Antisocial personality disorder: treatment, management and prevention

NICE guideline

Draft for consultation, August 2008

If you wish to comment on this version of the guideline, please be aware that all the supporting information and evidence is contained in the full version.

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Introduction

This guideline makes recommendations for the treatment, management and prevention of antisocial personality disorder in primary, secondary and tertiary (specialist) healthcare. The guideline also has implications for social care and the criminal justice system.

People with antisocial personality disorder exhibit traits of impulsivity, high negative emotionality, low conscientiousness and associated behaviours including irresponsible and exploitative behaviour, recklessness, and deceitfulness. This is manifest in unstable interpersonal relationships, disregard for the consequences of one's behaviour, a failure to learn from experience, egocentricity and a disregard for the feelings of others. The condition is associated with a wide range of interpersonal and social disturbance. People with antisocial personality disorder have frequently grown up in fractured families where parental conflict is the norm and where parenting is often harsh and inconsistent. As a result of parental inadequacies and/or the child's own difficult behaviour (or both), the child's care is often interrupted and transferred to agencies outside the family. This in turn often leads to school truancy, delinquent associates and substance misuse. These disadvantages frequently result in increased rates of unemployment, poor and unstable housing, and inconsistency in relationships in adulthood. Many have a criminal conviction and are imprisoned or die prematurely as a result of reckless behaviour.

Criminal behaviour is central to the definition of antisocial personality disorder, although this is often the culmination of previous and long-standing difficulties. Antisocial personality disorder therefore amounts to more than criminal behaviour alone, otherwise all of those convicted of a criminal offence would meet criteria for antisocial personality disorder and a diagnosis of antisocial personality disorder would be rare in those without a criminal history. However, this is not the case. The prevalence of antisocial personality

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disorder among prisoners is slightly less than 50%. Similarly, epidemiological studies in the community estimate that only 47% of people meeting criteria for antisocial personality disorder have significant arrest records; a history of aggression, unemployment and promiscuity were more common than serious crimes among people with antisocial personality disorder. The prevalence in the general population is 3% in males and 1% in females. Under current diagnostic systems, antisocial personality disorder is not formally diagnosed before the age of 18 but the features of the disorder can manifest earlier as conduct disorder (indeed a prerequisite for a diagnosis of antisocial personality disorder in DSM-IV is a history of conduct disorder prior to the age of 15). Its course is variable and although recovery is attainable over time, some people may continue to experience social and interpersonal difficulties. Antisocial personality disorder is often comorbid with depression, anxiety, alcohol and drug misuse.

This guideline draws on the best available evidence. However, it should be noted that there are significant limitations to the evidence base, notably a relatively small number of randomised controlled trials (RCTs) of interventions with few outcomes in common, some of which are addressed by recommendations for further research.

At the date of consultation (August 2008), no drug has UK marketing authorisation for the treatment of antisocial personality disorder. The guideline assumes that prescribers will use a drug's summary of product characteristics to inform their decisions for individual patients.

A separate guideline on borderline personality disorder is being developed by NICE (see section 6 – related NICE guidance).

Person-centred care

This guideline offers best practice advice on the care of people with antisocial personality disorder.

Treatment and care should take into account service users' needs and preferences. People with antisocial personality disorder should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If service users do not have the capacity to make decisions, healthcare professionals should follow the Department of Health guidelines – 'Reference guide to consent for examination or treatment' (2001) (available from www.dh.gov.uk). Healthcare professionals should also follow a code of practice accompanying the Mental Capacity Act (summary available from www.dca.gov.uk/menincap/bill-summary.htm).

If the person is under 16, healthcare professionals should follow guidelines in 'Seeking consent: working with children' (available from www.dh.gov.uk).

Good communication between healthcare professionals and service users is essential. It should be supported by evidence-based written information tailored to the service user's needs. Treatment and care, and the information service users are given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English.

If the service user agrees, families and carers should have the opportunity to be involved in decisions about treatment and care.

Families and carers should also be given the information and support they need.

Care of young people in transition between paediatric and adult services should be planned and managed according to the best practice guidance described in 'Transition: getting it right for young people' (available from www.dh.gov.uk).

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Key priorities for implementation

Developing an optimistic and trusting relationship

- Staff working with people with antisocial personality disorder should recognise that a positive and rewarding approach is more likely to be successful than a punitive approach in engaging and retaining service users in treatment. Staff should:
  - explore treatment options in an atmosphere of hope and optimism, explaining that recovery is possible and attainable
  - build up a trusting relationship, work in an open, engaging and non-judgemental manner, and be consistent and reliable. **[1.1.1.11]**

Children with conduct problems

- For children aged 8 years and older with conduct problems, cognitive problem-solving skills training may be considered. **[1.2.4.1]**

Assessment in specialist services

- Healthcare professionals in specialist services should consider, as part of a structured clinical assessment, the routine use of:
  - a standardised measure of the severity of antisocial personality disorder, for example the Psychopathy Checklist–Revised (PCL-R) or the Psychopathy Checklist–Screening Version (PCL-SV)
  - a formal assessment tool such as the Historical, Clinical, Risk Management-20 (HCR-20) in order to develop a risk management strategy. **[1.3.2.7]**

Treatment of comorbid disorders

- People with antisocial personality disorder should be offered treatment for any comorbid disorders in line with existing NICE guidance. This should be done irrespective of whether the person is receiving treatment for antisocial personality disorder. **[1.4.1.1]**

