cases, or a medical model precludes strong emphasis on prevention, and

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								As well as the USA rooted systemic models cited in the draft consultation, AFT requests the guidelines also consider the community based interventions developed in the UK, outlined in point 4 above. These models are proving highly effective in in engaging and supporting children , young people and families experiencing emotional, behavioural and social problems. Systemic family therapy approaches in health, social care and education services are also supporting many families to resolve and manage their difficulties before they escalate sufficient to trigger serious conduct disorders in vulnerable children and young people (Carr, 2009a). Family and Systemic Psychotherapists able to work with families with more complex difficulties are also supporting other professionals working with young people and families experiencing difficulties, through training, consultation and supervision. AFT is alert to the dangers of funding intensive interventions for conduct disorders at the expense of other clinic and community-based systemic family interventions that can prevent occurrence and/or escalation of conduct difficulties.	the guideline espouses this.
10	SH	Association For Family Therapy and Systemic Practice (AFT)	12	Full		General		AFT shares the concerns of many clinicians at the labelling of children and young people with a psychiatric disorder, when they may be exhibiting behavioural responses to contextual and relational factors and/or to trauma, abuse and fear in their lives. The tensions inherent in using a psychiatric 'medical' assessment lens, language and treatment model for a bio-psycho-social problem are clear.	Thank you.
11	SH	Association For Family Therapy and Systemic Practice (AFT)	14	Full		General		The recommendation to deliver an intensive intervention such as MST, involving 3 contacts with clients per week, will be unrealistic for most services to deliver. Currently this sort of intervention is only deliverable in the UK on pilot sites with substantial additional Government funding. The guidelines should include some recognition that while services may aspire towards such a provision, under current circumstances it is going to be problematic to achieve such a level of service.	Thank you for your comment. We agree that provision of intensive services is insufficient, and hope that the publication of the guideline will help commissioners realise the usefulness and importance of these therapies

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								Innovative partnerships with other agencies may be necessary to allow for this sort of intensity of intervention.	
12	SH	Association For Family Therapy and Systemic Practice (AFT)	15	Full		General		The guidance points out multimodal interventions, yet the only example given is MST (Multi Systemic Therapy). A single example creates unhelpful bias. The guideline is unhelpfully narrow in its recommendations. There is good evidence to support the effectiveness of MST for children with history of delinquency but there is not good evidence for its use beyond this. AFT requests a wider range of multimodal interventions.	Thank you for your comment. Although the evidence review identified three other types of multimodal intervention, only trials of MST provided sufficient data to be included in the meta-analysis. The trials not included in the meta-analysis did not provide clear support for the use of other multimodal interventions and therefore cannot be used as examples.
13	SH	Association For Family Therapy and Systemic Practice (AFT)	16	Full		General		AFT requests a greater recognition in the guidelines of the history of domestic violence and abuse in this population. Children at risk of developing conduct disorders may be helped earlier and more effectively by a CAMHS workforce better trained in systemic assessment and interventions, and by Systemic Family Psychotherapists able to work with more complex families, empowering families to transform their lives and often transgenerational patterns of violence.	Thank you for your comment. We do acknowledge in the introduction that violence in the home may be a contributory factor in the development of CD We also considered a number interventions focused on parenting and early intervention but we could find no evidence to support the approach you suggest.
14	SH	Association For Family Therapy and Systemic Practice (AFT)	18	Full		General		Priority areas for further research Assertive outreach and community based systemic interventions cited in point 4 of this response. Health economics: impact of interventions for conduct disorders on health service use by children and young people AND their parent(s)/carer(s)	Thank you for your comment. We have considered your research recommendations but felt that community based systemic interventions were adequately covered in the existing research (eg MST) The NICE HE model does cover the issue you raise and is part of a number of research recommendations we make.
37	SH	Association For Family Therapy and Systemic	1	Full		7	21	Sara Barratt's job title is Consultant Systemic Psychotherapist, not Systematic	Thank you, the correction has been made

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		Practice (AFT)							
38	SH	Association For Family Therapy and Systemic Practice (AFT)	6	Full		11	31-35	AFT welcomes this document's clear recognition of the importance of good therapeutic relationships, and of the importance of offering a range of treatments and approaches to engage the person and develop the context for effective delivery of interventions. This seems especially important to emphasise at a time of funding cuts and service constraints. As systemic practitioners, we also recognise the importance of engaging with and supporting those close to the person diagnosed with a conduct disorder. In particular, Family and Systemic Psychotherapists (aka Family Therapists) working with young people with conduct disorders and their families seek to tackle the complex interlocking problems that such families experience; for example, parental self-esteem and mental ill-health, parental relationships, parenting style, partner violence and domestic poverty, child behaviour, sibling antisocial behaviour, youth offending, educational attainment and social competence are linked in complex causal loops. They seek to provide a package of interventions to address a number of different problems experienced by the family so that the capacity for change is increased and the resources of the family and network are utilised. AFT therefore requests this paragraph (p11, lines 31+) be amended as follows to reflect the importance of family inclusive systemic practice: '…evidence-based treatments are often delivered within the context of an overall treatment programme including a range of activities, the purpose of which may be to help engage the person and those important in their lives, and provide an appropriate context for the delivery of specific interventions. It is important to maintain and enhance the service and relational contexts in which these interventions are delivered, otherwise the specific benefits of effective interventions will be lost. Indeed the importance of organising care in order to support and encourage a good therapeutic relationship, and to enhance the person's close	Thank you, we have amended the text.

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								personal relationships and potential networks of support, is at times as important as the specific treatments offered. '	
48	SH	Association For Family Therapy and Systemic Practice (AFT)	7	Full	2.2	16	6	The document states 'In addition to social causes there are substantial genetic and biological contributions to conduct disorders and therefore supports a medical approach to their care and management.' AFT does not follow the logic here – that a 'medical approach' is required when there are also clearly acknowledged social and familial factors. We wonder if this statement risks being construed as 'medical' treatment having primacy over other interventions? AFT would rather use the draft consultation's clear recognition of potential 'bio-psycho-social' factors to invite a clear statement of the importance of developing systemic and multimodal approaches to their care and management.	We thank you for this comment and this has now been clarified.
49	SH	Association For Family Therapy and Systemic Practice (AFT)	8	Full	2.2	16	14	AFT strongly supports the document's call for mental health professionals to work closely alongside other professionals and agencies to plan and deliver humane and effective services. We would add that this requires us to also work closely with the important non-professionals in the person's life who may be crucial to their recovery, and who provide the primary context of potential healing in the child or young person's life.	Thank you for this comment , the wording has been changed to include important other professionals and agencies.
50	SH	Association For Family Therapy and Systemic Practice (AFT)	9	Full	2.2	17	3	The 'disruption and damage to others' will depend in part on the 'others' beliefs and contexts – what's going on in the lives of those affected, their beliefs and the meanings attached to the person's behaviours, the available support networks and their felt ability to do something about their difficulties. Hence the importance of engaging and working with those around the person as well as the person with the diagnosis.	Thank you for your comment. We agree and have modified the introduction to reflect this.
51	SH	Association For Family Therapy and Systemic Practice (AFT)	10	Full	2.2	17	4	Those using this clinical guideline would be supported in safe, ethical and effective practice if a clear statement were inserted here, reminding them that many of the behaviours described as clinical features of conduct disorder may also indicate other serious difficulties in a child or young person's life, including	Thank you, we agree. In the section on explaining the implications of using the term diagnosis, the examples are given that it could be a response to trauma or abusive parenting

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								experiences of trauma, violence and abuse	
53	SH	Association For Family Therapy and Systemic Practice (AFT)	11	Full	2.2.4	18	14	AFT welcomes this section on 'impact'. It is a description of the impact of the child or YP's behaviour on others, and the impact of others on the child. This could usefully be stated clearly in the section introduction.	Thank you for your comment. As noted above, we now try to make clear that it could be a response to draw more abuse, as noted above
56	SH	Association For Family Therapy and Systemic Practice (AFT)	13	Full	2.5.1	24	37	AFT welcomes the clarity of the statement that genetic vulnerability increases the importance of environmental or psychosocial interventions	Thank you.
64	SH	Association For Family Therapy and Systemic Practice (AFT)	3	Full	2.7.2	32	26	AFT agrees with the statement that 'most other varieties of family therapy have not been subjected to controlled trials for young people with conduct disorder or delinquency'. It also notes the statement earlier in the consultation document that: 'It is important to remember that the absence of empirical evidence for the effectiveness of particular intervention is not the same as evidence for ineffectiveness.' (p11, lines 26 on).	We thank you for this comment.
93	SH	Association For Family Therapy and Systemic Practice (AFT)	17	Full	4.3	106	1.1.13	AFT welcomes the recommendation to 'take into account the child or young person's developmental level, emotional maturity and cognitive capacity, including any learning disabilities, sight or hearing problems or delays in language development ' AFT requests this be extended to take account also of the cognitive capacity of parents/carers.	Thank you for your comment however this is beyond the scope of the guideline.
15	SH	Association for Rational Emotive Behaviour Therapy	1	Full		Whole document		We have reviewed the document and support the guidelines.	Thank you for your support.

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1	SH	Association of Child Psychotherapists	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.	Thank you for this comment.
2	SH	Association of Child Psychotherapists	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.	Thank you, we are grateful for your comments and have strengthened and clarified the guidelines in relation to these points in several places. For example included a NICE recommendation 1.1.23 to take into account the comments on care leavers for looked after children. However the focus of NICE guidelines and recommendations is not on aetiology and the payment by results system is outside the scope
59	SH	Association of Child	2	Full	2.5.1	26	2	However, the report begins with a consideration of aetiology which is disappointingly inconclusive. The authors suggest that	Thank you for your comment. We agree that neurobiological differences

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		Psychotherapists						"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.	are fascinating, but as yet the literature is not clear on the significance of these in either causation or treatment, which is why more is not said
61	SH	Association of Child Psychotherapists	3	Full	2.5.2	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.	Thank you for your comment. We're not sure that the fact that there are neurobiological correlates of conduct disorder necessarily implies that attachment problems also have a role, but fully accept this may be the case in some individuals. Under section 2.5.2 we do discuss attachment problems as a contributory cause to conduct disorders. We do very much see the relational aspect of conduct disorder, and one of our major recommendations is for psychological therapies that improve the parent-child relationship and family functioning.
79	SH	Association of Child	5	Full	4.2.4	92	18	A related area of concern is that the consultation document does not, in our view, take sufficient account of the	Thank you for your comment. We agree that children with conduct

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		Psychotherapists						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".	disorder may in some cases be communicating distress, and others have got into a habit of antisocial responding. The interventions recommended strongly based on clear positive and warm communication with the child, and include elements of nondirective play, attentive listening, and sensitive responding which we feel are in the spirit of the comments being made here.
81	SH	Association of Child Psychotherapists	7	Full	4.2.4	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	Thank you for your comment. We agree that implementing some of the recommendations may be difficult to services, but one of the points of guidelines is to set standards which services should aspire to; controlling actual provision is outside our control. We agree that the transition to adult services is important for vulnerable young people and have revised the guideline to include this, see NICE recommendation 1.1.23. In regards to payment by results, this is not a system which we will be designing.

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								for independent causal factors. Guidelines in relation to outcome measurement, for example in educational settings, raise similar questions.	
84	SH	Association of Child Psychotherapists	6	Full	4.2.5	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".	Thank you for your comment; we agree that the relationship of trust is paramount.
103	SH	Association of Child Psychotherapists	4	Full	4.4	119	3-28	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.	Thank you for this comment. As noted above, whilst some of the children have indeed experienced trauma and the guideline now includes this specifically, and we also agree with the stance of non-stigmatisation, however a thorough review of the biological effects of trauma is outside the scope of this guideline. We do nonetheless note some of the biological contributions to the disorder in the introductory chapter.
137	SH	BPS	12	Full Nice	6.2.8	180 22	25 17	Risk assessments (harm to self or others) should be based on Structured Professional Judgment, making use of available well validated instruments, e.g. (SAVRY) Borum, R. Manual for the Structured Assessment of Violence Risk in Youth (SAVRY). Odessa, Florida: Psychological Assessment Resources, 2006.	Thank you for this comment. However, the SAVRY is but one instrument that is very good but is really aimed at delinquent adolescents; here we wished to take a broader view of risk.
179	SH	BPS	13	Full	7.5.1.16 (NICE 1.5.14)	264		*Individual, family, school, criminal justice and community*"- we believe it may be helpful to specifically note peers within this list, as this is one of the key stated components within MST interventions.	Thank you for your comment, we recognise peer groups are a focus of concern in MST however not necessarily in other multimodal intervention settings so adding peer groups here wouldn't be advisable.
187		BPS	14	Full	8.4	283	29-30	In relation to the statement 'Not normally commenced until psychosocial interventions have been given a thorough trial'. Given the clear guidance on the very limited evidence of benefit over risk and the recommendation that pharmacological interventions should not be offered for the routine treatment in	Thank you for your comment. The circumstances in which this would be applicable are in very severe behavioural problems, the immediate need to manage the problem or a

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								oppositional defiant disorder or conduct disorder - it is not clear in what circumstances medication might be offered prior to psychosocial interventions. We suggest that specific guidance is required about what these circumstances might be, or the recommendation amended to omit the word 'normally'.	previous history of non-response to psychosocial interventions. We have amended section 8.4 'from evidence to recommendations' in order to reflect this.
16	SH	British Association for Adoption and Fostering (BAAF)	1	Full				This response is being submitted on behalf of the BAAF Health Group, which is also a special interest group of the Royal College of Paediatrics and Child Health (RCPCH). The Health Group was formed to support health professionals working with children in the care system, through training, the provision of practice guidance and lobbying to promote the health of these children. With over 500 members UK-wide, an elected Health Group Advisory Committee with representation from community paediatricians working as medical advisers for looked after children and adoption panels, specialist nurses for looked after children, psychologists and psychiatrists, the Health Group has considerable expertise and a wide sphere of influence. Our area of concern is the particularly vulnerable group comprised of looked after and adopted children (LAC) and young people.	Thank you for your comments. The GDG have considered the issues you raise and agree that looked after and adopted children and young people are a particularly vulnerable group. Our responses are based on the GDG's discussion.
17	SH	British Association for Adoption and Fostering (BAAF)	3			General		The guidance makes little reference to attachment disorders which are highly relevant to LAC and other children with backgrounds of adversity, and which needs to be addressed.	Thank you for your comment; we have amended the introduction to ensure the issue of attachment is addressed.
18	SH	British Association for Adoption and Fostering (BAAF)				General		The guidance should address the importance of placement stability and quality for LAC as without this there is limited chance for interventions to succeed. Our members commonly note that CAMHS refuse to treat LAC who are not in a long term placement, yet without interventions the challenging behaviour of many LAC means it is impossible to sustain a placement. This must be addressed.	Thank you for your comment. We agree with the importance of your suggestion however we are not in a position to assess the quality and stability of care in this guideline.
19	SH	British Association for Adoption and Fostering				General		We are pleased to see that the guidance recognises that a variety of interventions are appropriate.	Thank you.

