2-year surveillance 2015 – Conduct disorders in children and young people (2013) NICE guideline CG158

Appendix A: decision matrix

Summary of new evidence from 2 year surveillance	Summary of new intelligence from 2-year surveillance	Impact
General Principles of Care		
158-01: What are the essential elements that assist in the transition into adulthood services for young people with conduct disorders? (1.1.1 – 1.1.23)		
No relevant evidence identified.	None identified relevant to this question.	No new evidence was identified that would affect recommendations.
158-02: For children and young people with a conduct disorder, what can be done to improve the experience of the disorder, and the experience of care? (1.1.1 – 1.1.23)		
No relevant evidence identified.	None identified relevant to this question.	No new evidence was identified that would affect recommendations.
Selective Prevention		
158-03: What selective prevention interventions for at risk individuals (including children/young people or their parents/families/carers) reduce the likelihood of children and young people developing a conduct disorder? (1.2.1 – 1.2.2)		
Equine Facilitated Learning Program An RCT[1] was identified which examined the effectiveness of an 11 week equine facilitated learning (EFL) program on social competence and behaviour. Children (n=131) were recruited through referral by	Clinical feedback suggested that causal factors for conduct disorder, in particular attachment difficulties, are not given sufficient consideration in the guideline. This could have implications for the interventions recommended although no specific evidence was provided.	No new evidence was identified that would affect recommendations. The new evidence on EFL found this intervention to have a moderate effect on social competence. CG158 currently recommends (recommendation 1.2.2) that programs for selective prevention should consist of

Summary of new evidence from 2 year surveillance	Summary of new intelligence from 2-year surveillance	Impact
school counsellors and schools and randomised to either the 11 week EFL program or to a wait list control group. The EFL program consisted of individual and team focused activities. The intervention was found to have a moderate treatment effect on social competence. Furthermore, high levels of intervention attendance were found to predict children's trajectories of observed positive and negative behaviour over the EFL program. **Parenting intervention** The effectiveness of a brief parenting intervention (Primary Care Triple P) on emotional and behavioural problems in preterm born or asphyxiated term born pre-schoolers was investigated in an RCT[2]. Children (n=67) were randomised to Primary Care Triple P or to a wait list control. Results showed that the intervention was not effective in reducing emotional and behavioural problems in preterm born or term born children with perinatal asphyxia. **Community Based Intervention** An RCT[3] evaluated a Communities that Care (CTC) prevention system. In this study, 24 small towns in 7 states were randomised to CTC or to the control. Follow-up was after 8 years. At follow-up results showed that students in the intervention group were more likely to abstain from drug use, alcohol use, smoking and delinquent behaviour compared to the control. In addition, students in the intervention group were less likely to ever have committed a violent act. However,		interventions which develop problem solving skills, increase awareness of the child's own and others emotions, teach self-control of arousal and behaviour and promote positive self-concept and good peer relations. However, the new evidence is limited since the study did not report antisocial behaviour as an outcome and only a moderate effect was reported for social competence. Further research on EFL is needed in order to confirm or refute the benefits of this intervention. The new evidence on parenting interventions indicated that the Primary Care Triple P intervention was not beneficial. Parent interventions were considered in the evidence base for selective prevention in CG158 but the evidence was inconclusive. As such, no recommendations on this type of intervention were made. This study may not provide enough conclusive evidence to enable a recommendation to be made. The new evidence on community based interventions is inconclusive as whilst the intervention was found to be beneficial in reducing delinquent behaviours, smoking, and drug and alcohol abuse it was not beneficial in reducing current levels of risk or the current prevalence of problem behaviour. Currently, CG158 does not make any recommendations about community based interventions. However, before recommendations can be made, further evidence on the effectiveness and cost of community based interventions is needed. Clinical feedback indicates that causal factors were not given enough consideration in CG158. In particular,