The role of psychological interventions

- People with antisocial personality disorder with a history of offending behaviour in community and institutional care should be offered group-based cognitive and behavioural interventions (for example, programmes such as Reasoning and Rehabilitation and Enhanced Thinking Skills) focused on reducing offending and other antisocial behaviour. **[1.4.2.2]**

Multi-agency networking

- Provision of services for people with antisocial personality disorder often involves significant inter-agency working. Therefore services should ensure that there are clear pathways for people with antisocial personality disorder so that the most effective multi-agency care is provided. These pathways should:
  - have established thresholds at transition points that are agreed locally and are made known to service users
  - specify the various interventions that are available at each point in the pathway
  - enable effective communication among clinicians and organisations at all points of the pathway and provide the means to resolve differences and disagreements. **[1.6.1.1]**

- Services should consider the establishment of antisocial personality disorder networks, where possible linked to wider personality disorder networks. These may be organised at the level of Strategic Health Authorities. These networks, which should be multi-agency and involve service users, should:

  - take a significant role in training, including of staff in specialist and general mental health services, and in the criminal justice system
  - have resources to provide specialist support and supervision
  - perform a central role in the development of standards for and the coordination of clinical pathways
  - monitor the effective operation of clinical pathways. **[1.6.1.2]**

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1 Guidance

The following guidance is based on the best available evidence. The full guideline ([add hyperlink]) gives details of the methods and the evidence used to develop the guidance.

1.1 *General principles to be considered when working with people with antisocial personality disorder*

People with antisocial personality disorder have historically been excluded from services, and a recent policy statement from the Department of Health, 'Personality disorder: no longer a diagnosis of exclusion' (2003) makes clear that this is no longer acceptable. If the historical position is to be reversed then staff need to work actively to engage people with antisocial personality disorder in treatment. Evidence from both clinical trials and scientific studies of antisocial personality disorder shows that positive and reinforcing approaches to the treatment of antisocial personality disorder are more likely to be successful than those that are negative or punitive.

1.1.1 Access to services

1.1.1.1 People with antisocial personality disorder should not be excluded from services because of their diagnosis or history of antisocial or offending behaviour.

1.1.1.2 Services should seek to minimise any disruption to therapeutic interventions for people with antisocial personality disorder by:

- avoiding unnecessary transfers between institutions wherever possible during an intervention
- ensuring that in the initial planning and delivery of treatment, transfers from institutional to community settings take into account the need to continue treatment.

1.1.1.3   Staff should ensure that people with antisocial personality disorder from black and minority ethnic groups have equal access to culturally appropriate services based upon individual need.

1.1.1.4   When language or literacy is a barrier to accessing or engaging with services for people with antisocial personality disorder, staff should provide:

- information in the person's preferred language and/or in an accessible format
- psychological or other interventions in the person's preferred language
- independent interpreters.

1.1.1.5   When a diagnosis of antisocial personality disorder is made, healthcare professionals should discuss the implications of the diagnosis with the service user, and where appropriate with the carer, and relevant staff involved in their care. Staff should also:

- acknowledge the issues around stigma and exclusion that have characterised care for people with antisocial personality disorder
- emphasise that the diagnosis does not preclude access to a range of treatments for comorbid mental health disorders.

1.1.1.6   Staff working with women with antisocial personality disorder should be aware of the higher incidences of comorbid Axis I and II disorders in such women, and the need to adjust and adapt interventions in light of this.

1.1.1.7   Staff, in particular key workers, working with people with antisocial personality disorder should establish regular one-to-one meetings to review progress, even where the primary treatments provided by the service are group based.

People with disabilities and acquired cognitive impairments

1.1.1.8   For people with learning or physical disabilities or acquired
cognitive impairments who present with symptoms and behaviour
suggestive of antisocial personality disorder, staff involved in
assessment and diagnosis should consider consulting with a
relevant specialist.

1.1.1.9   Staff providing interventions for people with antisocial personality
disorder with learning or physical disabilities or acquired cognitive
impairments should, where possible, provide the same
interventions as for other people with antisocial personality
disorder. Staff may need to adjust the method of delivery or
duration of the intervention to take account of the disability or
impairment.

Autonomy and choice

1.1.1.10   Staff should work in partnership with people with antisocial
personality disorder with the aim of developing their autonomy and
encouraging choice by:

- empowering people to remain actively involved in finding
solutions to their problems, even during crises
- encouraging people to consider the different treatment options
and life choices available to them, and the consequences of the
choices they make.

Developing an optimistic and trusting relationship

1.1.1.11   Staff working with people with antisocial personality disorder should
recognise that a positive and rewarding approach is more likely to
be successful than a punitive approach in engaging and retaining
service users in treatment. Staff should:

- explore treatment options in an atmosphere of hope and
optimism, explaining that recovery is possible and attainable

- build up a trusting relationship, work in an open, engaging and non-judgemental manner, and be consistent and reliable.

Engagement and motivation

1.1.1.12 When providing interventions for people with antisocial personality disorder, particularly in residential and institutional settings, attention should be paid to motivating service users to attend and engage with treatment. This should be done at initial assessment and be an integral and continual part of any intervention, as people with antisocial personality disorder are vulnerable to premature withdrawal from treatment and supportive interventions.

