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Antisocial personality disorder

Treatment, management and prevention

NICE clinical guideline 77
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NICE clinical guideline 77
Antisocial personality disorder: treatment, management and prevention

Ordering information
You can download the following documents from www.nice.org.uk/CG77

- The NICE guideline (this document) – all the recommendations.
- A quick reference guide – 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 and quote:

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

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

This guideline makes recommendations for the treatment, management and prevention of antisocial personality disorder in primary, secondary and forensic 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 (including substance misuse) services, 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 often grown up in fractured families in which parental conflict is typical and parenting is harsh and inconsistent. As a result of parental inadequacies and/or the child's difficult behaviour, the child's care is often interrupted and transferred to agencies outside the family. This in turn often leads to truancy, having delinquent associates and substance misuse, which frequently result in increased rates of unemployment, poor and unstable housing situations, and inconsistency in relationships in adulthood. Many people with antisocial personality disorder 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 it is often the culmination of previous and long-standing difficulties, such as socioeconomic, educational and family problems. Antisocial personality disorder therefore amounts to more than criminal behaviour alone, otherwise everyone convicted of a criminal offence would meet the criteria for antisocial personality disorder and a diagnosis of antisocial personality disorder would be rare in people with no criminal history. This is not the case. The prevalence of antisocial personality disorder among prisoners is slightly

less than 50%. It is estimated in epidemiological studies in the community that only 47% of people who meet the 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 of antisocial personality disorder in the general population is 3% in men and 1% in women.

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. People with conduct disorder typically show antisocial, aggressive or defiant behaviour, which is persistent and repetitive, including aggression to people or animals, destruction of property, deceitfulness, theft and serious rule-breaking. A history of conduct disorder before the age of 15 is a requirement for a diagnosis of antisocial personality disorder in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV).

The course of antisocial personality disorder 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, and alcohol and drug misuse.

Families or carers are important in prevention and treatment of antisocial personality disorder. This guideline uses the term ‘families or carers’ to apply to all family members and other people, such as friends and advocates, who have regular close contact with the person with antisocial personality disorder.

This guideline draws on the best available evidence. However, 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 the limitations are addressed in the recommendations for further research (see section 4).

At the time of publication (January 2009), 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 each person.

NICE has developed a separate guideline on borderline personality disorder (see section 6).

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 people's 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 someone does 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 the code of practice that accompanies the Mental Capacity Act (summary available from www.publicguardian.gov.uk).

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

Good communication between healthcare professionals and people with antisocial personality disorder is essential. It should be supported by evidence-based written information tailored to the person's needs. Treatment and care, and the information people 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 person agrees, carers (who may include family and friends) 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).

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 (see sections 1.2.6 and 1.2.7).
  - additional factors, such as callous and unemotional traits in the child, may reduce the likelihood of the child benefiting from parent-training programmes alone.

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 Psychopathy Checklist–Revised (PCL-R) or Psychopathy Checklist–Screening Version (PCL-SV)
  - a formal assessment tool such as 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 (see section 6). 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.

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.

1 Guidance

The following guidance is based on the best available evidence. The full guideline (www.nice.org.uk/CG77fullguideline) gives details of the methods and the evidence used to develop the guidance.

1.1 General principles for working with people with antisocial personality disorder

People with antisocial personality disorder have tended to be excluded from services, and policy implementation guidance from the Department of Health, 'Personality disorder: no longer a diagnosis of exclusion' (2003)[1], aims to address this. To change the current position, 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 and assessment

1.1.1.1 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.

1.1.1.2 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.

[1] Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009546www

1.1.1.3 Ensure that people with antisocial personality disorder from black and minority ethnic groups have equal access to culturally appropriate services based on clinical need.

1.1.1.4 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.

1.1.1.5 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.

1.1.1.6 When working with women with antisocial personality disorder take into account the higher incidences of common comorbid mental health problems and other personality disorders in such women, and:

- adapt interventions in light of this (for example, extend their duration)
- ensure that in inpatient and residential settings the increased vulnerability of these women is taken into account.

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 when the primary mode of treatment is group based.

1.1.2 People with disabilities and acquired cognitive impairments

1.1.2.1 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.

1.1.2.2 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 adjust the method of delivery or duration of the intervention to take account of the disability or impairment.

1.1.3 Autonomy and choice

1.1.3.1 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.

