NICE National Institute for Health and Care Excellence

NICE support for commissioning for antisocial behaviour and conduct disorders in children and young people

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1 Introduction

Implementing the recommendations from NICE guidance and other NICE-accredited guidance is the best way to support improvements in the quality of care or services, in line with the statements and measures that comprise the NICE quality standards. This report:

- Highlights the key actions that health and wellbeing boards, local authorities, clinical commissioning groups (CCGs), NHS England area teams, and providers from multiple health and social care agencies should take to improve the quality of care for children and young people with conduct disorders. Providers will typically be acute and specialist children's health and mental health providers, providers of community and primary care services including GPs and education and the criminal justice system. Priority actions for commissioners and providers are outlined in table 2.
- Identifies opportunities for collaboration and integration at a local level for commissioners and providers.
- Identifies the benefits and potential costs and/or savings from implementing the changes needed to achieve quality improvement.
- Directs commissioners and service providers to other tools that can help them implement NICE and NICE-accredited guidance.

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. The statements draw on

existing guidance, which provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement. For more information see NICE quality standards. By commissioning services in line with the quality standard, commissioners can contribute to improvements in the health and social care outcomes defined in national outcomes frameworks. For more information see How this quality standard supports delivery of outcome frameworks in the antisocial behaviour and conduct disorders in children and young people quality standard.

Commissioners can use the quality standards to improve services by including quality statements and measures in the service specification of the standard contract and establishing key performance indicators as part of the tendering process. They can also encourage improvements in provider performance by using quality standard measures in association with incentive payments such as the commissioning for quality and innovation (CQUIN) payment framework. CCGs can select CQUIN indicators from the NHS England pick list in appendix B. This includes indicators for improving diagnosis in mental health. NICE quality standards provide a baseline against which improvements can be measured and rewarded, enabling commissioners to address gaps in service provision, support best practice and encourage evidence-based care.

This report on the antisocial behaviour and conduct disorders in children and young people quality standard should be read alongside:

- Antisocial behaviour and conduct disorders in children and young people. NICE quality standard 59 (2014).
- Antisocial behaviour and conduct disorders in children and young people. NICE clinical guideline 158 (2013).

2 Overview of antisocial behaviour and conduct disorders in children and young people

Conduct disorders, and associated antisocial behaviour, are the most common mental and behavioural problems identified in children and young

people. Conduct disorders are characterised by repetitive and persistent patterns of antisocial, aggressive or defiant behaviour that amount to significant and persistent violations of age-appropriate social expectations.

Conduct disorders are linked to deprivation, with higher prevalence among children from more deprived households compared with those in the most affluent. Almost 40% of looked-after children, those who have been abused and those on child protection and safeguarding registers have been identified as having a conduct disorder.

A diagnosis of conduct disorder is associated with poor educational performance, social isolation and, in adolescence, substance misuse and increased contact with the criminal justice system. The behaviour associated with conduct disorders can become more severe and problematic as the child gets older. Up 50% of children and young people with a conduct disorder go on to develop an antisocial personality disorder and a high level of mental health problems in adult life[1].

Health and wellbeing boards need to drive integration by bringing together CCGs and local authorities to develop the joint strategic needs assessment (JSNA) and a joint strategy for meeting the needs of children and young people with antisocial behaviour and conduct disorders. This will need to include recommendations for joint commissioning and integrating services across health and care as well as addressing education provision.

2.1 Epidemiology of antisocial behaviour and conduct disorders in children and young people

The prevalence of conduct disorders increases throughout childhood and they are more common in boys than girls. The Office for National Statistics (ONS) survey (2004) reported that conduct disorders were prevalent in 5.8% of children and young people aged between 5 and 16 years:

[1] A report by the Sainsbury Centre for Mental Health (2009) estimated the lifetime cost of adverse outcomes among the people who have conduct disorder in childhood averages £225,000 per person, with the lifetime cost of each prolific offender being about £1.5 million.