Involving families and carers

1.1.1.13 Staff should ask the person with antisocial personality disorder directly whether they wish their families and carers to be involved in their care, and, subject to the service user's consent and rights to confidentiality:

- encourage carers to be positively involved where the service user has agreed to this
- ensure that the involvement of carers does not lead to a shift in the burden of care and the withdrawal of or lack of access to services.

1.1.1.14 Staff should consider the needs of families and carers of people with antisocial personality disorder, paying particular attention to the:

- impact of antisocial and offending behaviours on the family
- consequences of significant drug or alcohol misuse
- needs of and risks to any children in the family.

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1.2 Prevention of antisocial personality disorder – working with children

The evidence for the treatment of antisocial personality disorder in adult life is limited and the outcomes of interventions are modest. The evidence for working with at-risk children and their families points to the value of preventative measures.

1.2.1 General principles when working with children and their families

1.2.1.1 Child and adolescent mental health service (CAMHS) professionals working with young people should:

- balance the developing autonomy and capacity of the young person with the responsibilities of parents and carers
- be familiar with the legal framework applying to young people, including the Mental Capacity Act (2005), the Children Act (1989) and the Mental Health Act (2007).

1.2.2 Identifying children at risk of developing conduct problems and potentially subsequent antisocial personality disorder

1.2.2.1 Services should establish robust methods to identify children at risk of developing conduct problems. These should focus on identifying vulnerable parents, where appropriate antenatally, including:

- parents with significant drug, alcohol or other mental health problems
- mothers aged under 18 years, particularly those with a history of childhood maltreatment
- parents with a history of residential care
- parents with previous or current significant contact with the criminal justice system.

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1.2.2.2 When identifying vulnerable parents, staff should take care not to enhance any stigma associated with the intervention or increase the child's problems by labelling them as antisocial or problematic.

1.2.3 Early interventions for at-risk children

1.2.3.1 Early interventions aimed at reducing the risk of the development of conduct problems, and potentially subsequent antisocial personality disorder, may be considered for children identified to be of high risk. These should be targeted at parents of children with identified high-risk factors and include:

- non-maternal care (such as nursery care) for children aged younger than 1 year
- interventions to improve poor parenting skills for the parents of children aged younger than 3.

1.2.3.2 Early interventions should usually be provided by health and social care professionals over a period of 6 to 12 months, and should:

- consist of high-fidelity, well-structured, manualised programmes
- target multiple risk factors (such as parenting, school behaviour, parental health and employment).

1.2.4 Children with conduct problems

1.2.4.1 For children aged 8 years and older with conduct problems, cognitive problem-solving skills training may be considered.

1.2.4.2 Cognitive problem-solving skills training should be delivered individually over a period of 10 to 16 weeks and typically focus on cognitive strategies to enable the child to:

- generate a range of alternative solutions to interpersonal problems
- analyse the intentions of others
- understand the consequences of their actions

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- set targets for desirable behaviour.

1.2.4.3   For children who have residual problems following cognitive problem-solving skills training, anger control or social problem-solving skills training should be considered, depending on the nature of the residual problems.

1.2.4.4   Anger control should usually be conducted in groups over 10 to 16 weeks, and typically focus on strategies to enable the child to:

- build capacity to improve the perception and interpretation of social cues
- manage anger through coping and self-talk
- generate alternative 'non-aggressive' responses to interpersonal problems.

1.2.4.5   Social problem-solving skills training should usually be conducted in groups over 10 to 16 weeks, and typically focus on strategies to enable the child to:

- modify and expand their interpersonal appraisal processes
- develop a more sophisticated understanding of beliefs and desires in others
- improve their capacity to regulate their emotional responses.

1.2.5   Interventions for parents of children with conduct disorders

1.2.5.1   For parents of children aged between 5 and 12 years with conduct problems, parent training programmes should be offered.

1.2.5.2   For parents of children aged between 13 and 18 years with conduct problems, parent training programmes may be considered.

1.2.5.3   Parent training programmes should be delivered in a group format by health or social care professionals such as psychologists or social workers. The intervention should focus on the training of

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parents in skills that help to manage their children's behaviour, including:

- communicating (such as active listening, giving and receiving support)
- problem-solving (both for the parent and in helping to train their child to solve problems)
- promoting positive behaviour (for example, through support, use of praise and reward)
- reducing inappropriate behaviour (for example, establishing rules and routines, discipline, parental monitoring).

1.2.5.4   For children aged 8 years and older with conduct problems, cognitive problem-solving skills training focused on the child may be considered in addition to parent training programmes where additional factors, such as callous and unemotional traits in the child, may reduce the likelihood of the child benefiting from parent training programmes.

1.2.5.5   Additional interventions targeted specifically at the parents of children with conduct problems (such as interventions for parental, marital or interpersonal problems) should not be provided routinely alongside parent training programmes, as they are unlikely to have an impact on the child's conduct problems.

1.2.6   Interventions for families with children with conduct problems

1.2.6.1   For children aged 13 to 18 years with conduct problems, specific family interventions (brief strategic family therapy or functional family therapy) should be considered if the family is unable to or chooses not to engage with parent training programmes or where the severity of the conduct problems is such that they will be less likely to benefit from parent training programmes.

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1.2.6.2   Brief strategic family therapy should be considered for children aged 13 to 18 years, particularly those with severe conduct and drug-related problems. It should consist of at least fortnightly meetings over 3 months and focus on:

- engaging and supporting the family
- engaging and using the support of the wider social and educational system
- identifying maladaptive family interactions (including areas of power distribution and conflict resolution)
- promoting new and more adaptive family interactions (including open and effective communication).

