

Conduct Disorder: Practice Parameters for Assessment, Treatment, and Prevention

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INTRODUCTION

Purpose

These practice parameters summarize the current scientific research evidence about conduct disorder in children and youth in order to provide information about effective practices for assessment, treatment, and prevention. The target audiences for these parameters include families, policy-makers, and frontline workers, such as social workers, psychologists, police, teachers, physicians, and others who work with children and youth with conduct disorder in Canada.

Evaluation and Updating

These parameters will be updated as new research evidence becomes available. Written feedback is welcome from all users and will be considered for future editions. These parameters will also be formally evaluated in the future.

Evaluating Scientific Research Evidence

Most research evidence about conduct disorder comes from the fields of child psychology and psychiatry. Conduct disorder has usually been approached from 1 of 2 theoretical perspectives: either social or moral deficiencies lead to antisocial behaviour (these kids are “bad”), or antisocial behaviour is a reaction to harsh circumstances (these kids are “mad”) (1). Recently, most researchers have used models that incorporate both perspectives in investigating causal risk factors, prevention, and treatment for conduct disorder (2).

Causal risk factors are measurable characteristics in individuals or populations that precede outcomes of interest and that change the risk of outcome if manipulated (3). Causal

risk factors should not be confused with *correlates*, which are characteristics associated with outcomes of interest but which do not necessarily precede outcomes of interest and are therefore not necessarily causal (3). Knowledge about causal risk factors usually informs research about interventions. Preventive interventions modify causal risk factors early, before problems arise, while treatment interventions detect and ameliorate or rehabilitate established problems (4).

Given these definitions, the research findings on causal risk factors, treatment, and prevention with conduct disorder are summarized. Only findings supported by strong evidence from research using rigorous designs, such as randomized controlled trials, are summarized (5).

WHAT IS THE SCOPE OF THE PROBLEM?

What Is Conduct Disorder?

Definitions

“Conduct disorder” is a psychiatric term referring to children and youth who display repetitive and persistent antisocial behaviours such as bullying, cruelty, stealing, weapons use, fire-setting, lying, running away, and truancy (6–13). Youth who have been involved with the police and the courts are usually termed “delinquents” or “young offenders” and are thought, for the most part, to represent a subgroup with severe conduct disorder (8).

The following description (14) of a Hamilton, Ontario youth epitomizes severe conduct disorder:

The youth who sprang his girlfriend from Arrell Youth Centre has a record many career criminals would envy. Unfortunately for society, he just turned 15 and has discovered an interest in illegal handguns. “This is a one-kid crime wave,” said a Hamilton-Wentworth police officer who spoke on condition of anonymity. “He’s not like other child criminals—not even close. He’s a bad kid.” That kid is in police custody today.

Background history revealed that this youth had persistent antisocial behaviours, including stealing, weapons use, and running away, that qualified him for a diagnosis of conduct disorder (15).

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Diagnosis

To receive a diagnosis of conduct disorder, a child or youth must meet the criteria A and B outlined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) of the American Psychiatric Association (15) (Table 1).

Why Is Conduct Disorder Important?

Prevalence and Burden of Suffering

Conduct disorder is important for several reasons. First, it is relatively common. Approximately 5.5% of Ontario children aged 4 to 16 years are affected (7), and conduct disorder is the most common reason for referral to child psychiatry services in North America (9). Second, it causes a heavy burden of suffering for individuals. It usually persists over time, has associated impairments, and progresses on a continuum: aggressive children become conduct-disordered youth who later become antisocial adults (6,9,12). The more severe the childhood symptoms, the worse the adult outcomes (6,9).

Third, conduct disorder causes a heavy burden of suffering for society. Each year, approximately 10% of Canada's 2 million youths aged 12 to 17 years have contact with the police because of their criminal activities (16). Rates of violent crime for youth, though controversial, are thought to have doubled in Canada between 1986 and 1992 and to have stabilized since 1992 (17). It costs approximately \$95 000 each year to keep a youth in secure custody in Canada, double what it costs to keep an adult (13).