- Children aged 5 to 10 years – 6.9% of boys and 2.8% of girls have conduct disorders.
- Children and young people aged 11 to 16 years – 8.1% of boys and 5.1% of girls have conduct disorders.

Conduct disorders commonly coexist with other mental health problems: 46% of boys and 36% of girls with a conduct disorder have at least 1 coexisting mental health problem. The coexistence of conduct disorders with attention deficit hyperactivity disorder (ADHD) is particularly prevalent and in some groups, more than 40% of children and young people with a diagnosis of conduct disorder also have a diagnosis of ADHD.

3 Summary of commissioning and resource implications

The cost of meeting the quality standard for antisocial behaviour and conduct disorders in children and young people depends on current local arrangements and the progress organisations have made in implementing NICE and NICE-accredited guidance.

Conduct disorders are the most common reason for referral of young children to child and adolescent mental health services (CAMHS). Local authority, CCGs and NHS England area team commissioners need to ensure that care pathways for children and young people with a suspected or confirmed diagnosis of a conduct disorder are clear and are not adversely affected by commissioning and contracting boundaries.

Integrated services should be targeted where they are needed most, and the resource impact will vary dependent on local arrangements for service delivery and the demographic profiles of locality areas. However, potential savings of £150,000 have been estimated from successful early intervention, over the lifetime of each child who would otherwise develop a conduct disorder. Over 70% of this total is believed to be savings to the criminal justice system as a result of decreased criminal behaviour, and 13% from a decrease

in mental illness in adulthood. This amount is likely to be considerably higher for children and young people with more severe conduct disorders[2].

CAMHS services are non-cluster reference costs, so will vary depending on local contract agreements. However for 2012/13 the national reference costs for CAMHS included £225 for a community contact; £269 for an outpatient attendance; £234 for a CAMHS attendance from the mental health specialist team, and in the rare cases where an admission is required, £611 per bed day.

Table 1 Commissioning responsibilities

Commissioners	**Area of responsibility**
Local authorities	Social care and education provision
Clinical commissioning groups	Community and acute children's services including mental health services
NHS England	Primary care services including GPs.

Table 2 summarises the priority commissioning actions, provider implications and potential resource implications for commissioners working towards achieving the quality standard. See section 4 for more detail on commissioning and resource implications.

[2] Friedli L, and Parsonage M (2007) Mental health promotion: building an economic case. The saving of £150,000 per case of conduct disorder prevented by intervention is based on 2006/07 estimates of savings to the public sector as a whole. This is a weighted average based on savings of £115,000 from preventing conduct disorder in one of the 45% of children and young people considered to be at 'moderate risk' of developing the condition, and £230,000 from successful intervention in one of the 5% with a diagnosed conduct disorder.

Table 2 Priority commissioning actions, provider implications and potential resource implications for antisocial behaviour and conduct disorders in children and young people

Quality improvement area	Commissioning actions	Provider implications	Estimated resource implications
1 – Early intervention	Local authorities should ensure classroom-based emotional and problem-solving programmes are in place for children aged 3–7 years, where a high proportion of children are identified as at risk of developing a conduct disorder. They should work with CCGs and NHS England area teams to ensure programmes are included within local primary care pathways and early years.	Schools should ensure there is access to classroom-based emotional and problem-solving programmes for children aged 3–7 years and work with partners to identify children who are at risk of developing a conduct disorder[a]. Monitoring rates of antisocial behaviour in the classroom.	A programme of 30 classroom sessions during an academic year is estimated to cost £136 per child. Commissioned activity will need to depend on the demographic profile of the local area. Early intervention can potentially lead to long term savings.
2 – Comprehensive assessment	Local authorities and CCGs should work together to commission services to provide comprehensive assessments for children and young people with a suspected conduct disorder and significant complicating factors, and their parents or carers. Request monitoring of outcomes.	Specialist mental health practitioners in CAMHS (health and social care) should work together to provide comprehensive assessments for children and young people with a suspected conduct disorder and any significant complicating factors, and their parents or carers.	Resource impact will need to be assessed locally and will depend on current provision. However, improving the identification of conduct disorders and targeting interventions can be expected to lead to savings due to reduced costs related to criminal activity and long term treatment costs.
3 – Improving access to services	Local authorities and CCGs should specify that key workers are identified within relevant provider services to coordinate care and improve engagement with services. Request monitoring of outcomes.	CAMHS and relevant social care, education and healthcare providers should identify key workers to support coordination of care and facilitate engagement for children and young people. Monitoring treatment completion and 'did not attend' rates.	Improving awareness of referral procedures and engagement with services may increase demand on services initially, but could improve use of resources and successful treatment rates. This could lead to a reduction in the long term costs