1.2.6.3   Functional family therapy should be considered for children aged 13 to 18 years with severe conduct problems and a history of offending. It should be conducted over a period of 3 months by health or social care professionals and focus on improving the interactions within the family, including:

- engaging and motivating the family in treatment (enhancing perception that change is possible, positive reframing and establishing a positive alliance)
- problem-solving and behaviour change, through parent training and communication training
- promoting generalisation of change in specific behaviours to broader contexts, both within the family and within the community (such as schools).

1.2.7   Multi-component interventions

1.2.7.1   For children aged 13 to 18 years in foster care with conduct problems, multidimensional treatment foster care should be considered. It should be conducted over 6 months by a team of health and social care professionals able to provide case

management, individual therapy and family therapy. This
intervention should include:

- training foster care families in behaviour management and
  providing a supportive family environment
- the opportunity for the young person to earn privileges (such as
  time on the computer and extra telephone time with friends)
  when engaging in positive living and social skills (for example,
  being polite and making their bed) and good behaviour at school
- individual problem-solving skills training for the young person
- family therapy for the birth parents in order to provide a
  supportive environment for the young person to return to after
  treatment.

1.2.7.2 For children aged 13 to 18 years with severe conduct problems, a
history of offending and who are at risk of being placed in care or
excluded from the family, multi-systemic therapy should be
considered. It should be provided over 3 to 6 months by a
dedicated professional with a low caseload. The intervention
should:

- focus specifically on problem-solving approaches with the family
- involve and utilise the resources of peer groups, schools and the
  wider community.

1.3 Assessment and risk management of antisocial personality disorder

In primary and secondary care services, antisocial personality disorder is
often under-recognised. Even where it is identified, significant comorbid
problems such as treatable depression or anxiety are often not recognised. In
specialist services there are different and important concerns regarding the
assessment of violence and quantifying the level of risk.

1.3.1 Assessment

1.3.1.1 When assessing a person with a possible antisocial personality disorder, healthcare professionals in secondary and specialist mental health services should conduct a full assessment of:

- antisocial behaviours
- personality functioning, coping strategies, strengths and vulnerabilities
- comorbid mental disorders (including depression and anxiety, drug or alcohol misuse, post-traumatic stress disorder and other personality disorders)
- need for psychological treatment, social care and support, and occupational rehabilitation or development
- domestic violence and abuse.

1.3.1.2 Staff involved in the assessment of antisocial personality disorder in secondary and specialist services should use structured assessment methods whenever possible because these will increase the validity of the assessment. For specialist services, the use of measures such as the Psychopathy Checklist–Revised (PCL-R) or Psychopathy Checklist–Screening Version (PCL-SV) to assess the severity of antisocial personality disorder should be part of the routine assessment process.

1.3.1.3 Staff working in primary and secondary care (for example, drug and alcohol services) and community services (for example, the probation service) that include a high proportion of people with antisocial personality disorder should be alert to the possibility of antisocial personality disorder in service users. Where it is suspected and the person is seeking help, staff should consider referral to a specialist mental health service.

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1.3.2 Risk assessment

Primary care

1.3.2.1 While the assessment of violence risk is not a routine activity in primary care, the following should be considered if such assessment is required:

- an account of any current or previous violence, including severity, circumstances and victims
- the presence of comorbid mental illness and/or substance misuse
- current life stressors, relationships and life events
- the use of additional information from written records or families and carers, as the service user may not always be a reliable source of information; this is subject to the service user's consent and right to confidentiality.

1.3.2.2 Healthcare professionals in primary care should consider contact with and/or referral to specialist services where there is current violence or threats that suggest significant risk and/or a history of serious violence, including predatory offending or targeting of children or other vulnerable persons.

Secondary services

1.3.2.3 When assessing the risk of violence in mental health services, healthcare professionals should take a detailed history of violence and consider and record:

- an account of any current or previous violence, including severity, circumstances, precipitants and victims
- contact with the criminal justice system, including convictions and periods of imprisonment
- the presence of comorbid mental illness and/or substance misuse
- current life stressors, relationships and life events

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- the use of additional information from written records or families and carers, as the service user may not always be a reliable source of information; this is subject to the service user's consent and right to confidentiality.

1.3.2.4   The initial risk management should be directed at crisis resolution and ameliorating any acute aggravating factors. The history of previous violence should be an important guide in the development of any future violence risk management plan.

1.3.2.5   Staff in secondary care mental health services should consider a referral to specialist services where there is:

- current violence or threat that suggests immediate risk or disruption to the operation of the service
- a history of serious violence, including predatory offending or targeting of children or other vulnerable persons.

Specialist or tertiary services

1.3.2.6   When assessing the risk of violence in specialist mental health services, healthcare professionals should take a detailed history of violence, and consider and record:

- an account of any current and previous violence, including severity, circumstances, precipitants and victims
- contact with the criminal justice system including convictions and periods of imprisonment
- the presence of comorbid mental illness and/or substance misuse
- current life stressors, relationships and life events
- the use of additional information from written records or families and carers, as the service user may not always be a reliable source of information; this is subject to the service user's consent and right to confidentiality.