While not all young offenders have the severe and persistent form of antisocial behaviour known as conduct disorder, and while not all conduct disorder leads to criminal charges, the costs of conduct disorder to human services and justice systems are heavy, as are the costs of lost human potential and costs to victims. Overall, conduct disorder is one of the most important children's public mental health problems in North America (1,9,11–13).

Course and Outcomes

Numerous studies have evaluated the long-term course and outcomes of conduct disorder (6,11,12). Many children and youth with conduct disorder will have adult psychiatric, occupational, and relationship problems, including involvement in criminal activities (11). However, fewer than 50% of children with conduct disorder have severe and persistent antisocial problems as adults (9). What predicts the course and outcomes? In general, early age of onset (before 10 or 12 years of age), greater frequency and severity of antisocial activities, and occurrence of antisocial activities in both home and community settings all predict worse outcomes (11).

Table 1. Diagnosing conduct disorder

A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of any three (or more) of the following (15) criteria in the past 12 months, with at least one criterion present in the past 6 months:
Aggression to people and animals:
1) often bullies, threatens, or intimidates others
2) often initiates physical fights
3) has used a weapon that can cause serious physical harm to others (eg, a bat, brick, broken bottle, knife, gun)
4) has been physically cruel to people
5) has been physically cruel to animals
6) has stolen while confronting a victim (eg, mugging, purse snatching, extortion, armed robbery)
7) has forced someone into sexual activity
Destruction of property:
8) has deliberately engaged in fire setting with the intention of causing harm
9) has deliberately destroyed others' property (other than by fire setting)
Deceitfulness or theft:
10) has broken into someone's house, building, or car
11) often lies to obtain goods or favours or to avoid obligations (ie, "cons" others)
12) has stolen items of nontrivial value without confronting a victim (eg, shoplifting, forgery)
Serious violation of rules:
13) often stays out at night starting before age 13 years
14) has run away from home overnight at least twice (or once without returning for a lengthy period)
15) is often truant from school starting before age 13 years
B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

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WHAT DO WE KNOW ABOUT CONDUCT DISORDER?

Risk and Protective Factors

The search for causal risk factors usually starts with identifying correlates. There are many correlates of conduct disorder: male gender, chronic health problems, difficult temperament, reduced autonomic nervous system reactivity, school failure, parental criminality, parental discord, harsh and inconsistent parenting, large family size, and poverty (1,8,9,11). Many correlates overlap (8). One of the strongest correlates is harsh and inconsistent parenting (1,9,11). Poverty, affecting 18% of Canadian children (16), correlates strongly with psychosocial morbidity in general, including conduct disorder (18). The impact of exposure to television violence is unclear (1,12,13). Genetic markers of criminality have been sought but not yet found (8,9,11).

While conduct disorder has many correlates, only 3 risk factors have been clearly identified as *causal*: harsh, inconsistent parenting; poor academic performance; and exposure to parental discord (8). Many researchers suggest that conduct disorder is a complex problem with multiple social and biological determinants (1,8,9,11–13). Most researchers

Table 2. Effective treatments for conduct disorder

Intervention	Description	Evaluation
1. Cognitive problem-solving skills training	Individual or group training to improve cognitive problem-solving processes; for example, to correct negative attributions or impulsivity.	Several studies show good outcomes: long-term impact (beyond 2 to 5 years) not known; treated youth may still not function as well as healthy peers.
2. Parent management training	Individual or group training with high-risk parents to reduce coercion, to increase prosocial exchanges, and to increase consistency.	Numerous studies show positive long-term (1 to 14 years) effects; children in treated families function as well as peers; more effective for children than adolescents.
3. Functional family therapy	Treatment combining a systems approach with cognitive and behavioural modification to improve family communication patterns and support functions.	Several studies show improved outcomes for conduct-disordered youth; outcomes beyond 2 to 5 years not known.
4. Multisystemic therapy	Family-based treatment involving multiple systems (family, school, community) to improve prosocial behaviour in children and parents.	Several studies show effective outcomes with severe conduct disorder; improvements maintained at 5-year follow-up.

As summarized by Kazdin (11).

