



*National Institute for  
Health and Clinical Excellence*

## Quick reference guide

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# **Antisocial personality disorder**

Treatment, management and prevention

### About this booklet

This is a quick reference guide that summarises the recommendations NICE has made to the NHS in 'Antisocial personality disorder: treatment, management and prevention' (NICE clinical guideline 77).

### Who should read this booklet?

This quick reference guide is for healthcare professionals and others involved in the care of people with antisocial personality disorder.

### Who wrote the guideline?

The guideline was developed by the National Collaborating Centre for Mental Health, which is based at the Royal College of Psychiatrists and the British Psychological Society. The Collaborating Centre worked with a group of healthcare professionals (including consultants, GPs and nurses), people with antisocial personality disorder and carers, and technical staff, who reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

For more information on how NICE clinical guidelines are developed, go to [www.nice.org.uk](http://www.nice.org.uk)

### Where can I get more information about the guideline?

The NICE website has the recommendations in full, reviews of the evidence they are based on, a summary of the guideline for people with antisocial personality disorder and carers, and tools to support implementation (see pages 21 and 22 for more details).

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NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions in the NHS in England and Wales.

This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

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### Introduction

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.

This guideline makes recommendations for the treatment, management and prevention of antisocial personality disorder in primary, secondary and tertiary healthcare. This guideline is concerned with the treatment of people with antisocial personality disorder across a wide range of services including those provided within mental health services, substance misuse services, social care and the criminal justice system.

## Definitions of terms used in this guideline

**Anger control:** usually offered to children who are aggressive at school, anger control includes a number of cognitive and behavioural techniques similar to cognitive problem-solving skills training (see below).

**Brief strategic family therapy:** an intervention that is systemic in focus and is influenced by other approaches such as structural/systemic family therapy. The main elements include engaging and supporting the family, identifying maladaptive family interactions and seeking to promote new and more adaptive family interactions.

**Cognitive problem-solving skills training:** an intervention that aims to reduce children's conduct problems by teaching them different responses to interpersonal situations. Using cognitive and behavioural techniques with the child, the training has a focus on thought processes.

The training includes:

- teaching a step-by-step approach to solving interpersonal problems
- structured tasks such as games and stories to aid the development of skills
- combining a variety of approaches including modelling and practice, role-playing and reinforcement.

**Functional family therapy:** a family-based intervention that is behavioural in focus. The main elements include engagement and motivation of the family in treatment, problem-solving and behaviour change through parent-training and communication-training.

**Multidimensional treatment foster care:** using strategies from family therapy and behaviour therapy to intervene directly in systems and processes related to antisocial behaviour (for example, parental discipline, family affective relations, peer associations and school performances) for children or young people in foster care and other out-of-home placements.

**Multisystemic therapy:** using strategies from family therapy and behaviour therapy to intervene directly in systems and processes related to antisocial behaviour (for example, parental discipline, family affective relations, peer associations and school performances) for children or young people.

**Parent-training programmes:** an intervention that aims to teach the principles of child behaviour management, to increase parental competence and confidence in raising children and to improve the parent/carer–child relationship by using good communication and positive attention to aid the child's development.

**Self-talk:** the internal conversation a person has with themselves in response to a situation. Using or changing self-talk is a part of anger control training (see above).

**Social problem skills training:** a specialist form of cognitive problem-solving training that aims to:

- modify and expand the child's interpersonal appraisal processes through developing a more sophisticated understanding of beliefs and desires in others
- improve the child's capacity to regulate his or her own emotional responses.

## 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 people in treatment. Staff should:
  - explore treatment options in an atmosphere of hope and optimism, explaining that recovery is possible and attainable
  - build a trusting relationship, work in an open, engaging and non-judgemental manner, and be consistent and reliable.

### Cognitive behavioural interventions for children aged 8 years and older with conduct problems

- Cognitive problem-solving skills training should be considered for children aged 8 years and older with conduct problems if:
  - the child's family is unwilling or unable to engage with a parent-training programme
  - additional factors, such as callous and unemotional traits in the child, may reduce the likelihood of the child benefiting from parent-training programmes alone (see page 10).

### Assessment in forensic/specialist personality disorder services

- Healthcare professionals in forensic or specialist personality disorder services should consider, as part of a structured clinical assessment, routinely using:
  - a standardised measure of the severity of antisocial personality disorder such as 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) to develop a risk management strategy.