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		(BAAF)							
199	SH	British Association for Adoption and Fostering (BAAF)	2	NICE	Introduction	6	29	We welcome recognition that conduct disorders are highly prevalent in LAC	Thank you for your comment.
201	SH	British Association for Adoption and Fostering (BAAF)	4	NICE	Person centred care	10	10	Statement that 'CAMHS and adult services should work jointly to provide assessment and services' is welcome. In the experience of our members it is quite common for CAMHS to state that working with young people with a conduct disorder is not within their remit. The guidance should make it clear that commissioning must address this.	Thank you for your comment. Conduct disorders is a mental health issue, largely co-morbid with other mental health issues which therefore fall under the CAMHS remit.
204	SH	British Association for Adoption and Fostering (BAAF)	5	NICE	KPI Comprehensive Assessment	10	15	Guidance should specify who will be expected to carry out comprehensive assessments. See comment above.	Thank you for your comment but we do not specify or prescribe roles or formulate the process.
205	SH	British Association for Adoption and Fostering (BAAF)	6	NICE	KPI Psychosocial interventions	11	1	There is a high prevalence of LAC with conduct disorder cared for in residential homes due to their difficult behaviour, so residential care workers should also participate in relevant training programmes, and this should be made explicit in the guidance.	Thank you for your comment. We do not feel that residential workers are omitted from the guideline, notably in sections referring to training and developing care pathways. However it is outside of our remit to specify training for individual professions.
206	SH	British Association for Adoption and Fostering (BAAF)	7	NICE	1.1.1	13	10	1.1.1 – We fully support this recommendation for training, and recommend that there should be an acknowledgment of the resources which will be required to carry this out.	Thank you for your comment. NICE will be developing costing tools to support implementation of the guideline.
207	SH	British Association for Adoption and Fostering	8	NICE	1.1.3	13	20	1.1.3 – We welcome this continuity of care but it will require significant strategies to organise and deliver services which can offer this continuity.	Thank you for your comment. The NICE implementation team will be working with the Department of Health to ensure a collaborative

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		(BAAF)							approach to the implementation of government policy and the guideline.
208	SH	British Association for Adoption and Fostering (BAAF)	9	NICE	1.1.7	14	22	Again	Thank you for your comment. The NICE implementation team will be working with the Department of Health to ensure a collaborative approach to the implementation of government policy and the guideline
209	SH	British Association for Adoption and Fostering (BAAF)	10	NICE	1.1.12	15	24	1.1.12 –The experience of substitute parents is that professionals often believe them to be responsible for causing the difficult behaviour of their children, when in fact the aetiology of the problem lies in their experiences of developmental trauma before becoming looked after and adopted. This should be acknowledged in the guidance as well.	Thank you. Recommendation 1.1.6 has been adopted in light of this.
211	SH	British Association for Adoption and Fostering (BAAF)	11	NICE	1.1.19	18	6	1.1.19 – This is extremely important and will almost certainly involve further training in cultural competency and diversity. The guidance should recognise the resources required for such training.	Thank you, we agree the importance of your comment however this is an implementation issue.
212	SH	British Association for Adoption and Fostering (BAAF)	12	NICE	Transfer & discharge 1.1.20	18	20	1.1.20 – While this is very important the experience of LAC leaving care is that the transfer to adult services is often poorly handled, that adult services have limited knowledge and experience of their backgrounds and needs. This needs to be strengthened to recommend the provision of additional effective supports at the time of transfer.	Thank you. In light of your comment and after having consulted with the GDG, a separate recommendation, (NICE recommendation 1.1.23) has been drafted to address the continuation of care for young vulnerable people.
218	SH	British Association for Adoption and Fostering (BAAF)	13	NICE	Case id 1.2.4	20	1	1.2.4 - LAC have a high incidence of foetal alcohol spectrum disorder (FASD) and neurodevelopmental trauma (related to abuse and neglect) and these should be included in this list.	Thank you for the comment but FASD is outside of the scope.
221	SH	British Association for Adoption and Fostering (BAAF)	14	NICE	Case id 1.2.6	20	12	1.2.6 – As previously stated, in the experience of our members it is quite common for CAMHS to state that working with young people with a conduct disorder is not within their remit. Specific statements regarding remit and commissioning would strengthen the guidance.	Thank you for your comment, we agree that conduct disorders is a mental health issue, largely co morbid with other mental health issues which therefore fall under the CAMHS remit. This has been made clear in the full

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									guidance.
224	SH	British Association for Adoption and Fostering (BAAF)	15	NICE	Compassessment 1.2.9	21	5	1.2.9 – asking about a history of abuse and neglect as well as prenatal exposure to alcohol and substances should be included in this list	Thank you for your comment, we have included abuse in recommendation 1.3.13 and prenatal exposure to alcohol and drugs in recommendation 1.3.14 .
225	SH	British Association for Adoption and Fostering (BAAF)	16	NICE	Compassessment 1.2.10	21	18	1.2.10 – neurodevelopment conditions should include FASD and trauma/neglect	Thank you for your comment, however FASD is not in the scope and we feel that this issue has been covered in recommendation 1.3.14.
226	SH	British Association for Adoption and Fostering (BAAF)		NICE	Compassessment 1.2.14	22	1	1.2.14 - As previously stated, it is important to recognise that substitute carers are trying to be 'above average' parents through offering therapeutic reparenting and should not be held responsible for children's difficult behaviours.	Thank you for your comment, but we feel that this is covered by recommendation 1.1.13.
236	SH	British Association for Adoption and Fostering (BAAF)		NICE	Foster carer/ guardian training 1.4.6 & Parent/	26	1	1.4.6 and 1.4.10 – This training as well as interventions for adolescents, should be offered to residential care workers who care for the significant numbers of LAC with conduct disorder living in residential homes due to their difficult behaviour. If the management of these children is inconsistent, then results will be poorer.	Thank you for your comment However we were unable to look at the provision of training for residential care workers as this is outside of the scope.

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					child, complex needs 1.4.10				
241	SH	British Association for Adoption and Fostering (BAAF)		NICE	Selective prevention	28	15	1.4.16 and 1.4.17 – We fully support the principles of prevention but wonder who will be determining which children are at risk? And what programmes are recommended? Are there standardised and validated programmes, or are these to be individually developed and if so, who will take on this role?	Thank you for your comment – we have adjusted recommendation 1.2.1 to make clear what the risk factors are and the interventions are clearly set out in recommendation 1.2.2 and 1.2.3. NICE recommendations don't normally specify who will implement each recommendation as this is a decision for each trust. Any programme following 1.2.2 could be used, and again, who will take on this role is a decision for each trust.
246	SH	British Association for Adoption and Fostering (BAAF)		NICE	Pharmacological 1.5.3	30	10	1.5.3 – Some community paediatricians have expressed concern at the use of medication for explosive anger. If this is recommended it should be made clear that it will be used under close supervision and with other relevant interventions.	Thank you for your comment. We do not recommend medication for explosive anger, but rather only discuss it in the context of fully diagnosed conduct disorders, and then we are very cautious outside the context of coexistent ADHD
256	SH	British Association for Adoption and Fostering (BAAF)		NICE	Organisation & delivery of care 1.6.1	33	6	It is essential to ensure that when national mapping is done, the local pathways have consistency and sufficient services to deliver to those with identified needs. They should have wide enough criteria to include those in need – see earlier comments re CAMHS.	Thank you but this is an implementation issue and outside the scope of the guideline.
264	SH	British		NIC	Org	34-35		1.6.6 and 1.6.7 – Services are currently inconsistent in	Thank you for the comment, to do this

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		Association for Adoption and Fostering (BAAF)		E	anisation & delivery of care 1.6.6+.7			availability and expertise between regions and our members are not convinced this will improve with forthcoming changes to commissioning. The guidance should specify that robust efforts to collect local data should be instituted to influence commissioners.	would go beyond the scope of the guideline. We believe as we say in NICE recommendation 1.7.7, that services should use local data but it is outside of our scope to be any more prescriptive
40	SH	British Psychological Society	1		Full	15	22	Given that the majority of research with this population is with young people who have received a diagnosis of Conduct Disorder. Given the broad scope of the diagnostic criteria, many young people might meet the criteria without having been formally diagnosed. There may therefore be several factors that influence which young people are presented for diagnosis. It may be helpful to note this at this early stage of the document.	Thank you for this comment. We feel the section on causes does show the many different factors that influence the causation of antisocial behaviour and conduct disorders; probably the majority of this research is on children and young people with antisocial behaviour without having had a formal diagnosis. We also think the issue is addressed in the care pathway recommendations about access and in the research recommendations which seek to understand the problems some groups have in accessing effective interventions.
41	SH	British Psychological Society	2		Full	15	24	Throughout the guidance the terms "psychopathy" and "antisocial personality disorder" are used interchangeably. We believe that this is inaccurate and should be amended. For example, using the *DSM-IV* (American Psychiatric Association, 1994) criteria, 50% to 80% of offenders and forensic patients are diagnosed with Anti-Social Personality Disorder, however only 15% to 30% of those same individuals meet the PCL-R criteria for psychopathy (e.g., Hare, 1991; Hart & Hare, 1997). Hare, R. D. (1991). The Hare Psychopathy Checklist–Revised. Toronto, Canada: Multi-Health Systems. Hart, S. D., & Hare, R. D. (1997). Psychopathy: Assessment and association with criminal conduct. In D. M. Stoff, J. Breiling, & J. D. Maser (Eds.), Handbook of antisocial behavior	Thank you for this comment as well. In the introduction, we now clarify that psychopathy is only found in the subgroup of those with antisocial personality disorder. There is also a substantial section on the rise of research on psychopathic traits which appears in the differential diagnosis

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								(pp. 22-35). New York: John Wiley. This is particularly important as psychopathy remains a controversial concept in young people. (see Johnstone and Cooke, (2004) Psychopathic-Like Traits in Childhood: conceptual and measurement concerns, Behavioral Science and the Law, 22, p 103-125.	
44		British Psychological Society	3	Full		16	4-6 18-35	*"However, advances in the last three decades have shown that in addition to social causes, there are substantial genetic and biological contributions to conduct disorders and therefore supports a medical approach to their care and management."* The Society does not support the assertion that advances in understanding genetic and biological contributions necessarily equate to support for the effectiveness or appropriateness of a medical approach. Indeed, the guidance continues to note that most interventions are necessarily psychosocial. The use of the term 'medical' may give inadvertently give an inaccurate impression. It is suggested that a broader term is used which reflects the breadth of healthcare professionals contributing to assessment/intervention/management is used such as "comprehensive bio-psychosocial approach". This section is a coherent and helpful summary of the significant concerns of many professionals on the front line.	Thank you for your comment, we have rewritten the section on diagnosis accordingly to explain that it does not imply biological causation, and that biopsychosocial model is appropriate.
54	SH	British Psychological Society	4	Full		18	18-19	With respect to the sentence 'parents… may, as a last resort, give up the child to be cared for by the local authority' – whilst many clinicians will recognise this as 'short-hand' it may misrepresent a much more complex process. Parents may request that the local authority care for their child at least for a respite period but the process of a young person diagnosed with conduct disorder being placed into the care of the local authority is much more of a joint decision and not one that parents can make independently. We therefore recommend that this be revised as follows: *'as a last resort, speak to and work alongside social workers to try and have their child taken into the care of the local authority on a temporary or sometimes permanent*	Thank you for your comment. We agree that children being taken into care is a complex process, but feel that the difficulty of managing such children is covered by the existing statement.
55	SH	British Psychological Society	5	Full NICE		21 10	29 15	It is suggested that a discussion of the impact of complex developmental trauma is an omission in the guidance. This is of particular relevance to assessment and formulation of	Thank you. We have now included a specific reference to trauma (section 2.1.1 and 2.2) and are grateful for

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								conduct problems and should be highlighted rather than subsumed within co-morbid difficulties and/or differential diagnoses (e.g. adjustment reaction to an external stressor). For example, Flannery et al., (2001) report that dangerously violent adolescents reported higher levels of exposure to violence and victimization than did matched controls Ford et al., (1999) found that controlling for age, gender, severity of internalizing behaviour problems, social competence, family psychopathology, and parent–child relationship quality (assessed by parent report), an Oppositional Defiant Disorder diagnosis, with or without comorbid Attention Deficit-Hyperactivity Disorder, was associated with increased likelihood of prior victimization (but not non-victimization) trauma. Studies of both child and adult populations over the last 25 years have established that, in a majority of trauma-exposed individuals, traumatic stress in childhood does not occur in isolation, but rather is characterized by co-occurring, often chronic, types of victimization and other adverse experiences (e.g. Anda et al., 2006) Furthermore, McCrory et al., (2010) notes, the neurobiological mechanisms by which childhood maltreatment heightens vulnerability to psychopathology remain poorly understood. It is likely that a complex interaction between environmental experiences (including poor care giving) and an individual's genetic make-up influence neurobiological development across infancy and childhood, which in turn sets the stage for a child's psychological and emotional development. As such, the Society recommends that specific consideration of complex developmental trauma should be included as part of a comprehensive assessment – in addition to excluding PTSD as a co-existing mental disorder. (section 6.4.1.10) R. F. Anda, V. J. Felitti, J. D. Bremner, J. D. Walker, Ch. Whitfield, B. D. Perry, Sh. R. Dube and W. H. Giles (2006) The enduring effects of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology European Archives of Psychiatry and Clinical	these comments. We are aware that trauma can lead to biological changes, and in the section on causation a substantial amount is written about biological factors. However, because there are many pathways into conduct disorder, some of which do not involve traumatic influences, we have not gone into great detail about the points made here, which nonetheless we find very valid.

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								Neuroscience Volume 256, 174-186 McCrory. E., De Brito, S.,A. And Viding, E, (2010) Research Review: The neurobiology and genetics of maltreatment and adversity Journal of Child Psychology and Psychiatry, 51, 1079-1095. Flannery, D. J., Singer, M. I., & Wester, K. L. (2001). Violence exposure, psychological trauma, and suicide risk in a community sample of dangerously violent adolescents. Journal of the American Academy of Child and Adolescent Psychiatry, 40(4), 435-442. Ford, D., Racusin, R, Daviss, B., Ellis, G., Thomas, Rogers., Reiser, , Schiffman, ., Sengupta. Trauma exposure among children with oppositional defiant disorder and attention deficit–hyperactivity disorder. Journal of Consulting and Clinical Psychology, Vol 67(5), 786-789	
58	SH	British Psychological Society	6	full		24	39	In relation to the genetic contribution it may be helpful to reference the work of Viding and colleagues around the contribution of callous-unemotional traits, e.g. E Viding, PJ Frick, R. Plomin (2007) Aetiology of the relationship between callous–unemotional traits and conduct problems in childhood-The British Journal of Psychiatry, 190, 33-38. Viding, E., Frick, P.J., Plomin, R., Jones, A.P., Frick Paul, J., Moffitt, T.E., (2008) Heritability of antisocial behaviour at 9: do callous-unemotional traits matter? *Developmental Science*, 11, 17-22. Fontaine, N.M., McCrory, G., Eamon, J. P., Boivin, M., Moffitt, T.E., Viding, E, (2011) Predictors and outcomes of joint trajectories of callous–unemotional traits and conduct problems in childhood. *Journal of Abnormal Psychology*,120(3), 730-742	Thank you for your comments. We do already have some references about callous unemotional traits and psychopathy.