1.1.4 Developing an optimistic and trusting relationship

1.1.4.1 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.

1.1.5 Engagement and motivation

1.1.5.1 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.

1.1.6 Involving families and carers

1.1.6.1 Ask directly whether the person with antisocial personality disorder wants their family or carers to be involved in their care, and, subject to the person's 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.

1.1.6.2 Consider the needs of families and carers of people with antisocial personality disorder 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.

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

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 children and young people who are at risk, and their families, points to the potential value of preventative measures. There are definitions of the psychological interventions referred to in the recommendations in section 8.

1.2.1 General principles

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 that applies to young people, including the Mental Capacity Act, the Children Acts and the Mental Health Act.

1.2.2 Identifying children at risk of developing conduct problems

1.2.2.1 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.

1.2.2.2 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.

1.2.3 Early interventions for preschool children at risk of developing conduct problems and potentially subsequent antisocial personality disorder

1.2.3.1 Early interventions aimed at reducing the risk of the development of conduct problems, and antisocial personality disorder at a later age, may be considered for children identified to be of high risk of

developing conduct problems. These should be targeted at the parents of children with identified high-risk factors and include:

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

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

- consist of well-structured, manualised programmes that are closely adhered to
- target multiple risk factors (such as parenting, school behaviour, and parental health and employment).

1.2.4 Interventions for children with conduct problems younger than 12 years and their families

1.2.4.1 Group-based parent-training/education programmes are recommended in the management of children with conduct disorders.[2]

1.2.4.2 Individual-based parent-training/education programmes are recommended in the management of children with conduct disorders only in situations where there are particular difficulties in engaging with the parents or a family's needs are too complex to be met by group-based parent-training/education programmes.[3]

1.2.4.3 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.

[2] This recommendation is from 'Parent-training/education programmes in the management of children with conduct disorders' (NICE technology appraisal 102).

1.2.4.4 Programme providers should also ensure that support is available to enable the participation of parents who might otherwise find it difficult to access these programmes.[4]

1.2.4.5 Support to enable the participation of parents who might otherwise find it difficult to access these programmes might include:

- individual parent-training programmes
- regular reminders about meetings (for example, telephone calls)
- effective treatment of comorbid disorders (in particular, attention deficit hyperactivity disorder in line with 'Attention deficit hyperactivity disorder' NICE clinical guideline 72).

1.2.5 How to deliver interventions for children with conduct problems aged younger than 12 years and their families

1.2.5.1 It is recommended that all parent-training/education programmes, whether group- or individual-based, should:[5]

- be structured and have a curriculum informed by principles of social-learning theory
- include relationship-enhancing strategies
- offer a sufficient number of sessions, with an optimum of 8–12, to maximise the possible benefits for participants
- enable parents to identify their own parenting objectives
- incorporate role-play during sessions, as well as homework to be undertaken between sessions, to achieve generalisation of newly rehearsed behaviours to the home situation
- 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
- adhere to the programme developer's manual and employ all of the necessary materials to ensure consistent implementation of the programme.

[3–5] These recommendations are from 'Parent-training/education programmes in the management of children with conduct disorders' (NICE technology appraisal 102).

1.2.5.2 Programmes should 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).

1.2.5.3 Programmes should demonstrate proven effectiveness. This should be based on evidence from randomised controlled trials or other suitable rigorous evaluation methods undertaken independently.[6]

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

1.2.6.1 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 (see sections 1.2.4 and 1.2.5)
- additional factors, such as callous and unemotional traits in the child, may reduce the likelihood of the child benefiting from parent-training programmes alone.

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

1.2.7 How to deliver interventions for children aged 8 years and older with conduct problems

1.2.7.1 Cognitive problem-solving skills training should be delivered individually over a period of 10–16 weeks. Training should focus typically 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

[6] This recommendation is from 'Parent-training/education programmes in the management of children with conduct disorders' (NICE technology appraisal 102).

- set targets for desirable behaviour.

1.2.7.2 Anger control should usually take place in groups over a period of 10–16 weeks and focus typically 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.

1.2.7.3 Social problem-solving skills training should usually be conducted in groups over a period of 10–16 weeks. Training should focus typically 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.

Interventions for young people with conduct problems aged between 12 and 17 years and their families

1.2.7.4 For parents of young people aged between 12 and 17 years with conduct problems, consider parent-training programmes (see sections 1.2.4 and 1.2.5).