### Treatment of comorbid disorders

- People with antisocial personality disorder should be offered treatment for any comorbid disorders in line with recommendations in the relevant NICE clinical guideline, where available. This should happen regardless of whether the person is receiving treatment for antisocial personality disorder.

### The role of psychological interventions

- For people with antisocial personality disorder with a history of offending behaviour who are in community and institutional care, consider offering group-based cognitive and behavioural interventions (for example, programmes such as 'reasoning and rehabilitation') focused on reducing offending and other antisocial behaviour.

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### Multi-agency care

- 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:

- specify the various interventions that are available at each point
- enable effective communication among clinicians and organisations at all points and provide the means to resolve differences and disagreements.

Clearly agreed local criteria should also be established to facilitate the transfer of people with antisocial personality disorder between services. As far as is possible, shared objective criteria should be developed relating to comprehensive assessment of need and risk.

- Services should consider establishing antisocial personality disorder networks, where possible linked to other personality disorder networks. (They may be organised at the level of primary care trusts, local authorities, strategic health authorities or government offices.) These networks should be multi-agency, should actively involve people with antisocial personality disorder and should:
  - take a significant role in training staff, including those in primary care, general, secondary and forensic mental health services, and in the criminal justice system
  - have resources to provide specialist support and supervision for staff
  - take a central role in the development of standards for and the coordination of clinical pathways
  - monitor the effective operation of clinical pathways.

### Person-centred care

Treatment and care should take into account service users' individual needs and preferences. Good communication is essential, supported by evidence-based information, to allow service users to reach informed decisions about their care. Follow Department of Health advice on seeking consent if needed. If the service user agrees, families and carers should have the opportunity to be involved in decisions about treatment and care. If caring for young people in transition between paediatric and adult services refer to 'Transition: getting it right for young people' (available from [www.dh.gov.uk](http://www.dh.gov.uk)).

## General principles of care

### Access and assessment

- People with antisocial personality disorder should not be excluded from any health or social care service because of their diagnosis or history of antisocial or offending behaviour.
- Seek to minimise any disruption to therapeutic interventions for people with antisocial personality disorder by:
  - ensuring that in the initial planning and delivery of treatment, transfers from institutional to community settings take into account the need to continue treatment
  - avoiding unnecessary transfer of care between institutions whenever possible during an intervention, to prevent disruption to the agreed treatment plan. This should be considered at initial planning of treatment.
- Ensure that people with antisocial personality disorder from black and minority ethnic groups have equal access to culturally appropriate services based on clinical need.
- When language or literacy is a barrier to accessing or engaging with services for people with antisocial personality disorder, provide:
  - information in their preferred language and in an accessible format
  - psychological or other interventions in their preferred language
  - independent interpreters.
- When a diagnosis of antisocial personality disorder is made, discuss the implications of it with the person, the family or carers where appropriate, and relevant staff, and:
  - acknowledge the issues around stigma and exclusion that have characterised care for people with antisocial personality disorder
  - emphasise that the diagnosis does not limit access to a range of appropriate treatments for comorbid mental health disorders
  - provide information on and clarify the respective roles of the healthcare, social care and criminal justice services.
- When working with women with antisocial personality disorder take into account the higher incidences of common comorbid mental health disorders and other personality disorders, and:
  - adapt interventions accordingly (for example, extend their duration)
  - ensure that in inpatient and residential settings women's increased vulnerability is taken into account.
- Staff, in particular key workers, working with people with antisocial personality disorder should establish regular one-to-one meetings to review progress, even when the primary mode of treatment is group based.

### People with disabilities and acquired cognitive impairments

- When a person with learning or physical disabilities or acquired cognitive impairments presents with symptoms and behaviour that suggest antisocial personality disorder, staff involved in assessment and diagnosis should consider consulting with a relevant specialist.

- 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 might need to consider adjusting the method of delivery or duration of the intervention to take account of the disability or impairment.

### Autonomy and choice

- Work in partnership with people with antisocial personality disorder to develop their autonomy and promote choice by:
  - ensuring that they remain actively involved in finding solutions to their problems, including during crises
  - encouraging them 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

- Recognise that a positive and rewarding approach is more likely to be successful than a punitive approach in engaging and retaining people in treatment, and:
  - explore treatment options in an atmosphere of hope and optimism, explaining that recovery is possible and attainable
  - build a trusting relationship, work in an open, engaging and non-judgemental manner, and be consistent and reliable.

