

EARLY INTERVENTION IN PERSONALITY DISORDER:

**MST and Other Treatments for Socially Excluded
High Risk/High Harm Children and Families**

Report of conference held November 2007, London

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1 Glossary

High Risk/High Harm

This term is used throughout the report to refer to those children and youth who have traits consistent with early emerging antisocial personality disorder and who place an undue burden on the services. High risk and high harm refers both to the risk suffered by these children or the harm which could be inflicted upon them and also to the risk they pose to others or the harm suffered by others because of their antisocial behaviour. Both children with callous-unemotional traits and children with impulsive traits can fall within this category.

Callous-unemotional (CU)

The term CU is widely used in the research literature and refers to age appropriate markers of core psychopathic features (e.g. lack of guilt and empathy) in children and adolescents. Standardised instruments are used to assess CU traits. CU trait scores represent a sub-typing index currently used in research settings. Although conceived as a way to characterise risk of developing psychopathy in children, CU traits do not equal psychopathy syndrome. There is currently very little longitudinal data on these traits.

Multisystemic Therapy (MST)

MST is an intensive community- and family- based treatment addressing multiple risk factors and aimed at preventing costly out-of-home placements. Empowering parents is central to the therapy. MST integrates several evidence-based intervention techniques and uses an intensive quality assurance system to support treatment fidelity.

CAMHS

Child and Adolescent Mental Health Services.

SSDs

Social Service Departments.

ISSP

Intensive Supervision and Surveillance Programme

2 Foreword

I am pleased to introduce this report, produced by Dr Eileen Vizard and colleagues from the NSPCC and UCL, which is a comprehensive report of the seminar held in November 2007, which brought together national and international academics and practitioners, in the field of childhood conduct disorders, prevention and treatment of antisocial behaviour and the emergence of anti-social personality disorder.

The seminar was commissioned by the Department of Health as part of cross government work, with Department for Children, Schools and Families, the Youth Justice Board and the Cabinet office following the publication of The Social Exclusion Action Plan (2006) and the Care Matters White paper (2007). The focus of this work being to identify early those young people at risk of social exclusion and placement away from home, due to conduct problems and complex family needs and to consider and further develop the evidence base for effective interventions with these young people and their families.

The report provides an excellent summary of the current evidence base in this area, a comprehensive account of the seminar proceedings and pointers for future action for practitioners, policy makers and researchers. Thanks to Dr Vizard and colleagues for their dedicated work in organising the seminar and in authoring this invaluable report.

Nick Benefield
*Head of Personality Disorder Programme
Department of Health*

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3 Executive Summary

3.1 Antisocial Behaviour

Antisocial behaviour creates major costs for society. Prevention and treatment of antisocial behaviour is expensive, as are the legal proceedings and incarceration which often accompanies such behaviour. In addition, the social and emotional costs suffered by victims and families of antisocial individuals are likely to be large, although less easy to quantify.

3.2 Childhood Onset

One particular risk factor for persistent offending is the early-onset of antisocial behaviour (Moffitt 1993). Three quarters of adults displaying serious antisocial behaviour had also displayed antisocial behaviour during childhood (Blackburn 1989). Prospective cohort studies have demonstrated that onset of antisocial behaviour prior to age 13 years increases the risk of later serious, violent, and chronic offending by a factor of 2 to 3 and compared to juveniles who start offending at a later age, child delinquents tend to have longer delinquent careers (Loeber & Farrington 2000). In addition to criminality, early-onset conduct problems predict both psychiatric and physical health problems in adult life (Kim-Cohen et al. 2006; Odgers et al. 2007).

3.3 Continuities into Adulthood

A small number of individuals are responsible for a disproportionate amount of crime committed in adolescence and adulthood. One study reports that by 32 years of age, 6% of individuals account for half of all recorded convictions (Farrington & West 1993). In relation to violent offences, less than 5% of the male adult population are responsible for between 50 to 70% of violent crime (Hodgins 1994; Moffitt 1993). In adult prison populations, individuals with psychopathy are in the minority (approximately 15 to 30%), however, they commit a disproportionate amount of crimes (50% more than non psychopathic criminals) and are more likely to commit a wide variety of offences, including violent crimes (Hart & Hare 1997). Individuals with psychopathy are also more likely than non-psychopaths to have a history of severe early behavioural problems. Therefore, although childhood-onset of conduct problems identifies an 'at-risk' group, there is a need to establish those markers which signify heightened levels of vulnerability to persistent antisocial behaviour. A focus on emerging personality disorder traits is one approach that is being taken to identify children more vulnerable to such a trajectory.

3.4 Links between Antisocial Behaviour and Personality Disorder

Personality disorder does not suddenly manifest itself as a complete problem in adulthood; rather it has its origins and early indicators in childhood and adolescence (Robins 1966; Robins et al 1991; Swanson et al 1994; Royal College of Psychiatrists 1999; Loeber et al 2003; Vizard et al 2004). Research has demonstrated robust trajectories of antisocial behaviour and strong links between delinquency, conduct disorder and later antisocial personality disorder (Broidy et al 2003). Developmental research has focussed in particular on elevated callous-

unemotional (CU) traits in childhood as a potential risk factor for adult psychopathy. CU traits refer to limited empathy, guilt and emotional expression and preliminary evidence suggests that high levels of such traits are associated with an increased risk of persistent and violent antisocial behaviour (Oxford *et al.* 2003; Viding 2004; Salekin *et al.* 2005; Vizard *et al.* 2007; Viding *et al.* 2008).

3.5 The Cost of Youth Crime

Youth crime costs approximately one billion pounds per annum (Audit Commission, 1999). It has been estimated that the cost to the public of a child diagnosed with conduct disorder at 10 years will be £70,000 by the time they reach 27 years (Scott *et al.* 2001). However, within that group, children who also have high levels of CU traits are likely to cost public services even more (Knapp 1999). The implications for further research are clear - given the high burden and cost of antisocial behaviour, the development of effective, novel treatment approaches for children at risk of pursuing a high harm trajectory is essential. Within this group, there will be a need to take into account individual differences in personality and the underlying aetiology of the antisocial behaviour.

3.6 The Cost Benefits of Early Intervention

Early intervention strategies have potentially substantial cost benefits for the tax payer. The life-course persistent antisocial behaviour observed in the most high harm/high risk children is often apparent as young as 2 – 3 years of age (Broidy *et al.* 2003). High quality early intervention has been shown to be cost effective in the US (Schweinhart & Weikart 1998), and has been highly recommended by Romeo *et al.* (2006) in a study explicitly investigating the economic cost of severe antisocial behaviour in children.

3.7 Cross-government initiatives

Persisting concerns about youth crime and links with social exclusion together with the evidence base on early intervention with antisocial and socially excluded children and families informed the Government's decision to set up the Social Exclusion Task Force in 2006. The Social Exclusion Task Force aims to address the needs of the most socially excluded and deprived members of society, with a focus on preventative strategies for 'at risk' groups. The five guiding principles of the Social Exclusion Task Force emphasise the need for an evidence based early intervention strategy with families at risk:

1. Identifying and targeting those at-risk as early as possible
2. Systematically identifying 'what works'
3. Promoting multi-agency working
4. Personalisation, rights and responsibilities
5. Rigorous management of underperformance

These guiding principles are directly linked to the intended outcomes of the Task Force which are to: reduce exclusion ; break cycles of rejection; prevent care away from home; reduce offending; improve public protection and foster inclusion and prosocial development.

Based on these principles and intended outcomes, a concrete set of objectives were articulated in a recent Social Exclusion Task Force document "Reaching out: An action plan on social exclusion" (Cabinet Office 2006). The Action Plan identified 23 actions to be taken across a range of government departments to address social exclusion. These included setting up a centre of excellence for children's and family services (Action 4), the establishment of 10 health led parenting support demonstration projects from pre-birth to age 2 years old (Action 16) and tackling mental health problems in socially excluded young people (Action 20). In relation to this last objective the document states that: *'The Government will launch pilots to test different interventions for tackling mental health problems in childhood such as 'Multi-systemic therapy' and 'Treatment Foster Care' to prevent the onset of problems later in life'* (Cabinet Office 2006). Hence, Action 20 makes clear the government's intention to find effective, evidence based treatment interventions in childhood which will prevent later problems, such as offending, in adult life whilst remaining true to the guiding principles and intended outcomes of the Social Exclusion Task Force.

The Action Plan also notes the needs of children in the care system, confirms that the government will build on the 'Every Child Matters' (DfES 2004) agenda through the Green Paper in October 2006 by setting out proposals to transform outcomes for children in care. These were subsequently incorporated into the white paper 'Care Matters: Time for Change' (DfES 2007). 'Care Matters' sets out a framework for family and parenting support stating that *'Whenever possible, we should support children within their own families. This requires a focus of support for parents and the provision of evidence based parenting programmes and short breaks for families with more complex needs'*. However, for children and young people who are moving towards care, the white paper proposes *'funding the development of Multi-Systemic Therapy (MST) as an effective specialist intervention for older children and young people on the edge of care'*. For those children already within the care system, government intends *'asking all local authorities to analyse the profile of their children in care population....'* to ensure the design and delivery of appropriate services (DfES 2007).

Hence, the Care Matters agenda fits well with the guiding principles and proposed outcomes for the Social Exclusion Task Force, which aspire to keep at risk children and their families together wherever possible but also to provide appropriate assessment and treatment services for those children who need to stay in the care system.

3.8 The Remit of this Seminar

The overall remit of the seminar was to consider whether advances can be made in identifying and intervening with those children at most risk of persistent antisocial behaviour, in order to inform government policy. This was to be accomplished through the production and dissemination of this report and by the implementation of the report's recommendations. By bringing together speakers who could address clinical, research, policy and practice issues a forum was established to allow consideration of the rationale and challenges in meeting this objective.

In terms of intervention, one major theme of this seminar was the role of Multi-Systemic Therapy (MST) and other complex interventions in preventing social exclusion with high risk/high harm children. This theme is in line with current government policy which states that any intervention should be delivered in partnership with families and local services, that services should be personalised and they should take a life-course approach (DfES 2007).

MST is an intensive and comprehensive community and family based treatment aimed at decreasing the problems associated with adolescents with conduct problems living at home (Utting et al 2006). It integrates evidence based intervention strategies and focuses on empowering caregivers to be more effective. The outcome of MST with young offenders in U.K. has been the focus of recent interest from policy makers. There are currently three MST sites in the UK; in London and Cambridge as part of Youth Offending services and in Belfast in a high-risk care setting. Certain talks at this seminar provided an overview of the progress of long-standing MST programmes from international settings, as well as describing a newly initiated British MST programme.