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1.3.2.7   Healthcare professionals in specialist services should consider, as part of a structured clinical assessment, the routine use of:

- a standardised measure of the severity of antisocial personality disorder, for example the Psychopathy Checklist–Revised (PCL-R) or Psychopathy Checklist–Screening Version (PCL-SV)
- a formal assessment tool such as the Historical, Clinical, Risk Management-20 (HCR-20) in order to develop a risk management strategy.

1.3.3   Risk management

1.3.3.1   Services should develop a comprehensive risk management plan for people with antisocial personality disorder considered to be of high risk; the plan should involve other agencies in health and social care services and the criminal justice system. Probation should normally take the lead role, with mental health and social care services providing support and liaison. Such cases should routinely be referred to the local Multi-Agency Public Protection Panel.

1.4   Treatment and management of antisocial personality disorder and related and comorbid disorders

The evidence base for the treatment of antisocial personality disorder is limited. In the development of the recommendations set out below these limitations were addressed by drawing on four related sources of evidence, namely evidence for: (1) interventions targeted specifically at antisocial personality disorder; (2) the treatment and management of the symptoms and behaviours associated with antisocial personality disorder such as impulsivity and aggression; (3) the treatment of comorbid conditions such as depression and drug misuse; and (4) the management of offending behaviour. Although the focus of a number of these interventions is on offending behaviour, the interventions have the potential to help people with antisocial personality

disorder address a wider range of antisocial behaviours with consequent benefits for themselves and others.

1.4.1 General principles

1.4.1.1 People with antisocial personality disorder should be offered treatment for any comorbid disorders in line with existing NICE guidance. This should be done irrespective of whether the person is receiving treatment for antisocial personality disorder.

1.4.1.2 When providing psychological or pharmacological interventions for antisocial personality disorder, offending behaviour or comorbid disorders to people with antisocial personality disorder, staff should be aware of the potential for and possible impact of:

- poor concordance
- high attrition
- misuse of prescribed medication
- drug interactions (including with alcohol and illicit drugs).

1.4.1.3 When providing psychological interventions for comorbid disorders to people with antisocial personality disorder, consider lengthening the duration of interventions or increasing their intensity.

1.4.2 The role of psychological interventions

1.4.2.1 People with antisocial personality disorder in community and mental health services may be offered group-based cognitive and behavioural interventions, in order to address problems such as impulsivity, interpersonal difficulties and antisocial behaviour.

1.4.2.2 People with antisocial personality disorder with a history of offending behaviour in community and institutional care should be offered group-based cognitive and behavioural interventions (for example, programmes such as Reasoning and Rehabilitation and Enhanced Thinking Skills) focused on reducing offending and other antisocial behaviour.

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1.4.2.3   Young offenders aged 17 years or younger with a history of offending behaviour who are in institutional care should be offered group-based cognitive and behavioural interventions, provided in groups specifically for young offenders and that are focused on reducing offending and other antisocial behaviour.

1.4.2.4   When providing cognitive and behavioural interventions, staff should:

- assess the level of risk and adjust the duration and intensity of the programme accordingly (note that participants at all levels of risk may benefit from these interventions)
- provide support and encouragement to help participants to attend and complete programmes, including those legally mandated to do so.

1.4.3   The role of pharmacological interventions

1.4.3.1   Pharmacological interventions should not be routinely used for the treatment of antisocial personality disorder or associated behaviours of aggression, anger and impulsivity.

1.4.3.2   Pharmacological treatments for comorbid mental disorders, in particular depression and anxiety, should be based on the recommendations in relevant NICE guidance. When initiating and reviewing medication, particular attention should be paid to issues of adherence and the risks of misuse or overdose.

1.4.4   Drug and alcohol misuse

Drug and alcohol misuse occurs commonly alongside antisocial personality disorder, and is likely to aggravate risk and behavioural disturbances in people with antisocial personality disorder.

1.4.4.1   For people with antisocial personality disorder who misuse drugs, in particular opioids or stimulants, psychological treatments (in

particular, contingency management programmes) should be offered in line with existing NICE guidance.

1.4.4.2   For people with antisocial personality disorder who misuse or are dependent on alcohol, psychological and pharmacological interventions should be offered in line with existing national guidance for the treatment and management of alcohol disorders.

1.4.4.3   For people with antisocial personality disorder who are in institutional care and who misuse or are dependent on drugs or alcohol, referral to a specialist therapeutic community focused on the treatment of drug and alcohol problems should be considered.

1.5   Psychopathy and Dangerous People with Severe Personality Disorder (DSPD)

People with psychopathy and people who meet criteria for Dangerous People with Severe Personality Disorder (DSPD) represent a small proportion of people with antisocial personality disorder, but they present a very high risk and consume a significant proportion of the services for people with antisocial personality disorder. There is little high-quality evidence for the treatment of psychopathy or severe personality disorder that would meet criteria for DSPD, but the Guideline Development Group considered it reasonable to draw on the evidence for the treatment of antisocial personality disorder to arrive at their recommendations. The interventions will need to be modified as these individuals can be seen as having a lifelong disability that requires continued input and support over many years.

1.5.1   Adapting interventions for people who meet criteria for psychopathy or DSPD

1.5.1.1   People who meet criteria for psychopathy or DSPD in community and institutional settings should be considered for cognitive and behavioural interventions (for example, programmes such as Reasoning and Rehabilitation) focused on reducing offending and other antisocial behaviour. These interventions should be adapted

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1.5.1.2   People who meet criteria for psychopathy or DSPD should be offered treatment for any comorbid disorders in line with existing NICE guidance. This should be done irrespective of whether the person is receiving treatment for psychopathy or severe personality disorder because effective treatment of comorbid disorders may reduce the risk associated with the psychopathy or severe personality disorder.