### Engagement and motivation

- When providing interventions for people with antisocial personality disorder, particularly in residential and institutional settings, pay attention to motivating them to attend and engage with treatment. This should happen at initial assessment and be an integral and continuing part of any intervention, as people with antisocial personality disorder are vulnerable to premature withdrawal from treatment and supportive interventions.

### Involving families and carers

- Ask directly whether the person with antisocial personality disorder wants their family or carers to be involved in their care, and, subject to their consent and rights to confidentiality:
  - encourage families or carers to be involved
  - ensure that the involvement of families or carers does not lead to a withdrawal of, or lack of access to, services
  - inform families or carers about local support groups for families or carers.
- Consider the needs of families and carers and pay 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 and the safeguarding of their interests.

## Prevention of antisocial personality disorder – working with children and young people and their families

### General principles

- Child and adolescent mental health service (CAMHS) professionals working with young people should:
  - balance their developing autonomy and capacity with the responsibilities of parents and carers
  - be familiar with the legal framework that applies to young people, including the Mental Capacity Act, the Children Acts and the Mental Health Act.

### Identifying children at risk of developing conduct problems

- Services should establish robust methods to identify children at risk of developing conduct problems, integrated when possible with the established local assessment system. These should focus on identifying vulnerable parents, where appropriate antenatally, including:
  - parents with other mental health problems, or with significant drug or alcohol problems
  - mothers younger than 18 years, particularly those with a history of maltreatment in childhood
  - parents with a history of residential care
  - parents with significant previous or current contact with the criminal justice system.
- When identifying vulnerable parents, take care not to intensify any stigma associated with the intervention or increase the child's problems by labelling them as antisocial or problematic.

### Interventions

- See table (pages 10–13): Interventions for children at risk of developing, or who have, conduct problems.

### Transition from child and adolescent services to adult services

- Health and social care services should consider referring vulnerable young people with a history of conduct disorder or contact with youth offending schemes, or those who have been receiving interventions for conduct and related disorders, to appropriate adult services for continuing assessment and/or treatment.

**Interventions for children at risk of developing, or who have, conduct problems**

Target population	Intervention type	Intervention should:
<p>Parents of pre-school children at high risk of developing conduct problems</p>	<p>Consider early interventions including:</p> <ul style="list-style-type: none"> <li>• non-maternal care (such as well-staffed nursery care) for children younger than 1 year</li> <li>• interventions to improve poor parenting skills for parents of children younger than 3 years.</li> </ul>	<ul style="list-style-type: none"> <li>• Usually be provided by health and social care professionals over 6–12 months.</li> <li>• Consist of well-structured, manualised programmes that are closely adhered to.</li> <li>• Target multiple risk factors (such as parenting, school behaviour and parental health and employment).</li> </ul>
<p>Parents of children younger than 12 years with conduct problems</p>	<p>Offer group-based parent-training programmes.</p> <p>Where there are difficulties engaging with the parents or a family's needs are too complex to be met by group-based programmes, offer individual-based parent-training programmes.</p> <p>Do not routinely offer additional interventions specifically for the parents of children with conduct problems (such as interventions for parental, marital or interpersonal problems) alongside parent-training programmes.</p>	<ul style="list-style-type: none"> <li>• Be structured and have a curriculum informed by principles of social-learning theory.</li> <li>• Include relationship-enhancing strategies.</li> <li>• Offer a sufficient number of sessions, with an optimum of eight to 12.</li> <li>• Enable parents to identify their own parenting objectives.</li> <li>• Incorporate role-playing sessions, as well as homework to be undertaken between sessions, to achieve generalisation of newly rehearsed behaviours to the home situation.</li> <li>• Be delivered by appropriately trained and skilled facilitators who are supervised, have access to necessary ongoing professional development, and are able to engage in a productive therapeutic alliance with parents.</li> <li>• Adhere to the programme developer's manual and employ all of the necessary materials to ensure consistent implementation of the programme.</li> <li>• Include problem solving (both for the parent and in helping to train their child to solve problems) and the promotion of positive behaviour (for example, through support, use of praise and reward).</li> </ul> <p>Programme providers should ensure that support is available to enable the participation of parents who might otherwise find it difficult to access these programmes, such as:</p> <ul style="list-style-type: none"> <li>– individual programmes</li> <li>– regular reminders about meetings</li> <li>– effective treatment of comorbid disorders (in particular, attention deficit hyperactivity disorder in line with NICE clinical guideline 72).</li> </ul>