1.2.7.5 If the parents are unable to or choose not to engage with parent-training programmes, or the young person's conduct problems are so severe that they will be less likely to benefit from parent-training programmes, consider:

- brief strategic family therapy for those with predominantly drug-related problems
- functional family therapy for those with predominantly a history of offending.

1.2.7.6 For young people aged between 12 and 17 years with severe conduct problems and a history of offending and who are at risk of being placed in care or excluded from the family, consider multisystemic therapy.

1.2.7.7 For young people aged between 12 and 17 years with conduct problems at risk of being placed in long-term out-of-home care, consider multidimensional treatment foster care.

1.2.8 How to deliver interventions for young people with conduct problems aged between 12 and 17 years and their families

1.2.8.1 Brief strategic family therapy should consist of at least fortnightly meetings over a period of 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).

1.2.8.2 Functional family therapy 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 the community (such as schools).

1.2.8.3 Multisystemic therapy should be provided over a period of 3–6 months by a dedicated professional with a low caseload, and should:

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

1.2.8.4 Multidimensional treatment foster care should be provided over a period of 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, making their bed and being polite) and good behaviour at school
- individual problem-solving skills training for the young person
- family therapy for the birth parents to provide a supportive environment for the young person to return to after treatment.

1.2.9 Transition from child and adolescent services to adult services

1.2.9.1 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.

1.3 Assessment and risk management of antisocial personality disorder

In primary and secondary care services, antisocial personality disorder is under-recognised. When it is identified, significant comorbid disorders such as

treatable depression or anxiety are often not detected. In secondary and forensic services there are important concerns about assessing risk of violence and risk of harm to self and others.

1.3.1 Assessment

1.3.1.1 When assessing a person with possible antisocial personality disorder, healthcare professionals in secondary and forensic 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)
- the 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 to increase the validity of the assessment. For forensic services, the use of measures such as PCL-R or 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 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 should 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.

1.3.2 Risk assessment and management

Risk assessment is part of the overall approach to assessment and care planning as defined in the framework of the Care Programme Approach, and the following recommendations should be regarded in that context.

Primary care services

1.3.2.1 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.

1.3.2.2 Healthcare professionals in primary care should 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

1.3.2.3 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 disorder 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.

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 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

1.3.2.6 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:

- 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 disorder 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.

1.3.2.7 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 (for example, PCL-R or PCL-SV)
- a formal assessment tool such as HCR-20 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 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.

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 disorders such as depression and drug misuse; and (4) the management of offending behaviour. Although the focus of several interventions is 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 recommendations in the relevant NICE clinical guideline, where available (see section 6). This should happen regardless 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, 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 their duration or increasing their intensity.

1.4.2 The role of psychological interventions

1.4.2.1 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.

1.4.2.2 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.

1.4.2.3 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.

1.4.2.4 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.

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 interventions for comorbid mental disorders, in particular depression and anxiety, should be in line with recommendations in the relevant NICE clinical guideline (see section 6). When starting and reviewing medication for comorbid mental disorders, pay particular attention 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 of harm to self and others 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, offer psychological interventions (in particular, contingency management programmes) in line with recommendations in the relevant NICE clinical guideline (see section 6).

1.4.4.2 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.

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, consider referral to a specialist therapeutic community focused on the treatment of drug and alcohol problems.

1.5 Psychopathy and dangerous and severe personality disorder

People with psychopathy and people who meet criteria for dangerous and severe personality disorder (DSPD) represent a small proportion of people with antisocial personality disorder. However, they present a very high risk of harm to others and consume a significant proportion of the services for people with antisocial personality disorder. In the absence of any high-quality evidence for the treatment of DSPD, the Guideline Development Group drew on the evidence for the treatment of antisocial personality disorder to arrive at their recommendations. Interventions will often need to be adapted for DSPD (for example, a significant extension of the duration of the intervention). People with DSPD 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 For people in community and institutional settings who meet criteria for psychopathy or DSPD, consider 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 for this group 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.

1.5.1.2 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 because effective treatment of comorbid disorders may reduce the risk associated with psychopathy or DSPD.

1.5.2 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, due to increased risk of harm. This may be provided by staff outside the unit.

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:

- 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.

1.6.1.2 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.

