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**Cochrane Nursing Care Field – Cochrane Review Summary**

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**Cochrane Database of Systematic Reviews**  
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***TITLE: Atypical antipsychotic drugs for disruptive behaviour disorders in children and youths.***

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**Background:** There has been a significant increase in atypical prescribing for children and youths with disruptive behaviour disorder across a range of developed countries. (Dean, 2006; Doey, 2007; Harrison Woolrych, 2007; Rani 2008; Olfson, 2010). Controversial new diagnoses, such as disruptive mood regulation disorder (Baweja, 2016), and a rise in the use of atypical antipsychotic medication in vulnerable child populations, has made the diagnostic and prescribing picture for childhood behavioural disorders more complex (Greenhill, 2003).

It is important for nurses who are placed in community adolescent mental health teams (CAMHS) to be aware of prescribing issues related to the use of atypical antipsychotic medication for the children in their care. The majority of atypical antipsychotic prescribing is not conducted by consultant adolescent and child psychiatrists (Karanges, 2014), so it is crucial for front-line nursing practitioners to be able to offer objective, evidenced-based, balanced advice to allied practitioners, families and carers, when considering their use. Nurses are most likely to be the first point of contact for gatekeeping, as well as reviewing and monitoring child and adolescent behaviour post prescribing, including ongoing risk assessment and management (e.g. NHS England 2014).

Specified drug use must be seen within the overall context of a holistic blend of therapeutic interventions, which involve the use of 1:1 therapeutic approaches, multi-systemic family therapy, education and behavioural-guidance setting. The use of antipsychotic medication should not be used for the routine management of problem behaviours in children with conduct disorder, or oppositional defiant disorder (NICE, 2013,1.6.1). Effective nursing practice, particularly for CAMHS practitioners, should reflect a balanced approach based upon the needs and voice of the child, family and associated carers.

**Objective/s:**

To evaluate the effects and safety of atypical antipsychotic medication for children and adolescents with a range of disruptive behaviour disorders, as compared to a placebo.

To evaluate the effect of each brand of atypical antipsychotic, as opposed to the whole class effect.

**Intervention/Methods:** The review included randomised-controlled, double-blinded trials of children and adolescents up to and including 18 years of age with a diagnosed disruptive behaviour disorder, who were prescribed atypical antipsychotic medication, with those not prescribed medication as a control group. The studies covered children in any setting and included participants who had a comorbid diagnosis of ADHD, major depression, anxiety disorders or intellectual disability. Children with a comorbid diagnosis of pervasive developmental disorders, psychotic disorder, mood disorder, or autistic spectrum disorder were excluded from the study. The intention was to exclude studies where antipsychotic medication was being used to treat symptoms other than conduct disorder.

The review included studies of any atypical antipsychotic delivered by any means of delivery, for any duration, compared to placebo. Trials that involved the use of other medication, including additional associated psychosocial interventions were also eligible for inclusion to reflect 'real life' situations as mirrored in everyday clinical practice.

Intended outcome measures were reductions in the levels of aggressive behaviour, reductions in relation to conduct or disruptive behaviour problems, and any adverse events, such as weight gain or related to metabolic parameters. Intended time points for analysis of outcome measures were six weeks and six months.

**Results:** 10 studies, conducted between 2000 and 2014, were included in the review. Most (n = 8) included outpatients and in eight studies there were significantly more males than females. Of the 10 included studies, eight investigated the effect of risperidone, one quetiapine and the other ziprasidone. Consequently, it was only possible to evaluate the effects of risperidone by meta-analysis.

Results of a meta-analysis of three studies (238 children) suggested that risperidone reduced aggression at the six-week period, but the evidence for this was of low quality. Results of a meta-analysis of two studies (225 children) found that risperidone also led to reductions in conduct problems after six weeks of treatment, and the evidence for this was of moderate quality.

Levels of weight gain were significantly higher in children given either risperidone (2.37 kg higher; two studies, 138 children) or risperidone and a stimulant (2.14 kg higher; three studies, 305 children), than those given placebo, over the six to 10-week treatment period.

**Conclusions:** The review found some evidence that risperidone reduces aggression and conduct problems in children and youths with disruptive behaviour disorders. Both findings could be clinically significant, but should be interpreted with caution due to the small number of high-quality trials.

There is some concern with regards to weight gain associated with the use of risperidone over the treatment period. It is unclear whether this would attenuate or become a significant clinical issue over time.

The limited strength of the evidence suggests that the use of risperidone should be carefully considered. Medication should be used with, or preceded by effective psychosocial treatments. This is consistent with current clinical guidance, which states that medication should not be used alone as a method to reduce levels of aggression and conduct problems in a largely vulnerable and complex population.

**Implications for Practice:** There is limited but useful evidence to suggest that risperidone could be effective in reducing levels of aggression and conduct problems in children with disruptive behaviour disorders in the short term. This should be offset with considerations relating to likely weight gain and the consequent clinical and sociological impacts to a child.

The role of the nurse in monitoring prescribing is key to the area of CAMHS provision. The majority of children with disruptive behaviour disorder are likely to be managed within non-clinical environments such as the home and single agencies such as schools, general practitioner surgeries, social services, criminal justice agencies and education welfare services. The primary role for the CAMHS nurse will involve a signposting and gatekeeping role when individuals and agencies seek advice on how to manage disruptive behaviour. It is possible that the question of whether to prescribe atypical psychotic medication may arise in these discussions. The use of these medications need to be contextualised within the current framework of treatment and care, which includes a range of effective bio-psychosocial interventions, as prescribed via NICE guidance.

For those children who meet the threshold of CAMHS provision, the role of the nurse will be integral with regards risk management, intervention and ongoing therapeutic treatment of the child. The presence of some form of disruptive behaviour disorder is likely to be a primary cause for referral. The use of atypical antipsychotic medication is one intervention which given the limited strength of evidence, should be considered with caution and never as an isolated intervention.

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