Table 3. Effective prevention of conduct disorder

Intervention	Description	Evaluation
1. Preschool child development programs	Parents and families identified based on risk factors such as poverty; home visits provided to support healthy prenatal and child development.	Several studies show improved child health outcomes over 2- to 10-year follow-up, including reduction in child antisocial behaviour.
2. School programs	Children identified based on risk factors such as poverty; mix of interventions provided including classroom enrichment, home visits, and parent and teacher training.	Several studies show improved academic achievement and lower rates of antisocial behaviour at 2- to 15-year follow-up.
3. Community programs	Children and youth identified based on risk factors such as involvement with social agencies; mix of interventions provided including enhanced recreation programs, parent training, and mentoring by adults of children and youth.	Several studies show improved outcomes with antisocial children and youth; long-term outcomes not known.

As summarized by Kazdin (11).

agree that children and youth with conduct disorder are severely and multiply disadvantaged (1,8,9,11–13). In addition, many children and youth with conduct disorder have comorbid disorders such as attention-deficit hyperactivity disorder (ADHD), learning disabilities, or substance abuse (11).

In contrast to causal risk factors, causal protective factors reduce the incidence of conduct disorder, especially under conditions of high risk for its onset. Several factors have been shown to be protective regarding conduct disorder: easy temperament, above-average intelligence, competence at a skill, and a good relationship with at least 1 caregiving adult (8,11).

Treatment

Many treatment strategies have been researched for conduct disorder at the individual, parent, family, and community levels. Although there is still uncertainty, Table 2 outlines 4 approaches that have been shown to be effective based on good studies replicated in multiple trials (19–28), as summarized by Kazdin (11).

While many other treatments are used, these 4 show the most promise (11). In addition, given the severity and chronicity of conduct disorder, most authors advocate using multiple

interventions with long-term or continuing-care approaches (11,29).

Some interventions are clearly ineffective. Medications do not work (1,11), except where comorbid conditions such as ADHD are present (30). Tough, punitive measures such as prolonged incarceration or “boot camps” have not proven effective (11,13,29,31,32). In fact, incarceration or isolation with deviant peers may worsen outcomes (11,29,31,32). Many popular interventions such as “zero-tolerance” or “tough love” policies have not yet been rigorously evaluated (11,13,29,31). Finally, individual (psychodynamic) psychotherapy is not promising (11,29).

Prevention

Can we intervene early to prevent conduct disorder and its associated problems? Prevention is a priority, not just because of the suffering associated with conduct disorder, but also because treatments are costly and can only reach a minority of those in need (11,33–35). Prevention programs may be universal (applied to all children, youth, and families) or targeted (applied only to children, youth, and families identified as high-risk) (11,35). Although there is still uncertainty about

Table 4. Assessing conduct disorder

1. Clarify purpose of assessment:	community clinical forensic (court-related or court-ordered)
2. Obtain history (social, developmental, medical, psychiatric):	child or youth parents or family school community agencies justice system
3. Obtain or complete testing as needed:	assessments of intelligence and learning disabilities parent or teacher ratings or scales emotional or behavioural evaluations
4. Identify causal risk and causal protective factors:	child or youth parents and family school and community
5. Diagnosis (DSM-IV):	rule out other disorders and problems such as depression, substance abuse, attention-deficit hyperactivity disorder, learning disabilities, posttraumatic stress disorder, seizures, and maltreatment (abuse or neglect) confirm conduct disorder, comorbid disorders
6. Formulation:	why this child or adolescent with these problems at this time? identify causal risk and protective factors that can be targeted (where there is evidence that the intervention makes a difference)
7. Develop management plan:	involve child or youth together with parents or family (if available) and community agencies (including school, justice, and child protection agencies) ensure safety and instrumental needs are met plan for ongoing care and case management incorporating formulation

prevention, Table 3 outlines 3 approaches that show promise (8,9,12,29,33), as summarized by Kazdin (11).

Overall, few prevention interventions have been evaluated for their long-term effects (beyond 2 to 5 years), and few have focused on conduct disorder specifically (11). Little is known about actual mechanisms that produce change in children, families, or communities, or about optimal times to intervene (11).

Prevention is also not without costs. Universal programs avoid labelling but may be expensive and may benefit mostly children and families who are not at highest risk (35). Targeted programs depend on accurately identifying children at risk—which is difficult—and may expose children, particularly those who are identified, to labelling and stigmatization (35).