1.6.2 Inpatient services

1.6.2.1 Healthcare professionals should normally only consider admitting people with antisocial personality disorder to inpatient services 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.

1.6.2.2 Admission to inpatient services 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 forensic/specialist personality disorder services
- not usually be under a hospital order under a section of the Mental Health Act (in the rare instance that this is done, seek advice from a forensic/specialist personality service).

1.6.3 Staff training, supervision, support

Working in services for people with antisocial personality disorder presents a considerable challenge for staff. Effective training and support is crucial so that staff can adhere to the specified treatment programme and manage any emotional pressures arising from their work.

Staff competencies

1.6.3.1 All staff working with people with antisocial personality disorder should be familiar with the 'Ten essential shared capabilities: a framework for the whole of the mental health practice'[7] and have a knowledge and awareness of antisocial personality disorder that facilitates effective working with service users, families or carers, and colleagues.

1.6.3.2 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 example, 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.

1.6.3.3 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.

[7] Available from www.eftacim.org/doc_pdf/10ESC.pdf

Supervision and support

1.6.3.4 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.

1.6.3.5 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 (such as 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.

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 how well NHS organisations meet 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 NHS organisations should take into account national agreed guidance when 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/CG77).

- 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.
- 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 relatively large number of recommendations made reflects the paucity of research in this area.

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

Does the pre-treatment level of the severity of disorder/problem have an impact on the outcome of group-based cognitive and behavioural interventions for offending behaviour? A meta-analysis of individual participant data should be conducted to determine whether the level of severity assessed at the beginning of the intervention moderates the effect of the intervention. The study (for which there are large data sets that include over 10,000 participants) could inform the design of a large-scale RCT (including potential modifications of cognitive and behavioural interventions) to test the impact of severity on the outcome of cognitive and behavioural interventions.

Why this is important

Research has established the efficacy of cognitive and behavioural interventions in reducing reoffending. However, the effects of these interventions in a range of offending populations are modest. The impact of severity 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 severe or high-risk individuals may not benefit from cognitive and behavioural interventions, but if they 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 effective in reducing the behaviours associated with antisocial personality disorder (such as impulsivity, rule-breaking, deceitfulness, irritability, aggressiveness and disregard for the safety of self or others)? This should be tested in an RCT

that examines 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 publication of the Department of Health's policy guidance, 'Personality disorder: no longer a diagnosis of exclusion' (2003), it is likely that there will be an increased requirement in the NHS to offer treatments for antisocial personality disorder.

4.3 Effectiveness of multisystemic therapy versus functional family therapy

Is multisystemic therapy or functional family therapy more clinically and cost effective in the treatment of adolescents with conduct disorders? A large-scale RCT comparing the clinical and cost effectiveness of multisystemic therapy and functional family therapy 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 to determine the factors associated with benefits or harms of either multisystemic therapy or functional family therapy.

Why this is important

Multisystemic therapy and functional family therapy 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), multisystemic therapy is focused on both the family and the wider resources of the school,

community and criminal justice systems, and through intensive individual case work seeks to change the pattern of antisocial behaviour. In contrast, functional family therapy 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 multisystemic therapy or functional family therapy.

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 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 that 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 when these factors are agreed, engaging parents in treatment can be difficult. It is important that a range of effective interventions is developed to increase the treatment choice and opportunities for high-risk groups. Several interventions, such as Nurse–Family Practitioners, are being developed and trialled in the UK. It is important for this group of children to have an alternative, effective intervention.

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 of people with antisocial personality disorder and comorbid anxiety disorders that compares a sequenced treatment programme for the anxiety disorder with usual care should be conducted. It should examine, 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 the 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. There are effective treatments (psychological and pharmacological) for anxiety disorders but they 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 a reduction in antisocial behaviour would have wider societal benefits. The study should provide important information on the challenges of delivering these interventions for a population that has typically both rejected and been refused treatment.

4.6 Using selective serotonin reuptake inhibitors to increase cooperative behaviour in people with antisocial personality disorder in a prison setting

Although there is evidence that selective serotonin reuptake inhibitors (SSRIs), such as paroxetine, increase cooperative behaviour in normal people and do so independently of the level of sub-syndromal depression, this has

yet to be tested in other settings. Given that people with antisocial personality disorder are likely to have difficulties cooperating with one another (because of a host of personality traits that include persistent rule-breaking for personal advantage, suspiciousness, grandiosity, etc.). An RCT should be conducted to find out whether these reported changes of behaviour with an SSRI in normal people generalises to clinical populations in different settings.