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60	SH	British Psychological Society	7	Full		26	15	In addition to the Dodge (2006) reference regarding difficulties in social cognition for aggressive children, it may be helpful to include: a) The facial expression recognition research relating to children with conduct disorder. Fairchild, G.; Van Goozen, S.H.M., Calder, A.J., Stollery, S.J. & Goodyer, I.M. (2009) Deficits in facial expression recognition in male adolescents with early onset or adolescent onset conduct disorder, *Journal of Child Psychol Psychiatry* 50(5):627-36. b) The social communication deficits research relating to children with conduct disorder. Gilmour, J. Hill, B., Place, M. & Skuse, D.H. (2004) Social communication deficits in conduct disorder: a clinical and community sample, *J Child Psychol Psychiatry,* 45(5):967-978	Thank you for the suggested references. There are many neuropsychological differences in children with conduct disorder in terms of executive functioning and social deficits, but unfortunately space precludes us including more in this guideline.
62	SH	British Psychological Society	8	Full		27	271-33	The guideline notes the difficulties in identifying an observable independent causal link. However, it is tors and understanding these mechanism may lead to better formulations and intervention opportunities. Many of the parenting characteristics associated with aggressive and violent behaviour are also linked with insecure attachment in young children and adolescents (Benson, Buehler & Gerard, 2008; Doyle & Markiewicz, 2005; Karavasilis, Doyle & Markiewicz, 2003). Several studies have demonstrated a link between insecure attachment and aggressive and delinquent behaviour (e.g. Allen et al., 2002; Greenberg, Speltz, DeKlyen, & Jones, 2001; Rosenstein & Horowitz, 1996; Speltz, DeKylen, & Greenberg, 1999) and Shaw and Gross (2007) outline a mechanism to explain these links, they suggest that insensitive/negative parenting contribute to insecure attachments and child behaviour problems which then leads to coercive parenting and more difficulties both in parent-child relationship and externalising behaviours. In terms of intervention it should be noted that, to date, most attachment-based treatment programmes have been developed primarily for mothers of infants or young children and not young people diagnosed with conduct disorder. A meta-analytical review revealed a medium effect size for	Thank you for your comment. We agree that attachment problems can be related conduct disorders and these are discussed in section 2.5.2 on causation, but otherwise insecure attachment is outside of the scope of the guideline. We agree that parenting interventions designed for attachment problems may be rather similar to those for conduct disorders, in that they promote sensitive responding, warmth and calm firm limits rather than irregular explosion and neglecting the child's needs. We would welcome further research on this area, but the focus of research recommendations in NICE guidelines is on effectiveness and questions directly relevant to the guideline, rather than aetiology.

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								enhancing parental sensitivity and a small effect size for increased attachment security (Bakermans-Kranenburg, van IJzendoorn, & Juffer, 2003). However, there is a small but growing body of evidence for intervention programmes for Children and Young People with Conduct Disorders. For example the Connect programme which is for parents of adolescents referred for serious antisocial and aggressive behaviour. Two small pilot studies revealed significant pre to post treatment reductions in youth's internalising and externalising problems (Moretti, Holland, Moore, & McKay, 2004,. Subsequently a larger study (309 parents) reported significant pre- to post-treatment reductions in teen externalizing and internalizing problems; enhanced social functioning; and improvements in affect regulation Obsuth, Moretti, Holland, Braber, & Cross, 2006) The BPS suggests that a recommendation should be made for further research to enable the contribution of attachment difficulties to conduct disorder to be better articulated both in terms of causality and intervention. Examples of such research are: Farrington, D. P. (1991). Longitudinal research strategies: advantages, problems, and prospects. *Journal of the American Academy of Child & Adolescent Psychiatry*, 30(3), 369–374. Benson, M., Buehler, C., & Gerard, J. M. (2008). Interparental hostility and early adolescent problem behavior: spillover via maternal acceptance, harshness, inconsistency, and intrusiveness. *Journal of Early Adolescence*, 28(3), 428–454.Doyle, A. B., & Markiewicz, D. (2005). Parenting, marital conflict and adjustment from early- to mid-adolescence: mediated by adolescent attachment style? *Journal of Youth and Adolescence,* 34(2), 97–110. Karavasilis, L., Doyle, A. B., & Markiewicz, D. (2003). Associations between parenting style and attachment to mother in middle childhood and adolescence. *International Journal of Behavioral Development,* 27(2), 153–164. Allen, J. P., Marsh, P., McFarland, Ch., McElhaney, K., Land, D. J., Jodl, K. M., et al. (2002). Attachment and autonomy as predictors of the development of social skills and delinquency	

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								during midadolescence. *Journal of Consulting and Clinical Psychology*, 70(1), 56–66. Greenberg, M. T., Speltz, M. L., DeKlyen, M., & Jones, K. (2001). Correlates of clinic referral for early conduct problems: variable- and person-oriented approaches. *Development and Psychopathology*, 13(2), 255–276. Rosenstein, D. S., & Horowitz, H. A. (1996). Adolescent attachment and psychopathology. *Journal of Consulting and Clinical Psychology*, 64(2), 244–253. Speltz, M. L., DeKlyen, M., & Greenberg, M. T. (1999). Attachment in boys with early onset conduct problems. *Development and Psychopathology*, 11(2), 269–285. Shaw, D. S., & Gross, H. (2007). Early childhood and the development of delinquency: what we have learned from recent longitudinal research. In A. Lieberman (Ed.), The yield of recent longitudinal studies of crime and delinquency. New York: Springer. Bakermans-Kranenburg, M. J., van IJzendoorn, M. H., & Juffer, F. (2003). Less is more: meta-analysis of sensitivity and attachment interventions in early childhood. *Psychological Bulletin*, 129(2), 195–215. Moretti, M. M., Holland, R., Moore, K., & McKay, S. (2004). An attachment based parenting program for caregivers of severely conduct disordered adolescents: preliminary findings. *Journal of Child and Youth Care Work*, 19, 170–179. Obsuth, I., Moretti, M. M., Holland, R., Braber, C., & Cross, S. (2006). Conduct disorder: new directions in promoting effective parenting and strengthening parent-adolescent relationships. *Canadian Child and Adolescent Psychiatry Review*, 15(1), 6–15.	
63	SH	British Psychological Society	9	Full		32	20	This section refers to several approaches but appears to suggest that they are limited to teenagers – use of the word "teenagers" here may be misleading as some therapies, e.g. MST, are used from 11 upwards. We therefore suggest using "young people".	We thank you for this, and have changed the term teenagers and replaced it with young people
67	SH	British Psychological Society	10	Full	2.8	34	23	It may be helpful to expand this point to involving the school 'and/or local education authority' as the young person may not have a school placement that they are attending.	Thank you for your comment. The sentence has been amended to include local education authority.

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107	SH	British Psychological Society	11	Full		121	4.5.1.9	This section states 'discuss with young person how they want their parents or carers to be involved in their care'. We feel that this needs clarification as although it is obviously important to discuss this with young people the ultimate decision regarding this may not always lie with the young person and will be multi-factorial. Some clarification about the importance of discussing the decision making process might be useful. This will also be affected by the intervention model, e.g.in Multisystemic Therapy (MST) interventions the young person's view is on the whole given less weight than the parents' regardless of age.	Thank you for your comment. We have clarified when parents and carers should be involved in recommendation 1.1.12 of the NICE guideline.
20	SH	Centre for Mental Health	1	NICE		General		We welcome the clear recognition at the outset of the guideline document of the significance of early conduct difficulties and the negative impact that such difficulties have for a child's future life chances. The literature shows that there is a general under awareness of the significance of childhood behavioural problems among, for example, GPs.	Thank you for your comment. We believe that the case identification instruments set out in section 6.2.4 are focused on improving GP recognition of conduct disorders.
21	SH	Centre for Mental Health	2	NICE		General		We welcome the emphasis throughout the guideline document on developing an integrated health, social care and educational pathway with colleagues across these sectors working together to develop and deliver local care pathways.	Thank you for your comment.
42	SH	Centre for Mental Health	3	Full		15	30	We do not think that the discussion under the section 'Medicalising a social problem?' is particularly clear or helpful in fostering an integrated approach. This is particularly because recent research by Centre for Mental Health has somewhat worryingly highlighted that some CAMHS exclude children and young people on the basis that conduct disorder is not a mental health problem. We are concerned that severe behavioural problems are identified as a reason to exclude children from some CAHMS services, particularly given that it represents one of the most common childhood mental illnesses and is associated with some of the worst adult prospects.	Thank you for this comment. This section has now been modified to clarify a more bio psychosocial approach. We share the concern that some of these children and young people get excluded from services and the implementation team at NICE are taking steps to review this.

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57	SH	Centre for Mental Health	22	Full	2.5.1	24	35-39	It would be helpful to have the reference for the following statement clarified: "It is important to emphasise that because conduct disorders are partially genetically caused does not mean that environmental or psychosocial interventions will not work. The opposite is true; awareness of familial liability toward psychopathology increase the urgency to intervene to improve a child or young person's social environment".	Thank you, we have added the following reference: Odgers CL, Milne BJ, Caspi A, Crump R, Poulton R, Moffitt TE. Predicting prognosis for the conduct-problem boy: can family history help? J Am Acad Child Adolesc Psychiatry. 2007 Oct;46(10):1240-9.
189b	SH	Centre for Mental Health	4	Both	Both	General		In both the full and NICE versions, there is little or no emphasis on the public health implications of conduct disorder. We think that the guidelines are a missed opportunity to take a more strategic approach and to integrate public health with health, social care and education.	Thank you for your comment. We have taken account of the social work perspective both in membership of the GDG and in the guideline joint development with SCIE. NICE Public Health guidance 12, Promoting children's social and emotional wellbeing in primary education has been referenced in the NICE guideline.
190	SH	Centre for Mental Health	5	NICE		General		The document does not highlight the wide range of potential referring agencies and the importance of raising awareness of conduct problems. By focusing solely on health, social care and education the guidelines miss an important opportunity to identify the important role of other workers in local care and referral pathways including health visitors, early years workers, housing staff, those dealing with family violence, social workers and workers in adult services such as mental health and criminal justice. Further, the way the document is currently worded gives the impression that the key role in health is for mental health specialists. In particular, very little emphasis is given to the role of GPs, who are often approached by parents with children with behavioural problems but too often have poor awareness of the significance of early conduct problems, the range of parenting interventions available and of where to access effective local support (see for example Family Lives (2012) *General Practitioners and Family Support: Results of a 2011 Survey*).	Thank you for your comment. We disagree, we expect that primary care professionals and health visitors will be involved, especially in case identification (see Section 1.3) and access to care (see Section 1.7).
191	SH	Centre for	7	NIC		General		The way the document is currently structured and worded does	Thank you for your comment, but we

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		Mental Health		E				not capture s sense of a continuum of need or the range of different interventions and levels of support that need to be available depending on the child's and parents' needs. Reference is made on page, 27, lines 1-10, to offering individual parenting and child training programmes for children with needs which are severe and complex. However, what is not clear throughout the document is that there needs to be a range of interventions provided to reflect a continuum of needs; the point that different severities of problems need different intensities is illustrated by the case studies below. Further the way that the document is currently structured at pages 19-20 (in particular, page 20, lines 10-14) in relation to the initial and comprehensive assessment suggests that where a child is identified as having complicating factors in the initial assessment he or she will then have to be referred for a more comprehensive assessment by CAMHS. This suggests that in the meantime parents will have to wait for any support or intervention. The risk with the way the assessment process is currently presented in the document is that parents of children with the most complex needs could have to wait considerable time before they receive any support, while those with less complex needs will be referred for a parenting intervention immediately. However, we have found in our research that promptly offering parents with children with more complex needs a parenting intervention can still be beneficial until they receive additional support. It can also provide more opportunities for comprehensive assessment.	disagree. We think that in looking at selective prevention and indicated prevention and treatment we have considered a continuum of need. We accept it may be possible that there are delays in assessment but this is for local services to resolve and we are clear that for some families a referral straight to parent training is the right course of action (see recommendation 1.3.5 of the NICE guideline).
192	SH	Centre for Mental Health	7 (cont)					Variation in levels of support should also be considered at the point of initial contact. For example, some parents may be more accepting of an offer of support than others. Those with more challenging lives may require more support to maximise motivation to attend programmes. CASE STUDY A: Mr and Mrs A had two children under 5 and were about to have another. Their elder son had an easy temperament; their daughter, on the other hand, had always had a more fractious temperament and was prone to extreme tantrums which had persisted since the age of 2 and were	Thank you but we think this will be for local services to determine and not something we feel able to recommend.

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								getting worse. They had tried a number of different approaches but none had worked and some had made things worse. Her behaviour was considerably affecting the family's lifestyle (in terms of what they felt they could or couldn't do and was affecting her mother's wellbeing). Mrs A raised her concerns eventually with her health visitor when her third child was born. She completed a SDQ to confirm the nature and extremity of the problems faced by her daughter and her family. The parents were provided with some tips but these did not resolve the issue. A referral was made to the local Triple P programme which both parents wanted to attend (the father had to make a strong case to attend). The programme significantly and very swiftly helped them resolve the problem through the use of positive parenting techniques and through problem solving daily routines in the family to reduce stress points and their daughter's behaviour has continued to improve. This case study illustrates that most persistent child behavioural problems do not require in-depth assessment beyond screening of whether a child's behaviour has persisted and lies beyond accepted norms. SDQ screening and simple parenting interventions are cheap and resolve things easily for most children and parents.	
193	SH	Centre for Mental Health	7 (cont)					CASE STUDY B: Ms B had concerns about her son's behaviour from the age of 3 which was very extreme. He was now 5. She had raised concerns with her GP, the school and with school nurses but although everyone said they would mobilise support, she had been left with no input over a number of years. She had been told by her GP that specialist CAMHS did not deal with 'behaviour' but only dealt with 'mental health problems'. She was very scared of and for her son. He had always been prone to unpredictable and extreme moods and violence, kicking and hitting family members; he threatened to kill his mother and sister and had once tried to stab a friend in the eye with a knife. The only person he would let calm him was his elder sister (aged 8) who would try and soothe him when extreme tantrums occurred. Ms B described him always getting a strange look before one of these incidents occurred. His uncle had schizophrenia and another family	Thank you.

