National Institute for Health and Clinical Excellence

Antisocial personality disorders (ASPD)
Guideline Consultation Comments Table

8 August - 2 October 2008

US	Type	Who	NI NO	GL	Section	Comments	Responses
1	SH	Alder Hey Children's NHS Foundation Trust	1	Full	General	We welcome the consideration of prevention, transitional years and social exclusion. However, we feel strongly that the parenting agenda including perinatal issues (for ASPD parents) while acknowledged could have been more strongly integrated into the guideline throughout and many of our points will reflect this.	Thank you for your comment. We will address your comments (1-23) in detail below. Where the issue of ASPD parents relates to the prevention of ASPD to future generations this has been addressed. However it is beyond the scope of the document to address all the issues faced by parents with ASPD.
2	SH	Alder Hey Children's NHS Foundation Trust	2	Full	General	The NICE guideline development process uses the 'AGREE' protocol for evaluating evidence. In our opinion this needs to be reviewed in terms of the inherent biases that it will create. There is no system that can be free from bias, and this needs to be explored, stated and there must be some clarity about how this is dealt with. For example some of our respondents were worried that 'parenting' might not have been given the status in the review of evidence that it should have.	Thank you for your comments we hope this guideline will challenge therapeutic nihilism and improve service provision for people with antisocial personality disorder.
3	SH	Alder Hey Children's NHS Foundation Trust	3	Full	2.1 and general	Respondents pointed out the occasionally patronising style, eg page 16, line 36: 'Because *those* with antisocial …'. There is evidence that some of us, i.e. the health professionals involved in the care of ASPD might qualify ourselves for a diagnosis of personality disorder and that this potentially creates its own inherent bias (Board, B.J. & Fritzon, K. F. (2005). Disordered personalities at work. Psychology, Crime and Law, 11, 17-32). There was considerable discomfort about the use of the diagnosis of both 'ASPD' and 'conduct disorder'. This especially refers to the potentially pathologising effect of the diagnostic labeling and the limited validity of the construct of	Thank you for this comment, unfortunately the remit of the guideline requires that we focus on term antisocial personality disorder. While we appreciate that there are issues around the individuals' response to the diagnosis and the use of terms like conduct disorder, this was considered within the overall framework in which the guideline was developed. Although there has been some

						ASPD which underplay the multiple familial, systemic and social influences constraining the development of children. There is considerable overlap between diagnostic criteria and adolescent developmental processes. Therefore the use of 'conduct disorder' as a discrete diagnosis and as part of the wider ASPD diagnosis may be flawed and possibly damaging to young people. Generally, we consider the current concept of conduct disorder as outdated and its use should be discontinued. Though the guidelines try and deal with some of the dilemmas of the diagnostic systems available, much of the diagnosis is still based on behavioural observation and inference from behavioural observation. We felt that it could help if the guideline made the point that behaviour (including antisocial behaviour) can be understood as a form of communication which would also facilitate a more appropriately empathic stance on behalf of the professionals involved (Winnicott: Delinquency as a sign of hope). There was also a sense that ICD & DSM are not the only classification systems available and one respondent pointed out that there is a comprehensive Chinese classification system under development which includes mental health and might be worthwhile exploring. (Page 15 onward and general)	discussion of the diagnostic terms included in the introduction, we thought it would be positively confusing to try and arrive at different terminologies specifically for this guideline. We have therefore not made the changes along the lines that you have suggested.
4	SH	Alder Hey Children's NHS Foundation Trust	4	Full	2.3	It might be helpful to have a greater focus on the impact of adverse childhood experiences and the significant evidence base relating to the neurobiological development of children in traumagenic families. This could provide some additional explanatory power for the characterisation and understanding of the ASPD person. Respondents were not sure on the basis of the reported evidence that the claim of heritability and 'hard-wired' antisocial behaviour was responsible whereas more emphasis could be put on transgenerational transmission of familial environments and patterns of relating. (page 22, line 32)	Thank you for your comments. The evidence is still at a preliminary stage and therefore the detail contained in this section reflects that. Thank you, we have added further details on transgenerational transmission through environmental factors in chapter 5.
5	SH	Alder Hey Children's NHS Foundation Trust	4	Full	2.8	'Organisation of treatment and care': The preventive role of work with parents, including of work with antisocial personality disorder parents needs to be acknowledged in this section. (page 29 onward)	Thank you for this comment. We refer you to chapter 5 prevention of ASPD. In this chapter we make important recommendations about work with

							children and parents that could reduce and effectively treat/manage conduct disorder, thereby potentially reducing the long term consequences of ASPD. There is no specific evidence focussing on parents with anti social personality disorder for these interventions although it is probable that a significant number of parents in these programmes do have personality problems. We think that the ways we dealt with this matter in chapter 5 addresses your concerns.
6	SH	Alder Hey Children's NHS Foundation Trust	5	Full	2.10	The ethics section should include the consideration of capacity for consent (e.g. McClelland N. Beneficence in Ethical Practice in Diagnosis and Treatment of Personality Disorder. Therapeutic Communities, 2006, 27, 4, 477-493). Questions were raised about the claimed continuity of conduct disorder and ASPD and whether it could lead to Gillick-competent adolescents being compelled to treatment despite lack of consent. (page 30, line 38 onwards) We welcome that the issue of the ethics of children is addressed and there is some excellent material here. However, there is a logical limitation: Assuming that there should be no child without someone in a *complementary parenting* role then those two roles need to be considered as a unit. A heading like 'Ethical issues and the parent-child relationship' may be more appropriate, with a focus on that relationship. This enables consideration of the ASPD parent in conjunction with the child. The potential conflict of interest can then also be re-constructed: If the parent-child relationship is one of social roles (parenting person and child) then within these roles the best interests of the child are located within the parent-child relationship. The crucial issue is that the personality disorder (any mental health problem of the parent for that matter) may reduce the parent's capacity to attend to the parent-child relationship and its requirements; hence a conflict of interest between the parent as a person and the child as a person can	Thank you for the suggestion, but this is beyond the scope of the guideline. Thank you for your comment, the detail you suggest is beyond the scope of a guideline on adults with ASPD.