Summary of new evidence from 2 year surveillance	Summary of new intelligence from 2-year surveillance	Impact
using the intervention was not found to reduce current levels of risk or the current prevalence of problem behaviour.		attachment issues. However, no evidence of causal factors was identified during this 2 year surveillance review. Furthermore, NICE is currently developing a guideline on attachment in children and young people who are adopted from care, in care or at high risk of going into care (anticipated publication date: November 2015) which may address the issue raised by clinical feedback. This area will be examined further at the next surveillance review of the guideline to determine if there is an impact on the current recommendations.
158-04: What indicated prevention interventions for at risk individuals (including children/young people or their parents/families/carers) reduce the likelihood of children and young people developing a conduct disorder? (1.2.1 – 1.2.2)		
No relevant evidence identified.	None identified relevant to this question.	No new evidence was identified that would affect recommendations.
Identification and Assessment		
158-05: What concerns and behaviours (as expressed by the carer or exhibited by the child) should prompt any professional who comes into contact with a child or young person with a possible conduct disorder to consider referral for further assessment? (1.3.1-1.3.16)		
No relevant evidence identified.	None identified relevant to this question.	No new evidence was identified that would affect recommendations.
158-06: What are the most effective methods/tools for case identification of conduct disorders in children and young people? (1.3.1-1.3.16)		
No relevant evidence identified.	None identified relevant to this question.	No new evidence was identified that would affect recommendations.

Summary of new evidence from 2 year surveillance	Summary of new intelligence from 2-year surveillance	Impact
158-07: In children and young people with a possible conduct disorder, what are the key components of, and the most effective structure for, a diagnostic assessment? To answer this question, consideration should be given to: • **the nature and content of the interview and observation, which should both include an early developmental history where possible** • **formal diagnostic methods/ psychological instruments for the assessment of core features of conduct disorders** • **the assessment of risk** • **the assessment of need** • **the setting(s) in which the assessment takes place (1.3.1-1.3.16)**		
No relevant evidence identified.	None identified relevant to this question.	No new evidence was identified that would affect recommendations.
158-08: When making a diagnosis of a conduct disorder in children and young people, what amendments (if any) need to be made to take into account coexisting conditions (such as ADHD, depression, anxiety disorders and attachment insecurity)? (1.3.1-1.3.16)		
No relevant evidence identified.	None identified relevant to this question.	No new evidence was identified that would affect recommendations.
158-09: What amendments, if any, need to be made to take into account particular cultural or minority ethnic groups or sex? (1.3.1-1.3.16)		
No relevant evidence identified.	None identified relevant to this question.	No new evidence was identified that would affect recommendations.
158-10: What amendments, if any, need to be made to the agreed methods for case identification to take into account: • **demographics (for example, particular cultural or minority ethnic groups, or girls)** • **the environment in which case identification takes place (for example, social care, education)? (1.3.1-1.3.16)**		
No relevant evidence identified.	None identified relevant to this question.	No new evidence was identified that would affect recommendations.

Summary of new evidence from 2 year surveillance	Summary of new intelligence from 2-year surveillance	Impact
Identifying Effective Treatment and Care Options		
158-11: For children and young people with a conduct disorder, should interventions found to be safe and effective be modified in any way in light of coexisting conditions (such as ADHD, depression, anxiety disorders, attachment insecurity) or demographics (such as age, particular cultural or minority ethnic groups, or sex)? (1.4.1 – 1.4.3)		
No relevant evidence identified.	Clinical feedback indicated that Child and Adolescent Mental Health Services (CAMHS) are being transformed in England by NHS England (NHSE). It was suggested that guidance needs to be aligned with integrated services across social care, health and education. Service delivery models were not systematically considered in the guideline.	No new evidence was identified that would affect recommendations. The feedback from the topic experts indicates that guidance needs to be aligned with integrated services across social care, health and education and further suggests that service delivery models were not systematically considered in the guideline. However, no further details were provided and no new evidence on service delivery models was identified during this 2 year surveillance review. We will examine this area further at the next surveillance review of CG158 to determine if there is any impact on guideline recommendations.
Psychological Interventions – Treatment and Indicated Prevention		
158-12: For children and young people with a conduct disorder, what are the benefits and potential harms associated with individual and group psychosocial interventions? (1.5.1 – 1.5.14)		
Narrative Exposure Therapy An RCT[4] was identified which randomised 32 males (17 years old) scoring highly in appetitive aggression to either forensic offender rehabilitation narrative exposure therapy (FORNET) or to treatment as usual. At follow-up (4 to 7 months) significantly fewer offences were committed by those in the intervention group. **Psychodynamic Therapy**	Clinical feedback indicated that a trial of Multisystemic therapy (MST) for conduct disorder is ongoing.	New evidence is unlikely to impact on guideline recommendations. The new evidence on narrative exposure therapy shows this intervention to be beneficial. Currently, CG158 does not provide any recommendations on the use of narrative exposure therapy. However, the evidence identified during this 2 year surveillance review is limited. This is because the study was small and results may not be generalisable to the guideline population