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								member had been diagnosed with personality disorder. Ms B took many years to get help for her son despite multiple attempts. Eventually school psychological services became involve and together with speech and language therapists locally began detailed assessments. It was suspected that he had some form of emerging autistic spectrum disorder. There were suspicions that he may have another co-existing diagnosis. She had at the same time been referred to the parenting team and was receiving ongoing help with positive parenting techniques pending further clarification of diagnosis. This case study illustrates that some children have much more severe difficulties which are can be relatively easily identified if referrers listen to parents and know what to do. Most parents of children with conduct disorder approach services for advice (Green et al, 2005); few get the help they need (Spoth et al, 2007; Prinz et al, 2009). Children with more extreme presentations should be referred for specialist multi agency holistic assessment by CAMHS, educational psychology and possibly speech and language therapists. While this takes place, they should access evidence based parenting programmes as soon as possible to learn protective parental techniques. Parenting programmes can also add to the assessment process. The literature says that these children and families may need ongoing support and monitoring. At the moment, the Centre's recent investigation indicates that the parents of these children take some time to get to the right services and to receive the support they need to mobilise protective resources and to manage very stressful family environments. Specialist CAMHS should also not see behaviour as a reason to exclude vulnerable children.	
194	SH	Centre for Mental Health	8	NICE		General		We think the document could more clearly highlight parental mental illness as a risk factor for conduct problems and be more specific about the detail and extent of this risk. For example, parents of children with conduct disorder are twice as likely to have mental health issues compared to other parents (Green et al, 2005). Poor maternal health in particular has been identified as an important risk factor for conduct problems (Shaw, Gilliom, Ingoldsby & Nagin, 2003; Kessler &	Thank you for your comments. Page 35 lines 5 to 8 highlights the need to address parental mental health factors in treatment as does recommendation 1.4.1 in the NICE guideline.

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								McLaughlin, 2010). Maternal depression, particularly when it occurs in the context of general adversity, puts children at significant risk of developing conduct problems (Shaw et al, 2003; Sutton and Glover, 2004; Murray et al, 2010). For example Shaw et al (2003) found that the children whose mothers reported higher rates of depressive symptoms in the toddler period were more likely to have persistent conduct problems compared to their peers. However, it should also be noted that caution is required in interpreting the strong association between maternal depression and child conduct problems as depressed mothers might over-report child behaviour problems (Murray et al, 2010).	
195	SH	Centre for Mental Health	8 (contd)					Maternal anxiety has also been linked to the development of severe behavioural problems in childhood (O'Connor, Heron et al, 2002; O'Conner, Ben-Shlomo et al, 2005). Mothers with clinically significant levels of maternal anxiety during pregnancy are twice as likely to have children with persistent conduct problems, than mother with no anxiety (Barker and Maughan, 2009).Good quality early attachment between parents and children is important for children's positive health and wellbeing. Maternal post natal depression is thought to inhibit good parent/child attachment. Links between pre natal anxiety and children's health and wellbeing are more complex. Although some pre natal anxiety may persist beyond the birth thus affecting attachment, there is also some suggestion in research that such anxiety might have a toxic effect during pregnancy impacting foetal and brain development (Barker and Maughan, 2009).	Thank you for your comment. We agree that maternal attachment is important and this is covered in the aetiological causes
196	SH	Centre for Mental Health	15	NICE		General		We welcome the emphasis throughout the document on improving access to services and increasing the uptake of interventions. We know from our research that it is crucial to ensure that programme take-up is high and drop-out is low among high-risk groups. Currently the availability of family-based programmes is increasing but many are failing to deliver their full promise because of shortcomings in implementation.	Thank you for your encouraging comments. We are also aware of the implementation issues, which NICE will be addressing.
213	SH	Centre for Mental Health	9	NICE	1.2 Identific	19	11	Given what we know about parental mental health and antisocial behaviour as risk factors for conduct disorder in children and young people, we think that the section on case	Thank you for your comment however we think this is covered by the care pathway recommendations 1.7.9,

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					ation & assessment			identification and assessment should consider a recommendation on liaising with adult services such as mental health and criminal justice.	1.7.12, 1.7.13 and 1.7.17.
217	SH	Centre for Mental Health	10	NICE	Case id 1.2.4	20	1-3	We welcome the recommendation that the Strengths and Difficulties Questionnaire be used for the initial assessment. This is a useful tool for identifying children most likely to benefit from interventions and also as a tool for measuring progress. Indeed we would go further and argue for its routine use in early years activity (during early development preschool tests) and in school at key educational transition points as a gauge of healthy developmental progress.	Thank you for your comment.
220	SH	Centre for Mental Health	11	NICE	Case id 1.2.4	20	4-8	We have some concerns, however, about the suggestion (given the way the recommendation is currently worded) that the use of the SDQ should always coincide with a full assessment for the presence of a coexisting mental disorder, neurodevelopmental condition, learning disability or difficulty. In many instances, this will not be an efficient use of resources; neither is it clear who is expected to undertake this assessment (e.g. school, CAMHS) and at what stage (e.g. at same time as SDQ), or what tools to use. This could also conflict with the recommendation at 1.6.14 (p.38, line 7) that pathways should "keep to a minimum the number of assessments needed to access interventions". We would favour a system where the SDQ was used routinely and in a non stigmatising way by those tracking the health, social and educational progress of children. Behaviour should be considered as a gauge for general wellbeing and progress. Where children lie outside SDQ norms, this should be discussed with parents offering them access to support to strengthen parenting techniques which have been proven to make a difference to children's outcomes and progress. Attendance at such parenting programmes, often run by local authority parenting teams, is cost effective and can also be used as a mechanism to further assess who might need	Thank you for your comment, but the recommendation says that the use of the SDQ should only be considered in initial assessment and to aid the diagnosis of coexisting conditions. We are not saying it should always be undertaken. We have amended recommendation 1.3.4 and the evidence to recommendation to reflect who should be asked to complete the questionnaire.

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								ongoing support. Some children, based on our recent research, clearly have more complex needs and in this instance should receive prompt joint assessment including specialist CAMHS and educational psychology so that an appropriate package of evidence-based support can be coordinated. Such as system based on standard use of SDA and with greater discernment regarding children with the highest risks would be more efficient and cost effective in prompting positive outcomes for children and families.	
231	SH	Centre for Mental Health	13	NICE	Id treatment & care options 1.3.3	24	14-17	1.3.3 While we agree that it is important that the preferences of a child or young person and their parents or carers should be considered when deciding on the appropriate intervention, the way that this section is currently worded gives insufficient emphasis to the need to ensure that interventions are offered on the basis of what the evidence says works best for that particular child and family.	Thank you for your comment, however we believe this is implicit throughout the guideline.
233	SH	Centre for Mental Health	14	NICE	Staff supervision 1.4.1	24	20-26	1.4.1 We welcome the recommendation on building in staff supervision. However, this recommendation needs to emphasise that this supervision should be programme specific. This is important to ensure that programmes are implemented well with the core ingredients that are associated with positive change being maintained.	Thank you for your comment. We were unable to identify staff training to specific training programmes.
257	SH	Centre for Mental Health	16	NICE	Organisation & delivery of care 1.6.1	33	4-9	While we welcome the recommendation that health, social care and education professionals should collaborate to develop local care pathways, we would like to see a wider range of professionals and agencies involved. Health and wellbeing boards could play an important role in developing integrated pathways and facilitating partnership working.	Thank you for your comment. The function of HWBs is to oversee the commissioning process in a local area – this is essentially an implementation issue. We will therefore draw this to the attention of the NICE implementation team.
258	SH	Centre for Mental Health	17	NICE	Organisatio	33	13	We support the focus on entry rather than exclusion criteria.	Thank you for your support.

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					n & delivery of care 1.6.1				
259	SH	Centre for Mental Health	18	NICE	Organisation & delivery of care 1.6.1	33	16-18	While we accept that multiple points of access are important, it is essential that there is a clear entry point for parents seeking help and for those making referrals. The pathway also needs to include re-entry points if things start to deteriorate, as well as mechanisms to pick up any deterioration quickly.	Thank you, we agree this is an important point but feel that the current wording does address your concern.
265	SH	Centre for Mental Health	19	NICE	Organisation & delivery of care 1.6.7	35	4-17	We strongly support the recommendation on supporting access to services and increasing the uptake of interventions in a variety of settings including a person's home and community based settings. However, we believe this recommendation could go further to allow greater flexibility to ensure greater access among underserved populations. We know from our research that different people will prefer support in different settings and these can include a wide range of settings such as coffee shops, parks etc. This is particularly important for adolescents with conduct disorder.	Thank you for this comment. We think by stating a variety of settings that is good enough, but agree there are very many different contexts in the community where adolescents may be seen.
269	SH	Centre for Mental Health	20	NICE	Pathways 1.6.11	37	8-10	We do not think this statement is particularly clear. It seems to suggest that access to and movement across the pathway should not be dependent on symptom severity; if that is what is being recommended then we do not agree with this recommendation. If what is being recommended is that access should also be driven by risk factors and not just active symptoms then we would support such an approach. However, if this is the case, this needs to be made much clearer.	Thank you for your comment, however we feel that the recommendation is clear – it is saying that symptom severity alone should not determine movement within the pathway.
273	SH	Centre for Mental Health	6	NICE	Pathways 1.6.	38	3	We do not think the guideline document sufficiently emphasises the importance of prompt action. For example, at page 38, line 3, it is recommended that pathways should "offer prompt assessments and interventions". We believe that there	Thank you – while we do not disagree with your view that action should be undertaken promptly we have to be very careful in the use of such terms

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					14			should be greater reference throughout the document on the need for identification, assessments and interventions to be undertaken and offered promptly.	because (a) overuse would reduce their effectiveness and (b) we need to consider the responsibilities of the NHS for implementation and with it the need to locally determine timescales for action.
276	SH	Centre for Mental Health	21	NICE	Pathways 1.6.18	40	1-2	We would like to see more advice on how to measure the effectiveness of the pathway.	Thank you for your comment. This is outside of our remit. We have put forward 5 research recommendations which would go a long way in addressing your question.

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22	SH	Cochrane Collaboration's Developmental, Psychosocial and Learning Problems Group (CDPLPG)	1	Full	General			We (CDPLPG) have a large number of systematic reviews of relevance to this topic but only one of them has been referenced, which really surprised and confused us. The only one mentioned is Littell et al, *Multisystemic Therapy for social, emotional, and behavioral problems in youth aged 10-17.* I list below first our directly relevant reviews, and then those that might be considered more indirectly relevant. I can easily send you the full citation and weblink for any or all of these if you would like them. We also have a number of reviews relating to people with learning disabilities, which I have not listed as that population do not seem to be mentioned in the guideline so far as I can see. Again, these can be provided if required. Specifically relevant 1. Behavioural and cognitive-behavioural group-based parenting programmes for early-onset conduct problems in children aged 3 to 12 years 2. Family and parenting interventions in children and adolescents with conduct disorder and delinquency aged 10-17 3. Media-based behavioural treatments for behavioural problems in children 4. "Scared Straight" and other juvenile awareness programs for preventing juvenile delinquency 5. Antiepileptics for aggression and associated impulsivity 6. Behavioural and cognitive behavioural training interventions for assisting foster carers in the management of difficult behaviour 7. Cognitive-behavioral treatment for antisocial behavior in youth in residential treatment 8. Cognitive-behavioural interventions for preventing youth gang involvement for children and young people (7-16) 9. Opportunities provision for preventing youth gang involvement for children and young people (7-16) 10. Atypical antipsychotics for disruptive behaviour disorders in children and youths	Thank you for highlighting this issue. During scoping we identified the fact that there were a large number of Cochrane reviews that were directly relevant or had elements of relevance. However, early in the development of this guideline the GDG identified a number of issues they wished to explore, and this necessitated going back to the primary papers to extract data. In addition, a previous NICE guideline developed by the NCCMH (Antisocial Personality Disorder; CP11) reviewed a wide range of family and individual interventions for children with CD, searching up to June 2008, so it made sense to utilise this review to check our search was comprehensive. As you will be aware, some of the reviews you listed have not be assessed as up-to-date for some time, limiting usefulness for our purposes. Other reviews did not meet eligibility criteria (i.e., no. 4, 5, 6, 7, 8, 9, 13, 14, 15, 16, 17, 18, 19). In the interests of completeness, we have checked all reviews that you listed that were deemed relevant for trials we may have missed. These reviews are now cited in the relevant review protocols.

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								11. Multisystemic Therapy for social, emotional, and behavioral problems in youth aged 10-17 Some elements relevant 12. Treatment Foster Care for improving outcomes in children and young people 13. Kinship care for the safety, permanency, and well-being of children removed from the home for maltreatment 14. Cognitive-behavioural interventions for children who have been sexually abused 15. Group-based parent training programmes for improving parental psychosocial health 16. Individual and group based parenting programmes for improving psychosocial outcomes for teenage parents and their children 17. Independent living programmes for improving outcomes for young people leaving the care system 18. Group-based parent-training programmes for improving emotional and behavioural adjustment in children from birth to three years old 19. Individual and group-based parenting programmes for the treatment of physical child abuse and neglect	
23		Cochrane Collaboration's Developmental, Psychosocial and Learning Problems Group (CDPLPG)	1 (Cont.)			General		20. Antiepileptics for aggression and associated impulsivity 21. Behavioural and cognitive behavioural training interventions for assisting foster carers in the management of difficult behaviour 22. Cognitive-behavioral treatment for antisocial behavior in youth in residential treatment 23. Cognitive-behavioural interventions for preventing youth gang involvement for children and young	Thank you for providing these references, please see above (ref numbers 5-11)

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								people (7-16) 24. Opportunities provision for preventing youth gang involvement for children and young people (7-16) 25. Atypical antipsychotics for disruptive behaviour disorders in children and youths 26. Multisystemic Therapy for social, emotional, and behavioural problems in youth aged 10-17	
24		Cochrane Collaboration's Developmental, Psychosocial and Learning Problems Group (CDPLPG)	1 (Cont)	Full		General		Some elements relevant 1. Treatment Foster Care for improving outcomes in children and young people 2. Kinship care for the safety, permanency, and well-being of children removed from the home for maltreatment 3. Cognitive-behavioural interventions for children who have been sexually abused 4. Group-based parent training programmes for improving parental psychosocial health 5. Individual and group based parenting programmes for improving psychosocial outcomes for teenage parents and their children 6. Independent living programmes for improving outcomes for young people leaving the care system 7. Group-based parent-training programmes for improving emotional and behavioural adjustment in children from birth to three years old 8. Individual and group-based parenting programmes for the treatment of physical child abuse and neglect	Thank you for providing these references, please see above (ref numbers 12-19)
247	SH	College of Mental Health Pharmacy	1	NICE	Pharmacological 1.5.3	30	10	The College supports the use of risperidone, when appropriate for Conduct Disorder. The recommendations on an appropriately qualified Health Care Professional (HCPs), the recommended physical Health Checks are all appropriate recommendations. However, The College Questions the clarity and practicality of the recommendations in Footnote 31. This talks about the SPCs for some risperidones – Pharmacists will probably understand that this refers to the fact that certain generic presentation of risperidone might not be licensed for all indications e,g,	Thank you for your comment however NICE has agreed the approach for footnotes on drugs with the MHRA, across all guidelines.