			associated with conduct disorder.
4 – Parent or carer training	Local authorities and CCGs should work together to ensure evidence-based group or individual programmes for parents or carers of children and young people aged 3–11 years are available.	Competent professionals should deliver group or individual programmes that adhere to an evidence-based model for parents or carers of children and young people aged 3–11 years in line with NICE recommendations.	Resource impact will need to be assessed locally. Costs per parent have been estimated at £1600, but will vary according to intervention. Effective parent or carer training can lead to reduced long term costs associated with conduct disorder.
5 – Multimodal interventions	Local authorities and CCGs should work together to ensure a range of multimodal interventions with clear referral pathways for all young people aged 11–17 years with a conduct disorder are in place from a range of health and social care providers.	Specially trained case managers should deliver a range of integrated evidence-based multimodal interventions in line with NICE recommendations.	Resource impact will need to be assessed locally. Initial investment may be needed if interventions are not in place. However, significant savings may be possible from avoiding complex and long term problems into adulthood.
6 – Monitoring adverse effects of pharmacological interventions	CCGs should ensure that arrangements are in place so that when risperidone is prescribed, a baseline physical and metabolic investigation is carried out before the start of treatment, and that efficacy and adverse effects are monitored at regular intervals.	Appropriately qualified healthcare professionals with expertise in treating children and young people with conduct disorders should carry out and record a baseline physical and metabolic investigation before starting treatment with risperidone, and monitor for efficacy and adverse effects at regular intervals in line with NICE recommendations[b].	Resource impact will need to be assessed locally. Minor cost increases may be incurred for blood testing where monitoring is not in place. However, savings may be possible from avoiding adverse effects.

Abbreviations: CAMHS, Child and Adolescent Mental Health Services; CCG, clinical commissioning group.

[a] Individuals who may identify children and young people at risk of developing a conduct disorder should have expertise and knowledge of the risk factors and may include special educational needs coordinators (SENCO), teachers, educational psychologists, local education authority departments, CAMHS and community paediatric departments.

[b] All health and social care practitioners involved in assessing, caring for and supporting children and young people with conduct disorders and their families or carers should have sufficient and appropriate training and competencies to deliver the assessments, interventions and other actions described in the quality standard. For psychiatrists, this would include the specialist training in child and adolescent psychiatry that covers specific competencies in the assessment and management of adolescents with conduct disorders detailed in the Royal College of Psychiatrists' A competency-based curriculum for specialist training in psychiatry.

4 Commissioning and resource implications

This section considers the commissioning actions and potential resource impact of implementing the recommendations to achieve the NICE quality standard for antisocial behaviour and conduct disorders in children and young people.

4.1 Early intervention

Quality statement 1:

Children aged 3 to 7 years attending school classes where a high proportion of children are identified as at risk of developing a conduct disorder take part in a classroom-based emotional learning and problem-solving programme.