Other talks addressed a range of complementary issues including the rationale for early intervention with children showing high risk/high harm behaviours, neuro-cognitive and genetic research on children with callous-unemotional personality traits, developmental pathways towards antisocial behaviour, service development for high risk youth and the role of parenting interventions in the prevention of antisocial personality disorders. The translation of basic science into clinical practice is often a slow process, and this seminar provided an important opportunity for research and the reality of clinical practice to come together.

In addition to these informative and complementary talks, delegates also convened in three discussion groups which met twice and which focussed on:

1. The identification of high risk/high harm children
2. Potential sensitive periods for early intervention
3. Types of intervention and what is likely to work (and for whom).

The themes emerging from these discussion groups were fed back to the main seminar plenary meeting and discussed further. These themes are listed below. Conclusions were reached and recommendations were made by the delegates on the basis of the talks given, the discussions which occurred and subsequent feedback from the delegates. A preliminary government response to the conclusions of the seminar was presented at the end of the 2 days. This seminar report will be published on the government website for information, to promote professional discussion and to assist the further development of services and research in this field.

3.9 Emerging Themes

The seminar elicited a number of recurring themes during the presentations and in the discussions. Given the policy and research focus of the seminar it was thought useful to group the themes emerging as areas where there was good agreement, some agreement or a lack of agreement. In addition, it seemed helpful to list what

was known to work by way of therapeutic input and to identify deficits in service and research provision.

Antisocial children presenting with worrying personality traits are variously described in the literature as having 'psychopathic' or 'callous unemotional (CU)' traits. However, although these terms were used during some of the seminar presentations and in reference to the published literature, for the purposes of writing up the discussions at the seminar these children and young people are referred to here as having 'callous unemotional or (CU)' traits. This is because CU traits are thought to be one of the core problems driving many aspects of antisocial behaviour in this group of children. A glossary of relevant technical terms can be found at the back of this report.

3.9.1 Good Agreement

- Several risk factors can place children at increased risk of later antisocial behaviour. These include genetic, constitutional, emotional, cognitive and behavioural factors in the child, family functioning and environmental factors including the child's functioning at school.
- High risk children are likely to pursue particular developmental pathways (or trajectories) from early childhood towards antisocial behaviour and offending in adult life.
- There are several sub-groups of antisocial children who can now be identified, e.g. those with early onset of conduct disorder, those with callous-unemotional traits and those perpetrating sexually abusive behaviour.
- MST excludes intervention with high risk/high harm children in the residential care system and this raises the need to identify alternative, effective interventions for this substantial group of children.

3.9.2 Some Agreement

- Persistent forms of conduct disorder may comprise sub-groups of antisocial children, including those with early onset conduct problems and a sub-set with high levels of CU traits.
- There was emerging evidence for the early identification of these sub-groups of children
- Children with high levels of CU traits may show a differential response to parenting interventions.
- There was emerging evidence for certain developmental pathways (or trajectories) in children with sexually harmful behaviour towards adult anti-social behaviour.
- There was emerging evidence of the degree to which MST is effective with the sub-group of antisocial children who show sexually harmful behaviour.

3.9.3 *Lack of Agreement*

- Resilience and protective factors in high risk/high harm children with high CU traits.
- Sub-group appropriate interventions with children showing high levels of CU traits

3.9.4 *What works*

- Effective parenting interventions with young children displaying conduct problems who were still living at home.
- Systemic interventions, including MST for older children and adolescents presenting with conduct problems who were still living at home
- Effective, intensive fostering interventions with offending children placed away from home but not in care.
- Effective community based interventions with the sub-group of antisocial children showing sexually harmful behaviour

3.9.5 *Deficits in Service Provision*

- There is a lack of co-ordinated provision of treatment resources for antisocial children at local, regional and national levels and a particular deficit of services for the highest risk/high harm children and their families
- There is a lack of collaboration between agencies such as CAMHS and adult mental health services in the provision of transition services for children and young people showing antisocial behaviour. This applies particularly to those with learning disability, personality disorder or serious mental health problems who are moving from child to adult services.
- There are no treatment resources, in terms of modified assessment or enhanced parenting intervention, for sub-groups of children with conduct disorder who also had high levels of CU traits
- There are very few specialist treatment resources for young people showing sexually abusive behaviour who have concomitant CU traits.

3.9.6 *Research Deficits*

- There is a dearth of treatment outcome studies for antisocial children.
- There are no adequate longitudinal follow up studies of the sub-groups of treated or untreated antisocial children with sexually harmful behaviour or callous-unemotional traits.

3.10 Other points

The question of 'labelling' high risk/high harm children and their families recurred throughout the seminar. There was no easy answer to the legitimate concerns raised about applying potentially pejorative labels to young children and their families, particularly given the lack of research evidence on longitudinal outcomes for these children (mentioned above).

However, equally, concerns were raised about the long delays in local professionals agreeing to refer such high risk/high harm children for specialist services with the subsequent worsening of behaviour and the creation of more victims. The possibility of provision of universal preventative services (for high risk/high harm behaviour) where everyone is helped and less people are stigmatised was also discussed.

It was agreed that there was a need for appropriate and non-stigmatising language to be developed which would encourage engagement and effective clinical practice. At the same time, it was acknowledged that a balance needed to be struck between the risk of labelling a child or family and the need to nip emerging problems in the bud for a very small number of potentially dangerous and expensive young offenders.

3.11 Recommendations

1. There should be co-ordination of service provision for high risk/high harm antisocial children at local, regional and national level. This co-ordination should include the provision of transition services from child to adult services for all sub-groups of antisocial children including those with learning disability, personality disorder and serious mental health problems.
2. At local level, training should be given to CAMHS (Child & Adolescent Mental Health Services), SSD's (Social Services Departments) the YOS's (Youth Offending Services) and other services dealing with antisocial young people so that they can offer treatment when appropriate or refer to specialists when necessary.
3. A small number of specialist regional resources should be established to deal with much higher risk/high harm children and young people. These regional resources should offer consultation and training to local colleagues and assessment and treatment for the most disturbed and dangerous antisocial young people, including identified sub-types such as young people with callous-unemotional traits and those showing sexually harmful behaviour.

4. There should be regular monitoring of the implementation of the recommendations from specialist assessments undertaken at local and regional levels to ensure that interventions for antisocial young people are actually made as recommended. This process should include monitoring the implementation of the guidance suggested in point 5 below, in line with earlier good practice recommendations (Academy of Medical Sciences 2007).
5. At a national level, there should be government guidance on the provision of local and regional services. The guidance should be informed by up to date scientific thinking in the area of antisocial behaviour including recent advances in neuroscience. The guidance should also cover good practice such as inter-agency collaboration, dealing with children who are in both the care and criminal justice systems and referral to specialist resources.
6. A UK based treatment outcome study (RCT) with the sexually harmful behaviour sub-type of high risk/high harm children and their families should be funded to establish whether MST works for this sub-type. There should be a minimum of three to five years follow up for such an outcome study to give a realistic appraisal of treatment efficacy.
7. A pilot study of a novel parenting treatment approach with young children (3 – 6 years) showing callous-unemotional traits and their families should be funded to establish likely effective treatments, to generate hypotheses about the functioning of these children and to pave the way for later (RCT) outcome studies.
8. Prospective, longitudinal follow up studies should be undertaken with the sub-types of antisocial children and their families. These prospective studies should be for a minimum of five years to allow follow up of young people into adult life and to track their outcomes as parents.

4 Background to the Seminar

The government has already commissioned work to look at the prevention of ASPD (Utting et al. 2006). The selective review by Utting and colleagues covered six well-evidenced programmes that have been commonly implemented: *The Incredible Years*, *Triple P*, *Nurse-Family Partnership*, *Multisystemic Therapy (MST)*, *Multidimensional Treatment Foster Care*, and *Functional Family Therapy*. All have demonstrated effectiveness in the short to medium-term in reducing problem behaviours and some have been shown to reduce re-offending rates (with MST shown to even reduce adult recidivism). More attention is currently needed to investigate what individual child factors may moderate the suitability and success of any therapeutic intervention.

Within the at risk group of children and youth, a core of 'high risk/high harm' youth are responsible for a disproportionate amount of service use and demand. This group should receive detailed attention to enable the limited resources to be applied in the most beneficial manner. New evidence from genetic, brain imaging, behavioural, and clinical studies suggests that it may be possible to identify sub-groups of high/risk high/harm children with particular vulnerability profiles (Viding & Jones, 2008). Some of these 'high risk/high harm' children appear to have stronger biological vulnerability (e.g. those with callous-unemotional traits), while for others there are documented environmental risk factors (e.g. those who display aggression in response to perceived threat). More importantly, these differences in biological/environmental risk appear to also relate to differences at the level of the brain and cognition and affect. This finding has real implications for the diagnosis and treatment of children at risk for continued antisocial behaviour. However, it should be noted that a range of behavioural therapy programmes and differing levels of family involvement may be appropriate for the differing sub-groups discussed in this report.

This seminar was set up to examine 1) the emerging evidence base in relation to 'high risk/high harm children and youth, 2) to reflect on possible preventative and treatment interventions and 3) to make recommendations to the government about possible ways forward.

5 Summary of the Presentations at the Seminar

This section of the report briefly summarises the main content of each presentation of the seminar. The full presentations are also available in the slide format in the appendix of this report.

5.1 The Government's Action Plan on Social Exclusion: Action 20 – Early Intervention in Personality Disorder - *Nick Benefield*

Nick Benefield presented the opening session in his capacity as the Department of Health National Personality Disorder Lead. The focus of his presentation was the relevance to the seminar of the government's avowed intention in Action 20 of the Action Plan (Cabinet Office 2006) to tackle mental health problems in childhood, including the development of later personality disorder. Nick Benefield's remit covered the management of services for adults with DSPD (Dangerous Severe Personality Disorder) and other adults within the forensic and prison sectors and it was well known in these services that many very high risk individuals had shown early childhood signs of antisocial behaviour.

Nick Benefield started by outlining various recent cross-government initiatives which had interlinked to provide a framework for the provision of services for socially excluded children and their families. He explained that government thinking had been influenced by a number of earlier initiatives and reports. These included Every Child Matters (DfES 2004), The Utting report (Utting et al 2006), the Personality Disorder Programme in the Department of Health and the DSPD (Dangerous Severe Personality Disorder Programme) in the Home Office as well as various collaborations between the DCSFM the DH and the YJB. It appeared clear that, in recent years, government had been considering various ways in which the emergence of risk factors for personality disorder in childhood could be identified and tackled preventatively on a cross departmental basis.