Finally, epidemiological evidence supports preventive interventions with conduct disorder. Given the high (20%) prevalence rates for childhood psychiatric disorders in general (7), specialized mental health clinics that serve only individuals that come to them cannot meet the needs adequately (34). Rather, communities need population health approaches (universal or targeted) that focus on broad determinants of

Table 5. Treating conduct disorder

1. Child or youth:	ensure safety and instrumental needs are met (food, shelter, health care, finances, caregiving adult) provide education and support treat comorbid mental health problems ensure academic support ensure recreation or skill competence ensure ongoing good relationship with at least 1 adult trial of cognitive problem-solving skills training manage any medical problems ensure long-term and multiple interventions
2. Parent or family:	ensure safety and instrumental needs are met (food, shelter, health care, finances) provide education and support ensure community supports, including child protection if maltreatment trial of parent management training if coercive or inconsistent parenting trial of functional family therapy if poor communications treat any parental medical or psychiatric illness
3. Community:	encourage full participation by all children and parents in community life encourage mentoring and recreation programs provide education and support to community stakeholders identify continuing care and case management plan in community avoid labelling and stigmatization multisystemic therapy involving child and family together with school and community agencies, including justice system, to increase prosocial behaviours consider community service or “diversion” programs for “young offenders” consider foster care or residential treatment as a last resort

mental health in addition to clinical programs to deal adequately with children’s mental health problems, including conduct disorder (34,35).

WHAT DO WE DO ABOUT CONDUCT DISORDER?

Assessment

Since conduct disorder involves multiple problems affecting multiple domains of functioning, assessment is complex (29). Children and youth with conduct disorder also interact with multiple systems, any of which may be the entry point for assessment, such as social services, schools, primary care, or juvenile justice systems (29,36). Assessment should involve multiple informants and multiple methods in multiple settings (29). Table 4 outlines a comprehensive approach to assessment and formulation (37) best used with a multidisciplinary team.

Treatment

Once comprehensive assessment is completed, a treatment plan can be developed involving children or youth, parents or families, and community agencies. No single intervention is likely to be effective; rather, multiple long-term interventions are needed (29). Table 5 outlines a comprehensive approach to treatment best provided by a multidisciplinary team (11,29). This approach assumes that conduct disorder is

chronic and needs ongoing care (similar, for example, to diabetes), and is based on the evidence summarized in Table 2.

Predicting Violence

Many community and clinical caregivers are concerned with predicting the future risk of violence, particularly among “young offenders.” Youth involved with the justice system are often caught between the competing and often contradictory agendas of treatment and punishment (38). The justice system, to predict violence, often needs tools to ensure community safety and to determine whether treatment or punishment should predominate (38).

Little is certain regarding the prediction of violence in youth or adults (38–41). The concept of “psychopathy” has been used to develop adult checklists of symptoms that correlate with DSM-IV disorders and which predict recidivism in violent adults (39). However, reliable and valid checklists, especially for individuals, have not yet been developed for predicting the onset or course of child or youth antisocial behaviour or recidivism (38,40).

What predicts violence in children and youth in the absence of reliable and valid checklists? In general, early onset (before age 10 or 12 years) and greater frequency and severity of antisocial behaviours in both home and community settings all predict worse outcomes (11). However, it is important to note the function of protective factors and to recall that fewer than 50% of children and youth with conduct disorder become persistently antisocial as adults (9).

Prevention and Policy Considerations

Preventive measures against conduct disorder can have positive effects and can save money on future remedial and correctional services (8,9,11–13,29,33,40). Most prevention evidence focuses on programs targeted for high-risk children and families in general (Table 3). Clinical programs alone cannot adequately reduce the burden of suffering from conduct disorders (34). There is no evidence to support policies favouring punitive approaches such as prolonged incarceration, “boot-camps,” or increased sentences for youth (13,29,31,32). Short-term and individual approaches alone do not work (11).

Instead, coordinated community programs with synergistic effects are needed to reduce the burden of suffering (35). Conduct disorder starts early and grows, lending itself to prevention, so the earlier communities and front-line workers intervene, the better. In addition to specific preventive programs, all children’s mental health programs need the support of civic communities, where a mixture of universal, targeted, and clinical programs can flourish (35).