*continued*

**Interventions for children at risk of developing, or who have, conduct problems *continued***

Target population	Intervention type	Intervention should:
<p>Children aged 8 years and older with conduct problems if their family is unwilling or unable to engage with a parent-training programme or additional factors, such as callous and unemotional traits in the child, may reduce the likelihood of parent-training programmes alone being effective</p>	<p>Consider cognitive problem-solving skills training</p>	<ul style="list-style-type: none"> <li>● Take place individually over 10–16 weeks.</li> <li>● Focus on strategies to enable the child to:                             <ul style="list-style-type: none"> <li>– generate a range of alternative solutions to interpersonal problems</li> <li>– analyse the intentions of others</li> <li>– understand the consequences of their actions</li> <li>– set targets for desirable behaviour.</li> </ul> </li> </ul>
<p>Children aged 8 years and older with conduct problems who have residual problems after cognitive problem-solving skills training</p>	<p>Consider anger control</p>	<ul style="list-style-type: none"> <li>● Take place in groups over 10–16 weeks.</li> <li>● Focus on strategies to enable the child to:                             <ul style="list-style-type: none"> <li>– build capacity to improve the perception and interpretation of social cues</li> <li>– manage anger through coping and self-talk</li> <li>– generate alternative ‘non-aggressive’ responses to interpersonal problems.</li> </ul> </li> </ul>
	<p>Consider social problem-solving skills training</p>	<ul style="list-style-type: none"> <li>● Take place in groups over 10–16 weeks.</li> <li>● Focus on strategies to enable the child to:                             <ul style="list-style-type: none"> <li>– modify and expand their interpersonal appraisal processes</li> <li>– develop a more sophisticated understanding of beliefs and desires in others</li> <li>– improve their capacity to regulate their emotional responses.</li> </ul> </li> </ul>

*continued*

**Interventions for children at risk of developing, or who have, conduct problems *continued***

Target population	Intervention type	Intervention should:
<p>Parents of young people aged 12–17 years with conduct problems</p>	<p>Consider parent-training programmes</p>	<ul style="list-style-type: none"> <li>● See page 10 for how to deliver parent-training programmes.</li> </ul>
<p>Young people aged 12–17 years with conduct problems and their families, where the parents are unable to choose not to engage with parent-training programmes or the young person's conduct problems are so severe that they are less likely to benefit from parent-training programmes</p>	<p>Consider brief strategic family therapy for young people with predominantly drug-related problems</p>	<ul style="list-style-type: none"> <li>● Consist of at least fortnightly meetings over 3 months.</li> <li>● Focus on:                             <ul style="list-style-type: none"> <li>– engaging and supporting the family</li> <li>– engaging and using the support of the wider social and educational system</li> <li>– identifying maladaptive family interactions (including areas of power distribution and conflict resolution)</li> <li>– promoting new and more adaptive family interactions (including open and effective communication).</li> </ul> </li> </ul>
<p>Consider functional family therapy for young people with predominantly a history of offending</p>		<ul style="list-style-type: none"> <li>● Be conducted by health or social care professionals over 3 months.</li> <li>● Focus on improving the interactions within the family, including:                             <ul style="list-style-type: none"> <li>– engaging and motivating the family in treatment (enhancing perception that change is possible, positive reframing and establishing a positive alliance)</li> <li>– problem-solving and behaviour change through parent-training and communication training</li> <li>– promoting generalisation of change in specific behaviours to broader contexts, both within the family and the community (such as schools).</li> </ul> </li> </ul>
		<p><i>continued</i></p>

