The recent launch of NICE guidelines on antisocial behaviour and conduct disorder in children addresses the commonest mental health problem among children and young people. Often seen as particularly difficult to handle in the consulting room, children and young people who exhibit challenging or ‘anti-social’ behaviour represent a small but significant minority whose mental health needs are often unrecognised and inadequately addressed. If such behaviour is repetitive and persistent the young person may be diagnosed with ‘conduct disorder’.

The term conduct disorder describes a constellation of behaviours, characterised by impulsivity, apparent disregard for social norms and conformity, and frequent confrontation or defiance of accepted behaviours. This disorder is also associated with a diminished sense of reward from pro-social behaviour.

Children under 11 years who are given this diagnosis are more likely to be said to have ‘oppositional defiant disorder’, while older youth – typically 11-16 years – are viewed as showing conduct disorder, with or without aspects of anti-social behaviour. Such children have conventionally been seen as naughty, wilful or deliberately confrontational. But this view ignores the growing awareness of how emotional distress may present in early childhood, such as the ingestion of alcohol by young people can unsurprisingly lead to anti-social and offending behaviour, which will often act as a barrier to help being offered to tackle unsafe drinking and the other associated risks. Young people with psychiatric diagnoses, including ADHD and conduct disorder, are also more vulnerable to the effects of smoking and cannabis use.

Responding to youth mental health is a significant clinical challenge and one for which the majority of GPs feel unprepared and unsupported. Raising awareness of how emotional distress may present in young people is therefore essential. There are signs of a growing understanding of the importance of recognising emotional and mental distress in young people and intervening early, which is to be welcomed.

The co-existence of conduct disorder with other mental health problems is the rule rather than the exception. The recent guidelines highlight this association between conduct disorder and other mental health problems, including common neurodevelopmental disorders, such as attention deficit hyperactivity disorder (ADHD). In some populations more than 40% of diagnosed conduct disorder occurs in the presence of ADHD and the autistic spectrum disorder.

The relationship between poverty and diagnosis of conduct disorder is also highlighted in the guidelines, with children in low income families (socio-economic groups D and E) being 3-4 times more likely to exhibit conduct disorder than children in social class A.

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Co-existing mental health problems

The co-existence of conduct disorder with other mental health problems in children is the rule rather than the exception. This contrasts with clinical presentations of mental health problems in adults, as seen in primary care. The nature of presentations also varies with age; for example, depression in adolescence can manifest as irritability and anger outbursts, rather than sadness – although both mood states may co-exist.

Experimentation with alcohol and drugs is a feature of the developmental stage of adolescence, with recent figures suggesting 50% of young people over 16 years drink at least once a week. The ingestion of alcohol by young people can unsurprisingly lead to anti-social and offending behaviour, which will often act as a barrier to help being offered to tackle unsafe drinking and the other associated risks. Young people with psychiatric diagnoses, including ADHD and conduct disorder, are also more vulnerable to the effects of smoking and cannabis use.

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The RCGP identified youth mental health as a clinical priority in April 2013 (www.rcgp.org.uk/clinical-and-research) and NICE is focusing on providing guidelines for good practice in this area. However, child and adolescent mental health remains an area of major concern for clinicians and policy makers alike.
which is poorly covered in undergraduate medical education and at CPD level.

**Guideline and clinical pathway**

The new NICE guidelines on conduct disorder cite data derived from the Office for National Statistics (ONS) survey (2004) which identified that 5% of 5-16 year olds exhibit behaviour consistent with conduct disorder, making this the most common mental health problem in childhood. It is particularly prevalent in children who have had the most difficult childhoods and are now ‘looked after’, with 40% of this vulnerable group found to have the disorder.

The Guideline Development Group advocates the preferred treatment modality to be psychosocial, with a particular emphasis on working with parents or guardians. There is no role for using pharmacological intervention, unless ADHD has also been co-diagnosed after a thorough assessment and non-pharmacological therapies have proved inadequate. Only with secondary care involvement might anti-psychotic medication, typically risperidone, be prescribed for the management of acute and severe aggression.

Diagnosis is multi-factorial and needs to be comprehensive with input from the young person, parents, teachers and relevant health professionals. The NICE Guidelines specify that assessment should be undertaken by a ‘health or social care professional who is competent to undertake (such an) assessment’. This would not usually be a GP. An evaluation of risk also needs to be undertaken.

The NICE Guidelines advocate that the assessing team produce a care plan which takes account of the personal, social, housing and educational or occupational needs (and strengths) of the young person, as well as those of the parents or carers.

The pathway of care begins with the family requesting help from health, social care or educational providers. Once a comprehensive assessment from secondary care (CAMHS) has confirmed the diagnosis, the child and their family need to be offered appropriate psychosocial intervention, which is delivered locally by an integrated team. The range of psychosocial modalities incorporated in the recommended interventions include parent training programmes, which use modelling, rehearsal and feedback to improve parenting skills. Other modalities may include cognitive behavioural problem-solving and multi-systemic therapy.

Of these interventions, the greatest weight of evidence lies with parent training programmes to improve parenting skills of parents with younger aged children (3-11 years).