Summary of new evidence from 2 year surveillance	Summary of new intelligence from 2-year surveillance	Impact
An RCT[5] randomised 66 adolescents diagnosed with mixed disorders of conduct and emotion to manualised in-patient psychodynamic therapy (PDT) or a waiting list/treatment as usual. Results showed that those in the PDT group had higher rates of remission and had significantly better outcomes on the Strength and Difficulties questionnaire. Furthermore, PDT was found to further necessary preconditions for long-term stabilisation. **Child-centred Play Therapy** A pilot RCT[6] assessed Child-centred Play Therapy (CCPT) in 54 children with disruptive behaviour. Children were randomised to CCPT or to reading mentoring (RM). Results showed a statistically significant decrease in disruptive behaviour in the CCPT group compared to the control. Furthermore, the CCPT group showed statistically significant decreases in aggression and attention problems. **Williams LifeSkills Training** In an RCT[7] 66 Chinese young male violent offenders were randomised to routine intervention alone or to routine intervention plus Williams LifeSkills Training (WLST). Results showed that WLST may be effective in reducing overt aggression in this population. **Collaborative Care**		since participants were 17 year olds in the criminal justice system. As such, this evidence is unlikely to be sufficient to warrant an update of CG158. Further evidence on the effectiveness of narrative exposure therapy is needed before the potential impact on recommendations can be established. Limited evidence also found psychodynamic therapy to be beneficial. Currently, CG158 does not provide recommendations on psychodynamic therapy. However, the evidence identified during this 2 year surveillance review is limited to one small study in a mixed disorder population. Further large studies in children and adolescents with antisocial behaviour and conduct disorders are needed before the impact on recommendations can be assessed. The new evidence concerning child-centred play indicates that this intervention is beneficial in reducing disruptive behaviour, aggression and attention problems. Child focussed interventions are included in this guidance but CG158 does not make specific recommendations on child-centred play. However, the evidence identified during this 2 year surveillance review is limited to a pilot study. As such, more evidence is required on the effectiveness of this intervention before the potential impact on guideline recommendations can be established. Limited new evidence on WLST shows this intervention to be effective in Chinese young male offenders. At present, CG158 does not make any recommendations as to the use of WLST and no studies involving this