**Interventions for children at risk of developing, or who have, conduct problems *continued***

Target population	Intervention type	Intervention should:
<p>Young people aged 12–17 years with severe conduct problems, a history of offending and who are at risk of being placed in care or excluded from the family</p>	<p>Consider multisystemic therapy</p>	<ul style="list-style-type: none"> <li>● Be provided over 3–6 months by a dedicated professional with a low caseload.</li> <li>● Focus on problem-solving approaches with the family.</li> <li>● Involve and use the resources of peer groups, schools and the wider community.</li> </ul>
<p>Young people aged 12–17 years with conduct problems at risk of being placed in long-term out-of-home care</p>	<p>Consider multidimensional treatment foster care</p>	<ul style="list-style-type: none"> <li>● Be provided over 6 months by a team of health and social care professionals able to provide case management, individual therapy and family therapy.</li> <li>● Include:                             <ul style="list-style-type: none"> <li>– training foster care families in behaviour management and providing a supportive family environment</li> <li>– 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, making their bed and being polite) and good behaviour at school</li> <li>– individual problem-solving skills training for the young person</li> <li>– family therapy for the birth parents to provide a supportive environment for the young person to return to after treatment.</li> </ul> </li> </ul>

## Assessment and risk management

### Recognition and referral

- In primary and secondary care services (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, be alert to the possibility of antisocial personality disorder in service users.
- Where antisocial personality disorder is suspected and the person is seeking help, consider offering a referral to an appropriate forensic mental health service depending on the nature of the presenting complaint. For example, for depression and anxiety this may be to general mental health services; for problems directly relating to the personality disorder it may be to a specialist personality disorder or forensic service.

### Assessment

#### Secondary care and specialist/forensic services

- When assessing a person with possible antisocial personality disorder, fully assess:
  - 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)
  - the need for psychological treatment, social care and support, and occupational rehabilitation or development
  - domestic violence and abuse.

- In secondary and specialist services use structured assessment methods whenever possible to increase the validity of the assessment. In forensic services, use measures such as PCL-R or PCL-SV to assess the severity of antisocial personality disorder as part of the routine assessment process.

### Risk assessment and management

- Services should develop a comprehensive risk management plan for people with antisocial personality disorder who are considered to be of high risk. The plan should involve other agencies in health and social care services and the criminal justice system. Probation services should take the lead role when the person is on a community sentence or is on licence from prison 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.

#### Primary care services

- Assessing risk of violence is not routine in primary care, but if such assessment is required consider:
  - current or previous violence, including severity, circumstances, precipitants and victims
  - the presence of comorbid mental disorders and/or substance misuse
  - current life stressors, relationships and life events
  - additional information from written records or families and carers (subject to the person's consent and right to confidentiality), because the person with antisocial personality disorder might not always be a reliable source of information.

- Consider contact with and/or referral to secondary or forensic 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 people.

### Secondary care services

- When assessing the risk of violence in secondary care mental health services, take a detailed history of violence and consider and record:
  - 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 disorders and/or substance misuse
  - current life stressors, relationships and life events
  - additional information from written records or families and carers (subject to the person's consent and right to confidentiality), as the person with antisocial personality disorder might not always be a reliable source of information.
- Direct initial risk management 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.
- Consider a referral to forensic 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 people.

### Specialist personality disorder or forensic services

- When assessing the risk of violence in forensic, specialist personality disorder or tertiary mental health services, take a detailed history of violence, and consider and record the points listed in the box above (in the section on secondary care services).
- Consider, as part of a structured clinical assessment, routinely using:
  - a standardised measure of the severity of antisocial personality disorder (for example, PCL-R or PCL-SV)
  - a formal assessment tool such as HCR-20 to develop a risk management strategy.

## Treatment of antisocial personality disorder and related and comorbid conditions

### General principles

- When providing psychological or pharmacological interventions for antisocial personality disorder, offending behaviour or comorbid disorders, 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).

### Psychological interventions

- For people with antisocial personality disorder, including those with substance misuse problems, in community and mental health services, consider offering group-based cognitive and behavioural interventions, in order to address problems such as impulsivity, interpersonal difficulties and antisocial behaviour.

- For people with antisocial personality disorder with a history of offending behaviour who are in community and institutional care, consider offering group-based cognitive and behavioural interventions (for example, programmes such as 'reasoning and rehabilitation') focused on reducing offending and other antisocial behaviour.

- For young offenders aged 17 years or younger with a history of offending behaviour who are in institutional care, offer group-based cognitive and behavioural interventions aimed at young offenders and that are focused on reducing offending and other antisocial behaviour.
- When providing cognitive and behavioural interventions:
  - assess the level of risk and adjust the duration and intensity of the programme accordingly (participants at all levels of risk may benefit from these interventions)
  - provide support and encouragement to help participants to attend and complete programmes, including people who are legally mandated to do so.