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								conduct disorder. It is questionable that other HCPs will know this or understand this from the wording in the footnote. In addition, the advice to the prescriber to consult the individual risperidone SPC is impractical as the prescriber will have no knowledge or control over which particular brand/generic version of risperidone will eventually be dispensed for the patient from a pharmacy. This foot note is repeated on several succeeding pages The section on "Different risperidones" needs to be reworded. Given that the prescriber has no control over the product dispensed the value of recommending the individual SPC is considered is questionable. It might be more appropriate to advise the parent that the information provided with the dispensed medicine might be different from that given by the prescriber and to ensure the provision of appropriate written information.	
250	SH	College of Mental Health Pharmacy	2	NICE	Pharmacological 1.5.6	31	9	The College supports the recommendation on baseline monitoring. However, the College believes the recommendations could be improved by adopting the wording in the Draft Guideline for Psychosis and schizophrenia in children and young people that is also out for Consultation – these recommendations are more robust	Thank you for your comment, we have considered baseline monitoring, we think the fortnightly monitoring of height and weight that we suggest in NICE recommendation 1.6.7 is sufficient. The rationale for adapting the recommendation (rather than incorporating) is given in Table 101: 'This recommendation was adapted to make it relevant for the short-term management of severely aggressive behaviour in young people with conduct disorder; only risperidone is licensed for use in children and young people with a conduct disorder therefore only this drug is recommended. The original recommendation has therefore been adapted to take account of this, including reference to the BNFC, rather than the adult BNF. The GDG also judged that it was

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									prudent to provide further specificity around dosing and monitoring in young people, including weight and height, fasting blood glucose, HbA1c, blood lipid and prolactin levels.'
254	SH	College of Mental Health Pharmacy	3	NICE	Pharmacological	32	12	The College supports the recommendation to Monitor and record systematically throughout treatment, Given the serious long term metabolic adverse effects the College would prefer the guideline to be explicit on a timeframe for monitoring. The current version only gives a frequency for monitoring for height and weight of weekly. the College believes the recommendations could be improved by adopting the wording in the Draft Guideline for Psychosis and schizophrenia in children and young people that is also out for Consultation – this recommendation is more robust with	Thank you for your comment, we have considered baseline monitoring, we think the fortnightly monitoring of height and weight that we suggest in NICE recommendation 1.6.7 is sufficient. The reason why the baseline monitoring recommendation could not be taken from the schizophrenia in children and young people guideline is because it is based on the long term use of antipsychotics, where as in conduct disorders we recommend that if resperidone is to be prescribed it should only be for short term use.
197	SH	Department for Education	1	NICE		General		The NICE version of the document makes reference to 'classroom based' interventions in a way that I could not find reflected in the full report (which has an analysis of them but nothing more concrete in terms of guidelines). From a schools' perspective, it is not fully clear to us what 'classroom-based' interventions actually entail, how they would be set up or the level of expectation on schools to facilitate, what would be a significant commitment. I do not think we have anything against them in principle, as long as they are locally agreed and devised by someone with a clear idea of what they entail, with time to adopt any necessary training and agreement over evaluation. Indeed, I think better ongoing engagement between schools and health services on the nature and impact of mental health services is, I think, something we are keen to encourage. If these are going to figure at all significantly, it might help if this were explained further. Also I am not sure if this is the place, but it may be helpful to be clearer about how the school can contribute to helping to	Thank you for your comment. We have revised recommendation 1.2.1 to clarify classroom based interventions and the role of the school. The expectation is that staff working in schools can have a clear role in case identification by working with senior health practitioners. NICE recommendations on the delivery and organisation of care go some way to facilitating this (please see recommendations 1.7.5 and 1.7.9-1.7.18); however how this will be Simplemented will be for schools and social workers to establish.

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								identify children with problems make a referral to the appropriate services.	
25	PR	Expert reviewer - Carolyn Webster Stratton	4			General		I am wondering where you put the following RCTs? Webster-Stratton, C., Reid, M. J., & Stoolmiller, M. (2008). Preventing conduct problems and improving school readiness: Evaluation of the Incredible Years Teacher and Child Training Programs in high-risk schools. Journal of Child Psychology and Psychiatry 49(5), 471-488. Reid, M. J., Webster-Stratton, C., & Hammond, M. (2007). Enhancing a classroom social competence and problem-solving curriculum by offering parent training to families of moderate-to-high-risk elementary school children. Journal of Clinical Child and Adolescent Psychology, 36(5), 605-620. I would think that the 2008 study would be selective as well. Judy Hutchings papers to my knowledge are also selective ~ I don't believe her studies were with diagnosed children rather with Sure Start families. Is there a study I am not familiar with? PS have you seen the Holland study? ~ they are presenting it in Ireland when I am there in 2 weeks. They are doing some lovely research. Here is the reference and a copy of the paper is on our IY web site. This is also a selective prevention study I believe. Another study has come out of Ireland.	Thank you for your comment. Webster-Stratton et al (2008) met criteria for the selective prevention review (study ID: WESBTER-S2008), but outcomes could not be extracted from the paper, hence were not appropriate for meta-analysis. Reid et al (2007) was included in the review of indicated prevention and treatment interventions (study ID: REID2007). This study was categorised as indicated prevention because the samples from different referral methods (selected and indicated) were combined. We included two studies by Hutchings (HUTCHINGS2002 & HUTCHINGS2007). Both used the ECBI to select participants in the clinical range, therefore, these studies were included in the indicated prevention & treatment review. The Holland study (Posthumus et al, 2011) was not included in the review as it was not an RCT.
26	PR	Expert reviewer - Carolyn Webster Stratton	4 (contd)			General		Posthumus, J. A., Raaijmakers, M. A. J., Maassen, G. H., Engeland, H., & Matthys, W. (2011). Sustained effects of Incredible Years as a preventive intervention in preschool children with conduct problems Journal of Abnormal Child Psychology. Some other papers of note are: Lau, A. S., Fung, J. J., Ho, L. Y., Liu, L. L., & Gudino, O. G.	Lau et al (2011) was included in the review of indicated prevention and treatment interventions (study ID: LAU2011). McDaniel et al (2011) and Fergusson et al (2009) were not included in the review as they were not RCTs.

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								(2011). Parent training with high-risk immigrant chinese families: A pilot group randomized trial yielding practice-based evidence. Behavior Therapy, 42, 413-426. McDaniel, B., Braiden, H. J., Onyekwelu, J., & Murphy, M. (2011). Investigating the effectiveness of the Incredible Years Basic Parenting Programme for foster carers in Northern Ireland. Child Care in Practice, 17(1), 55-67. Axberg, U., & Broberg, A. G. (2012). Evaluation of "The Incredible Years" in Sweden: Teh transferability of an American parent-training program to Sweden. Scandinavian Journal of Psychology, 53, 224-232. (NO CONTROL GROUP HOWEVER) Fergusson, D., Stanley, L., & Horwood, L. J. (2009). Preliminary data on the efficacy of the Incredible Years basic parent programme in New Zealand. Australian & New Zealand Journal of Psychiatry, 43(1), 76-79.	Axberg & Broberg (2012) was not picked up by the search, as this study is not an RCT, therefore was not included in the review.
110	PR	Expert reviewer - Carolyn Webster Stratton	1	Full	Chapter 5	125-157		I found the chapters very interesting and somewhat surprising. I had a question about Chapter 5 and why none of the RCTs we did with Head Start families using the Incredible Years Parent and Teacher programs were not included. This is clearly a selective population of high risk families (due to socioeconomic disadvantage). Are you aware of these studies? Webster-Stratton, C., Reid, M. J., & Hammond, M. (2001). Preventing conduct problems, promoting social competence: A parent and teacher training partnership in Head Start. Journal of Clinical Child Psychology, 30(3), 283-302. Webster-Stratton, C., Reid, M. J., & Stoolmiller, M. (2008). Preventing conduct problems and improving school readiness: Evaluation of the Incredible Years Teacher and Child Training Programs in high-risk schools. Journal of Child Psychology and Psychiatry 49(5), 471-488. Webster-Stratton, C. (1998). Preventing conduct problems in	Thank you very much for your comments. Regarding Webster-Stratton et al. (2001), this was originally categorised as indicated prevention, but we agree it should be selective prevention. The analysis will be updated. Regarding Webster-Stratton et al. (2008), this was included, but the paper had no data that were appropriate for inclusion in the meta-analysis. Given the size of the overall review, we did not have the resources to write to all authors of papers where the data were inappropriate for meta-analysis. Regarding Webster-Stratton (1998), this was originally categorised as

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								Head Start children: Strengthening parenting competencies. Journal of Consulting and Clinical Psychology, 66(5), 715-730. Also there are studies with Sure Start by Judy Hutchings in Wales. But I think the 2008 study might be of particular interest and is a very large sample.	indicated prevention, but we agree it should be selective prevention. The analysis will be updated. We included two studies by Hutchings, but both classified as treatment (all children scored in the clinical range of the ECBI at baseline), and so these studies are included in Chapter 7.
151	PR	Expert reviewer - Carolyn Webster Stratton	2	Full	7.3	235		For Chapter 7 I wonder if you are aware of our 10 year follow up in terms of the economic modeling section of the paper page 247. Webster-Stratton, C., Rinaldi, J., & Reid, J. M. (2010). Long Term Outcomes of the Incredible Years Parenting Program: Predictors of Adolescent Adjustment. Child and Adolescent Mental Health, 16(1), 38-46. And our latest research with children diagnosed with ADHD of whom half also have ODD/CD. Webster-Stratton, C., Reid, M. J., & Beauchaine, T. P. (2011). Combining Parent and Child Training for Young Children with ADHD. Journal of Clinical Child and Adolescent Psychology, 40(2), 1-13. Webster-Stratton, C., Reid, M. J., & Beauchaine, T. P. (in press). One-Year Follow-Up of Combined Parent and Child Intervention for Young Children with ADHD. Journal of Clinical Child and Adolescent Psychology.	Thank you for the references. Evidence from these studies was considered with respect to objectives of the economic modelling. Though there is some positive evidence on longer term effect of Incredible Years, it was difficult to incorporate such evidence into the economic (comparative) model as it was not compared to a control. Doing so will potentially over-estimate the effect of Incredible Years. Also, the population in the latter two studies was outside that considered eligible for the model.
152	PR	Expert reviewer - Carolyn Webster Stratton	3	Full				I also wondered if you had done any work in your reviews of the dosage of intervention provided and effect sizes?	Thank you for raising this issue. In the moderator analysis we did identify that some parent-focused interventions were attenuated versions, and this was explored with meta-regression. We did not do the

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									same for child-focused interventions due to the smaller number of trials and lack of consistent reporting, which would enable this to be done accurately. We attempted to look at this issue, but found it difficult to accurately quantify dosage based on the information given in each paper. This will be made clearer in the full guideline.
153	PR	Expert reviewer - Carolyn Webster Stratton	4	Full	7.5			I notice you recommend an average range of sessions to be offered ~ how was this derived? For example the Lavigne study was half the dosage of our study (1 hour per week instead of 2 hours) and did not get much in terms of change except for those children with more behavior problems to begin with. In this study, leaders had scant training, did not follow protocol and often offered the program in one on one format rather than group format. There are many reasons for their low effect sizes that have to do with fidelity of delivery and program dosage.	Thank you for raising this issue. We derived the number of sessions from exemplar trials included in the meta-analyses (therefore, Lavigne 2008 was not used to derive this information as insufficient data were reported for the trial to be included in the meta-analysis). We have also added a sensitivity analysis to the meta-regression of child-focused interventions to control for dose (see section 7.2.7).
161	PR	Expert reviewer - Carolyn Webster Stratton	5	Full	7.2.8	235		I am also surprised by your summary on page 235, because our own research in 2 RTCs showed that adding the child program component to the parent intervention significantly enhanced changes in children's behavior at school in classroom and with peers more so than parent intervention alone. In other words parent programs change behaviors at home but usually not in the classroom unless they are combined with a child training or teacher training component. In our latest ADHD study which only had the child and not the teacher training component - we had fewer changes in the classroom because teacher behaviors did not change ~ however we did have some changes in peer relationships etc but not as powerful as the parent + teacher + child combined components. Finally did you see Fosters paper on the economics of this.. Foster, E. M., Olchowski, A. E., & Webster-Stratton, C.	Thank you for your comments. In our analysis, it was not clear from the head-to-head meta-analysis (section 7.2.6), that adding a child-focused intervention was clearly more effective than a parent-focused alone. In addition, the Foster et al. 2007 paper was reviewed in section 7.3.4. Taking all data into consideration, the GDG did not think that there was sufficient evidence to make a recommendation for "stacking" interventions.

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								(2007). Is stacking internvention components cost-effective? An analysis of the Incredible Years Program. Journal of American Academy of Child and Adolescent Psychiatry, 46(11), 1414-1424. Thank you for this very important and informative work.	
133	PR	Expert reviewer - Eric Taylor	2	Full	6.2.8	179	39	'Selective autism' - ?mutism?	Thank you for your query. It was supposed to be 'selective mutism' , but we have now removed reference to this from the full and NICE guideline.
136	PR	Expert reviewer - Eric Taylor	3	Full	6.2.8	180	6	'Conners' is the correct spelling – here and elsewhere (and there are several Conners scales)	Thank you, this has now been corrected.
148	PR	Expert reviewer - Eric Taylor	1	Full	6.4.1.11 (NICE 1.3.10)	186		SWAN, SNAP and 'Iowa Conners' are all brief measures that include CP but not considered here. It is OK to exclude them - they are meant for ADHD primarily - , but the reason should be explicit. (I haven't seen the list of excluded papers, it may well be included there already). In considering the presence of coexistent mental disorders, I should like to see substance misuse included, as these guidelines refer to adolescents as well as younger children. The association between C/D and S/U is very strong and many dominate the outcome Tourette disorder raises particular issues, as apparently aggressive acts may in fact be involuntary, and would also be usefully included in the listing of other conditions for which to assess. It is also relevant to drug treatment as it might well in included in the listing of those conditions, for which drugs may play a part.	Thank you for raising this issue. We didn't identify any formal evaluations of the structure and content of the overall clinical assessment process for children and young people with a suspected conduct disorder other than the data on the various case identification and assessment instruments examined in 6.2.4 (This has been described in section 6.2.8). Studies of case ID instruments that were excluded are described in Appendix 16b.
150	PR	Expert reviewer - Eric Taylor	5	Full	7	189-264		I have now had the chance to review the psychological management section in addition, and have a rather similar comment to my previous note that the guideline is restricted to those without intellectual disability – and that the restriction should be made more explicit. Functional behavioural analysis (FBA) on an individual basis is, or in my view should be, a major part of the management of individuals with severe aggression who do not respond to	Thank you for raising this issue. As you rightly point out FBA is outside the scope. However, NICE is currently developing a guideline on Challenging Behaviour in Children with Learning Disability.

