Health Education England

Dorset HealthCare University NHS Foundation Trust

Reaching the Correct Diagnosis for Children (aged 11 –18 years) referred to CAMHS with challenging behaviours.

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Aim To develop and implement a template for the assessment of young people referred to camhs with primarily challenging behaviours.

Background There is a nationally recognised gap in provision to meet the needs of young people who have symptoms of conduct disorder. Parenting programmes such as Incredible Years are a well validated treatment for children under 12 at risk of conduct disorder. NICE provides guidance re recommended treatments for over 11years but they acknowledge there are well recognised negative outcomes (e.g. young people learning antisocial behaviours from each other). Klahr in a review paper talks about targeting interventions for specific subgroups within the conduct disorder diagnosis. This gives an opportunity to refine the assessment process and discriminate treatment recommendations, give advice to referrers or contribute to multiagency management of risk.

Design and Methods The QI methods included the formation of a small group who were willing to support the work . Stakeholder views from families and professionals had been gathered over the previous two years via challenging behaviour workshops . Meetings were held with various camhs managers, clinical governance meetings and camhs consultants to gather their views. Most concern was expressed by consultant colleagues re the validity of the diagnosis and whether it was work we should be doing. We completed a run diagram reviewing a 6 month period looking at all the young people referred into Weymouth camhs 11 years and above. The young people who met the criteria were divided into sets consecutive 5 compliant referrals and the same person assessed whether a full assessment had been made and whether the correct treatment had been recommended.

Actions to achieve improvement We met with the team and the wider camhs transformation group to develop a pathway and template for assessment. We carried out a one off training session in August 2016 and I continue to provide informal supervision re these cases.

We completed a further run diagram for 6 months of referrals which was a similar time of the year as the first set. Less referrals were received that met the criteria but the run diagrams

Summary of improvement The camhs staff were overall very positive about the ideas and training. Their experience had been that they often felt very alone with dealing with very risky behaviour without a clear way of working. The idea of contributing into a multiagency forum to manage risk they found very helpful.

July—Dec 2015 141 patients were referred for whom 55 (39%) presented primarily with externalising disorders. 60/40 male :female

After the template development and training : Aug 16—Jan 17 127 patients were referred for whom 24 presented with primarily externalising disorders. There was the same ratio of 60/40 of males to females.

On a wider trust basis I have also collected initial figures for two other camhs patches on request, having presented the initial run diagram. Over a six month period one team had 16% externalising disorders and the other 14% . This has highlighted the differing referral practices or acceptance through screening. The trust is now more actively looking at the numbers of young people who present risks to others as well as the those who are at high risk to themselves. It has opened the debate about whether camhs should be involved with assessing and treating these young people rather than seeing it as a social care problem. Currently camhs is developing a number of pathways regarding their services and conduct disorder has its own pathway. Therefore this work has fed into a wider agenda .

Diagnostic criteria for conduct disorder in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)

In conduct disorder, a repetitive and persistent pattern of behavior occurs in which the basic rights of others or major age-appropriate societal norms or rules are violated. This manifests as the presence of at least 3 of the following 15 criteria in the past 12 months from any of the categories below, with at least one criterion present in the past 6 months:

Aggression to people and animals:
- Often bullies, threatens, or intimidates others
- Often initiates physical fights
- Has used a weapon that can cause serious physical harm to others (eg, a bat, brick, broken bottle, knife, gun)
- Has been physically cruel to people
- Has been physically cruel to animals
- Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)

Has forced someone into sexual activity

Destruction of property:
-Has deliberately engaged in fire setting with the intention of causing serious damage
Has deliberately destroyed others' property (other than by fire setting)

Deceitfulness or theft:
- Has broken into someone else's house, building, or car
- often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)

Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)

Serious violations of rules:
-Often stays out at night despite parental prohibitions, beginning before age 13 years
- Has run away from home overnight at least twice while living in the parental or parental surrogate home, or once without returning for a lengthy period

Is often truant from school, beginning before age 13 years

The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

Template assessment of externalising disorders over 11years

Developmental

1. **Does the child have adhd symptoms**
   Consider referral for assessment and treatment of ADHD
2. **Does the child have ASD symptoms**
   - **Re empathy – not able to read what others are thinking but can be prosocial?**
     Consider referral for assessment and treatment of ASD
3. **Does the child have long standing callous unemotional symptoms**
   – **not respond to punishment, not respond to social rewards, lack of remorse, and ability to read what others are thinking but using skills to his/her advantage**
   Recommendations are that this does not respond to one to one work.
   Consider Functional family therapy
   Consider Multisystemic therapy
   Manage risk - Consider offering to be part of multiagency assessment e.g. referring into MARAC or coordinating a SAVRY if there is a history of violent episodes
   Referrers generally want to be sure that we have excluded a mental health component. It is acceptable to write back with our assessment and give a diagnosis of conduct disorder and say what are recommendations are.
4. **Does the child have a specific reading problem?**
   Seek educational support and assessment

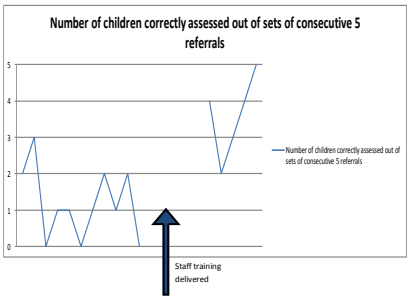
Psychological symptoms

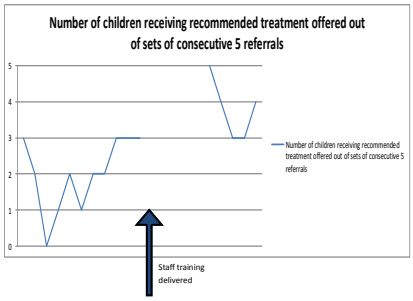
1. **Does the child have anxiety symptoms as a primary cause?**
   Treat as per NICE recommendations
2. **Does the child have low mood symptoms – have a low threshold for treating low mood**
   Treat as per NICE recommendations but recognise that these young people can be hard to engage and they want immediate solutions so have a low threshold for medication
3. **Are the child's angry outbursts alone without asd/adhd symptoms / cu traits**
   Consider social skills work – this may be most appropriately done in an educational or youth club setting

Trauma

1. **Is the child looked after?**
   Follow lac protocol and provide advice as appropriate
2. **Is there a history of post traumatic stress disorder?**
   Follow NICE guidance for PTSD

Run diagrams





Conclusions and Learning

Conduct disorder remains under diagnosed due to practitioners concern over the usefulness of the diagnosis and confidence in bringing about change. The process of drawing up a pathway and template for the assessment of these young people has opened up a wider debate about camhs' role in providing assessment treatment and advice. Run diagrams have shown that the team has developed increasing confidence in assessing these young people over the last year. Despite trying to build the team involved it continues to need an advocate for these children within the trust . My consultant colleagues raised more concern re the change in practice and it is clear that there is very variable practice across the county. This may reflect catchment areas and availability of other services. As with neurodevelopmental disorders the clarification of ideal services and who might provide them will be part of an education, social care and health agenda. The QI approach helped with focusing areas of change.

Embedding change has been challenging due to change of all senior personnel both medical leads and managers and I have continued to have an advocate role to continue to highlight the needs of these children and families.

The run diagrams have been very helpful in presenting complex data visually and will be a technique I will use going forward .

Acknowledgements

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NICE Scope www.nice.org.uk/.../**conduct-disorders**-in-children-and-young-people-final-scope2

Providing care all of us would recommend to family and friends