Summary of new evidence from 2 year surveillance	Summary of new intelligence from 2-year surveillance	Impact
The efficacy of collaborative care for behaviour problems was investigated in a cluster RCT[8] in which 321 children and their caregivers in paediatric primary care were randomised to Doctor Office Collaborative Care (DOCC) or an enhanced version of usual care. Overall, it was found that DOCC was associated with higher rates of completion, treatment initiation, improvement in behaviour problems, hyperactivity and internalising behaviour, parental stress, remission in behaviour and internalising behaviour, goal improvement, treatment response and consumer satisfaction. **Guided self-change** The effectiveness of a guided self-change intervention in minority adolescents was investigated in an RCT[9]. In this study, 514 high school students reporting substance use and perpetrating aggression were randomised to Guided Self-change (GSC), involving a brief motivational intervention and cognitive behavioural therapy (CBT), or standard care. GSC led to significant reductions in the total number of alcohol use days, drug use days and aggressive behaviour incidents when compared to the control.		intervention were included in the development of the original guideline. However, the evidence identified in this 2 year surveillance review is limited to one small study which may be insufficient to warrant an update at this time. Further RCTs investigating the effectiveness of WLST are needed before consideration for inclusion in CG158. The new evidence found during this 2 year surveillance review on collaborative care indicates that it is beneficial. Currently, CG158 does not make any recommendations about collaborative care in a paediatric primary care population. However, the study identified is unlikely to impact on CG158 since the findings may not be generalisable to a conduct disorder population. This is because the study population included children with behavioural problems, attention-deficit hyperactivity disorder (ADHD) or anxiety. Further evidence investigating collaborative care in children with antisocial behaviour and conduct disorders is required before any potential impact on guideline recommendations can be assessed. The new evidence on GSC also shows this intervention to be beneficial for minority adolescents. This evidence is consistent with guideline recommendations 1.5.11 and 1.5.12 which recommend group and problem solving programmes based on cognitive –behavioural problem solving models. This is because the GSC programme is based on a cognitive-behavioural model. Clinical feedback states that a trial of Multisystemic therapy is due to report. However, no further details of

Summary of new evidence from 2 year surveillance	Summary of new intelligence from 2-year surveillance	Impact
		this study were reported and no new evidence on this intervention was identified during this 2 year surveillance review. This area will be examined further at the next surveillance review of the guideline.
158-13: For children and young people with a conduct disorder, what are the benefits and potential harms associated with parenting and family interventions? (1.5.1 – 1.5.14)		
Parenting Matters An RCT[10] was identified in which parents (n=178) with concerns about their 2 to 5 year olds discipline problems were randomised to usual care or to the Parenting Matters intervention combined with usual care. The intervention involved a self-help booklet with telephone calls to a coach and follow-up was after 6 months. Behavioural problems were found to decrease significantly more in the intervention group compared to the control. Furthermore, greater improvements were found in psychopathology with the intervention but no differences were found between the two groups in parenting. **Incredible Years program** The effectiveness of the Incredible Years Program was investigated in an RCT[11] of 150 parents of toddlers (aged 2 to 4 years) with disruptive behaviours in a paediatric primary care setting. Parents were randomised to the Incredible Years Program or to a wait list control. The intervention was found to lead to greater improvements in child disruptive behaviours and	None identified relevant to this question.	No new evidence was identified that would affect recommendations. The new evidence on parenting interventions suggests that they are beneficial in some outcomes. Currently, CG158 recommends parent training interventions (1.5.1 to 1.5.4) but is not specific on which parent training interventions to use. Further evidence is necessary on the effectiveness of parenting interventions, particularly focusing on the components of the intervention and short and medium-term outcomes over at least 18 months to confirm any definite impact on guideline recommendations.

Summary of new evidence from 2 year surveillance	Summary of new intelligence from 2-year surveillance	Impact
parenting practices. Another RCT[12] was identified which randomised 154 families with children with ODD, conduct disorder and/or ADHD to either the BASIC Incredible years parenting intervention or to a waiting list control. The intervention was found to reduce parent reported disruptive child behaviour and teacher reported hyperactive and inattentive child behaviour and increase parent reported use of praise and incentives. However, it was found to have no effect on parent reported hyperactive and inattentive child behaviour, teacher reported child conduct problems and parent reported use of appropriate discipline techniques, clear expectations, parenting stress and physical punishment.		
158-14: For children and young people with a conduct disorder, what are the benefits and potential harms associated with multi-modal/ multiple interventions? (1.5.1 – 1.5.14)		
No relevant evidence identified.	None identified relevant to this question.	No new evidence was identified that would affect recommendations.
158 -15: For children and young people with a conduct disorder, what are the benefits and potential harms associated with school behaviour management? (1.5.1 – 1.5.14)		
Classroom based interventions ***Incredible Years Training*** A cluster RCT[13] investigated the effectiveness of the	None identified relevant to this question.	No new evidence was identified that would affect recommendations. The new evidence on classroom based interventions shows these interventions to be beneficial. Currently