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								parent/caregiver/teacher interventions. Such individuals often have neurodevelopmental problems including intellectual disability. Although they may be referred to informally as showing "challenging behaviour" , they usually have a formal diagnosis of conduct disorder. An evidence base does exist, but much of it is in the form of N=1 trials in behavioural designs such as reversal or multiple baseline. I do encounter individuals who have been subjected to multiple ineffective drug trials but have never received thorough behavioural intervention. It would be unfortunate if the guidelines were to amplify this trend. I think that if the IQ < 60 exclusion is made more salient this would go a long way towards answering this point; and I hope that FBA could be referred to in the guideline – eg in section 1.4 on treatments provided – and the point made that it is outside the scope of the guideline - so that readers do not suppose that it is being discouraged.	
180	PR	Expert reviewer - Eric Taylor	4	Full	8	266-286		This is a good, balanced account and I agree with all the recommendations. One major comment is that it should be made explicit throughout – including in the preface and summaries – that the guidance applies only to those with IQs of 60 or above. The scope is given as applying to all young people with CD, but would be misleading if applied to those with intellectual disability. Exclusion of people with IQ<60 is a pity - a comprehensive treatment service should be offered and guidance is needed for this group (for whom the ideal of comprehensive CAMH service is often not even attempted). I understand the reasons; but It should be more clearly stated (p.282 and elsewhere – including the preface) that the absence of RCT evidence applies only to those with IQs greater than 60; and that the recommendations apply only to this group. Paediatricians are often involved in the care of children with intellectual disability and may sometimes be the appropriate discipline to manage medication. There is an evidence base of RCTs in this group; so the general conclusions may not apply completely, and if followed unintelligently could exclude young people with intellectual disability and conduct disorder from some aspects of appropriate care.	Thank you for your comment. The trials which we reviewed do not include those with an IQ below 60; there are separate trials for them when it is usually called challenging behaviour rather than conduct disorder. Likewise because we are excluding this group, we think our cautioned approach about medication is well founded, and whilst we agree with you that for those with marked intellectual disability may be indicated, this is not what is covered in this guideline. NICE is currently developing a guideline on Challenging Behaviour in Children with Learning Disability.

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								The hazards to medication are probably overstated by listing the BNF recommendations. Some of these hazards would apply only to dose regimes higher than those normally given to young people for conduct problems. Blood testing is sometimes unacceptable – again, particularly in those with coexistent intellectual disability and refusal should not be taken to disqualify from medication: rather, alternatives (eg urinary glucose) should be offered.	
111	PR	Expert reviewer - Frances Gardner	1	Full	5			Lumping interventions. In chapter 5, selective prevention, I can see it is logical to lump together all 'social learning theory'-based parenting interventions - clearly these have a very similar underlying theory of behaviour change. However, some interventions may be more effective than others because of the ways they engage parents, train and supervise, ensure fidelity etc. There should be enough trials for subgroup analyses. Is there any evidence from the review that some are more effective than others? This could be helpful for a question where there are lots of trials, including where the conclusions suggest that there's no evidence of effect, as with parenting interventions in a selective prevention context. In Ch 7, Treatment and indicated prevention, however, this issue is dealt with well in the meta-regression and ensuing discussion.	Thank you for your comments. We choose not to explore moderators of intervention effectiveness, primarily because the meta-analysis demonstrated no heterogeneity that could not be explained by chance (indicated by an I-squared = 0%). Furthermore, by looking at the forest plot presented in Appendix 17 (section 1.2.1) you can see that only three studies produced effect sizes greater than -0.20 (a small effect). Meta-regression or sub-group analyses under these conditions would not produce reliable results, therefore, we felt that without more evidence we could say nothing further about parent focused selective prevention interventions.
112	PR	Expert reviewer - Frances Gardner	2	Full	5			The term 'Selective prevention interventions': The conclusions and take-home policy messages of this chapter depend hugely on the definition of 'selective prevention'. The authors have been really careful to make their definition clear, in a coherent explanation that is spread over several pages. Unfortunately the field uses varied and inconsistent definitions of these terms (even, I have noticed, when people base their thinking on the same IOM report), and people wont always read the NICE definition. This means that those reading selected parts of this chapter (and other summary docs) will need to be told, in a word, what NICE means by selective prevention, each time a conclusion or evidence summary is made. I suggest that it is	Thank you for your suggestion. The GDG agreed and we have defined the population which can be found under the title Psychosocial interventions in the NICE guideline.

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								made clear that the evidence refers to selective prevention defined as basing intervention on socio-demographic or family risk factors for conduct problems. The clinical impact is non-trivial: some may assume that the wording below: 'at risk for conduct disorders' includes samples where low income kids are chosen on the basis of early behavioural difficulties (eg as in the North Wales sure start trial). As a result, there is a danger that they will not commission/ fund / implement parenting interventions for 3-11 year olds in these groups. Suggested form of edits to section 5.6, and other summary sections:-- "5.2.6 Clinical evidence summary Overall, there is limited moderate to high quality evidence that for younger children (< 11 years old), who are at risk of a conduct disorder based on socio-demographic or family risk factors, classroom-based interventions delivered by teachers may be effective with regard to reducing antisocial behaviour. In addition, moderate quality evidence suggests that a parent-focused intervention involving prenatal and infancy home visitation by nurses (known in the UK as Family Nurse Partnership) may reduce the risk of serious offending behaviour over the long-term. There is insufficient evidence to determine if any other intervention is effective." The same could be added in para 3 of p157. However, section 5.5.1 is fine- the definition is made amply clear.	
27	PR	Expert Reviewer - Robert McMahon	1	Full	General			Let me begin by saying what an impressive and comprehensive set of documents this is! The final versions will provide direction not only to service providers, researchers, and policy makers in the UK, but to the field in general. My comments about specific items in the document are below. (I did not review the Appendices, as I do not seem to have them.)	Thank you for your comment. We are grateful for your feedback.
28	PR	Expert Reviewer - Robert	6	Full	General			MISC. There is only one dated reference (from 2004) to the very important work on economic analyses of various interventions	Thank you for your comments and for the reference. We are aware of the updated economic analysis

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		McMahon						to treat/prevent conduct problems by Aos and colleagues at the Washington State Institute for Public Policy. There are extensive and in-depth reports on their website that focus on most of the interventions presented in this document. I have attached a PDF of a report from April 2012 on the cost-effectiveness of various programmes. Other reports are on their website: http://www.wsipp.wa.gov/topic.asp?cat=19&subcat=0&dteSlct=0 The Foster & Jones (205) citation (pp. 36, 303) is incomplete. The correct citation is Foster, Jones, & the Conduct Problems Prevention Research Group. Again, thank you for the opportunity to review this document. I hope that my comments will be helpful to the group as you finalize it. Please do contact me if you have any questions about my comments or suggestions.	[Lee, S., Aos, S., Drake, E., Pennucci, A., Miller, M., & Anderson, L. (2012)]. The quality and applicability of this study was checked using a standard checklist and was found to have significant limitations in terms of methodology and perspective (see Appendix 19, page 3, for details) Thank you, we have corrected the citation.
69	PR	Expert Reviewer - Robert McMahon	2	Full	2.9	35		Inaccurate information is presented about Fast Track. First, the document implies that it is a universal intervention. We have described Fast Track as adopting a "unified" model of prevention, as it includes both a universal component (PATHS) and a number of targeted interventions (e.g., parent training, child social skills training, academic tutoring) (as you note). Second, please delete "Families and Schools Together" from the text. Although that was originally part of our name, we were advised early on that this name was already registered to a completely different program in the U.S. (FAST: Families and Schools Together). So the proper way to refer to our program is simply "Fast Track." Third, the description of the study and the results is not completely accurate: 891 children were randomized rather than "almost 1000." We have not yet published our young adult outcomes (an initial group of those papers is currently under review). The CPPRG 2011 paper that you cite only followed youth through age 18. Furthermore, a 50% reduction in lifetime diagnoses of conduct disorder in the intervention condition by age 18 in the very highest risk subgroup of our high-risk sample is more than "modest."	Thank you for these comments. We have redrafted the section accordingly. We note early on that fast track took only the top 10% of antisocial children, so do not believe that it gives the impression that it was a universal intervention. We have replaced the term 'families and schools together' with fast track. Although the overall effects were negative, we have been more positive about the sub-analysis of the most severe subgroup, relaced teh term 'by adulthood ' with 'by 18' and inserted the 50% reduction in diagnosis of CD

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114	PR	Expert Reviewer - Robert McMahon	3	Full		135		CHAPTER 5 Table 16 (p. 135) PATHS has typically been considered to be a universal intervention, rather than a selective one. There are eight categories of interventions in this chapter. With the exception of parent-focused interventions, none of the other categories have more than 6 studies; in fact, four of the remaining seven categories have only one or two RCTs each. This raises concerns about the strengths of conclusions made for these categories.	Thank you for your comments. We have amended Table 16 (although we did find one trial where PATHS was used a selective prevention intervention). Regarding the categories of interventions – the GDG set out in the review protocol the categories before the results were analysed. They did not think it was appropriate to change this classification after seeing the results. However, we agree that this raises concerns about the strength of conclusions, and for this reason, the evidence summary states there is insufficient evidence for some categories, and a research recommendation was developed recommending that school-based interventions are further researched.
128	PR	Expert Reviewer - Robert McMahon	4	Full				CHAPTER 6 Thank you for citing a chapter I wrote on the assessment of conduct problems (McMahon & Estes, 1996). I have attached two more recent chapters that provide more current reviews of various approaches to assessing conduct problems.	Thank you for providing these papers, the chapter will be updated accordingly.
160	PR	Expert Reviewer - Robert McMahon	5	Full	7.2.7	229-244		CHAPTER 7 pp. 229-34 (7.2.7 Moderators of intervention effectiveness) Was the severity of conduct problem behavior at baseline included in these moderation analyses? For example, the finding that group parent training had a larger effect size than individual parent training may be due to more serious cases of child conduct problems being assigned to individual, rather than group, parent training. pp. 231-232, Table 72 (7.2.7 Moderators of intervention effectiveness) The text fails to mention that 30% of the variance accounted for was explained by the child's age. This is an important finding.	Thank you for raising this issue. We have added baseline severity to the moderator analyses (section 7.2.7). In doing so, we re-ran the multivariate models using a forward stepwise. We believe this is the right approach to use given the danger of over-fitting the model. The findings suggest that it was useful to control for severity, but on its own is not a predictor of effect. The 30% variance accounted for by age was a typo. The actual variance

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								p. 244 (7.3.2 Parent-focused interventions) The Foster et al. (2006) study on the cost-effectiveness analysis re Fast Track does not belong in this section, since, as you note earlier in the document, Fast Track is a multicomponent intervention. It is not possible to disentangle the parent training component of Fast Track from the other components. It should be placed in 7.3.4 Multi-component programmes (pp. 252-253).	accounted for was 0%.The table has been amened. Regarding Foster et al. (2006), we agree and have amended the guideline.
149	PR	Expert reviewer-Frances Gardner	3	Full	7.5.1.3 (NICE 1.5.1)	263		The issue arises again about precise labelling of types of prevention and its possible effect on decision-makers. I suggest ch7 be relabelled 'Treatment and indicated prevention'. Having the 'prevention' part in brackets implies it could be omitted, and the message is still the same. It is not. Just to confirm this fear, when I get to the key summary sentence on p 263, I find the prevention word has indeed been dropped;it says: "Parent training programmes 7.5.1.3: Offer a group parent training programme to the parents of children and 3 young people aged between 3 and 11 years with oppositional defiant 4 disorder or conduct disorder." I recommend adding ".....and to those who show elevated levels of behavioural problems on a parent screen, including those in non-specialist children's services (or similar) Otherwise, a commissioner or manager in non specialist /or non-CAMHS children's services might think, "we're not a treatment service, our difficult 4 year olds don't have a disorder, indicated prevention seems to be for things called 'prodromal disorders', that doesn't sound like us, so we can only do universal or selective prevention, but NICE says parenting in this context doesn't work. So we wont implement a parenting programme for our low income parents in our children's centre/ school/ (etc) who are finding their children quite hard to manage (based on a simple screen), as it these interventions only work for 'treatment' cases". Yet this is not the case, as many of the trials in this category (esp in the UK) have been conducted in exactly these kinds of	Thank you for raising this issue. We agree and have amended the guideline accordingly. Please see NICE guideline section 1.5 and Chapter 7 of the full guideline.

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								non-specialist settings. So its really important the message and wording is clear. I don't think this is a trivial concern- I've heard so many people in the field making crude and potentially misleading distinctions about what is possible in clinical and non clinical settings and samples, and we need to take care not to reinforce these. In sum: Make it crystal clear in the intro and conclusions to ch 7 that the evidence is applicable to these kids with elevated scores but not necessarily 'disorders', and to these settings; take indicated prevention out of brackets throughout, make sure its included in every key sentence.	
287	PR	Expert reviewer- Frances Gardner	4	NICE	Research recommnedations	43	23-45	In the summary document, the above issues about levels of prevention need attending to. I had one other comment on this document. In section 4.4 , it could be pointed out that evidence from trials and Cochrane reviews suggests that parenting interventions can reduce maternal depression (Barlow review; Hutchings 2007 trial) and the children of depressed parents do as well or better in parenting interventions than those with non depressed children (Gardner et al 2010, trial moderator analyses).	Thank you for your suggestion. We have considered the supporting statement again, and think the level of detail is sufficient.
29	SH	NHS Direct	1	General		General		NHS Direct welcome the guideline and have no comments following consultation.	Thank you for your comment.
65	SH	Partnership Projects UK Ltd	1	Full		32	26	The draft states, in referring to FFT, MST and Treatment Foster Care, that "Most other varieties of family therapy have not been subjected to controlled trials for young people with conduct disorders or delinquency, so cannot be evaluated for their efficacy". However, the draft guidelines do not consider Non Violent Resistance or NVR (Omer, H. (2001) Helping parents deal with children's acute disciplinary problems without escalation: the principle of non-violent resistance. *Family Process*, 40: 53-66; Omer, H. (2004/1) *Nonviolent resistance. A new approach to violent and self-destructive children*. Cambridge University Press.), which is a more recent form of systemic family therapy that has been specifically developed for conduct disorders, and which has been evaluated by three controlled outcome studies on young people with conduct problems to date. Of these, two outcome studies have been published in peer reviewed journals, and one is a doctoral	Thank you for highlighting NVR. The GDG agrees that this should be included in the review and has been added to the full guideline, chapter 7, section 7.2.5. With regard to the studies you have cited, our search picked up only one RCT of NVR: Weinblatt, U. and Omer, H. (2008). The study in German was not picked up as we limit our evidence base to English-Language papers. We do not have access to the Lavi-Levavi dissertation.

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								dissertation that has been accepted at the university of Tel Aviv. All three studies are referenced below. As FFT and MST have been in existence for several decades, it is important for guidelines to reflect the more recent developments in the field, especially as in the case of NVR there is an emerging evidence base. Please find references for these studies below: Cont.... 1. Weinblatt, U. and Omer, H. (2008) Non-violent resistance: a treatment for parents of children with acute behavior problems. Journal of Marital and Family Therapy, 34: 75-92. 2. Ollefs, B., Von Schlippe, A., Omer, H., and Kriz, J. (2009) Adolescents showing externalising problem behaviour. Effects of parent coaching (German). Familiendynamik, 3: 256-265. 3. Lavi-Levavi, I., (2010). Improvement in systemic intra-familial variables by "Non- Violent Resistance" treatment for parents of children and adolescents with behavioral problems, PhD dissertation, Tel- Aviv University, Tel Aviv.	
30	SH	Royal College of Paediatrics and Child Health (RCPCH)	8	Mainly the brief version		General		The excellent and commendable recommendations in the guideline will be very difficult to implement in practice. While NICE has not normally discussed the disparity between its recommendations and what is possible in practice, this gap is so extreme in this case that we wonder whether a section could be included to discuss it? This might not fit easily into the brief guideline, but could perhaps form an extra section in the full guideline. Our impression is that the majority of Tier 3 CAMHS services are unable to offer more than a limited amount of what the guideline recommends. For instance assessment, parenting groups and a trial of medication. Examples of interventions that many such services would find it difficult to offer are: • A foster carer training programme • Group social and cognitive problem solving programmes for children and young people aged between 7 and 14 years	Thank you, we agree that the implementation of the guideline will be challenging but we think it important that we set high standards based on the best available evidence to improve the outcomes for the children and young people with conduct disorders. We have also discussed the issue with the NICE implementation team and will work with them and key government departments to support implementation of the guideline.