More recently, the Cabinet Office's Social Exclusion Task Force had been asked to produce the Action Plan on Social Exclusion which had outlined 23 Actions to be taken to end Social Exclusion. The Action Plan (Cabinet Office 2006) had dovetailed in with many of the objectives of the government's white paper on children in care (Care Matters 2007) and both initiatives shared the hope that early intervention in socially excluded families might ensure that the family could remain intact and that entry into care by the child might be avoided. To this end, the government had announced funding for the development of MST (Multi Systemic Therapy) as an effective specialist intervention for older children and young people on the edge of care (Care Matters 2007).

Nick Benefield explained that it was the government's intention to gather evidence of the effectiveness of MST in the English context, given that most of the existing evidence on efficacy came from the USA and other countries. Twelve MST pilot sites were to be funded in the U.K. and these would be announced shortly. It was expected that these sites would operate as registered MST sites and that they would provide evidence of: partnership delivery; a research programme and a sustainable funding programme.

Some of the government's intended outcomes from funding the development of MST pilot projects included: reducing exclusion; breaking the cycles of rejection; preventing care away from home; reducing offending; improving Public Protection and fostering inclusion and pro-social development.

However, it was acknowledged that the evidence base on what interventions worked was sparse or absent in relation to other groups of antisocial children such as much younger conduct disordered children and the sub-group of seriously disturbed children who showed early signs of callous-unemotional traits, often linked with the later development of personality problems. In addition, it was acknowledged that there were limitations to the uses of MST which was currently being adapted in the USA for use with a range of sub-groups of antisocial children including children showing sexually harmful behaviour. The UK government would be interested to hear, in the course of this seminar, what the international speakers who had been invited had to say about clinical developments in these and other areas of work with antisocial children.

5.2 The Rationale for Early Intervention in Personality Disorder - *Eileen Vizard*

This presentation first reviewed three themes from the evidence base that were central to this conference: Delinquency and crime, personality disorder and psychopathy, and childhood origins of personality disorder.

On reviewing the evidence base for delinquency and crime, Dr Vizard highlighted that a small number of people are responsible for much of the recorded crime. This is true for both adolescent and adult offenders.

She then went on to briefly review findings on personality disorder and psychopathy. A large proportion of offenders (50-80%) meet criteria for a diagnosis Antisocial Personality Disorder (APSD), but a much smaller number (15-30%) meet criteria for psychopathy. As individuals with psychopathy display the severest form of antisocial behaviour, Dr Vizard queried whether we could identify early indicators that would reliably characterise an 'at risk' group of children and youth. She also asked whether such early identification would facilitate improved treatment and outcome.

In her brief review of childhood origins of personality disorder Dr Vizard contended that there is now robust evidence on delinquency trajectories and links between delinquency, conduct disorder (CD) and APSD. She also highlighted the fact that boys with both CD and callous-unemotional (CU) traits share many features with adult psychopathy and that preliminary evidence suggests that CU traits show strong developmental continuity. Dr Vizard placed emphasis on the fact that not all badly behaved young children go on to develop later antisocial behaviour. Regardless, it may be important to consider a constellation of personality disorder traits emerging in childhood as a developmental disorder. If this is the case, the implications for treatment need considered.

Dr Vizard went on to review data from her own research group that supports the early emergence of severe personality disorder traits in children. A full report of this study can be downloaded at:

www.dspdprogramme.gov.uk/pages/publications/publications1.php

In short, Dr Vizard and colleagues' study of serious juvenile sexual abusers identified a sub-group of children with high levels of psychopathy traits who appeared to be on a distinct trajectory of offending. These children and youth were described as having *Early Severe Personality Disorder (ESPD) traits*. They differed from other juvenile sexual abusers on several key factors, including early difficult temperament, changes in care placement, insecure attachment, abuse patterns, physical aggression, cruelty to animals, and violent convictions. Interestingly, however, when childhood factors were studied for both the ESPD and non-ESPD group, it was noted that the groups did not differ in the incidence of childhood sexual, physical, and emotional abuse or neglect. This suggests that other risk factors besides abuse and neglect also play a role in the severe offending pattern seen in the youth with ESPD traits.

Dr Vizard concluded her presentation by reminding the audience of likely cost-benefits of early intervention. She also outlined three key areas where research is needed: follow-up studies of delinquent youth to map trajectories, treatment outcome studies that offer long-term (in excess of five years) follow-up, and treatment studies that evaluate new treatment approaches that target high risk/high harm children with CU traits and their families.

5.3 What do we know about children with psychopathic traits? - Essi Viding and Eamon McCrory

Drs McCrory and Viding jointly presented a review of research on psychopathic traits in children. They covered research evidence on predictive utility and stability of CU traits; affective, neural and genetic basis of a CU sub-type of antisocial behaviour; and also discussed the implications of the current research on CU for treatment of conduct problems.

Dr McCrory began the presentation by re-iterating the point made by Dr Vizard, that although small in number, adults with psychopathy are responsible for a large amount of crime. A consensus is emerging that CU traits, rather than other childhood conditions such as ADHD, appear to best capture the core risk persistent and violent offending. Dr McCrory then put forward the argument that the utility of CU traits in sub-typing children with antisocial behaviour largely lies in their ability to independently predict future antisocial behaviour. He also highlighted the fact that it was important to demonstrate some stability of CU traits across different developmental periods, before undue weight is put on assessment of these traits. A review of evidence from the past research indicates that CU traits both adds to the prediction of antisocial behaviour and are stable across development. However data are still required to chart CU traits longitudinally from early childhood through adolescence. In addition, no validated measures for charting CU traits in pre-school children exist and this is an important area of research.

Dr Viding reviewed the evidence base for affective, neural and genetic basis of psychopathy / CU traits. Both adult psychopaths and children with antisocial behaviour and CU traits are poorer at recognising fear and sadness than other individuals with antisocial behaviour. In addition, they show reduced psychophysiological reactivity to others' distress. They are also insensitive to

punishment at the behavioural and psychophysiological levels. These findings have led researchers, such as Blair to propose that normal socialisation is disrupted in CU individuals as both empathy induction and punishments are ineffective. The findings from the behavioural studies are in line with the suggestion that there may be amygdala and orbitofrontal cortex dysfunction in individuals with psychopathy/CU. This suggestion has received preliminary support in brain imaging studies. Finally, recent twin studies support the notion that children with both antisocial behaviour and CU traits may be at a particularly strong genetic risk for antisocial behaviour. Their non-CU peers show much stronger environmental risk for antisocial behaviour. For both groups child specific environmental risk factors appear to be most important in increasing vulnerability to behavioural problems. Dr Viding summarised this part of the presentation by suggesting that molecular genetic research on antisocial behaviour should focus on the group of children with CU traits. She also highlighted the potential importance of child-specific factors in early intervention and in line with this suggested that more 'genes-brain-behaviour' studies on antisocial behaviour were required, but that these would need to take sub-type of antisocial behaviour into account.

In the final section of this joint presentation Dr McCrory considered a number of clinically relevant issues. In relation to treatment the small evidence base to date suggests that CU traits may be malleable in children and that even when the core traits remain stable, the adverse behaviours associated with these traits can be changed. One recent study suggests that punishment reliant interventions (e.g. Time-Out) may not be as effective for these children, but that a focus on reward oriented approaches may be preferable. The challenges for treatment research and practice are manifold. Firstly, there is legitimate concern regarding labelling children – particularly with terms that in the adult services are associated with resistance to behavioural change. Dr McCrory emphasised that the goal of early identification is successful intervention, but that we might need to re-consider the terminology that is currently employed to describe this group of youngsters. Specifically he suggested that the term CU traits may be re-conceptualised as a 'Stress-Resilient Temperament' in view of the fact that these children appear to be less susceptible to internalising problems. Understanding more about those children with high levels of CU traits who do not show conduct problems may also help reduce negative connotations associated with such terminology. Secondly, an evidence base that evaluates current treatments in relation to children with CU traits is needed and development of new approaches to cater for these youngsters may be necessary. Finally, there is a need for continued development of age-appropriate and clinically available measures for the assessment of CU traits, accompanied by longitudinal research efforts.

Dr McCrory concluded the presentation by proposing that CU traits appear to characterise a unified and stable developmental construct that predicts severe antisocial behaviour. Children with these traits have a particular neuro-affective profile that makes them resistant to others' distress and punishment. This neuro-affective profile may reflect strong genetic vulnerability. However, this genetic vulnerability does not equal immutability. Current interventions may show differential outcomes in those children with high and low levels of CU traits, but currently little is known in this regard. A research priority is to chart what treatment approaches work best for these sub-groups of children

5.4 Multisystemic Therapy (MST) with Children and Families: Progress on the MST Adaptations in the USA - *Charles M. Borduin*

Professor Borduin gave a thorough overview of Multisystemic Therapy (MST). He has been a key figure in the development of MST and started by first outlining the increase in dissemination of MST in the past thirteen years, with approximately 350 MST teams now existing, as compared with under 10 such teams in 1994. Professor Borduin then went on to summarise the key features of MST. MST is an intensive (low caseloads), comprehensive (addresses multiple risk factors), community-and family-based treatment that is aimed at decreasing youth problems and preventing out-of-home placements that are extremely costly. Caregivers are considered the key to achieving favourable clinical outcome and it is the aim of MST to enable caregivers to engage in more effective interactions with their adolescents. Several evidence-based intervention techniques (e.g. cognitive-behavioural therapy, family therapy, and behavioural therapy) are integrated in MST. A final key feature of MST is an intensive quality assurance system, which is in place to ensure treatment fidelity. Detailed principles regarding the delivery and principles of MST were outlined in this presentation, including the expectation of maximum effort by family and staff towards goals, finding a good fit for individual clients, using developmentally appropriate therapeutic tools, evaluation and accountability. Full details are listed on the presentation slides included in this report.

Professor Borduin reviewed extensive evidence in support of the efficacy of MST, spanning more than fifteen years of research. MST has been observed to be superior (as compared with treatment as usual) in reducing juvenile re-offending; the effects of MST were evident in a number of studies five years post-treatment. The effect sizes for MST Delinquency Clinical Trials range from small to large, but most trials report medium effect sizes in relation to the level to behavioural change. MST has also been found to be effective in reducing several phenomena associated with youth delinquency, such as substance abuse, child maltreatment, truancy, and physical health problems. A recent application of this treatment approach was reported in relation to juvenile sexual offending, with promising preliminary results. Professor Borduin speculated that the key to MST success in treating juvenile sexual offending may lie in its promotion of youth's competencies in real world settings. In other words, MST addresses common multiple risk factors that are shared with young people with more generic conduct problems, rather than focussing only on sexual offending behaviour using treatment approaches drawn from adult interventions (e.g. cognitive restructuring and deviant arousal reduction).