What are the implications for policy-makers? Children, youth, families, and society can all benefit from approaches that make the best use of evidence for treatment and prevention. For conduct disorder, this means using multiple long-term treatment approaches that focus on children and families with early symptoms of conduct disorder. It also means launching and continuously monitoring effective universal and targeted prevention programs within the context of communities that are concerned about children and youth at risk.

REFERENCES

1. Earls F. Oppositional-defiant and conduct disorders. In: Rutter M, Taylor E, Hersov L, editors. *Child and adolescent psychiatry*. 3rd ed. Oxford: Blackwell Science; 1994. p 308–29.
2. Rutter M. Antisocial behavior: developmental psychopathology perspectives. In: Stoff D, Breiling J, Maser J, editors. *Handbook of antisocial behaviour*. Toronto: Wiley and Sons; 1997. p 115–24.
3. Kraemer H, Kazdin A, Offord D, Kessler R, Jensen P, Kupfer D. Coming to terms with the terms of risk. *Arch Gen Psychiatry* 1997;54:337–43.
4. Shah C. *Public health and preventive medicine in Canada*. 3rd ed. Toronto: University of Toronto Press; 1994.
5. Sackett D, Haynes B, Tugwell P. *Clinical epidemiology: a basic science for clinical medicine*. Toronto: Little, Brown and Company; 1985.
6. Robins L. *Deviant children grown up*. Baltimore (MD): Williams and Wilkins; 1966.
7. Offord DR, Boyle MH, Fleming JE, Munroe Blum H, Rae Grant NI. Ontario Child Health Study: summary of selected results. *Can J Psychiatry* 1989;34:483–91.
8. Offord D. Conduct disorder: risk factors and prevention. In: Shaffer D, Philips I, Enzer N, editors. *Prevention of mental disorders, alcohol and other drug use in children and adolescents*. Rockville (MD): US Department of Health and Human Services; 1989. p 273–307.
9. Robins L. Conduct disorder. *J Child Psychol Psychiatry* 1991;32:193–212.
10. Offord D, Boyle M, Racine Y, Fleming J, Cadman D, Munroe Blum H, and others. Outcome, prognosis, and risk in a longitudinal follow-up study. *J Am Acad Child Adolesc Psychiatry* 1992;31:916–23.
11. Kazdin A. *Conduct disorders in childhood and adolescence*. 2nd ed. Thousand Oaks: Sage Publications; 1995.
12. Offord D, Bennett K. Conduct disorder: long-term outcomes and intervention effectiveness. *J Am Acad Child Adolesc Psychiatry* 1994;33:1069–78.
13. Werry JS. Severe conduct disorder—some key issues. *Can J Psychiatry* 1997;42:577–83.
14. Herron S. 'Bad Kid' behind breakout only 15. *The Hamilton Spectator*. 1995 Sept 23.
15. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders*. 4th ed. Washington (DC): American Psychiatric Association; 1994.
16. Hanvey L, Avard D, Graham I, Underwood K, Campbell J, Kelly C. *The health of Canada's children: a CICH profile*. 2nd ed. Ottawa: Canadian Institute of Child Health; 1994.
17. Scott K. *The progress of Canada's children 1996*. Ottawa: Canadian Council on Social Development; 1996.
18. Lipman E, Offord D, Boyle M. Relation between economic disadvantage and psychosocial morbidity in children. *Can Med Assoc J* 1994;151:431–7.
19. Crick N, Dodge K. A review and reformulation of social information processing mechanisms in children's social adjustment. *Psychol Bull* 1994;115:74–101.
20. Finch A, Nelson W, Ott E. *Cognitive-behavioural procedures with children and adolescents: a practical guide*. Needham Heights (MD): Allyn & Bacon; 1993.
21. Shure M. *I can problem solve (ICPS): an interpersonal cognitive problem solving program*. Champaign (IL): Research Press; 1992.
22. Kazdin A. Treatment of conduct disorder: progress and directions in psychotherapy research. *Dev Psychopathol* 1993;5:277–310.
23. Forehand R, McMahon R. *Helping the non-compliant child: a clinician's guide to parent training*. New York: Guilford; 1981.