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								• Multisystemic Therapy or Functional Family Therapy or an equivalent multimodal therapy • A classroom-based emotional learning and problem solving programme • An integrated assessment and care pathway Our suggestion is that these shortfalls in provision are unlikely to be remedied just because of the existence of the guideline; and that, partly because of the high prevalence of conduct disorders in the community, and partly because of the economic consequences of *not* providing effective treatment; this deserves discussion in one or other version of the guideline.	
198	SH	Royal College of Paediatrics and Child Health (RCPCH)	9	NICE version	Introduction	5		Exclusion criteria for conduct disorders should be mentioned	There are no specific exclusion criteria, thus it can be diagnosed (and should be) in the presence of ADHD; whilst this guideline does not include consideration of children whose IQ is less than 60, this is not of itself an exclusion criterion
214	SH	Royal College of Paediatrics and Child Health (RCPCH)	5	NICE	Case id	19	12	Assessment: this section seems rather too focused on establishing the diagnosis, rather than constructing a biopsychosocial formulation capable of examining predisposing, precipitating and perpetuating factors, as well as resilience, in order to construct a family-centred intervention plan.	Thank you for your comment – we have revised NICE recommendation 1.3.15 in light of your comment.
216	SH	Royal College of Paediatrics and Child Health (RCPCH)	1	NICE version	Case id 1.2.3	19	24	It is encouraging to see that it is recommended that a neurodevelopmental disorder should not be a barrier to assessment (of a conduct disorder).	Thank you for your comment.
219	SH	Royal College of Paediatrics and Child Health (RCPCH)	2	NICE version	Case id 1.2.4	20	1	It is encouraging to see that a child with a suspected conduct disorder should also be assessed for the possibility of a neurodevelopmental disorder and (such as ADHD or autism), and a learning disability or disorder.	Thank you for your comment.
222	SH	Royal College of Paediatrics	6	NICE	Case id	20	12	It is welcome to have guidance regarding access to specialist CAMHS for this population, but we do wonder whether it is	Thank you for your comment. The NICE implementation team will be

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		and Child Health (RCPCH)			1.2.6			practicable for every child with a conduct disorder and a learning difficulty to access tier 3.	working with the Department of Health to ensure a collaborative approach to the implementation of government policy and the guideline.
232	SH	Royal College of Paediatrics and Child Health (RCPCH)	7	NICE	Psychosocial interventions	24	18	The section on intervention focuses too much on the manifestations of the child's difficulties, rather than addressing the underlying factors. There is insufficient emphasis on the multi-agency nature of optimal intervention in these children. There should, in our view, be a greater emphasis of working with housing departments than of risperidone. There ought to also be more consideration of lifestyle issues, particularly access to sport and leisure activities, and community activities generally.	Thank you for your comment. We have taken a multi- agency approach but housing is outside of the scope's remit. We have also covered some of the issues addressed in the 'delivery and organisation of care' section of chapter 4 'access to and delivery of services and the experience of care.'
239	SH	Royal College of Paediatrics and Child Health (RCPCH)	3	NICE version	Parent/child, complex needs 1.4.11	27	6	Why is it recommended that parents of children with complex needs (and a conduct disorder), receive about 2/3^{rds} of the amount of training as parents of children (with a conduct disorder) who do not have complex needs (compare the '8 – 10 sessions of 60 – 90 mins' in 1.4.5 with the 'up to 10 sessions of 60 mins' in 1.4.11)? Surely parents of children with complex needs ought to be offered more training than the parents of children without complex needs?	Thank you. We agree that this could be seen as being misleading and have restructured the recommendation in light of your comment.
253	SH	Royal College of Paediatrics and Child Health (RCPCH)	10	NICE version	Pharmacological 1.5.7	32	1	It is suggested the rare but important side effect on neuroleptic malignant syndrome be mentioned.	Thank you for your comment which we have considered carefully. As risperidone is recommended on a short term basis, it was decided that adding neuroleptic malignant syndrome be appropriate. Please see NICE rec 1.6.6
255	SH	Royal College of Paediatrics and Child Health (RCPCH)	11	NICE version	Pharmacological 1.5.	32	16	The suggestion of weekly height and weight has not been referenced. The major risk with resperidone is morbid obesity; would monitoring BMI be a better suggestion? Is weekly monitoring of height and weight necessary? We would think that monthly monitoring would be sufficient.	Thank you for your comment, given that the recommendation advises for use of risperidone in the short term only, the GDG felt that weekly monitoring of height and weight was necessary.

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					7				
261	SH	Royal College of Paediatrics and Child Health (RCPCH)	4	NICE	Organisation & delivery of care 1.6.1	33	55	Unlike much NICE guidance designed to refine existing services, in many areas this guidance will be wishing services into existence. It is therefore vital to give clear instructions (1.6.1) to commissioners regarding the nature of services needed, and the consequences of failing to provide these services. The current draft is too vague on this point. The introduction of joint commissioning for SEN gives an opportunity to extend these structures to conduct disorders, for instance.	Thank you for your comment, however this is outside the scope of the guideline.
268	SH	Royal College of Paediatrics and Child Health (RCPCH)	12	NICE version	Pathways 1.6.9+1.6.11	36, 37	13, 11 respectively	Provider is advised about the pathways focussed on outcomes and monitor progress and outcomes in these two paragraphs: Can there be any specific examples of outcome measures?	Thank you but we have not specifically recommended outcome measures as the CYP IAPT programme is currently developing core outcome measures for parents undergoing parent training programmes.
274	SH	Royal College of Paediatrics and Child Health (RCPCH)	13	NICE version	Pathways 1.6.14	38	3	A time limit to complete the assessments would be a helpful tool to guide the providers from the time of referral or entry into the pathway.	Thank you. Whilst we agree that it is important that assessments are completed in a timely manner, this should be an issue for care pathways amongst individual PCTs, rather than prescribed by NICE.
31	SH	Royal College of Speech and Language Therapists	1	Full		General		There is almost no acknowledgement that children with conduct disorder may also have speech and language difficulties. Evidence shows that children with conduct disorders can have verbal and communication problems. (Lynham D, Henry B, the role of neuropsychological deficits in conduct disorder).	Thank you for this comment. We have emphasised that assessment should be comprehensive and we did review the evidence on social skills and communication interventions.
32	SH	Royal College of Speech and Language Therapists	2	Full		General		The RCSLT is very concerned that there is no mention of speech and language therapy in the guideline.	Thank you, we have addressed the issue of communications in the introduction and in recommendation 6.4.1.11.
33	SH	Royal College of Speech and Language Therapists	3	Full		General		It needs to be stressed that the communication difficulties children and young people with conduct disorder experience may not be obvious or previously detected.	Thank you for this comment. We have emphasised that assessment should be comprehensive and we did review the evidence on social skills and

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								McCool S and Stevens I C (2011) International Journal of language and Communication Disorders 46 6 665-675. Gilmour, J; Hill, B; Place, M. Skuse, D. H. (2004), Social communication deficits in conduct disorder: a clinical and community survey Journal of Child Psychology & Psychiatry. 45(5):967-978) Training social communication skills is a key part of developing pro-social behaviour. (*Adams, C., Lockton, E., Freed, J., Gaile, J., Earl, G., McBean, K., Nash, M., Green, J., Vail, A. and Law, J. (2012), The Social Communication Intervention Project: a randomized controlled trial of the effectiveness of speech and language therapy for school-age children who have pragmatic and social communication problems with or without autism spectrum disorder. International Journal of Language & Communication Disorders, 47: 233–244)*	communication interventions.
66	SH	Royal College of Speech and Language Therapists	4	Full	2.7.3	33	19	This section refers to learning skills to enable people to make and sustain friendships - Speech, language and communication skills will be crucial to this. Children with SLI as well as conduct disorder will require speech and language therapy input. We recommend that this is added.	Thank you for your comment. We acknowledge in the introduction the contributing factors of conduct disorders include learning and language difficulties, however analysing speech, language and communication therapies were outside the scope of the guideline.
80	SH	Royal College of Speech and Language Therapists	5	Full	4.2.4	92	22-25	When discussing Davies 2008 the guideline says that the children showed an ambivalence towards talking therapies. Is this ambivalence or lack of skill? We suggest that this clarification is made to avoid confusion.	Thank you highlighting this issue. It's not clear from the review how much is genuine ambivalence, so we have amended the text to read: "The review also reported that although children and young people have a desire to talk, they have difficulty doing so, and they value non-verbal communication in helping engagement in the therapy process (DAVIES2008).

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97		Royal College of Speech and Language Therapists	6	Full	4.3	107	1.1.3	This suggests that language difficulties can be solved by interpreters. This fails to consider those who have English as a first language and still have language difficulties. Any reference of "interpreters" requires clarification (4.5.1.16). We also recommend mentioning speech and language therapists.	Thank you for your comment. We agree that language difficulties cannot be solved by interpreters, and our adapted recommendation acknowledges this by making the need for interpreters a separate point. However we do not judge that this is a matter for SLTs.
105	SH	Royal College of Speech and Language Therapists	7	full	4.5	121	4.5.1.12 Bullet one	In the first bullet the reference to language delay is not enough, there should also be reference to social communication difficulties as these are the very likely to occur. *References: (Bonamy R. Barker E D, Mandy WPL, Skuse,DH, Maughan B (2011) Social Cognition and Conduct Problems: A Developmental Approach Journal of the American Academy of Child & Adolescent Psychiatry 50, 4, 385–394).* *(Gilmour, J; Hill, B; Place, M. Skuse, D. H. (2004) Social communication deficits in conduct disorder: a clinical and community survey Journal of Child Psychology & Psychiatry. 45(5):967-978)*	Thank you for this comment. Social communication difficulties have been added to the first bullet point.
106	SH	Royal College of Speech and Language Therapists	8	Full	4.5	121	4.5.1.12 Bullet four	There appears to be an over reliance on the use of communication aids, without considering the different strategies to manage the language ability, e.g. breaking up information, checking back, summarising, re-capping.	Thank you for this comment, these strategies have now been inserted into recommendation 1.1.15 of the NICE guideline.
134	SH	Royal College of Speech and Language Therapists	9	Full	6.2.8	179	39	Is this a typo - selective autism should presumably be selective mutism? Also we are not that aware of research on the co- morbidity of conduct disorder and selective mutism? It is not that a common combination seen in practice.	Thank you for your query. It was supposed to be 'selective mutism' , but we have now removed reference to this from the full and NICE guideline.
135	SH	Royal College of Speech and Language Therapists	10	Full	6.2.8	179	39	When mentioning communication disorders the only example given is mutism (see typo correction above). Specific Language Impairment is far more common in this group and would make people think more broadly if this example was added.	Thank you for your query. We have removed selective mutism from the full and NICE guideline. and given a broader example of 'speech and language problems'.
143	SH	Royal College of Speech and	11	full	6.4.1.11	186	16	Social communication difficulties should be included not just speech and language.	Thank you for your comment, we agree and social communication

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		Language Therapists			(NICE rec 1.3.10)				difficulties have been added to the NICE recommendation 1.3.10
144	SH	Royal College of Speech and Language Therapists	12	Full	6.4.1.12 (NICE rec 1.3.11)	186	18	In section 6.4.1.11 it says to consider speech and language disorders, however in section 6.4.1.12 it discusses the use of assessments for these considerations, but does not mention a communication assessment. The RCSLT recommends CeLF/TOALE and a functional measure such as the communication checklist. We also recommend adding that where the child is difficult to communicate then a detailed speech and language therapy assessment is needed.	Thank you for your comment. We believe recommendation 1.3.10 goes a long way to recognise and address learning difficulties, including language. We are unable to include CeLF/ TOALE in NICE recommendation 1.3.11 due to the lack of evidence.
200	SH	Royal College of Speech and Language Therapists	13	NICE	Person centred care	8	17	This section stresses the importance of good communication between the child and staff but makes no mention of referral to speech and language therapy if communication proves difficult. We recommend that this statement is added.	Thank you for this comment but we do not think that if there are communication difficulties then the first port of call should necessarily be a speech and language therapist, although if social communication or other similar difficulties are suspected, then of course that should be the case.
202	SH	Royal College of Speech and Language Therapists	14	NICE	KPI Comprehensive Assessment Rec 1.2.9	10	16	The RCSLT recommends that all references to comprehensive assessment should include speech, language and communication.	Thank you, this has been added to recommendation 1.3.10.
203	SH	Royal College	1	NIC	KPI	10	16-20	This section stresses the importance of relationships in	Thank you, this has been added to

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		of Speech and Language Therapists	5	E	Comprehensive Assessment Rec 1.2.9			managing conduct disorders but does not acknowledge that communication difficulties will impact adversely on relationships and some children may need speech and language therapy intervention. We recommend that this statement is added.	recommendation 1.3.10.
210	SH	Royal College of Speech and Language Therapists	16	NICE	1.1.14	16	18-19	It is worth stipulating how to check if the individual has understood; too many people still check by asking if the person understood, to which the answer is "yes" even if this is not the case.	Thank you but this is a matter for local implementation and is outside the scopes remit.
34	SH	The Association of Educational Psychologists (AEP)	5	Full		General		The AEP would like to put on record our major concern about the new edition of the internationally recognised diagnostic manual DSM5 which we fear will lead to more children and young people being diagnosed with psychiatric disorders. This new criteria will lead to many more children being diagnosed as mentally ill. New categories are subjective and unscientific which we fear will result in a shy child being diagnosed with social anxiety; a sad, grieving or temporarily withdrawn child could even be diagnosed with depression. We are further concerned that this guidance will consequently lead to treatment via drugs, rather than recognising that, in many situations, the children's observed and reported symptoms are a transient reaction to stress within their environments. Alleviating the child's difficulties may be more effectively helped by changes to the environment rather than by the prescription of drugs. We would like to see NICE and the Department for Health recognise the concerns about DSM5 and issue clear guidance	Thank you for your comment, but it is outside of our scope to comment on the development of DSM5.