In the final part of his presentation, Professor Borduin reviewed evidence for the cost-effectiveness of MST. He stated that it is not appropriate to assume that clinical effectiveness equals cost effectiveness, but that this needs to be formally assessed. Cost-benefit models have recently been applied to MST. These models estimate that at nearly nine years post-MST, the benefit-to-cost ratio ranges from \$12.40 to \$38.52. In other words, for every tax dollar spent on MST the tax-payer can expect a return of between ten and forty dollars in the years ahead. Professor Borduin highlighted that despite this apparent cost-benefit of MST, there are major challenges for dissemination of this intervention. According to him funding structures in the U.S. often favour incarceration and residential treatment over community-based services. The clinical resources required to implement MST are

not in place at all sites and training and quality assurance standards that are key to maintaining treatment fidelity can seem undesirable for those clinicians not used to delivering this type of service. Professor Borduin proposed that funding should shift from ineffective institution-based services (and narrowly-focused community-based services) to intensive and effective community-based services. He contended that a major shift in training and clinical practice is required, as currently there appears to be minimal outcome accountability and professional degrees do not ensure that empirically validated treatments are used. Accountability, successful treatment outcome, and use of evidence-based practices should all be promoted.

Professor Borduin summarised his presentation by emphasising that the widespread transport of evidence-based treatments will more than likely require a public health perspective involving legal and fiscal mandates and involvement from policymakers, as well as collaboration between government and practice. All of this should be embedded within a continuous quality improvement system.

5.5 MST in Cambridgeshire - *Brigitte Squire*

The presentation by Dr Squire outlined a programme of MST in practice in the U.K.. This is a relatively new approach in the U.K. and the Cambridgeshire Service Provision for MST has been in operation since December 2001, alongside the Intensive Supervision and Surveillance Programme (ISSP). MST is currently offered for those children and young people with severe behavioural problems, who are at risk of out-of-home placements.

Dr Squire reviewed the theoretical assumptions and beliefs of MST therapy and outlined the basic principles of MST intervention. She reminded the audience that programme fidelity was critical to treatment success. Dr Squire presented preliminary findings on a small number of cases that have gone through the Cambridge MST services. She was able to compare the descriptive statistics from the Cambridge MST programme to national ISSP averages, as such programmes are reviewed nationally. Cambridge ISSP with MST clients showed higher therapy completion rates, less reconvictions and less reoffending. Dr Squire highlighted that the most effective ISSP projects show committed leadership, well-integrated delivery, the use of clearly understood models of change (such as MST), well co-ordinated electronic and tracking arrangements, and quality staff with positive working relationships with young people.

In the next section of her talk Dr Squire described some very recent data regarding MST. This included findings regarding the characteristics of unsuccessful completions, which included: a distant care giver, abuse and neglect during early childhood, and strong anti-social peer groups. However, within the completers, the satisfaction with MST appeared high and the descriptive outcome statistics look promising.

Dr Squire also presented some qualitative data detailing the experiences of clients involved in MST. The clients found the programme quite intense at first, but both young people and parents placed high value on their relationship with the therapist. On the whole the parents felt supported and not blamed and young people felt heard and not judged by this approach. Parents felt more confident in their parenting after the programme and reported closer relationship with their

adolescent children. However, some parents reported disappointments and concerns that their children's problems remained. Young people felt closer to their parents and reported that they were starting to think more about their behaviour.

Dr Squire finished by listing some of the strengths and challenges of MST from a clinician's point of view. The strengths included a clear treatment framework and continuous quality assurance measures, accountability of therapists, accessibility of the treatment with the home service provision, and empowerment of carers. The challenges included finding the right, skilled staff, managing the stress resulting from the intensity of MST, therapist anxiety regarding accountability, and MST with older children or child protection cases.

5.6 Service development for High Risk/High Harm Adolescents – *André Picard*

Professor Picard provided an overview of the Youth Forensic Psychiatric Services in British Columbia, including examples from programmes for the treatment of individuals convicted of carrying out sexual or violent offences, as well as discussing plans for service development.

The Youth Forensic Psychiatric Services were developed in the 1980's for the purposes of assisting the youth court and providing mental health services to young offenders. In British Columbia, under Professor Picard's directorship there are eight outpatient clinics and one inpatient assessment unit. These aim to provide for adolescents aged 12 to 17 years of age who are in need of services to address mental health or behavioural problems. Typically, these services are community-based and mandated directly by the youth criminal justice system. The inpatient unit provides facilities for short-term assessment stays. Professor Picard explained that the main reason for the service being community based was that it was preferable to work with the adolescent in the context of their own community. He said that community based intervention had contributed toward a lower rate of adolescent incarceration in British Columbia. The service is staffed by a multi-disciplinary personnel with strong academic links with local universities. He made clear that it was the goal of the service to promote accountable assessment and treatment based on best practice, while balancing the needs of the client with the protection of the public. It is also an on-going aim of the programme to enhance service delivery and contribute to the field of forensic psychiatry through on-going evaluation and research. Indeed, since its conception, Professor Picard noted at least five different evaluations and program reviews.

In this talk, Professor Picard used two examples of MST-based programmes developed by the service: The Sexual Offence Treatment Program (SOTP) and the Violent Offender Treatment Program (VOTP). He outlined recidivism figures for up to 20 years following therapy, and reported that among over 480 adolescent sex offenders, only 14% were subsequently convicted of another sexual offence over a ten year period. This figure increased to 49% after a 20 year period. Professor Picard was also able to report recidivism figures split by scores on the Psychopathy Checklist Youth version (PCL-YV; Hare REF). Those high-scorers who had not completed the treatment programme had fared worse, with almost all having been convicted of a sexual or violent offence since the cessation of treatment, this was followed by low-scorers who had not completed treatment. Among those high scorers who had completed the programme, there was

evidence of a treatment effect. Although in the ten-year follow period approximately 50% had been convicted of a sexual or violent offence, this group had done significantly better than those high-scorers who had not completed treatment. Professor Picard also noted that among his sample there were also significant cultural differences, and that these were worth bearing in mind when thinking about how to refine and individualise treatment strategies.

Professor Picard also presented findings from the Violent Offenders Treatment Program, which was a risk-focussed programme providing assessment and intervention to adjudicated adolescents whose violence or aggressive behaviour was deemed a risk to society. The components of the overall program were titrated according to specific need, and where possible individuals were offered a family-based approach with flexible use of treatment modalities. Professor Picard presented findings from a case-control study for adolescents. Among both cases and controls, the majority had a history of conduct problems and ADHD symptoms, as well as substance abuse; in addition, 25% of both cases and controls had a history of suicide attempts on file. Again, Professor Picard reported that treatment completers fared significantly better than non-completers, and that although low-scorers on the PCL-YV showed a smaller re-offending rate than high-scorers, the latter group still showed a decrease in their re-offending rate.

Professor Picard concluded his talk by discussing what the outcomes of these studies have meant for service development. He observed that some challenges to successful treatment include cultural differences, family involvement, treatment completion and motivation, and that risk-focussed approaches for the most high-risk of groups should intervene with the young person, their family, peers as well as with their school and wider community. In terms of future service development, Professor Picard advocated using an evidence-based approach with clear program standards and measurable outcomes which are regularly evaluated. He suggested that the implementation of these would benefit from a 'three-pronged approach' incorporating organizational management, clinical expertise and programme research and evaluation.

5.7 Developmental pathways towards childhood psychopathy: The potential for effective early intervention - *Randall Salekin*

Professor Salekin started his presentation by outlining evidence that juvenile crime has risen sharply in the past twenty years. Given the greater levels of detention and lesser tolerance for repeat juvenile offending in the U.S. justice system, there is now clear need to reduce juvenile offending to avoid early institutionalisation of young people. The individual's personality may be a factor that can be used to predict the likelihood of negative and positive outcome. In his presentation Professor Salekin reviewed the evidence for stability of personality in children and adolescents. He also reviewed data on juvenile psychopathy and considered factors that might be important for treatment success in young offenders with juvenile psychopathy.

Professor Salekin first presented evidence that temperament and personality are relatively stable and linked. Although neither is fixed and there is clearly room for change and intervention, there is significant stability to personality development. This means that it would be erroneous to consider that there is no consolidation or emergence of personality before adulthood. The research interest in the field has

been in identifying and studying those processes that underlie continuity and change. Contextual factors such as learning processes and social environment have been documented to influence change in personality, whereas stability in personality is underpinned by genetic factors.

Professor Salekin outlined data from several studies that demonstrated how various pathologies outlined by diagnostic manuals could be captured by scores on different personality facets. For example externalising spectrum disorders (e.g. conduct disorder) are often marked by extraversion, low conscientiousness, and low agreeableness. Several models of personality pathology development were reviewed in this talk and Professor Salekin highlighted that there was now good support for the spectrum and vulnerability models in particular. The spectrum model states that pathology is an extreme form of personality (viewed along a continuum). The vulnerability model states that personality sets in motion and is the cause of pathology. Processes described by both models may work in concert to generate pathology.

Psychopathic personality is a form of personality pathology that is associated with extreme antisocial conduct. Individuals with psychopathy appear to lack warmth and empathy and are reported not to feel guilty for the offences they commit. Professor Salekin considered the appropriateness of extending psychopathy construct to juveniles. He highlighted that some critics claim that all adolescents behave like psychopaths. However, research clearly indicates that this is not the case and that individuals with extreme manifestations of psychopathic personality can be distinguished even among adolescents. Professor Salekin went on to review data from his own research group showing that juvenile psychopathy mediates the relationship between anxiety and offending, This finding is different from the adult psychopathy data that does not find association between core psychopathy construct and anxiety. In line with the adult research, the relationship between fearlessness and offending was mediated by psychopathy, whereas the relationship between trauma and offending was not. Recent research from Salekin's group and others has also examined protective factors associated with improved outcome in juvenile psychopaths. Positive parenting variables, well adjusted peers and motivation to change all predict better outcome for individuals with initially high psychopathy scores.

Professor Salekin rounded up his talk by stating that juveniles at risk for psychopathy are amenable to treatment. In the face of evidence for change from both studies of normal personality development and studies of juvenile psychopathy, it is possible to argue for treating, rather than punishing juvenile psychopaths.

5.8 Can parenting interventions help prevent antisocial personality? The role of the Parenting Academy - *Professor Stephen Scott*

Professor Scott's talk provided some background as to why parenting can be such an important influence on a child's behaviour, and also provided some evidence on the effectiveness of parenting programmes based in clinic and community settings. He also considered the nature of effective intervention with those children presenting with elevated levels of callous-unemotional traits.

