Antisocial behaviour and conduct disorders in children and young people

Affects 5% of children aged between 5 years -16 years. Behavioural problems account for 30% of typical GP's child consultations and is the most common reason for CAMHS referral.

More common in:

- Boys and becomes more common as they grow older
- Lower social class [3-4 times as prevalent in social class D/E as compared to class A].
- Varies with ethnicity - more common in Afro-Caribbean and less common in south Asian family origin.
- Of those children who are in care/have been abused/on child protection register 40% were found to have conduct disorder.
- Have other mental health problems e.g. ADHD [this is found in 40% of children with conduct disorder]

ICD10- divides it into

- Socialised conduct disorder
- Unsocialised conduct disorder
- Conduct disorders confined to the family context
- Oppositional defiant disorder [as characterized by the extent and severity i.e. isolated antisocial/criminal acts are not sufficient to support diagnosis of conduction disorder]

Can have lifelong implications. 50% of children will go onto develop antisocial personality disorder. Also impacts other services e.g. education [may require education special needs]/criminal justice system

Strong association with:

- Substance misuse
- Criminal justice system (as high as 50% in some groups)
- Social isolation
- Poor educational performance
- Mental health problems [90% of people with antisocial personal disorder will have another mental health problem]

Treatment:
Focuses on 3 key strategies:

- Working with parents and families
- Recognition of the importance of the wider social system in enabling effective interventions
- focus on preventing or reducing the escalation of existing problems.

Younger children: parenting programmes
Older: Multisystem approaches e.g. CAMHS teams and general community-based services such as Sure Start.

Assess capacity. If a young person is 'Gillick competent' ask them what information can be shared before discussing their condition with their parents or carers.

Careful planning when moving from CAMHS to adult mental health services. Clarify who is the lead clinician to ensure continuity of care.

Assessing:
Use the Strengths and Difficulties Questionnaire (completed by a parent, carer or teacher) from:
http://www.sdqinfo.org/py/sdqinfo/b3.py?language=Englishqz(UK)

The questionnaire looks at the child's behaviour in terms of:

- Emotional problems (anxious, unhappy, worried, afraid, lonely)
- Conduct problems (tantrums, fights with other children, lying, cheating, stealing)
- Hyperactivity (easily distracted, impulsive, restless/overactive)
- Peer problems (do they pick on other children or does their behaviour result in them being picked on by other children, does it make it difficult for them to make close friends)
- Prosocial (do they care if someone is hurt, do they share readily with others, do they care about being nice to other people)
- Impact (home life, friendships, classroom learning) as assessed by the child, parents and teachers

Assess for the presence of the following significant complicating factors:

- a coexisting mental health problem (for example, depression, post-traumatic stress disorder)
- a neurodevelopmental condition (in particular ADHD and autism)
- a learning disability or difficult
- substance misuse in young people.

More detailed assessment will include patterns of negativistic, hostile, or defiant behaviour in children aged under 11 years and aggression to people and animals, destruction of property, deceitfulness or theft and serious violations of rules in children aged over 11 years. Consider situation at home e.g. domestic violence

Interventions
Can involve:

- Parent training programmes [try and involve both parents]/Foster carer/guardian training programmes
- Child-focused programmes [cognitive–behavioural problem-solving model use modelling, rehearsal and feedback to improve skills]
- Multimodal interventions [interventions provided at individual, family, school, criminal justice and community levels] e.g. classroom-based emotional learning and problem-solving programmes to increase children's awareness of their own and others' emotions, teach self-control of arousal and behaviour, promote a positive self-concept and good peer relations, develop children's problem-solving skills.
- Pharmacological interventions [specialist treatment for ADHD with methylphenidate or atomoxetine, or risperidone if aggressive]
- Improving access to services[allows access in residential settings/school, facilitate crèche facilities]

Remember that parent may feel stigmatized. Consider offering parents and carers an assessment of their own needs including:

- personal, social and emotional support
- support in their caring role, including emergency plans
- advice on practical matters e.g. childcare, housing, finances- offer help to obtain support.

Recognize which children are at high risk and try and intervene EARLY e.g. in children with low school achievement and impulsiveness; family risk factors including parental contact with the criminal justice system and child abuse; social risk factors including low family income and little education.