Classroom-based interventions for populations with a high proportion of children who are at risk of developing a conduct disorder have been shown to be effective in reducing antisocial behaviour in children[3]. Local authorities need to work with CCGs and NHS England area teams to ensure that evidence-based emotional and problem-solving programmes are in place for children aged 3–7 years who attend classes with a high proportion of children identified as at risk of developing a conduct disorder. Programmes should be included within local pathways for primary care and early years[4].

There are a range of evidence-based classroom-based programmes available that are delivered by teachers in schools with relevant support and training, and which may involve third-sector bodies. The costing template produced for NICE clinical guideline 158 estimated the cost per child at £136 for up to 30 classroom-based sessions throughout a school year. This includes relevant

[3] Recommendation 1.2.2 in Antisocial behaviour and conduct disorders in children and young people (NICE clinical guideline 158) describes the interventions that classroom-based emotional learning and problem-solving programmes should include.

[4] Recommendation 1.2.1 in Antisocial behaviour and conduct disorders in children and young people (NICE clinical guideline 158) identifies factors for increased risk of a child or young person developing a conduct disorder as: low socioeconomic status, low school achievement, child abuse or parental conflict, separated or divorced parents, parental mental health or substance misuse problems, parental contact with the criminal justice system.

teacher training, learning materials and the support of a programme coordinator. Commissioners may need to consider the recurrent costs if interventions are delivered to the same group over a number of years. Schools should record outcomes by undertaking monitoring of antisocial behaviour rates within classroom populations that have received the interventions.

4.2 Comprehensive assessment

Quality statement 2:

Children and young people with a suspected conduct disorder and any significant complicating factors have a comprehensive assessment, including an assessment of the child or young person's parents or carers.

All factors that can contribute to a child or young person developing a conduct disorder (including the home environment) should be considered when a conduct disorder is suspected[5]. Local authorities and CCGs should work together to commission assessment services from CAMHS (health and social care) for children and young people with a suspected conduct disorder who have had an initial assessment that has identified any significant complicating factors[6]. Specialist mental health practitioners in health and social care should be available to provide comprehensive assessments for children and young people and their parents or carers to inform any appropriate interventions and support plans, in line with NICE clinical guideline 158[7].

[5] Children and young people are considered to have a suspected conduct disorder if their parents or carers, health or social care professionals, school or college, or peer group raise concerns about persistent antisocial behaviour.

[6] Recommendation 1.3.5 in Antisocial behaviour and conduct disorders in children and young people (NICE clinical guideline 158) defines significant complicating factors assessed for in the initial assessment of children and young people with a possible conduct disorder as: a coexisting mental health problem, a neurodevelopmental condition (in particular attention deficit hyperactivity disorder [ADHD] and autism), a learning disability or difficulty and substance misuse.

[7] Further information can be found in the quality standard for antisocial behaviour and conduct disorders in children and young people and NICE clinical guideline 158 (recommendations 1.3.8, 1.3.10, 1.3.11, 1.3.12, 1.3.14 and 1.3.15).

The scale of any initial investment that may be needed for comprehensive assessment is heavily dependent on the demographics of the local area and the level of current provision. Commissioners in areas of high deprivation or where there is a large proportion of looked-after children for example, may wish to review their services to ensure there is sufficient capacity. Improving the identification of conduct problems and the targeting of interventions, by offering comprehensive assessments, can be expected to lead to savings due to reduced costs that would otherwise have been associated with criminal activity and long term treatment costs.

Commissioners may wish to refer to the Department for Communities and Local Government's Helping troubled families turn their lives around programme. This sets out the government's commitment to working with local authorities and their partners to help 120,000 troubled families in England by 2015, part of which potentially includes funding for up to 40% of the costs of intervention for the most troubled families, and some of which is available up-front to fund the transition to providing new services.

4.3 Improving access to services

Quality statement 3:

Children and young people with a conduct disorder who have been referred for treatment and support have a key worker to oversee their care and facilitate engagement with services.