Professor Scott began his talk with an overview of how negative parenting can affect a child's development, both in the short and long-term. Effects include deficits in social and emotional regulation skills needed to forge interpersonal relationships, and low self-esteem which can lead to involvement in antisocial behaviour. The influence and emotional impact of negative and coercive parenting was aptly illustrated by a short video clip of a young child interacting with his parents.

Professor Scott went on to discuss the findings from a ten-year follow up study of a clinic based intervention of 141 children aged between 3 and 7 years of age, referred to CAMHS (Child and Adolescent Mental Health Services). Their behaviour placed them within the 'top' 1% of conduct-disordered children for their age range. Their parents attended the Webster-Stratton parenting programme which included a focus on boundary setting, the effective use of praise to reward desired behaviours, and appropriate strategies to respond to negative behaviours. In the follow-up study, 75% of children were traced, and it was found that of these children who had previously fell within the top percentile for conduct problems, only 6 individuals were now considered to meet a diagnosis of Oppositional Defiant Disorder or Conduct Disorder. Compared to a control group who were not offered this kind of intervention, the Parenting intervention group showed lower conduct problem scores on a standardised measure of behaviour, as well as lower callous-unemotional scores. Professor Scott also referred to a research finding by an Australian research group led by Hawes and Dadds who have reported changes in the level of CU traits among some children whose parents received a parenting intervention.

Professor Scott also discussed another high risk/high harm group: looked after children with whom parenting strategies had also been found to be useful. Here, children were required to carry out a number of tasks per day in order to win 'points' (for example, getting up on time, offering to help with housework etc). Feedback was immediate, and children could lose as well as win points. However, a loss of points for misbehaviour was immediately followed with an opportunity to win them back. He reported that this intervention, which was monitored daily by telephone, had led to a significant reduction in conduct problems among the children involved.

The final study that Professor Scott discussed was a population based programme called Supporting Parents in Kids Education (SPOKES). Based on the premise that early intervention is key, this programme aimed to address both child behaviour and learning. The outcomes of this intervention were an increase in facilitative behaviour and a decrease in conduct problems as well as an increase in reading age. However, there was no effect of the intervention on emotional problems. Predictors of poorer outcome included elevated levels of hyperactivity symptoms, a hostile attribution style in the parents, and lower treatment fidelity. Professor Scott also made the observation that professional style can be a key part of intervention success; he demonstrated an observed association between a non-directive, facilitative approach and poor outcome for the child and family.

Professor Scott concluded his presentation by discussing the importance of considering different neuro-developmental issues that contribute toward conduct problems, including autistic traits, callous-unemotional traits and symptoms of ADHD. He advocated distinguishing between callous-unemotional traits and other

neuro-developmental difficulties. He re-iterated the point that a prediction of poorer outcome for this group does not equal a group who are untreatable. Interventions should take into account the child's personality and neuro-developmental profile in order to ensure maximal treatment responsiveness.

6 Discussion Groups

Seminar delegates were allocated to one of three discussion groups, each of which convened on two occasions over the course of the seminar. The three topics covered were: 1) Identification of high risk/high harm children; 2) Sensitive developmental periods for early intervention; and 3) Types of intervention and what is likely to work.

The groups were led by a delegate with an interest in the topic under discussion in that group and all three groups reported back to the plenary sessions of the seminar for a fuller review of their deliberations. The outcome of the group discussions were therefore central to the final conclusions and recommendations of the seminar.

6.1 Identification of high risk/high harm children

The first issue that was raised by this group related to what concept was actually being identified. The concept of high risk/high harm caused some controversy in the first instance by being thought of by some as a stigmatizing term. However, it was pointed out that 'high risk' should not necessarily translate as 'permanent risk'. It should instead be accepted that a child considered 'high risk' at one point in time may become a 'low risk' child with appropriate intervention, or indeed as a result of being shaped by future natural life experiences. The issue also arose as to what type of 'harm' was being identified in this label: was it harm to self or others; and if others, which specific groups: family, peers, society as a whole? A concern was raised that there may be a strong political drive to combat harm to others, in particular society, whereas harm to self may continue to be relatively unaddressed.

This discussion about the terms being used informed the first theme of the group: the dilemmas associated with 'labelling'. Controversies regarding the labelling of children are not new. For researchers, it is deemed important to use a common language for purposes of being able to faithfully replicate findings and to communicate research between institutions. However, there are arguments for and against labelling in a clinical context. Concerns about stigmatisation of a child is a major concern and the issue of labelling children who are considered high risk/high harm is a complicated one. It is not a desirable outcome for a child to be left with a label that will be more of a hindrance than help and there is some concern amongst clinicians that a label implicating a certain profile will lead to a certain attitude or outcome. To illustrate this point, one clinician felt concerned that a child with a 'label' of callous-unemotional traits might lead clinicians to think about adult psychopaths, and the prevailing attitude that 'nothing can be done'. This view was disputed by other clinicians who argued that personality was still malleable enough in children for change to occur, and recent research findings had demonstrated scope for successful interventions even for children previously considered 'hard to treat'. The term *risk* is key: the child may be 'at risk', but their

actual future behaviour or pathology is in no way determined. However the right terms in the 'wrong hands' can still result in the perjorative use of an otherwise non-perjorative label. Overall, it was the prevailing belief of the group that every child should also have a right to access appropriate services and interventions, and that it is difficult to identify a problem if a common language is not used. It is the treatment that is considered to be the most important outcome of identification. Creative solutions to the problem need to be generated, rather than fears about labelling leading to the topic being ignored, which is leading to both identification and the concomitant treatment not taking place.

One other concern about labelling was in the context of the criminal justice system. The approach used by the authors of the Psychopathy Checklist – Youth Version was noted. They recommend describing the individual traits that appear to be a problem for children with callous-unemotional traits instead of using a general label such as psychopathy, for instance. It is not useful to consider the callous-unemotional group a homogenous one, and in a clinical setting, the more important outcome of assessing these traits should be to tease out the individual deficits, problems and concerns for each child.

One possible alternative to directly labelling children was to think about the child in terms of their environmental and psychosocial context. Instead of talking about a child being high risk/high harm, it may be useful to talk about a 'High-Risk Dynamic' existing between the child and its family. This concept has obvious implications for thinking about treatment, implying that a systemic approach is likely to be important for this child and their family.

A second theme that emerged related to where and when assessments for identifying 'high harm/high risk' children might be carried out. It was agreed that schools could be a convenient and timely setting for assessments and interventions to take place. At a later point in the seminar, Dr Salekin reported on a successful U.S. based intervention practice called 'Coping Power' which targets children at approximately 10 years of age when children are starting middle school. This intervention is based on a contextual social-cognitive model which focuses on contextual parenting processes and children's cognitive processing in order to decrease aggressive behaviour (Lochman & Wells, 2004). Children who score within the top-third of their school year for disruptive and aggressive behaviour (as rated by teachers) are selected for intervention. This dimensional approach ensures that both children with severe behavioural problems and those with less severe behavioural problems (but potentially at risk for persistent antisocial behaviour) are targeted. Evaluation of the programme compared two treatment groups, full Coping Power programme (parent and child interventions) and child component only, with a no treatment control group (Lochman & Wells, 2004). A 15 month intervention with the full Coping Power programme (comprising of parent and child interventions) resulted in a significant decrease in covert delinquency (e.g. theft, property damage), substance use and behavioural problems in school at one year follow up. The child component only group were also reported to have less behavioural problems in school. This evaluation study suggests that interventions aimed at aggressive children and their parents at a time of transition to middle-school can have a positive and lasting impact on behaviour.

A third theme that arose, (common in fact to across all of the discussion groups) was the need for joined up services. There is often a lack of integration between services, resulting in children and families falling between the gaps. This means that recommendations made at assessment are not always followed up and carried out. It was the experience of several clinicians present that clinical recommendations made had not been followed up, and that this was to great detriment to the child. The group explored why this might be the case, and it was noted that it is sometimes that case that recommendations are made during assessment which simply cannot be carried out by the local services due to lack of resources or expertise. There is also no overarching mandate for interventions to be provided (except in cases where the legal system is involved), meaning that services can overlook or decide against offering interventions with no negative implications for themselves. This underlines the need for agencies and services to work together for the good of the child, and one suggestion of how this could be improved was to introduce across children's services the Care Plan Approach scheme that has been working relatively successfully across agencies involved in supporting adults with mental health problems.

6.2 Sensitive developmental periods for early intervention

The concept of a sensitive period is a maximal window of opportunity for promoting health and growth. This discussion group raised a number of factors to take into consideration when thinking about possible sensitive periods for intervention. It was decided that the most important factor in facilitating actual change was to determine when a 'high risk' family would be most open for intervention and accomplishing change. Possible windows of opportunity suggested by members of this group included times of crisis and times of transition. It was also noted that transitions served to highlight gaps in services, and in particular for adolescents, the gap between child and adult services. In addition, as children get older, the potential sensitive periods for intervention become more complex, and are likely to involve more factors and agencies.

In thinking about when to intervene, reference was also made to the Swedish model of compulsory treatment for mothers-to-be with substance dependency. Although, this model was not necessarily advocated by the attendees of this seminar, it was raised to illustrate the point that it may never be too young in child's life to intervene. Indeed, Dr Tessa Baradon proposed that atypical mother-infant interactions may represent a highly pertinent indicator of an early risk dynamic.

Other considerations for achieving successful intervention with a family include parental mental health and community factors. These factors may be of special relevance when thinking about those children and families who do not complete or engage in treatment.

Recommendations stemming from this group concentrated on the research that is still required. It was thought that developmental research is not yet fine-grained enough to identify sensitive developmental periods reliably. More longitudinal work is required to better specify developmental trajectories, particularly as these may apply to distinct subtypes. Sensitive periods for development for social and emotion regulation skills that may directly influence likelihood of antisocial

behaviour have been specified relatively well in the attachment, developmental psychology, and developmental neuroscience fields. Yet more work is required to combine different theoretical approaches to truly inform intervention. The participants also commented on the importance of being mindful of factors that may assume exaggerated importance at key developmental points and aggravate existing socio-emotional risk for antisocial behaviour, e.g. poor intellectual ability and co-occurring psychopathologies. Many group members noted the lack of continuity of services as key developmental points, such as adolescence. It was thought that government strategy should focus on integration of services and for commissioning interdisciplinary research at community, educational and clinic settings.

6.3 Types of intervention and what is likely to work

This group focussed on what kind of interventions are available to practitioners and what was likely to work.