Evaluation and monitoring of the treatment programmes offered is highlighted as an important role of the local team in establishing that such programmes are effective and acceptable to the patient population.

### Causative mechanisms

Understanding of the causative mechanisms of conduct disorder is increasing, with a growing knowledge of the developmental trajectories of the brain, and the effects of early exposure to environmental stimuli which might promote or hinder healthy neuro-development.

Infants raised by parents who are attentive to their baby’s needs to be constantly held, soothed and face additional pressures in raising their own children – for example through low earning capacity secondary to poor educational performance – are likely to be less able to provide the optimal conditions for their baby’s neuro-development. The NICE Guidelines specify that assessment should be undertaken by a ‘health or social care professional who is competent to undertake (such an) assessment’.

Points to consider

- How might you respond?
- Consider what you might include in your history taking?
- What can be covered in this first consultation, and later in subsequent booked appointments?
- What would you like to cover when you meet Kyle?
- Who else could help in this scenario?

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**A TYPICAL CASE SCENARIO**

Kyle is 14, lives with his mother – Linda – and elder brother – John – on a housing estate which is plagued with vandalism, theft and car break-ins. He has no contact with his father, who split-up with Linda when Kyle was a toddler. Kyle shrugs his shoulders when asked about his dad. Kyle has been spending long periods outside with his friends, usually all weekend and often not coming home until very late. He was recently involved in setting fire to an abandoned car with a few mates and apprehended by the police, who came to the house and gave him a formal warning. His mother worried more about the fact that he ‘thought it was funny’ and did not seem scared by the process. John has also been in trouble with the police and has a criminal record for assault in a pub brawl.

Linda suffered with post-natal depression when Kyle was born and again when the relationship broke up. She has not met anyone since with whom she has formed a lasting relationship. She is worried that Kyle is ‘turning out like his brother’. He did want to be a mechanic but now says he’s not interested in school or going to college and she worries that he is mixing with ‘a bad crowd’. The local youths drink cheap alcohol on Fridays and Saturdays on a local park/wasteland and she has smelt alcohol on Kyle when he’s come home late.

Linda makes an appointment to see you to talk about Kyle and to see what can be done for him.
Conduct disorder is the most common mental health problem. Studies into causative pathways have found links with parenting skills. Parent training programmes to improve parenting skills are recommended. GPs have a key gatekeeper role in co-ordinating the necessary services. Conduct disorder is strongly linked to adverse conditions in families. For minority ethnic families there is also the additional challenge of being a cultural minority. Differences in levels of social support from extended families. For minority ethnic families there is also the additional challenge of being a cultural minority.

Demographic trends
The causative pathway helps explain why diagnoses of conduct disorder cluster in low income families, and in young people who end up in care because of a breakdown in their family’s ability to care for them. The intergenerational pattern reveals that parents who cannot provide the best conditions to raise their infant were usually themselves deprived of basic needs as young children. Similarly, if the signs of developmental trauma in their own offspring are not addressed, their children risk failing at school, compromising their life chances. This pattern explains why rates of diagnosis of conduct disorder are 3-4 times higher in low income families.

There are also differences in cultural and ethnic groups. For example, it is reported that boys of south Asian origin are less likely to be diagnosed with conduct disorder when compared to boys of African-Caribbean descent. This may be for a number of reasons, including socio-economic standing, and differences in levels of social support from extended families. For minority ethnic families there is also the additional challenge of being a cultural minority.

Implications for general practice
The initial assessment of the child or young person needs to take into account the past social and medical history, developmental history including birth, any co-existing or suspected health problems and drug history, including both prescribed and illicit drugs, and a summary of educational achievements. Early liaison with school will facilitate information sharing and may mean that school based services can be accessed quickly and support mechanisms may be put in place. The privileged position of the GP in knowing the family history also means that if support for parents’ mental and physical health needs is required this can be co-ordinated promptly from within primary care.

The GP’s role can be seen to include requesting prompt assessment by CAMHS, facilitated by gathering helpful information from medical records and from listening to the young person and their family to establish the details of the presenting problems. Once referred, the GP has an important role in co-ordinating input from secondary care and social services, if involved, and liaising with educational providers. Local knowledge of the practice patch might also mean that local youth agencies could be invited to work with the young person as part of a co-ordinated plan to support the development of problem-solving skills. As the situation currently stands, GP input at this level would not be reimbursed through QOF criteria but may well be supported through local clinical commissioning.

References

KEY POINTS
1. Conduct disorder is the most common mental health problem in adolescent children, with an incidence of 5% among children between 5-16 years.
2. Conduct disorder is strongly linked to adverse conditions in early childhood and is far more prevalent in low income families and among ‘looked after’ children.
3. The disorder typically coexists with other mental health problems, such as ADHD.
4. Diagnosis is multi-factorial and requires input from the young person, parents, teachers and relevant health and social care professionals.
5. Parent training programmes to improve parenting skills are cited as the most effective evidence-based intervention.
6. Studies into causative pathways have found links with deprivation and trauma in early infancy.
7. GPs have a key gatekeeper role in co-ordinating the necessary multi-agency support and treatment.