Why this is important

There is little evidence in the literature on the pharmacotherapy of antisocial personality disorder to justify the use of any particular medication. However, multiple drugs in various combinations are used in this group either to control aberrant behaviour or in the hope that something might work. Current interventions lack a clear rationale. This recommendation has the potential to advance the field in that (a) it is linked to a clear hypothesis (that cooperative behaviour is linked to a dysregulation of the serotonin receptors – for which there is substantial evidence) and (b) that it is feasible to obtain an answer to this question, given that there are a large number of individuals detained in prison settings who would meet ASPD criteria. Constructing an experimental task that requires cooperative activity would not be difficult in such a setting, since all of those who might be willing to participate are already detained. The successful execution of this research would be important in that it (a) would establish the feasibility of conducting such a trial in a prison setting with this group, and (b) provide a clear and sensible outcome measure of antisocial behaviour that might be generalised to other settings.

4.7 A therapeutic community approach for antisocial personality disorder in a prison setting

Is a therapeutic community approach in a prison setting more clinically and cost effective in the treatment and management of antisocial personality disorder than routine prison care? There should be a large-scale RCT comparing the clinical and cost effectiveness of the therapeutic community approach for adults with antisocial personality disorder with routine care. It should examine the medium-term outcomes (for example, offending behaviour, mental state and vocational outcomes) over a period of at least 18 months following release from prison. The study should also be designed to explore the moderators and mediators of treatment effect, which could help

to determine the factors associated with benefits or harms of the therapeutic community approach.

Why this is important

There is evidence from RCTs that the therapeutic community approach is of value with drug and alcohol misusers in a prison setting at reducing the incidence of offending behaviour on release. However, there are no equivalent studies of a programme in the prison system on antisocial personality disorder populations that do not have significant drug or alcohol problems. Data that do exist are from non-UK settings. Answering this question is of importance because outcomes for adults with antisocial personality disorder are poor and there are already considerable resources devoted to a therapeutic community approach in the UK prison system (for example, HMP Grendon Underwood). The study could inform policy and resources decisions about the management of antisocial personality disorder in the criminal justice system.

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/CG77fullguideline) and the National Library for Health (www.nlh.nhs.uk).

5.2 Quick reference guide

A quick reference guide for healthcare professionals is available from www.nice.org.uk/CG77quickrefguide

For printed copies, phone NICE publications on 0845 003 7783 or email publications@nice.org.uk (quote reference number N1763).

5.3 'Understanding NICE guidance'

A summary for patients and carers ('Understanding NICE guidance') is available from www.nice.org.uk/CG77publicinfo

For printed copies, phone NICE publications on 0845 003 7783 or email publications@nice.org.uk (quote reference number N1764).

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

Borderline personality disorder: treatment and management. NICE clinical guideline 78 (2009). Available from www.nice.or.uk/CG78

Attention deficit hyperactivity disorder: diagnosis and management of ADHD in children, young people and adults. NICE clinical guideline 72 (2008). Available from www.nice.org.uk/CG72

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/CG22

Depression (amended): management of depression in primary and secondary care. NICE clinical guideline 23 (2007). Available from www.nice.org.uk/CG23

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

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

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/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

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/CG31

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/CG26

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/CG25

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/CG16

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/CG1

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.

8 Definitions of psychological interventions

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). It also includes training of other skills such as relaxation and social skills.

Brief strategic family therapy: an intervention that is systemic in focus and is influenced by other approaches. 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, and seeking to generalise change from specific behaviours to positively influence interactions both within the family and with community agencies such as schools.

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. This includes group meetings and other support for the foster parents and family therapy with the child's biological parents.

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. Examples of well-developed programmes are the Triple P (Sanders et al. 2000) and Webster-Stratton (Webster-Stratton et al. 1988).

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.

References

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Webster-Stratton C, Kolpacoff M, Hollinsworth T (1988) Self-administered videotape therapy for families with conduct-problem children: comparison with two cost-effective treatments and a control group. Journal of Consulting and Clinical Psychology 56: 558–66.

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.

Mr Peter Robb - Chair
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