One strand of discussion considered potential application of MST. Although MST had received attention during the seminar talks, it became apparent during this discussion that although MST was likely to be effective for a range of young people there were some uncertainties about its use for many children considered high risk/high harm as well as its limited applicability for young children. Concerns about using MST on a wide-ranging scale included its intensity and resultant cost in terms of resources and financial cost to local services. It was also acknowledged that there are some high risk/high harm children for whom MST is not appropriate or applicable. This includes children in institutional care, for example incarcerated young offenders.

A second strand of discussion focussed on an alternative to MST that would be applicable to a younger age group. One particular idea that evolved across the discussion was the possibility of a universal programme parent training-based intervention that could be complimented by an enhanced version for those children and families deemed at high risk. The appeal of a universal programme was that it could protect against 'singling out' and stigmatisation of the children in need of extra support. Reference was made to the model reported by Dr Salekin referred to in the Summary of Discussion Group 1. Although some members of the group expressed concern that such a universal programme may end up treating children and families who did not necessarily fall into the high risk/high harm group, it was thought that if the intervention provided practical help and advice it could provide a framework for a positive input for all families. Indeed more functional families could in fact act as models for those in need of greater support.

This model would require the development of clinically appropriate criteria and tools to differentiate those a higher risk / need for whom the enhanced programme would be relevant. These may include a consideration of the child's personality and general family functioning into consideration. The enhanced programme would differ from the universal programme by, for example, taking a more systemic approach incorporating interventions with the school and providing individual therapeutic work with the child. These 'enhanced' components would need to take into account individual differences in the children; for example, children with callous-unemotional may require more reward-focussed and

boundary setting techniques. Potential intervention would do well to consider such child-specific factors rather than ignore them or work 'against the grain'.

Thus, it was the consensus of the group that research should focus on treatment efficacy and the potential role for a form of enhanced intervention for more vulnerable children. Any research endeavour would need to consider a range of factors including the child's personality and neuropsychological profile; the family context; and experiences of abuse, domestic violence and neglect. It was acknowledged that while intervention may be best offered in the context of the family, the importance of child protection issues should borne in mind.

A third them that emerged in the discussion was the need to ensure that interventions were appealing to parents, pragmatic and positive in nature. It was felt that interventions need to be collaborative and needs-focussed. Thinking about a hierarchy of needs, intervention might begin by offering pragmatic help, somewhat in the style of MST and provide practical skills and support that could extend across family and school settings. How these would be balanced across universal and enhanced forms of the programme remained an open question.

This discussion linked to a fourth them: a major area of concern for was that of 'hard to engage' families, who often were the ones with children most in need of help. Those working in adults in the criminal justice system who had received diagnoses of antisocial personality disorder, reported that not enough had been done for these personality disordered adults during their childhoods. Clearly, these individuals had continued in their life of antisocial behaviour and crime, and had not been helped by the interventions available at that time. It is known that those individuals who do not engage in or complete treatment are likely to have the poorest outcome, and it was the strong belief of this group that thought needs to be given to these children and their families who will otherwise be missed or lost in the system. Indeed, it was argued that it is these individuals who may be the most high risk/high harm of all. One other thought was whether intervention needed to be consensual. Parenting orders have existed in the UK since June 2000 and require parents to co-operate in tackling their child's antisocial behaviour. Although compulsory treatment is a subject which requires careful thought and discussion, one clinician wondered whether it may take the onus of the family to have to agree to treatment that they feel anxious about. Innovative ways of working need to be adopted to capture these individuals and families, and one suggestion made along these lines was the widespread use of Community Adolescent Outreach services.

A fifth line of discussion considered those children who are already incarcerated. These young people have already missed out on first-line interventions and because they are not within their family context, and systemic approaches are generally not applicable. The degree to which a multi-systemic approach could be adapted to work at an institutional level, and the need for a shift from institutional toward community working were discussed. Evidence for cognitive behavioural interventions for such institutional settings also exist. For these very hard to treat children, it is likely that intervention will be of a high-intensity, involving face-to-face work, that lasts over a long period of time. There was concern from many clinicians that this was not always going to be practical, particularly at a local services level.

A range of general points also emerged from the discussion. A number of factors were noted that would be important to take account of when designing and implementing intervention programmes, including the gender of the child, the child's experience of abuse or domestic violence, whether the child was still within its biological family home (and the potential inclusion of the father in intervention strategies), the child's stage of emotional and cognitive development, and the influences of the peer group and community. It was pointed out that time would be well spent assessing what is already in place and thinking about how best to use what has already been shown to be effective. It is also important to look across-disciplines and agencies; from the Youth Justice Board initiatives to ideas from the Parenting Academy to ensure that there is no duplication of effort, and that all possible intervention ideas are being explored. It is hoped that fostering such a culture of collaboration at the conception stage of intervention will help multi-modal/agency treatments be a success in practice as well as theory.

In conclusion, this group recommended that future research needs to focus on treatment efficacy, particularly what works for whom. A high risk/high harm group encompasses a wide range of children, and although a universal intervention may be desirable (for example, parenting programmes), it was suggested that future work would consider the development of a systemic, pragmatic needs based 'enhanced' parenting programme that could be made available to those children assessed to have higher level of need or risk. Such assessment and any intervention would need to be carefully constructed to meet the needs and aspirations of parents and the specific needs of sub-groups of children. It was agreed that although local services are often chronically under resourced, there must be an effort for intervention to be multi-modal and multi-agency. At present, it is felt that communication between agencies is poor and recommendations made by one service are made with little thought to the practicalities of how these will be followed up. Political will alongside some fundamental changes to the way that services work alone and in conjunction are imperative.

7 Government response to Seminar and Conclusions

Nick Benefield summarised his observations over the two days of the seminar with reference to the themes emerging, the areas of agreement and disagreement and the likely implications for government policy.

Nick Benefield commented that this had been an exciting and challenging seminar. He highlighted the importance of translating academic and clinical work and ideas into strategy. Each speaker had offered a different perspective and the series of presentations had helped to clarify the fact that research, practice and conceptual theory are directly related, and cannot be thought about in isolation. While there was obvious pressure from those responsible for policy to pull these elements apart in strategy and planning, it could not be denied that this subject was very complex and should not be over-simplified.

It was important to remember that those who were high risk/high harm individuals were often at risk of harming themselves as well as harming others. The fact was that these high risk/high harm behaviours were often present in the same individuals who should not be excluded from our planning and consideration. It should also be remembered that the high risk/high harm group who were

responsible for a disproportionate amount of crime were still a very small percentage of the larger group which was labelled as personality disordered.

Nick Benefield went on to say that the relationship between neuroscience, genetics and behaviour required sophisticated analyses. One point which he highlighted was that genetic heritability did not mean determinism, i.e. high risk individuals would not necessarily go on to offend. We needed to remember the environment in which they lived, their own resilience and the importance of change being moderated through therapy which accessed the inner as well as the outer worlds of the offender.

Hence it was unlikely that there was a simple solution to antisocial behaviour. Antisocial behaviour was a systemic problem with its' roots in societal and familial problems. There were many factors which influenced behaviour and it might be the case that therapeutic interventions were only a partial solution. However, this was not necessarily a cause of pessimism but simply a sensible way of setting limits to therapeutic endeavour. On this basis, therapeutic programmes should make it clear that they can offer only partial solutions to the complex problems of antisocial behaviour.

It was also felt important that there was some common purpose in terms of what we, as a society and as individual professionals, should be aiming to protect against. It is unlikely that we can stop all individuals from offending, so perhaps the aim should be to protect individuals from their own worst outcome, bearing in mind that this will not be the same for every subtype of antisocial individual.

Nick Benefield also emphasized that it was necessary to carry out research on new interventions to find out what works and for whom. It was felt very strongly that research, evidence and practice must always be kept closely together.

Over recent years, the NHS had changed so that local services now had more control over their own money. In order to influence policy, it was also necessary to disseminate our research and knowledge to NHS commissioners since there was always competition for money. In terms of prioritisation, early intervention and particularly parenting interventions were currently quite high profile. However, the emphasis on these issues might shift, so it was necessary for researchers and clinicians to keep up the pressure on policy makers to invest in early intervention. In putting forward these arguments, it would be important to remain coherent, particularly when we began to think about interventions focussed on subgroups. For instance, it would be necessary to show how our ideas tied in to the larger government funding programme for prevention of personality disorder. Having said this, there was also a definite need for seeding and pilot work with subgroups for whom there was no current effective intervention. However, ideas must be tested rigorously before they should be presented to the commissioners.

Currently, there are various different intervention strategies happening. There are 12 MST sites under commission; there are initiatives in the Youth Justice Board; and the National Academy for Parenting Practitioners is dedicated to bringing together existing knowledge, conducting clinical trials of parenting programmes, and evaluating the effectiveness of promising approaches to develop evidence based practices. It is necessary for intervention strategies to show connections

across different services, but not duplication. Collaboration and communication will be key in devising and testing strategies for intervention.

In summary, Nick Benefield made the point that it was still the intention of the government to pilot therapeutic work for high risk/high harm children. However, clinical leadership was needed from individuals who could show that there was a clinical need for new services in the context of an evidence based, systematic strategy for taking such proposals forward. He emphasised the need for coherence of thought across the different specialities dealing with antisocial behaviour as well as the need for effective collaboration in both practice and research.

8 Discussion

The seminar was set up to examine the emerging evidence base in relation to high risk/high harm children and young people, to reflect on possible preventative and treatment interventions and to make recommendations to government about possible ways forward with this group of children. The presentations and discussions reflected these aims.

The seminar elicited a number of recurring themes during the presentations and in the discussions. Given the policy and research focus of the seminar it was thought useful to group the themes emerging as areas where there was good agreement, some agreement or a lack of agreement. In addition, it seemed helpful to list what was known to work by way of therapeutic input and to identify deficits in service and research provision.

Antisocial children presenting with worrying personality traits are variously described in the literature as having 'psychopathic' or 'callous unemotional (CU)' traits. However, although these terms were used during some of the seminar presentations and in reference to the published literature, for the purposes of writing up the discussions at the seminar these children and young people are referred to here as having 'callous unemotional or (CU)' traits. This is because CU traits are thought to be one of the core problems driving many aspects of antisocial behaviour in this group of children. A glossary of relevant technical terms can be found at the back of this report.

8.1 Labelling

An important theme discussed throughout the seminar was that of labelling. The issues devolved around certain key points as follows. For instance, it was important to note that a child designated as 'high risk' at one point might well become a 'low risk' child with the appropriate intervention. There was good evidence from the presentations that effective interventions including parenting programmes and MST for older children, could move certain high risk children into a low risk category. Whilst there were concerns about the stigmatisation of children through labels such as 'callous unemotional (CU) traits', it was noted that, for the effective replication of research findings in a clinical setting, a consistent language should be used.