Children and young people with a conduct disorder and their families who have been referred for treatment and support have high treatment dropout rates and can find it difficult to access and engage with services. To support coordination of services and facilitate engagement for children or young people and their families, local authorities and CCGs should specify that key workers are identified. This can include a member of staff from CAMHS, or a member of staff from a relevant social care, education or healthcare setting.

The decision about who is the most appropriate professional will depend on what service is best placed to meet the needs of the child or young person – based on the severity and nature of the disorder. Commissioners may also ask the relevant provider(s) to measure treatment completion rates and 'did not attend' rates and check that providers can demonstrate steps to ensure children and young people are gaining access to and completing treatment.

NICE clinical guideline 158 (recommendations 1.7.7 and 1.7.8) provides examples of ways to support engagement (for example, through following up on missed appointments, the use of alternative settings for assessment and interventions, provision of crèche facilities, assistance with travel and interpreter and advocacy services).

Increased awareness of referral procedures and greater engagement with services may increase demand on services initially, but can be expected to lead to more efficient use of resources. People receiving successful treatment can help to reduce the long term costs associated with conduct disorders.

Commissioners may wish to refer to a service model example: Nottinghamshire Healthcare NHS Trust CAMHS Head 2 Head team offers a community-based assertive outreach service to children and young people who are known to Youth Offending Team (YOT) and have mental health difficulties and/or conduct disorders. Each young person has a key worker to facilitate engagement with the YOT, education and/or social care[8].

4.4 Parent or carer training

Quality statement 4:

Parents or carers of children with a conduct disorder aged 3 to 11 years are offered a referral for group or individual parent or carer training programmes.

[8] This example is offered to share good practice and NICE makes no judgement on the compliance of this service with its guidance.

Parent or carer training is an intervention to help people gain skills needed to support children with a conduct disorder. It is a suitable intervention for parents or carers of children who are in contact with the criminal justice system for antisocial behaviour or who have been identified as being at high risk of a conduct disorder, and can be delivered in a number of different ways. Local authorities and CCGs should work together to ensure that evidence-based group and individual parent training, and group and individual foster carer/guardian are provided in line with NICE recommendations.

Commissioners may wish to check that programmes are delivered by competent professionals with enough capacity for all parents or carers of children with a conduct disorder (aged between 3 to 11 years) to be offered a referral.

The resource impact will depend on the level of current provision and commissioning decisions taken locally. However, extensive savings have been estimated in studies on similar interventions and an examination of the cost effectiveness of one parenting training programme found that an intervention costing approximately £950–£2100 per family (2008/09 prices) was cost-saving to the public sector as a whole within a timescale of 5–8 years. The savings across health, social care and education over 25 years were estimated at around £16,400[9].

The costing template for NICE clinical guideline 158 also provides costs based on the 'Incredible Years' parent training programme, and estimates of the costs to be £1600 per parent for a group of 12 parents, undergoing 10-16 meetings of 90–120 minutes' duration and the training of 2 group leaders, learning materials, facilities and travel costs.

CCG and local authority commissioners may also find it helpful to refer to the NICE shared learning database for a service model example of parent training/education programmes. Conduct disorder in children – parent

[9] Bonin EM, Stevens M, Beecham J et al. (2011) Costs and longer-term savings of parenting programmes for the prevention of persistent conduct disorder: a modelling study. BMC Public Health 11

training/education programmes describes a 10-week parenting group for parents with children from universal to complex needs aged 0–18 years. The programmes are delivered by trained professionals from a range of professions and agencies through joint working and follow a resource manual for parents with children[10].

4.5 Multimodal interventions

Quality statement 5:

Children and young people aged 11 to 17 years who have a conduct disorder are offered a referral for multimodal interventions, with the involvement of their parents or carers.

Multimodal interventions are effective in helping older children and young people with antisocial behaviour who are in contact with the criminal justice system, or who have been identified as being at high risk of a conduct disorder, to manage their behaviour in different social settings and there are a variety of interventions available. Local authorities and CCGs need to work together to ensure a range of multimodal interventions with clear referral pathways are in place.