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								to all health practitioners about its limitations when presented with children and young people with mental health difficulties.	
43	SH	The Association of Educational Psychologists (AEP)	1	Full		15	30	The AEP is pleased that the guidance document considers the issues of medicalising a social problem. Over the past few years the AEP has received increased numbers of reports from our members that children with behavioural difficulties are being prescribed drugs without full discussions with other professionals to see if other strategies or approaches could be used instead of, or at least alongside, the medication. Figures from the Department of Health show that the number of prescriptions for these drugs has gone up from 158,000 prescriptions in 1999 to 610,000 in 2009. Behaviours develop over a long period of time, often with a range of complex causes; we can't "cure" the behaviours we don't like with a quick fix of medicine. They usually require careful management by all the adults around the child. Simply relying on medication is no solution; there should be a more collaborative approach to the treatment of school-aged children with conditions such as ADHD – involving GPs, teachers, educational psychologists and healthcare professionals alongside the child's parents – that is not reliant on medication, but considers a comprehensive programme of treatment and alternative therapies.	Thank you for your comment, the GDG agreed that this issue is important and we think this is reflected in the recommendations made, which if followed, should ensure a more comprehensive and collaborative approach to treatment.
181	SH	The Association of Educational Psychologists (AEP)	2	Full	8.1	266	8	While the AEP recognises that there is already a national policy on the prescription of ADHD medication as set out in the NICE Clinical Guidelines on Attention Hyperactivity Disorder. These guidelines set down some important parameters, for the treatment of ADHD and prescription of medication which the AEP would agree with. These recommend that ADHD medication should not be prescribed • to pre-school age children, e.g. under the age of six; • on a long term basis and in insolation from other therapeutic interventions; or	Thank you for your comment but this is outside the scope of the guideline.

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								• without consultation with other professionals working with the child, including school staff and psychological advice. While the AEP would support much of the current NICE guidelines, we are extremely concerned that clinical practice is not reflecting policy and is concerned by the increasing number of cases which are brought to its attention where these guidelines are being breached.	
182	SH	The Association of Educational Psychologists (AEP)	2 (cont)		8.1	266		It is of particular concern to the AEP that the number of children aged under six, and as young as three, who have been prescribed ADHD drugs to address challenging behaviour, including inattentiveness and hyperactivity, is rising substantially. An informal survey of educational psychology practitioners across the West Midlands has shown that there are over 100 children aged under six on psycho-stimulant medication. This is reaffirmed across the country by our members. Similarly, the guidelines should place appropriate emphasis on properly observed, recorded and triangulated behavioural data. It is essential that this is undertaken in different settings by trained observers. For example, it should be established that a child is exhibiting similar behaviours at school as well as at home.	Thank you for your comment but this is outside the scope of the guideline.
183	SH	The Association of Educational Psychologists (AEP)	3	Full		266	22	The AEP would like to put on record our concern about some of the practices around the prescription of powerful psycho-stimulant drugs, such as Ritalin, to manage children's behavioural issues. Educational psychologists take forward a wide range of work around children's needs, child development and the emotional and social wellbeing of children. An important role of the educational psychologist is to provide advice and guidance to other professionals, e.g. mainstream teachers, SENCOs or early years staff for example, on managing challenging behaviour, identifying and addressing issues of concern related to a child's mental or learning development, as well as providing training or advice around specific conditions, including ADHD or other behavioural	Thank you for your comment but this is outside the scope of the guideline.

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								disorders. Educational psychologists also work directly with parents and children, including making important contributions to help parents translate a medical diagnosis into a personalised plan that helps support a child in terms of learning development in an educational setting.	
184	SH	The Association of Educational Psychologists (AEP)	4	Full	8.1	266	7	There are certainly children with conditions that need medication. However, the AEP feels that there is insufficient evidence to have confidence in what the long-term neurological impact of these drugs might be on the developing brains of children. More and more studies are identifying long term side effects of using these drugs, including higher instances of reliance on other drugs. It is becoming a common practice that children are prescribed with a regimen of more than one strong medication, e.g. Ritalin, an antipsychotic drug and/or an antidepressant at the same time. There is little to no evidence about the effect which these cocktails of drugs are having on the development of children's brains. Moreover, clinical studies show that the beneficial effects of psycho-stimulant medication are not sustained over the long-term, necessitating stronger and stronger dosages to be prescribed over time. It is also becoming a common practice for children to be prescribed stronger dosages than recommended in the morning as a "top-up" or "kick-start" dose so that medication lasts the full school day.	Thank you for your comment, however this is outside the scope and we believe we have been very circumscribed in the recommendation regarding medication for children and young people with conduct disorders.
45	SH	The British Association of Play Therapists	1	Full	2.2	16	31	Needs to be an acknowledgement that defiant or externalising behaviours can be a communication of human need. It is likely that a need is not being , or hasn't in the past, been adequately satisfied or responded to and can lead to a development of an 'anti-social' behaviour to insist that need is met.	We thank you for this comment. Whilst we agree that this may be sometimes the case, in other cases, for example those born with psychopathic traits, it may not be an expression of need in our view in the sense that we understand you intend it, and have not modified the guideline

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									to take this stance. However, the very fact that we have developed this guideline indicates that we do take this problem extremely seriously and have set out how this can be achieved in the assessment section of the guideline.
46	SH	The British Association of Play Therapists	2	Full	2.2	16	27	The behaviour can only be fully understood with a full, systemic assessment of the child – accounting for history, family dynamics and social context within which the child has developed.	We agree, and this is advocated in the section on assessment.
52	SH	The British Association of Play Therapists	3	full	2.2.1	17	5	The description of typical behaviours of different developmental stages is essential to put it into context.	Thank you for your comment. We feel we are taking a developmental approach by showing different manifestations at different life stages and the point has been strengthened to demonstrate that typical behaviour may be a response to stressful contexts
70	SH	The British Association of Play Therapists	4	full		38	1	Multi-disciplinary approach is necessary. Combination of family / relational working, parenting skills and understanding, attachment work when necessary and addressing social stress factors should be looked at first. If this is not effective then exploration of more organic reasons for a child's behaviours, eg: ASD / mental health difficulties / sensory processing difficulties etc can be done. This should not be the only / first route of treatment.	Thank you, we agree with a comprehensive assessment, and this is stated in the introduction as an appropriate way to proceed. Also, you will see from the subsequent reviews of the evidence we make a number of recommendations to address issue both of assessment and the needs for complex interventions, for example MST.
35	SH	Welsh Government	7	Full		all		Lack of clarity re definition of CAMHS sometimes using Tier 1 e.g. sure start etc but referral figures almost certainly Tier 2+	Thank you for your comment. We are unsure of the precise intent of your query but we hope that the recommendations on care pathways and the specification of which children and young people may benefit from which type of intervention may help address your comment.

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36	SH	Welsh Government	8	Full		all		Given paucity of evidence overall need to highlight those important recommendations that are Group concensus AND moderate to good quality evidence and those that are just consensus. Also need to separate out those that apply to general provision of services and those that are specific to CD or ODD as guideline suggests	Thank you for your suggestions. Each 'Evidence to Recommendation' section attempts to do exactly as you have suggested. NICE recommendations no longer make a distinction between those that are evidence based and those that are based on expert opinion and derived through consensus. Regarding general versus specific recommendations, this has been done in the NICE version of the guideline.
47	SH	Welsh Government	1	Full	2.1.1	16	4	Disagree with wording "medical contribution" not approach". Agree medical role but sure require integrated service social and medical. We now know (and have always surmised) that most behaviours and actions have a biological component. This would mean all behaviour of mankind requires medical input	We agree with this point, and the biopsychosocial model and role of other agencies has now been strengthened in the guideline.
68	SH	Welsh Government	2	Full	2.8	34	23	Opinion not fact/research base. Recent multimodal research in England did not show improvement	Thank you for your comment however we are unable to respond to this without more detail on the research that you are referring to.
76	SH	Welsh Government	3	Full		69-117	36	Document increasingly reads as promotion for Conduct disorder services moving away from focus when it suits. Access and patient centred requirements of services is helpful but should be separate guideline and overlaps with Welsh mental health measure, social services and education guidance	Thank you. We do not quite understand the first point you make. In relation to your second point we believe it is important there is an integrated approach to the care and treatment of children and young people with conduct disorders. The recommendations are developed as 'in principle' recommendations and we would hope that they may inform the implementation of the Welsh guidance you refer to.
104	SH	Welsh Government	4	full	4.5	119-128		Recommendations for all users not CD specific	Thank you for your comment. However we think these recommendations have direct relevance to children and young

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									people with conduct disorders and their families.
113	SH	Welsh Government	5	Full	5.1	132	14	Professionals across agencies not just mental health	Thank you for your comment, we have adjusted section 5.1 to make reference to other agencies.
129	SH	Welsh Government	6	full	6.1	159	1	No specialist service can provide for 10% of population so fact that minority access is self evident. Indeed if all did have CAMHS input no one would have effective treatment for any disorder	Thank you for your comment and we agree this is an important issue.

These stakeholders were approached but did not comment;

4 Children

Action for ADHD - Northants

Alder Hey Children's NHS Foundation Trust

Allocate Software PLC

Associate Development Solutions Ltd

Association for Dance Movement Psychotherapy UK

Association for Psychoanalytic Psychotherapy in the NHS

Association of Anaesthetists of Great Britain and Ireland

Association of Directors of Childrens Services

Association of Professional Music Therapists

Autism Treatment Trust

Autism West Midlands

Bath Spa University

Bradford and Airedale Primary Care Trust

Bradford District Care Trust

Bristol-Myers Squibb Pharmaceuticals Ltd

British Association for Counselling and Psychotherapy

British Association for Music Therapy

British Association of Behavioural and Cognitive Psychotherapies

British Association of Dramatherapists

British Association of Psychodrama and Sociodrama

British Association of Social Workers

British Confederation of Psychotherapists / Psychoanalytic Council

British Dietetic Association

British Medical Association

British Medical Journal

British National Formulary

British Paediatric Mental Health Group

Buckinghamshire Hospitals NHS Trust

Camden Link

Capsulation PPS

Care Quality Commission (CQC)

Caspari Foundation

Central & North West London NHS Foundation Trust

Central Lancashire Primary Care Trust

Central London Community Healthcare

Cerebra

Children's Commissioner for Wales

Children's Services Development Group

CIS' ters

College of Occupational Therapists

Commission for Social Care Inspection

Community District Nurses Association

Critical Psychiatry Network

Department for Communities and Local Government

Department of Health

Department of Health, Social Services and Public Safety - Northern Ireland

Dorset Primary Care Trust

Drinksense

East London NHS Foundation Trust

Education Otherwise

Eli Lilly and Company

Faculty of Sport and Exercise Medicine

Fair Play for Children

Family Futures

Flynn Pharma

Forum for Advancement in Psychological Intervention

Fostering Network Wales, the

Foundation for People with Learning Disabilities

George Eliot Hospital NHS Trust

Great Western Hospitals NHS Foundation Trust

Greater Manchester West Mental Health NHS Foundation Trust

Hammersmith and Fulham Primary Care Trust

Hampshire Partnership NHS Trust

Health Protection Agency

Health Quality Improvement Partnership

Healthcare Improvement Scotland

Healthcare Inspectorate Wales

Heart To Heart Psychotherapy Outreach Clinic

Hertfordshire Partnership NHS Trust

Hindu Council UK

Humber NHS Foundation Trust

Independent Children's Homes Association

Information Centre for Health and Social Care

Kent and Medway NHS and Social Care Partnership Trust

La Leche League Great Britain

Lancashire Care NHS Foundation Trust

Leeds Community Healthcare NHS Trust

Leicestershire Partnership NHS Trust

Liverpool Community Health

Liverpool Primary Care Trust

Luton and Dunstable Hospital NHS Trust

Medicines and Healthcare products Regulatory Agency

Medicines for Children Research Network

Mencap

Mild Professional Home Ltd

Mind Wise New Vision

Ministry of Defence

National Association for Gifted Children

National Autistic Society

National CAMHS Support Service

National Commissioning Group

National Institute for Health Research Health Technology Assessment Programme

National Offender Management Service

National Organisation on Fetal Alcohol Syndrome - UK

National Patient Safety Agency

National Public Health Service for Wales

National Treatment Agency for Substance Misuse

Neonatal & Paediatric Pharmacists Group

NHS Bedford & Luton Cluster

NHS Clinical Knowledge Summaries

NHS Confederation

NHS Connecting for Health

NHS National Specialised Commissioning Team

NHS Plus

NHS Sheffield

NHS Warwickshire Primary Care Trust

NHS Worcestershire

North Essex Mental Health Partnership Trust

Northumberland, Tyne & Wear NHS Trust

Nottingham Support Group for Carers of Children with Eczema

Nottinghamshire Healthcare NHS Trust

Office of the Children's Commissioner

Parenting UK

Partneriaeth Prifysgol Abertawe

PERIGON Healthcare Ltd

Pfizer

Play Therapy UK

Psychology Resources for Families

Public Health Wales NHS Trust

Qbtech Ltd

Rainbows Childrens Hospice

Rethink Mental Illness

Royal Berkshire NHS Foundation Trust

Royal College of Anaesthetists

Royal College of General Practitioners

Royal College of General Practitioners in Wales

Royal College of Midwives

Royal College of Nursing

Royal College of Obstetricians and Gynaecologists

~~Royal College of Paediatrics and Child Health~~ , Gastroenetrology, Hepatology and Nutrition

Royal College of Physicians

Royal College of Psychiatrists

Royal College of Psychiatrists in Scotland

Royal College of Psychiatrists in Wales

Royal College of Radiologists

Royal College of Surgeons of England

Royal National Institute of Blind People

Royal Pharmaceutical Society

Royal Society of Medicine

Safeguarding the Rights of Children with Autism

Scottish Intercollegiate Guidelines Network

Sensory Integration Network

Sheffield Childrens Hospital

Sheffield Teaching Hospitals NHS Foundation Trust

Sing & Grow UK

SNDRi

Social Care Association

Social Care Institute for Excellence

Solent NHS Trust

South Asian Health Foundation

South Staffordshire and Shropshire Healthcare NHS Foundation Trust

South West London and St George's Mental Health NHS Trust

South West Yorkshire Partnership NHS Foundation Trust

Spinda Bifida . Hydrocephalus . Information . Networking . Equality

St Andrews Healthcare

St John's RC School

St Mary's Hospital

Sussex Partnership NHS Foundation Trust

Swindon Borough Council

TACT

Tavistock Centre for Couple Relationships

Tees, Esk and Wear Valleys NHS Trust

The Children's Trust

The College of Social Work

The National Association for Children of Alcoholics

The National LGB&T Partnership

The Rotherham NHS Foundation Trust

The Sound Learning Centre

Treating Autism

Triple P - Positive Parenting Programe

Unite - the Union

United Kingdom Council for Psychotherapy

United Lincolnshire Hospitals NHS

University of Edinburgh

University of York

User Voice

Walsall Local Involvement Network

Warrington Primary Care Trust

Welsh Scientific Advisory Committee

West London Mental Health NHS Trust

Western Cheshire Primary Care Trust

Western Health and Social Care Trust

Whitstone Head Educational

Wigan Council

Worcestershire Acute Hospitals Trust

York Hospitals NHS Foundation Trust

YoungMinds

Youth Justice Board for England and Wales