However, concerns were expressed that the application of such labels to children could lead to clinicians adopting a nihilistic 'nothing can be done' attitude. It was felt by some, that this was more or less the case with adults who had severe personality disorders with psychopathic traits and by giving children similar labels surely we might be pushing them towards a hopeless future. It was also pointed out that 'psychopathy' was originally an adult construct and the validity of applying an adult term to children was questioned. The need to have clarity and agreement about language when describing children with CU traits was stressed since using a range of overlapping but contentious terms could lead to confusion and failure to refer to the right specialist services. It was also noted that there are no evidence based effective interventions for adult psychopaths many of whom are over represented in secure units. Furthermore, it was clear from the presentations and from discussion (in contrast to the less disturbed but conduct disordered children) there were as yet, no evidence based effective treatments for children with CU traits. Surely this was another reason not to label them in this way if there was no help available.

Set against these concerns were the points made from a developmental perspective. It was noted that children, unlike adults, have the natural potential for huge changes in thinking, emotional processing and attitudes, including changes in callous unemotional traits, as part of the normal process of maturation. Children's personalities were present from earlier than we tended to think. Research showed that temperament and personality were relatively stable, were linked, had a genetic basis and a pervasive impact on a range of behaviours. Both temperament and personality shared the quality of early observability which linked to early identification for high risk individuals. It was also the case that individuals with signs of psychopathy (high levels of CU traits) in their personalities could be distinguished reliably from other adolescents. There were developmental differences between the ways in which juveniles with high levels of CU traits and adult psychopaths processed emotions such as fear and anxiety. There were also key developmental protective factors for juvenile psychopaths which predicted better outcomes and these included positive parenting, well adjusted peers and motivation to change. It was argued that such developmental protective factors allowed for the real possibility that children initially scoring high on CU traits could, with effective help, move away from this label towards a better outcome.

Finally, it was noted that there is emerging research evidence showing that intervention programmes which address the needs of both parents and their high risk/high harm delinquent child as opposed to intervention for the child alone, result in a lasting reduction of problem behaviours in the child. Hence, there was help available for high risk/high harm children and the early evidence was that they could be helped by identification through the use of a perceived label.

8.2 Good agreement

There was good agreement between delegates about the presence and nature of the risk factors which put some children at increased risk of later antisocial behaviour. These genetic, constitutional, emotional, cognitive and behavioural factors in the child along with the child's family functioning and school based factors meant that some high risk children embarked on developmental pathways towards antisocial behaviour and adult offending. Sub-groups of antisocial children

with, for instance, an early onset of conduct disorder, high levels of CU traits or sexually abusive behaviour could now be reliably identified. However, the dearth of treatment outcome studies and longitudinal follow up studies on these sub-groups of children meant that, despite legitimate concerns about the adverse trajectories upon which they were embarked when seen in specialist services, it was not known how many children in these sub-groups showed adult antisocial behaviour.

It was noted that one of the exclusion criteria for entry into an MST programme is when the child lives in residential care. This is because the MST model requires family participation. However, concerns were expressed about the fact that a very substantial number of the most high risk/high harm children and young people go through the residential care system and there are few evidence based interventions available for them, whilst in care, which address their needs including their offending behaviour. It was agreed that more thought needed to be given to appropriate services for these young people.

8.3 Some agreement

There was considerable agreement on the existence of several sub-groups of antisocial children. Those sub-groups which were discussed in the seminar were children with early onset of conduct problems, those with high levels of CU traits and those showing sexually harmful behaviour. It was agreed that there may well be overlap between some or all of these sub-groups. A minority of children may, for instance, fulfil criteria for a severe childhood onset conduct disorder with high levels of CU traits and may, in addition, show sexually harmful behaviour. Such a combination of presenting features would be likely to raise the level of risk posed by the child and would also present problems in terms of specialist service provision.

There was emerging evidence for developmental trajectories towards adult antisocial behaviour in children showing sexually harmful behaviour. The research showed that children with sexually abusive behaviour in adolescence were convicted far less for sexual crimes than for antisocial crimes as adults. However, the true prevalence of any persistent sexually abusive behaviour in adult life which did not reach the criminal courts was not known and neither were other adult indicators of adjustment such as prevention of future abuse in the family of procreation, mental health and employment. This meant that the existing research based on criminal statistics gave only a partial picture of the outcomes for children in the sexually abusive sub-group.

However, there was good, emerging evidence from the USA of the extent to which adapted MST can be effective with juvenile sex offenders and their families who are available for that intervention. This success of MST with juvenile sex offenders emphasises the fact that they can be understood and treated, in many ways, the same as their antisocial-only delinquent counterparts with interventions which address their competencies in the real world (such as social skills) and those risk factors which are common to all delinquents.

Questions still arise, however, about the need for this adaptation of MST (with juvenile sex offenders) and other adaptations (e.g. with the mental health sub-group) to address the specifics of the problem which presents for attention (i.e. the sexually harmful behaviour or the mental health problem) in order to optimise outcomes.

8.4 Lack of agreement

In contrast to the emerging evidence on effectiveness with other groups of antisocial children, there was little evidence on effective interventions with the high risk/high harm group of children with high levels of CU traits. The evidence which did exist showed that interventions which jointly addressed family and child needs in high risk cases were more likely to lead to lasting improvements.

However, given the central role of elevated levels of CU traits in predicting later psychopathy and offending it was noted that more child specific interventions which addressed the callous unemotional traits and promoted the capacity for empathy would need to be developed in parallel with parenting inputs. These child specific interventions would ensure that long term change was internalised by the child him/herself and was not dependent solely upon change in the external family and environmental context.

8.5 What works

It was encouraging to hear about the interventions with high risk/high harm children and families which did work and which did appear to address social exclusion.

These included: very effective parenting interventions with the families of young children displaying conduct problems whilst living at home; MST for older children and adolescents presenting with conduct problems and offending behaviour who were still living at home; intensive fostering schemes for offending children placed away from home in specialist forensic foster placements; community based interventions with the sub-group of children showing sexually harmful behaviour.

The common threads running between all of these evidence based, successful interventions are the combination of the complex systemic context in which the therapy is placed, fidelity to the particular treatment approach and effective case management, clinical supervision and interagency liaison. In other words, the interventions are successful because the context in which they occur is carefully set up and maintained to a very high, supervised standard for the duration of the therapy. It was clear from the presentations made and from the discussions during the seminar that these elements of a successful treatment model were very familiar to experienced delegates.

It was also clear that such complex, successful therapeutic interventions carry a relatively high price tag in terms of resources and staff costs. However, persuasive cost benefit analysis arguments were put forward during presentations and in discussions to justify the output of such funding. These arguments were on the

basis that the money saved from later care, offending, incarceration and victim costs far exceeded the initial outlay for therapy. The task was to persuade policy makers and service providers of the wisdom of such investments which were unlikely to show rapid returns but would show great savings to the public purse in the longer term.

8.6 Services

A key, recurring theme in the presentations and in the discussion was the lack of co-ordination of specialist services for antisocial young people locally, regionally and nationally.

Firstly, it was agreed that there is patchy regional and very poor local provision of specialist services for children and young people with antisocial behaviour. The resistance of CAMHS to being involved in the assessment and treatment of children with serious conduct problems or emerging personality disorders was mentioned several times as an obstacle to setting up local interagency services for this client group.

On a local basis, it was repeatedly pointed out that some of the most socially excluded, high risk/high harm children and young people will require specialist transition services as they move from childhood to adult life. It is usually well known that such transition services will be required for the young person, for instance from CAMHS to adult mental health or from children's to adult services. This is particularly important and is always well known in relation to young people with a learning difficulty who may be within one or more of the antisocial sub-groups and therefore in need of a range of specialist services. There appear to be very few transition services available around the UK and such services are often set up on a case by case basis with little sense of what constitutes good practice for these challenging clients.

It was frequently noted that there is a dearth or absence of collaboration between the agencies responsible for providing transition services. Whilst there can be speculation about the reasons for this poor collaboration, it is particularly weak in relation to antisocial young people with an emerging personality disorder who are often very difficult for agencies to manage. There is often a tendency to 'pass the parcel' of care from one agency to another.

It was clear from discussions that government guidance was needed on: the provision of specialist services for high risk/high harm children and their families; good practice on inter-agency collaboration in relation to these challenging cases; good practice on providing transition services from childhood to adult life.

The seminar presentations and discussions confirmed the fact that there are no treatment resources, in terms of modified assessment or enhanced parenting interventions for the sub-group of conduct disordered children with high levels of CU traits. It is clear that new treatment resources are required for this sub-group of children who can now be identified much more readily and who will, without treatment intervention incur very high costs for society by dint of their antisocial behaviour.

Although there is a good, emerging evidence base on effective treatment for children with sexually harmful behaviour, there are very few specialist resources for such children who also show high levels of CU traits. Furthermore, there are very few residential treatment resources for more seriously disturbed juvenile sex offenders.

As mentioned earlier, young people with offending behaviour who are in the residential care system are excluded from effective treatments such as MST or intensive fostering. Even the minority of young people who are given some form of therapy whilst in residential care, very seldom receive offence specific therapeutic input from trained therapists – their therapy often focuses only on past victimisation. This means that the attitudes and distorted thinking patterns which led them to offend and to become involved in the care system are seldom addressed directly whilst in a residential setting. There is therefore a specialist service deficit for the substantial number of offending young people in residential care.

8.7 Research

Most of the presentations and much of the discussion at the seminar commented on the dearth of outcome research in relation to two particular areas: treatment outcome studies for antisocial children; longitudinal follow up studies for the sub-groups of treated or untreated antisocial children, i.e. children with high levels of CU traits of those with sexually harmful behaviour.

It was acknowledged that there is a very substantial evidence base on the continuities between childhood precursors of general antisocial behaviour (including early indicators of high levels of CU traits) and adult antisocial behaviour. This very substantial literature has described the characteristics, risk, protective and resilience factors in relation to antisocial children in great detail over many decades of research. However, there has been relatively little written about the long term treatment outcomes for antisocial children. There has been hardly anything written about long term treatment outcomes for children in the sub-group with sexually harmful behaviour although some studies have tracked recidivism of untreated samples of these children over time. In the more recently described sub-group of children with high levels of CU traits, there are no treatment outcome studies since there is not yet agreement on what would constitute appropriate treatment. What is needed with the CU sub-group are pilot studies to ascertain the best, novel treatment approach for these young children and their parents.

Finally it was agreed that longitudinal follow up studies of antisocial children, including those in the sub-groups, should occur over a much longer period of time, from five to ten years. This long term follow up will allow time to see if children and young people assessed as high risk/high harm at an earlier stage of their childhoods so, in reality go on to become antisocial adults. It will be important that much longer term follow up studies should measure a wider range of issues than simple recidivism and that the social, parenting, workplace and emotional functioning of the child who is followed up into adulthood are also assessed.