Summary of new evidence from 2 year surveillance	Summary of new intelligence from 2-year surveillance	Impact
Incredible Years Teacher Training intervention in 24 community pre –schools for children with reported conduct problems. Schools were randomised to either the Incredible Years Teacher Training intervention or to a control group. Children in the intervention group were found to show significant reductions in conduct problems and significant decreases in teacher and parent reported behavioural difficulties. ***Cognitive Behavioural Therapy*** Another RCT[14] investigated a child-focussed CBT program introduced into schools. In total, 173 children with disruptive behaviour aged 8 to 12 years were randomised to CBT with active teacher support (ATS), CBT plus educational teacher support (ETS) or to a wait-list control. Results showed positive post treatment effects for both CBT groups compared to the control on disruptive behaviour. Whilst no consistent effect of teacher type was found between the two CBT groups at post treatment, at 3 month follow up children in the ETS group had significantly better outcomes.		CG158 does not make any recommendations on classroom-based interventions as the topic experts felt that the evidence did not currently support a recommendation for interventions given separately to teachers or to classroom-based interventions. This was because the evidence on the effectiveness of these interventions was inconclusive and none of the included studies reported any follow-up data. Whilst the two identified studies add to the evidence base more conclusive evidence on the effectiveness and cost effectiveness of both classroom and teacher based interventions is needed before they can be considered for inclusion in the guideline.
Pharmacological Interventions		
158-16: For children and young people with a conduct disorder, what are the benefits and potential harms associated with pharmacological interventions? (1.6.1 – 1.6.7)		
No relevant evidence identified.	None identified relevant to this question.	No new evidence was identified that would affect recommendations.

Summary of new evidence from 2 year surveillance	Summary of new intelligence from 2-year surveillance	Impact
158-17: For children and young people with a conduct disorder, what are the benefits and potential harms associated with physical interventions (for example, diet)? (1.6.1 – 1.6.7)		
Omega 3 supplementation A crossover RCT[15] randomised 21 children with disruptive behaviour disorders and impulsive aggression to either fish oil capsules or placebo. Results showed that fish oil did not improve aggression in this population.	None identified relevant to this question.	New evidence is unlikely to impact on guideline recommendations. The new evidence on omega 3 supplementation showed this supplementation to not be beneficial for disruptive behaviour disorders or impulsive aggression. Currently, CG158 does not make any recommendations concerning diet and supplementation. As the study showed no benefit and had a small sample size it is unlikely to be sufficient new evidence to warrant an update of CG158.
Organisation and Delivery of Care		
158-18: What are the barriers to access that prevent children and young people at risk of or diagnosed with a conduct disorder from accessing services? (1.7.1 – 1.7.18)		
No relevant evidence identified.	Clinical feedback stated that many children with conduct disorder are excluded from child and adolescent mental health services. As such, there is a large issue about enabling access to this group who are notably disabled in terms of current social functioning and future life prospects. It was also highlighted that Pupil Premium, Adoption support Fund and the in-development NICE Children's attachment Guidelines may impact on how mental health services for children and young people are delivered in the future. Lastly, clinical feedback stated that there are safety	No new evidence was identified that would affect recommendations. Clinical feedback indicates that children with conduct disorder are excluded from mental health services and suggests that there is an issue around enabling access to this group. However, no data about the uptake of the guideline is currently available to highlight the extent of this issue. We will examine this area further at the next surveillance review of CG158 to determine if there is any impact on current guideline recommendations. Clinical feedback also highlights that certain guidelines may impact on how mental health services for children