### Pharmacological interventions

- Pharmacological interventions should not be routinely used for the treatment of antisocial personality disorder or associated behaviours of aggression, anger and impulsivity.
- Pharmacological interventions may be considered in the treatment of comorbid disorders (see page 17).

### Treatment for comorbid disorders

- Offer treatment for any comorbid disorders in line with the relevant NICE clinical guideline, where available. This should happen regardless of whether the person is receiving treatment for antisocial personality disorder.
- When starting and reviewing medication for comorbid mental disorders, pay particular attention to issues of adherence and the risks of misuse or overdose.
- When providing psychological interventions for comorbid disorders to people with antisocial personality disorder, consider lengthening their duration or increasing their intensity.

### Comorbid drug and alcohol misuse

- For people with antisocial personality disorder who misuse drugs, in particular opioids or stimulants, offer psychological interventions (in particular, contingency management programmes) in line with recommendations in the relevant NICE clinical guideline.
- For people with antisocial personality disorder who misuse or are dependent on alcohol, offer psychological and pharmacological interventions in line with existing national guidance for the treatment and management of alcohol disorders.
- For people with antisocial personality disorder who are in institutional care and who misuse or are dependent on drugs or alcohol, consider referral to a specialist therapeutic community focused on the treatment of drug and alcohol problems.

## Psychopathy and dangerous and severe personality disorder

### Adapting treatments for psychopathy or dangerous and severe personality disorder

- For people in community and institutional settings who meet criteria for psychopathy or dangerous and severe personality disorder (DSPD), consider cognitive and behavioural interventions (for example, programmes such as 'reasoning and rehabilitation') focused on reducing offending and other antisocial behaviour.
- Adapt these interventions by extending the nature (for example, concurrent individual and group sessions) and duration of the intervention, and by providing booster sessions, continued follow-up and close monitoring.
- For people who meet criteria for psychopathy or DSPD, offer treatment for any comorbid disorders in line with existing NICE guidance. This should happen regardless of whether the person is receiving treatment for psychopathy or DSPD.

### Intensive staff support

- Staff providing interventions for people who meet criteria for psychopathy or DSPD should receive high levels of support and close supervision, due to increased risk of harm. This may be provided by staff outside the unit.

## Organisation and planning of services

### Multi-agency care

- Provision of services for people with antisocial personality disorder often involves significant inter-agency working. Services should ensure that there are clear pathways so that this is as effective as possible. These pathways should:
  - specify the interventions available at each point
  - enable effective communication among clinicians and organisations at all points and provide the means to resolve differences and disagreements.

Clearly agreed local criteria should also be established to facilitate the transfer of people with antisocial personality disorder between services. As far as is possible, shared objective criteria should be developed relating to comprehensive assessment of need and risk.

- Services should consider establishing antisocial personality disorder networks, where possible linked to other personality disorder networks. (This may be organised at the level of primary care trusts, local authorities, strategic health authorities or government offices.) These networks should be multi-agency, should actively involve people with antisocial personality disorder and should:
  - take a significant role in training staff, including those in primary care, general, secondary and forensic mental health services, and in the criminal justice system
  - have resources to provide specialist support and supervision for staff
  - take a central role in the development of standards for and the coordination of clinical pathways
  - monitor the effective operation of clinical pathways.

### Inpatient services

- In general, consider admission to inpatient services only for crisis management or for the treatment of comorbid disorders.
- Admission should be brief, where possible set out in a previously agreed crisis plan and have a defined purpose and end point.
- Admission solely for the treatment of antisocial personality disorder or its associated risks is likely to be lengthy and should:
  - be under the care of forensic/specialist personality disorder services
  - not usually be under a hospital order under a section of the Mental Health Act (in the rare instances that this is done, seek advice from a forensic/specialist personality service).

## Staff training, supervision and support

### Staff competencies

- All staff should be familiar with the 'Ten essential shared capabilities: a framework for the whole of the mental health practice'<sup>1</sup> and have a knowledge and awareness of antisocial personality disorder that facilitates effective working with service users, families or carers, and colleagues.
- All staff should have skills appropriate to the nature and level of contact with people with antisocial personality disorder. 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 (such as inappropriate relations with service users)
  - 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.
- Services should ensure that all staff providing psychosocial or pharmacological interventions for the treatment or prevention of antisocial personality disorder are competent and 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 use of sessional outcome measures
  - routine direct monitoring and evaluation of staff adherence, for example through the use of video and audio tapes and external audit and scrutiny where appropriate.