1.5.2   Need for intensive staff support

1.5.2.1   Staff providing interventions for people who meet criteria for psychopathy or DSPD should receive high levels of support and close supervision, with consideration given to the provision of support and supervision by staff external to the unit in which those staff work.

1.6   Organisation and planning of services

There has been a considerable expansion of services for people with antisocial personality disorder in recent years involving a wider range of agencies in the health and social care sector, the non-statutory sector and the criminal justice system. If the full benefit of these additional services is to be realised, effective care pathways and specialist networks need to be developed.

1.6.1   Multi-agency care

1.6.1.1   Provision of services for people with antisocial personality disorder often involves significant inter-agency working. Therefore services should ensure that there are clear pathways for people with antisocial personality disorder so that the most effective multi-agency care is provided. These pathways should:

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- have established thresholds at transition points that are agreed locally and are made known to service users
- specify the various interventions that are available at each point in the pathway
- enable effective communication among clinicians and organisations at all points of the pathway and provide the means to resolve differences and disagreements.

1.6.1.2 Services should consider the establishment of antisocial personality disorder networks, where possible linked to wider personality disorder networks. These may be organised at the level of Strategic Health Authorities. These networks, which should be multi-agency and involve service users, should:

- take a significant role in training, including of staff in specialist and general mental health services, and in the criminal justice system
- have resources to provide specialist support and supervision
- perform a central role in the development of standards for and the coordination of clinical pathways
- monitor the effective operation of clinical pathways.

1.6.2 Transition between child and adolescent services to adult services

1.6.2.1 Health and social care services should ensure that for vulnerable young people with a history of conduct disorder or contact with youth offending schemes, or who have been in receipt of interventions for conduct and related disorders, consideration is given to referral to appropriate adult services for possible continuing assessment and treatment.

1.6.3 Inpatient services

1.6.3.1 Healthcare professionals should normally only consider admission of people with antisocial personality disorder for crisis management

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or for the treatment of comorbid conditions; admission should be brief and have a defined purpose and end point.

1.6.3.2   Admission solely for the treatment of antisocial personality disorder or its associated risks is likely to be a lengthy process and should be:

- under the care of specialist forensic personality disorder services
- rarely, if ever, under a hospital order under a Section of the Mental Health Act for a person with antisocial personality disorder alone and should involve the advice of a specialist service.

1.6.4   Staff training, supervision, support

Working in services for people with antisocial personality disorder presents a considerable challenge for staff including maintaining a proper fidelity to the intervention model and managing the emotional pressure this involves. Effective training and support is crucial for dealing with such issues.

Staff competencies

1.6.4.1   All staff working with people with antisocial personality disorder should be familiar with the Ten Essential Shared Capabilities for Mental Health Practice and have a knowledge and awareness of antisocial personality disorder that facilitates effective working with service users, families or carers, and colleagues.

1.6.4.2   All staff working with people with antisocial personality disorder should have skills appropriate to the nature and level of contact with service users. These skills include:

- for all frontline staff, knowledge about antisocial personality disorder and understanding behaviours in context, including awareness of the potential for therapeutic boundary violations

- for staff with regular and sustained contact with people with antisocial personality disorder, the ability to respond effectively to the needs of service users
- for staff with direct therapeutic or management roles, competence in the specific treatment interventions and management strategies used in the service.

1.6.4.3   Services should ensure that all staff providing psychosocial or pharmacological interventions for the treatment or prevention of antisocial personality disorder are competent, properly qualified and supervised, and that they adhere closely to the structure and duration of the interventions as set out in the relevant treatment manuals. This should be achieved through:

- use of competence frameworks based on relevant treatment manuals
- routine direct monitoring and evaluation of programme adherence, for example through examination of service records
- routine direct monitoring and evaluation of staff adherence, for example through the use of video and audio tapes
- regular auditing of programme and staff adherence, involving external scrutiny where appropriate.

Supervision and support

1.6.4.4   Services should ensure that staff supervision is built into the routine working of the service, properly resourced within local systems and monitored. Supervision, which may be provided by staff external to the service, should aim to:

- support adherence to the specific intervention
- promote general therapeutic consistency and reliability
- counter negative attitudes.

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1.6.4.5   Specialist services should ensure that systems for all staff working
with people with antisocial personality disorder are in place that
provide:

- comprehensive induction programmes, in which the purpose of
the service is made clear
- a supportive and open environment, which encourages reflective
practice, and honesty about individual difficulties and areas
where individual staff or the service may be open to compromise
- continuing staff support to review and explore the ethical and
clinical challenges involved in working in high-intensity
environments, thereby building staff capacity and resilience.

2   Notes on the scope of the guidance

NICE guidelines are developed in accordance with a scope that defines what
the guideline will and will not cover. The scope of this guideline is available
from www.nice.org.uk/nicemedia/pdf/ASPDscopeFinalforweb.pdf.

How this guideline was developed

NICE commissioned the National Collaborating Centre for Mental Health to
develop this guideline. The Centre established a Guideline Development
Group (see appendix A), which reviewed the evidence and developed the
recommendations. An independent Guideline Review Panel oversaw the
development of the guideline (see appendix B).