8.8 Summary

8.8.1 *Good Agreement*

- Several risk factors can place children at increased risk of later antisocial behaviour. These include genetic, constitutional, emotional, cognitive and behavioural factors in the child, family functioning and environmental factors including the child's functioning at school.
- High risk children are likely to pursue particular developmental pathways (or trajectories) from early childhood towards antisocial behaviour and offending in adult life.
- There are several sub-groups of antisocial children who can now be identified, e.g. those with early onset of conduct disorder, those with callous-unemotional traits and those perpetrating sexually abusive behaviour.
- MST excludes intervention with high risk/high harm children in the residential care system and this raises the need to identify alternative, effective interventions for this substantial group of children.

8.8.2 *Some Agreement*

- Persistent forms of conduct disorder may comprise sub-groups of antisocial children, including those with early onset conduct problems and a sub-set with high levels of CU traits.
- There was emerging evidence for the early identification of these sub-groups of children
- Children with high levels of CU traits may show a differential response to parenting interventions.
- There was emerging evidence for certain developmental pathways (or trajectories) in children with sexually harmful behaviour towards adult anti-social behaviour.
- There was emerging evidence of the degree to which MST is effective with the sub-group of antisocial children who show sexually harmful behaviour.

8.8.3 *Lack of Agreement*

- Resilience and protective factors in high risk/high harm children with high CU traits.
- Sub-group appropriate interventions with children showing high levels of CU traits

8.8.4 *What works*

- Effective parenting interventions with young children displaying conduct problems who were still living at home.
- Systemic interventions, including MST for older children and adolescents presenting with conduct problems who were still living at home
- Effective, intensive fostering interventions with offending children placed away from home but not in care.

- Effective community based interventions with the sub-group of antisocial children showing sexually harmful behaviour

8.8.5 Deficits in Service Provision

- There is a lack of co-ordinated provision of treatment resources for antisocial children at local, regional and national levels and a particular deficit of services for the highest risk/high harm children and their families
- There is a lack of collaboration between agencies such as CAMHS and adult mental health services in the provision of transition services for children and young people showing antisocial behaviour. This applies particularly to those with learning disability, personality disorder or serious mental health problems who are moving from child to adult services.
- There are no treatment resources, in terms of modified assessment or enhanced parenting intervention, for sub-groups of children with conduct disorder who also had high levels of CU traits
- There are very few specialist treatment resources for young people showing sexually abusive behaviour who have concomitant CU traits.

8.8.6 Research Deficits

- There is a dearth of treatment outcome studies for antisocial children.
- There are no adequate longitudinal follow up studies of the sub-groups of treated or untreated antisocial children with sexually harmful behaviour or high levels of CU traits.

8.9 Other points

The question of 'labelling' high risk/high harm children and their families recurred throughout the seminar. There was no easy answer to the legitimate concerns raised about applying potentially pejorative labels to young children and their families, particularly given the lack of research evidence on longitudinal outcomes for these children (mentioned above).

However, equally, concerns were raised about the long delays in local professionals agreeing to refer such high risk/high harm children for specialist services with the subsequent worsening of behaviour and the creation of more victims. The possibility of provision of universal preventative services (for high risk/high harm behaviour) where everyone is helped and less people are stigmatised was also discussed.

It was agreed that there was a need for appropriate and non-stigmatising language to be developed which would encourage engagement and effective clinical practice. At the same time, it was acknowledged that a balance needed to be struck between the risk of labelling a child or family and the need to nip emerging problems in the bud for a very small number of potentially dangerous and expensive young offenders.

8.10 Recommendations

1. There should be co-ordination of service provision for high risk/high harm antisocial children at local, regional and national level. This co-ordination should include the provision of transition services from child to adult services for all sub-groups of antisocial children including those with learning disability, personality disorder and serious mental health problems.
2. At local level, training should be given to CAMHS (Child & Adolescent Mental Health Services), SSD's (Social Services Departments) the YOS's (Youth Offending Services) and other services dealing with antisocial young people so that they can offer treatment when appropriate or refer to specialists when necessary.
3. A small number of specialist regional resources should be established to deal with much higher risk/high harm children and young people. These regional resources should offer consultation and training to local colleagues and assessment and treatment for the most disturbed and dangerous antisocial young people, including identified sub-types such as young people with callous-unemotional traits and those showing sexually harmful behaviour.
4. There should be regular monitoring of the implementation of the recommendations from specialist assessments undertaken at local and regional levels to ensure that interventions for antisocial young people are actually made as recommended. This process should include monitoring the implementation of the guidance suggested at 5. below, in line with earlier good practice recommendations (Academy of Medical Sciences 2007).
5. At a national level, there should be government guidance on the provision of local and regional services. The guidance should be informed by up to date scientific thinking in the area of antisocial behaviour including recent advances in neuroscience. The guidance should also cover good practice such as inter-agency collaboration, dealing with children who are in both the care and criminal justice systems and referral to specialist resources.
6. A UK based treatment outcome study (RCT) with the sexually harmful behaviour sub-type of high risk/high harm children and their families should be funded to establish whether MST works for this sub-type. There should be a minimum of three to five years follow up for such an outcome study to give a realistic appraisal of treatment efficacy.
7. A pilot study of a novel parenting treatment approach with young children (3 – 6 years) showing callous-unemotional traits and their families should be funded to establish likely effective treatments, to generate hypotheses about the functioning of these children and to pave the way for later (RCT) outcome studies.
8. Prospective, longitudinal follow up studies should be undertaken with the sub-types of antisocial children and their families. These prospective studies should be for a minimum of five years to allow follow up of young people into adult life and to track their outcomes as parents.

9 Conclusions

There are no easy answers to the complex issues highlighted by this seminar. However, it has become clearer what we do know about early intervention in personality disorder based on the evidence as well as the areas where there are substantial gaps in our knowledge and where there is little or no agreement. The seminar recommendations draw on both the areas of evidence based knowledge and those areas where there are substantial gaps.

In order to address the needs of this challenging group of socially excluded children and their families better in future, it is clear that there needs to be a substantial investment of time and funding directed towards services and research

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APPENDIX I

11 LIST OF DELEGATES

| Name | | Job Title | Organisation |
|---------------|-----------|--|---|
| Prof. Sue | Bailey | Registrar | The Royal College of Psychiatrists |
| Tessa | Baradon | | The Anna Freud Centre |
| Geoffrey | Baruch | Director | The Brandon Centre |
| Nick | Benefield | National Personality Disorder Team | Department of Health |
| Sam | Blackburn | Research Psychology Assistant | The Anna Freud Centre |
| Charles | Borduin | Department of Psychological Sciences | University of Missouri-Columbia |
| Prof. Gwyneth | Boswell | School of Allied Health Professions | University of East Anglia |
| Dr Stephen | Butler | Senior Lecturer in Psychology / Consultant Clinical Psychiatrist | University College London / Islington CAMHS |
| Dr Jackie | Craissati | Head of Forensic Speciality | The Bracton Centre |
| Chris | Cuthbert | Deputy Director | Social Exclusion Task Force, Cabinet Office |
| Minna | Daum | Clinical Manager | The Anna Freud Centre |
| Deirdre | Dowling | Head of Child Psychotherapy | Cassell Hospital, West London Mental Health Trust |
| Claire | Etches | Social Exclusion Task Force | Cabinet Office |
| Dr Elly | Farmer | Clinical Psychologist | The National Clinical Assessment & Treatment Service, NSPCC |
| Samantha | Foster | Senior Research Officer, DSPD & TC Programme | Ministry of Justice |
| Dr Lesley | French | Consultant Clinical Psychologist | Oxleas Foundation NHS Trust |
| Dr Peter | Fuggle | Consultant Clinical Psychologist | Islington CAMHS |
| Deborah | Ghate | Principal Research Officer | Thomas Coram Research Unit |
| Dr Vinesh | Gupta | Consultant Adolescent Forensic Psychiatrist | St Andrew's Healthcare |
| Simon | Hackett | Deputy Head, School of Applied Social Sciences | Durham University |
| Nicole | Hickey | Forensic Research Psychologist | Imperial College London |
| Dr Nick | Hindley | Consultant Child & Adolescent Forensic Psychiatrist | Oxon & Bucks Mental Health Partnership NHS Trust |
| Cathy | James | Project Lead MST Programme | Department of Health |
| Helen | Jones | Professional Adviser | DCSF |
| Alice | Jones | Researcher | University College London |
| Dr Alexandra | Lewis | Consultant Psychiatrist | West London Mental Health Trust |
| Dr Eamon | McCrorry | Clinical Psychologist & Lecturer | University College London |

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|---------------|------------|--|--|
| Dr Linda | Meina | Consultant Clinical & Forensic Psychologist | Oxfordshire & Buckinghamshire Mental Healthcare NHS Trust |
| Dr Peter | Misch | Consultant Adolescent Forensic Psychiatrist | South London & Maudsley NHS Trust |
| Dr Paul | Monks | Clinical Researcher / Consultant Forensic Psychiatrist | Department of Forensic Mental Health Science, Institute of Psychiatry, KCL |
| Dr Theo | Mutale | Consultant Child & Adolescent Forensic Psychiatrist | South London and Maudsley NHS Trust |
| Theresa | Noutch | Women's Services Lead | PSPD Programme, Ministry of Justice |
| André | Picard | Director of Youth Forensic Psychiatric Services | British Columbia, Canada |
| Lorraine | Radford | Head of Research | NSPCC |
| Graeme | Richardson | Head of Psychology | Northern Forensic Mental Health Service for Young People |
| Prof. Randy | Salekin | Associate Professor of Psychology | The University of Alabama, USA |
| Prof. Stephen | Scott | Department of Child Psychiatry | Institute of Psychiatry |
| Dr David | Shelton | Consultant Clinical Psychologist | West London Mental Health Trust |
| Brigitte | Squire | ISSP/MST Services Manager | Cambridge Youth Offending Service |
| Alex | Sumich | Research Scientist | Institute of Psychiatry |
| Martin | Teff | Social Exclusion Action Plan | Department of Health |
| Dr Troy | Tranah | Consultant Psychologist | Maudsley Hospital / SLAM |
| David | Utting | Independent Writer and Researcher | |
| Dr Essi | Viding | Department of Psychology | University College London |
| Dr Eileen | Vizard | Consultant Child & Adolescent Psychiatrist, Honorary Senior Lecturer | University College London |
| Peter | Wedge | Emeritus Professor | University of East Anglia |