Commissioners may wish to check that there are enough specially trained case managers for all children and young people aged 11 to 17 years to be offered a referral and to receive treatment and support with parental participation, in line with NICE recommendations.

The costs of multimodal interventions can vary widely depending on the needs of the individual, but courses can incur significant costs where they are not already provided. However, the health economic modelling for NICE clinical guideline 158 estimated that around 50% of people with conduct

[10] Examples in the NICE shared learning database are offered to share good practice and NICE makes no judgement on the compliance of these services with its guidance.

disorder who are given this intervention will have either a milder version of the condition, or no conduct problems, after completing the course. Significant savings are therefore possible by avoiding potentially more complex and long term problems into adulthood.

4.6 Monitoring adverse effects of pharmacological interventions

Quality statement 6:

Children and young people with a conduct disorder and severely aggressive behaviour who have been prescribed risperidone have a baseline physical and metabolic investigation and are monitored for efficacy and adverse effects at regular intervals.

Antipsychotic treatment (most commonly risperidone) can have significant physical effects and, in some cases, significant adverse effects. Therefore, CCGs should ensure that pharmacological interventions are not offered for the routine management of behavioural problems in children and young people with a conduct disorder, except in defined circumstances for the short-term management of severely aggressive behaviour[11].

CCGs should ensure that when risperidone is prescribed, it is started by an appropriately qualified healthcare professional with expertise in treating children and young people with conduct disorders and severely aggressive behaviour, and is based on a comprehensive assessment and diagnosis. Arrangements should be in place for a baseline physical and metabolic investigation to be carried out before the start of treatment with risperidone, and for efficacy and adverse effects to be monitored at regular intervals in line

[11] This refers to the behaviour of children and young people with a conduct disorder who have problems with explosive anger and severe emotional dysregulation. Adapted from Antisocial behaviour and conduct disorders in children and young people (NICE clinical guideline 158), recommendation 1.6.3.

with NICE clinical guideline 158 (recommendation 1.6.5)[12,13]. CCGs should consider working with local area prescribing and medicines management committees to ensure protocols are in place for when risperidone is prescribed.

The resource impact will need to be assessed locally, but undertaking baseline physical and metabolic investigations and regular monitoring could lead to an increase in costs around blood testing where these are not already carried out. However, baseline investigations and monitoring may lead to long-term savings by avoiding adverse effects.

The Royal College of Psychiatrists' Prescribing observatory for mental health, National audit of antipsychotic prescribing (2012) topic 10b: Prescribing antipsychotics for children and adolescents will help commissioners with data collection for this quality statement.

5 Other useful resources

5.1 Policy documents

- Department of Health (2012) No health without mental health: implementation framework.
- Department of Health (2011) Children and young people's emotional wellbeing and mental health national support team: The learning: 'What good looks like'.

[12] Baseline physical and metabolic investigations are defined in the quality standard for antisocial behaviour and conduct disorders and have been adapted from NICE clinical guideline 158 (recommendation 1.6.5).

[13] Regular intervals are defined in the quality standard for antisocial behaviour and conduct disorders and have been adapted from Psychosis and schizophrenia in children and young people (NICE clinical guideline 155, table 1).

5.2 Useful resources

- Royal College of Paediatrics and Child Health (2014) MindEd e-portal – free online education to help adults to identify and understand children and young people with mental health issues.
- Children and young people's Improving access to psychological therapies.
- Joint commissioning panel for mental health (2013) Guidance for commissioning public mental health services.
- Department for Communities and Local Government (2012) The troubled families programme – financial framework for the troubled families programme's payment-by-results scheme for local authorities.

5.3 NICE implementation support

- Conduct disorders in children and young people. Implementation tools and resources (2013).

5.4 NICE pathways

- Antisocial behaviour and conduct disorders in children and young people
- Attention deficit hyperactivity disorder