There is more information in the booklet: 'The guideline development process:
an overview for stakeholders, the public and the NHS' (third edition, published
April 2007), which is available from www.nice.org.uk/guidelinesprocess or
from NICE publications (phone 0845 003 7783 or email
publications@nice.org.uk and quote reference N1233).

3   Implementation

The Healthcare Commission assesses the performance of NHS organisations in meeting core and developmental standards set by the Department of Health in 'Standards for better health' (available from www.dh.gov.uk). Implementation of clinical guidelines forms part of the developmental standard D2. Core standard C5 says that national agreed guidance should be taken into account when NHS organisations are planning and delivering care.

NICE has developed tools to help organisations implement this guidance (listed below). These are available on our website (www.nice.org.uk/CGXXX). *[NICE to amend list as needed at time of publication]*

- Slides highlighting key messages for local discussion.
- Costing tools:
  - costing report to estimate the national savings and costs associated with implementation
  - costing template to estimate the local costs and savings involved.
- Implementation advice on how to put the guidance into practice and national initiatives that support this locally.
- Audit support for monitoring local practice.

4   Research recommendations

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future. The Guideline Development Group's full set of research recommendations is detailed in the full guideline (see section 5).

4.1   *Risk as a potential moderator of effect in group-based cognitive and behavioural interventions*

Does the pre-treatment level of risk of re-offending impact on the outcome of group-based cognitive and behavioural interventions (CBI) for offending behaviour? A meta-analysis of individual participant data should be conducted to determine whether the level of risk of re-offending assessed at the

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beginning of the intervention moderates the effect of the intervention. The study (for which there are large data sets, comprising over 10,000 participants) could inform the design of a large-scale randomised controlled trial (RCT) (including potential modifications of CBI) to test the impact of risk on the outcome of CBI.

Why this is important

Existing research has established the efficacy of CBI in reducing re-offending. However, the effects of these interventions in a range of offending populations are modest. The impact of risk on the outcome of these interventions has not been systematically investigated, and post hoc analyses and meta-regression of risk as a moderating factor have been inconclusive. Expert opinion suggests that high-risk individuals may not benefit from CBI, but if it were to be of benefit then the cost savings could be considerable.

4.2 Group-based cognitive and behavioural interventions for populations outside criminal justice settings

Are group-based cognitive and behavioural interventions (CBI) effective in reducing the behaviours associated with antisocial personality disorder (such as impulsivity, rule-breaking, deceitfulness, irritability, aggressiveness and disregard for safety of self or others)? This should be tested in an RCT which should examine medium-term outcomes (including cost effectiveness) over a period of at least 18 months. It should pay particular attention to the modification and development of the interventions to ensure the focus is not just on offending behaviour, but on all aspects of the challenging behaviours associated with antisocial personality disorder.

Why this is important

Not all people with antisocial personality disorder are offenders but they exhibit a wide range of antisocial behaviours. However the evidence for the treatment of these behaviours outside the criminal justice system is extremely limited. Following the Department of Health's policy guidance, 'Personality disorder: no longer a diagnosis of exclusion' (2003), it is likely that there will

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be an increased requirement in the NHS to offer treatments for antisocial personality disorder.

4.3 Effectiveness of multi-systemic therapy versus functional family therapy

Is multi-systemic therapy (MST) or functional family therapy (FFT) more clinically and cost effective in the treatment of adolescents with conduct disorders? A large-scale RCT comparing the clinical and cost effectiveness of MST and FFT for adolescents with conduct disorders should be conducted. It should examine the medium-term outcomes (for example, offending behaviour, mental state, educational and vocational outcomes and family functioning) over a period of at least 18 months. The study should also be designed to explore the moderators and mediators of treatment effect, which could help determine the factors associated with benefits or harms of either MST or FFT.

Why this is important

MST and FFT are two interventions with a relatively strong evidence base in the treatment of adolescents with conduct disorders, but there have been no studies directly comparing their clinical and cost effectiveness. Their use in health and social care services in the UK is increasing. Both interventions target the same population, but although they share some common elements (that is, work with the family), MST is focused on both the family and the use of the wider resources of the school, community and criminal justice systems, and through intensive individual case work seeks to shift the pattern of antisocial behaviour. In contrast, FFT focuses more on the immediate family environment and uses the resources of the family to change the pattern of antisocial behaviour. The study should be designed to facilitate the identification of sub-groups within the conduct disorder population who may benefit from either MST or FFT.

4.4 Interventions for infants at high risk of developing conduct disorders

Do specially designed parent training programmes focused on sensitivity enhancement (a set of techniques designed to improve secure attachment behaviour between parents and children) reduce the risk of behavioural disorders, including conduct problems and delinquency, in infants identified at high risk of developing these problems? An RCT comparing parent training programmes focused on sensitivity enhancement with usual care should be undertaken. It should examine the long-term outcomes over a period of at least 5 years, but with consideration given to the possibility of a further 10-year follow-up. The study should also be designed to explore the moderators and mediators of treatment effect which could help determine the factors associated with benefits or harms of the intervention.

Why this is important

There is limited evidence from non-UK studies that interventions focused on developing better parent–child attachment can have benefits for infants at risk of developing conduct disorder. Determining the criteria and then identifying children at high risk (usually via parental risk factors) is difficult and challenging. Even where these factors are agreed, engaging parents in treatment can be difficult and it is important that a range of effective interventions are developed that increase the choice and opportunities for high-risk groups for treatment. A number of interventions such as Nurse-Family Practitioners are being developed and trialled in the UK; having an alternative, effective intervention for this group of children would be important.