Summary of new evidence from 2 year surveillance	Summary of new intelligence from 2-year surveillance	Impact
	concerns regarding referral, treatment time, intervention and practice. It was stated that whilst the guideline sets criteria and time guidance for service users this is not the case in actual practice.	and young people are delivered in the future. As such, the impact of these in-development guidelines will be evaluated at the next surveillance review of the guideline. Lastly, it is indicated that there are safety concerns surrounding some areas of the guideline and that whilst CG158 sets criteria and time guidance about the recognition and management of conduct disorders for service users these are not used in practice. However, no data on the uptake of this guidance is currently available to highlight the extent of this problem. We will examine this area further at the next surveillance review of CG158 to determine if there is any impact on current guideline recommendations.
158-19: Do methods designed to remove barriers to services increase the proportion and diversity of children and young people accessing treatment? (1.7.1 – 1.7.18)		
No relevant evidence identified.	None identified relevant to this question.	No new evidence was identified that would affect recommendations.
158-20: What are the effective models for the delivery of care to children and young people with a conduct disorder including: • **the structure and design of care pathways (for example, primary care, education, social services, private and voluntary organisations, and the criminal justice system)** • **systems for the delivery of care (for example, case management)** • **specialist teams? (1.7.1 – 1.7.18)**		
No relevant evidence identified.	Clinical feedback suggested that the guideline should have made more explicit reference to pathways and interventions within the youth justice contexts.	New evidence is unlikely to impact on guideline recommendations.

Summary of new evidence from 2 year surveillance	Summary of new intelligence from 2-year surveillance	Impact
	It was also suggested that at most 30% of children with conduct disorder receive mental health services. It was stated that adolescent males are least likely to access help and that there may be significant issues related to care pathways which mean that certain ethnic groups are less likely to access support.	Clinical feedback indicates that the guideline should make more explicit reference to pathways and interventions in the youth justice contexts. The Guideline Committee ran a focus group with User voice during the development of CG158 to explore the experiences of young people who have a conduct disorder and who have been involved in the youth justice services. The focus group explored access to care, interventions, and delivery and coordination of care. Information gathered from this focus group helped to inform CG158. However, no further evidence was provided and no new evidence in youth justice contexts was identified during this 2 year surveillance review. Clinical feedback also indicates that few children with conduct disorder receive mental health services and suggests that certain groups are less likely to access support. However, no further evidence was provided and no new evidence on this issue was identified during this 2 year surveillance review. Furthermore, no data on the uptake of this guidance is currently available to highlight the extent of this issue. We will examine this area further at the next surveillance review of CG158 to determine if there is any impact on current guideline recommendations.
158-21: What are the effective ways of monitoring progress in conduct disorders? (1.7.1 – 1.7.18)		
No relevant evidence identified.	None identified relevant to this question.	No new evidence was identified that would affect recommendations.

Summary of new evidence from 2 year surveillance	Summary of new intelligence from 2-year surveillance	Impact
158-22: What components of an intervention for children and young people with a conduct disorder, or the way in which it is implemented (for example, the competence of the practitioner), are associated with successful outcomes? (1.7.1 – 1.7.18)		
No relevant evidence identified.	None identified relevant to this question.	No new evidence was identified that would affect recommendations.
Research recommendations		
RR-01: What is the effectiveness of parent training programmes for conduct disorders in children and young people aged 12 years and over?		
No relevant evidence identified.	None identified relevant to this question.	No new evidence was identified that would affect recommendations.
RR-02: What strategies are effective in improving uptake of and engagement with interventions for conduct disorder?		
No relevant evidence identified.	None identified relevant to this question.	No new evidence was identified that would affect recommendations.
RR-03: What is the effectiveness of interventions to maintain the benefits of treatment and prevent relapse after successful treatment for conduct disorder?		
No relevant evidence identified.	None identified relevant to this question.	No new evidence was identified that would affect recommendations.
RR-04: What is the efficacy of combining treatment for mental health problems in parents with treatment for conduct disorders in their children?		
No relevant evidence identified.	None identified relevant to this question.	No new evidence was identified that would affect recommendations.
RR-05: What is the efficacy of classroom-based interventions for conduct disorders?		
No relevant evidence identified.	None identified relevant to this question.	No new evidence was identified that would affect recommendations.