24. Sanders M, Dadds M. *Behavioural family intervention*. Needham Heights (MD): Allyn & Bacon; 1993.
25. Alexander J, Parsons B. *Functional family therapy*. Monterey (CA): Brooks Cole; 1982.
26. Alexander J, Holtzworth-Munroe A, Jameson P. The process and outcome of marital and family therapy research: review and evaluation. In: Bergin A, Garfield S, editors. *Handbook of psychotherapy and behavior change*. 4th ed. New York: Wiley; 1994. p 595–630.
27. Henggeler S. *Treatment manual for family preservation using multisystemic therapy*. Charleston (SC): Medical University of South Carolina; 1994.
28. Henggeler S, Schoenwald S, Borduin C, Rowland M, Cunningham P. *Multisystemic treatment of antisocial behavior in children and adolescents*. New York: Guilford; 1998.
29. American Academy of Child and Adolescent Psychiatry. Practice parameters for the assessment and treatment of children and youth with conduct disorder. *J Am Acad Child Adolesc Psychiatry* 1997;36:122S–139S.
30. Klein R, Abikoff H, Klass E, Ganeles D, Seese L, Pollack S. Clinical efficacy of methylphenidate in conduct disorder with and without attention deficit hyperactivity disorder. *Arch Gen Psychiatry* 1997;54:1073–80.
31. Sheldrick C. Treatment of delinquents. In: Rutter M, Taylor E, Hersov L, editors. *Child and adolescent psychiatry*. 3rd ed. Oxford: Blackwell Science; 1994. p 968–82.
32. Lewis D, Yeager C, Lovely R, Stein A, Cobham-Portorreal C. A clinical follow-up of delinquent males: ignored vulnerabilities, unmet needs, and the perpetuation of violence. *J Am Acad Child Adolesc Psychiatry* 1994;33:518–28.
33. Boyle M, Offord D. Primary prevention of conduct disorder: issues and prospects. *J Am Acad Child Adolesc Psychiatry* 1990;29:227–33.
34. Rae Grant N, Offord D, Monroe Blum H. Implications for clinical services, research and training. *Can J Psychiatry* 1989;34:492–9.
35. Offord D. The state of prevention and early intervention. In: Peters R, McMahon R, editors. *Preventing childhood disorders, substance abuse, and delinquency*. Thousand Oaks (CA): Sage Publications; 1996. p 329–44.
36. Hinshaw S, Zupan B. Assessment of antisocial behaviour in children and adolescents. In: Stoff D, Breiling J, Maser J, editors. *Handbook of antisocial behaviour*. Toronto: Wiley and Sons; 1997. p 36–50.
37. Weerasekera P. *Multiperspective case formulation*. Malabar (FL): Krieger; 1996.
38. Tolan P, Gorman-Smith D. Treatment of juvenile delinquency: between punishment and therapy. In: Stoff D, Breiling J, Maser J, editors. *Handbook of antisocial behaviour*. Toronto: Wiley and Sons; 1997. p 405–15.
39. Hart S, Hare R. Psychopathy: assessment and association with criminal conduct. In: Stoff D, Breiling J, Maser J, editors. *Handbook of antisocial behaviour*. Toronto: Wiley and Sons; 1997. p 22–35.
40. Tremblay R, Craig W. Developmental crime prevention. In: Torry M, Farrington D, editors. *Building a safer society: strategic approaches to crime prevention*. Chicago: University of Chicago Press; 1995. p 151–236.
41. Ash P, Devdeyn A. Forensic child and adolescent psychiatry: a review of the past 10 years. *Am J Child Adolesc Psychiatry* 1997;36:1493–1502.

FEEDBACK ABOUT THESE PARAMETERS

These parameters will be updated every 3 years, and user feedback will be considered for future editions. Please answer the following questions:

1. Who are you and what do you do?

2. How did you obtain these parameters?

3. How do these parameters apply to your work? If they do not, why not?

4. What did you learn from these parameters?

5. What, if anything, will you do differently because of these parameters?

6. Any concerns about format? What would help?

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