4.5 Treatment of comorbid anxiety disorders in antisocial personality disorder

Does the effective treatment of anxiety disorders in antisocial personality disorder improve the long-term outcome for antisocial personality disorder? An RCT for people with antisocial personality disorder and comorbid anxiety disorder comparing a sequenced treatment programme for the anxiety disorder compared with usual care should be conducted. It should examine
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over a period of at least 18 months the medium-term outcomes for key symptoms and behaviours associated with antisocial personality disorder (including offending behaviour, deceitfulness, irritability and aggressiveness, and disregard for safety of self or others), as well as drug and alcohol misuse, and anxiety. The study should also be designed to explore the moderators and mediators of treatment effect which could help determine the role of anxiety in the course of antisocial personality disorder.

Why this is important

Comorbidity with Axis I disorders is common in antisocial personality disorder, and chronic anxiety has been identified as a particular disorder that may exacerbate the problems associated with antisocial personality disorder. Effective treatments (both psychological and pharmacological) for anxiety disorders exist but are often not offered to people with antisocial personality disorder. Current treatment guidelines set out clear pathways for the stepped or sequenced care of people with anxiety disorders. An RCT to test the benefit of this approach in the treatment of anxiety would potentially lead to a significant reduction in illness burden, but also in reducing antisocial behaviour would have wider societal benefits. The study should provide important information on the challenges of delivering these interventions for a population which has traditionally both rejected and been refused treatment.

5 Other versions of this guideline

5.1 Full guideline

The full guideline, 'Antisocial personality disorder: treatment, management and prevention' contains details of the methods and evidence used to develop the guideline. It is published by the National Collaborating Centre for Mental Health, and is available from www.nccmh.org.uk, our website (www.nice.org.uk/CGXXXfullguideline) and the National Library for Health (www.nlh.nhs.uk). **[Note: these details will apply to the published full guideline.]**

5.2 Quick reference guide

A quick reference guide for healthcare professionals is available from www.nice.org.uk/CG<mark>XXX</mark>quickrefguide

For printed copies, phone NICE publications on 0845 003 7783 or email publications@nice.org.uk (quote reference number N1<mark>XXX</mark>). **[Note: these details will apply when the guideline is published.]**

5.3 'Understanding NICE guidance'

Information for patients and carers ('Understanding NICE guidance') is available from www.nice.org.uk/CG<mark>XXX</mark>publicinfo

For printed copies, phone NICE publications on 0845 003 7783 or email publications@nice.org.uk (quote reference number N1<mark>XXX</mark>). **[Note: these details will apply when the guideline is published.]**

We encourage NHS and voluntary sector organisations to use text from this booklet in their own information about antisocial personality disorder.

6 Related NICE guidance

Published

Schizophrenia: core interventions in the treatment and management of schizophrenia in primary and secondary care. NICE clinical guideline 1 (2002). Available from www.nice.org.uk/CG001

Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. NICE clinical guideline 16 (2004). Available from www.nice.org.uk/CG016

Violence: the short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments. NICE clinical guideline 25 (2005). Available from www.nice.org.uk/CG025

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Post-traumatic stress disorder (PTSD): the management of PTSD in adults and children in primary and secondary care. NICE clinical guideline 26 (2005). Available from www.nice.org.uk/CG026

Obsessive-compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder. NICE clinical guideline 31 (2005). Available from www.nice.org.uk/CG031

Bipolar disorder: the management of bipolar disorder in adults, children and adolescents in primary and secondary care. NICE clinical guideline 38 (2006). Available from www.nice.org.uk/CG038

Parent-training/education programmes in the management of children with conduct disorders. NICE technology appraisal guidance 102 (2006). Available from www.nice.org.uk/TA102

Anxiety (amended): management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care. NICE clinical guideline 22 (2007). Available from www.nice.org.uk/CG022

Depression (amended): management of depression in primary and secondary care. NICE clinical guideline 23 (2007). Available from www.nice.org.uk/CG023

Drug misuse: psychosocial interventions. NICE clinical guideline 51 (2007). Available from www.nice.org.uk/CG051

Drug misuse: opioid detoxification. NICE clinical guideline 52 (2007). Available from www.nice.org.uk/CG052

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Under development

NICE is developing the following guidance (details available from www.nice.org.uk):

Attention deficit hyperactivity disorder: diagnosis and management of ADHD in children, young people and adults. NICE clinical guideline (publication expected September 2008).

Borderline personality disorder: treatment and management. NICE clinical guideline (publication expected January 2009).

7 Updating the guideline

NICE clinical guidelines are updated as needed so that recommendations take into account important new information. We check for new evidence 2 and 4 years after publication, to decide whether all or part of the guideline should be updated. If important new evidence is published at other times, we may decide to do a more rapid update of some recommendations.

Appendix A: The Guideline Development Group

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Appendix B: The Guideline Review Panel

The Guideline Review Panel is an independent panel that oversees the development of the guideline and takes responsibility for monitoring adherence to NICE guideline development processes. In particular, the panel ensures that stakeholder comments have been adequately considered and responded to. The panel includes members from the following perspectives: primary care, secondary care, lay, public health and industry.

[NICE to add]

[Name; style = Unnumbered bold heading]
[job title and location; style = NICE normal]