Summary of new evidence from 2 year surveillance	Summary of new intelligence from 2-year surveillance	Impact
RR-06: For children and young people with a conduct disorder and coexisting depression, are selective serotonin reuptake inhibitor antidepressant drugs when used in combination with a psychosocial intervention for conduct disorders effective and cost-effective at reducing antisocial behaviour?		
No relevant evidence identified.	None identified relevant to this question.	No new evidence was identified that would affect recommendations.

References

1. Pendry P, Carr AM, Smith AN et al. (2014) Improving adolescent social competence and behavior: a randomized trial of an 11-week equine facilitated learning prevention program. Journal of Primary Prevention 35:281-293.

2. Schappin R, Wijnroks L, Uniken VM et al. (2013) Brief parenting intervention for parents of NICU graduates: a randomized, clinical trial of Primary Care Triple P. BMC Pediatrics 13:69.

3. Hawkins JD, Oesterle S, Brown EC et al. (2014) Youth problem behaviors 8 years after implementing the communities that care prevention system: a community-randomized trial. JAMA Pediatrics 168:122-129.

4. Crombach A and Elbert T. (2015) Controlling offensive behavior using narrative exposure therapy: A randomized controlled trial of former street children. [References]. Clinical Psychological Science 3:270-282.

5. Salzer S, Cropp C, Jaeger U et al. (2014) Psychodynamic therapy for adolescents suffering from co-morbid disorders of conduct and emotions in an in-patient setting: A randomized controlled trial. [References]. Psychological Medicine 44:2213-2222.

6. Bratton SC, Ceballos PL, Sheely-Moore AI et al. (2013) Head start early mental health intervention: Effects of child-centered play therapy on disruptive behaviors. [References]. International Journal of Play Therapy 22:28-42.

7. Chen C, Li C, Wang H et al. (2014) Cognitive behavioral therapy to reduce overt aggression behavior in Chinese young male violent offenders. Aggressive Behavior 40:329-336.

8. Kolko DJ, Campo J, Kilbourne AM et al. (2014) Collaborative care outcomes for pediatric behavioral health problems: a cluster randomized trial. Pediatrics 133:e981-e992.

9. Wagner EF, Hospital MM, Graziano JN et al. (2014) A randomized controlled trial of guided self-change with minority adolescents. Journal of Consulting & Clinical Psychology 82:1128-1139.

10. Reid GJ, Stewart M, Vingilis E et al. (2013) Randomized trial of distance-based treatment for young children with discipline problems seen in primary health care. Family Practice 30:14-24.

11. Perrin EC, Sheldrick RC, McMenamy JM et al. (2014) Improving parenting skills for families of young children in pediatric settings: a randomized clinical trial. JAMA Pediatrics 168:16-24.

12. Leijten P, Raaijmakers MAJ, and Orobio de Castro B et al. (2015) Effectiveness of the Incredible Years Parenting Program for Families with Socioeconomically Disadvantaged and Ethnic Minority Backgrounds. Journal of Clinical Child & Adolescent Psychology 1-15.

13. Baker-Henningham H, Scott S, Jones K et al. (2012) Reducing child conduct problems and promoting social skills in a middle-income country: cluster randomised controlled trial. British Journal of Psychiatry 201:101-108.

14. Liber JM, De Boo GM, Huizenga H et al. (2013) School-based intervention for childhood disruptive behavior in disadvantaged settings: a randomized controlled trial with and without active teacher support. Journal of Consulting & Clinical Psychology 81:975-987.

15. Dean AJ, Bor W, Adam K et al. (2014) A randomized, controlled, crossover trial of fish oil treatment for impulsive aggression in children and adolescents with disruptive behavior disorders. Journal of Child & Adolescent Psychopharmacology 24:140-148.