### Supervision and support

- Services should ensure that staff supervision is built into the routine working of the service, is properly resourced within local systems and is monitored. Supervision, which may be provided by staff external to the service, should:
  - make use of direct observation (for example, recordings of sessions) and routine outcome measures
  - support adherence to the specific intervention
  - promote general therapeutic consistency and reliability
  - counter negative attitudes among staff.
- Forensic 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 that encourages reflective practice and honesty about individual difficulties such as the potential for therapeutic boundary violations (for example inappropriate relations with service users)
  - 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.

<sup>1</sup> Available from [http://www.eftacim.org/doc\\_pdf/10ESC.pdf](http://www.eftacim.org/doc_pdf/10ESC.pdf)

## Implementation tools

NICE has developed tools to help organisations implement this guidance (listed below).

These are available on our website ([www.nice.org.uk/CG77](http://www.nice.org.uk/CG77)).

- Slides highlighting key messages for local discussion.
- Audit support for monitoring local practice.
- Costing tools:
  - costing report to estimate the national savings and costs associated with implementation
  - costing template to estimate the local costs and savings involved.

## Further information

### Ordering information

You can download the following documents from [www.nice.org.uk/CG77](http://www.nice.org.uk/CG77)

- The NICE guideline – all the recommendations.
- A quick reference guide (this document) – a summary of the recommendations for healthcare professionals.
- ‘Understanding NICE guidance’ – a summary for patients and carers.
- The full guideline – all the recommendations, details of how they were developed, and reviews of the evidence they were based on.

For printed copies of the quick reference guide or ‘Understanding NICE guidance’, phone NICE publications on 0845 003 7783 or email [publications@nice.org.uk](mailto:publications@nice.org.uk) and quote:

- N1763 (quick reference guide)
- N1764 (‘Understanding NICE guidance’).

### Related NICE guidance

For information about NICE guidance that has been issued or is in development, see [www.nice.org.uk](http://www.nice.org.uk)

#### Published

Borderline personality disorder. NICE clinical guideline 78 (2009). Available from [www.nice.org.uk/CG78](http://www.nice.org.uk/CG78)

Attention deficit hyperactivity disorder. NICE clinical guideline 72 (2008). Available from [www.nice.org.uk/CG72](http://www.nice.org.uk/CG72)

Anxiety (amended). NICE clinical guideline 22 (2007). Available from [www.nice.org.uk/CG22](http://www.nice.org.uk/CG22)

Depression (amended). NICE clinical guideline 23 (2007). Available from [www.nice.org.uk/CG23](http://www.nice.org.uk/CG23)

Drug misuse: psychosocial interventions. NICE clinical guideline 51 (2007). Available from [www.nice.org.uk/CG51](http://www.nice.org.uk/CG51)

Drug misuse: opioid detoxification. NICE clinical guideline 52 (2007). Available from [www.nice.org.uk/CG52](http://www.nice.org.uk/CG52)

Bipolar disorder. NICE clinical guideline 38 (2006). Available from [www.nice.org.uk/CG38](http://www.nice.org.uk/CG38)

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](http://www.nice.org.uk/TA102)

Obsessive-compulsive disorder. NICE clinical guideline 31 (2005). Available from [www.nice.org.uk/CG31](http://www.nice.org.uk/CG31)

Post-traumatic stress disorder (PTSD). NICE clinical guideline 26 (2005). Available from [www.nice.org.uk/CG26](http://www.nice.org.uk/CG26)

Violence. NICE clinical guideline 25 (2005). Available from [www.nice.org.uk/CG25](http://www.nice.org.uk/CG25)

Self-harm. NICE clinical guideline 16 (2004). Available from [www.nice.org.uk/CG16](http://www.nice.org.uk/CG16)

Schizophrenia. NICE clinical guideline 1 (2002). Available from [www.nice.org.uk/CG1](http://www.nice.org.uk/CG1)

### Updating the guideline

This guideline will be updated as needed, and information about the progress of any update will be available at [www.nice.org.uk/CG77](http://www.nice.org.uk/CG77)

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