						arise because of the non-fulfilment of the parental role. Thus the ethical dilemma addressed here is one of non-fulfilment of the parental role. However as long as the parent is motivated to be a good enough parent there should be no dilemma of conflicts of interests. The key points practically are that 1) while the resources may have to be allocated via child or parent in a system that only recognises individual needs, the target of the resource needs to be the relationship of parent and child if this is to be improved or kept viable for the child. 2) The parent may feel less blamed and more supported by such an approach because of the differentiation of parental role and personal capacity. In order to achieve parental role fulfilment when there are mental health issues interfering with parenting capacity the individual needs of each party to that relationship must be formulated, especially the needs of the parent that must be met for the parent to fulfil her role. It is necessary but not sufficient that the needs of the child are deemed paramount. For this reason it is in the best interest of the child that services make the parent-child relationship the focus of addressing the child's needs as long as the parent-child relationship is deemed viable (with or without intervention). This must include the needs of the parent. Hence for a parent with an antisocial personality disorder, all the treatment issues identified in this guidance are relevant in the best interest of the child. This should be upheld from time to time throughout the text especially in view of the fact that sometimes the motivation to be a good enough parent may be the only available motivation for change in a person with ASPD. This is particularly relevant because of the principally pro-social effect of the parenting role. Respondents also commented on the dilemma of clinicians who have to balance client benefit and responsibility to the public. There was a strong sense that it would be useful if the guideline could clarify further the primacy of role and issues of confidentiality e.g. when working with risky families, the catch 22 arising from the possibility of the clinician having to provide	

						compulsory treatment, a clinician's requirement to report to court as 'expert witness' or to participate in a MAPPP. If a patient exercises their right of refusal of treatment will this be viewed as symptomatic, oppositional behaviour? The document outlines some of these dilemmas very clearly but it would be welcome if a structure for arriving at solutions could be provided.	
7	SH	Alder Hey Children's NHS Foundation Trust	6	Full	3.1	We feel strongly that perinatal and parenting issues need to be routinely addressed in all guideline development where the social role of parent is likely to be affected. The point is similar to the first point we make on the 'AGREE' methodology. This should include service users who are parents, young carers who have a parent with ASPD and more than the one parenting expert on the guideline development group. The choice of 'population' should include 'parents' and this should then be appropriately reflected in the clinical questions. It was not always clear to our respondents to what extent this may have happened. (page 38)	Thank you for this comment. This seems to relate more to the overall methodology of the guideline development and not specifically to ASPD. We feel we have adequately dealt with the issues in a comprehensive way in this guideline.
8	SH	Alder Hey Children's NHS Foundation Trust	7	Full	4.2.4	'Assessment' should include explicit and separate recognition of any needs arising from a patient's parenting role if applicable. (page 66, line 7)	Thank you for this comment. We have made specific recommendations about parenting in section 1.1.1.14. There are more specific recommendations regarding parent training programmes in section 1.2. Is there anything more specific with regard to parenting roles that we could reasonably include within this guideline given the evidence base that currently exists?
9	SH	Alder Hey Children's NHS Foundation Trust	8	NICE and Full	**1.1.1.1** 4.2.4.4	Reference to any exclusion from services should include a review of social services' provision and the undoubtedly existing exclusion patterns in those services with respect to both parents with ASPD and emerging ASPD in young people. It could also be more prominently related to the issue of conduct disorder which in the child mental health field mirrors the issue of service provision for personality disorder in adult mental health. (page 67, line 2)	It is not the responsibility of the NICE guideline to comment specifically on the policies of social services departments. Therefore we do not think it appropriate to take up your suggestion.
10	SH	Alder Hey Children's NHS	9	NICE and	**1.6.1.1**	Consideration needs to be given separately to the issue of 'thresholds' in relation to parenting and the 16-18 group.(page	Thank you. We have made some further comments on the issues of

		Foundation Trust		Full	4.2.4.9	67, line 31)	thresholds. Our aim was not to develop a guideline on parenting skills and we don't think it correct to take up your suggestion about thresholds in relation to parent training. However, we have made some adjustments to the issues around transition from child adolescent mental health to adult services.
11	SH	Alder Hey Children's NHS Foundation Trust	10	Full	4.3	Training etc.: This needs to include separate consideration of the parenting dimension, the parent-child relationship and the responsibility for meeting the child's needs. There was a clear bias towards thinking forensic services. Training and supervision requirements and how they should be met must include all ASPD patients, including ASPD parents, wherever they are. This may well include emerging ASPD in schools as well before the person becomes eligible for the services of the local YOT team. There are many other agencies which encounter ASPD patients who are possibly not as such identified, e.g. CAFCASS, or voluntary agencies such as some of the services of NYAS or NCH. Not recognising and identifying the true nature and complexity of the parental problem and what should be done and what can be done about it can create real difficulties and stuckness. Generally child services are not always skilled up for all the aspects of dealing with antisocial conduct problems, or the ASPD parent. (page 68, line 16)	Thank you for this comment. We ask for services to consider this issue in any part of the assessment. Where we have evidence for effective interventions regarding the role of parents we make them. It would be difficult beyond what we have already said in the guideline to specify any further with regards to children with conduct disorder or parents with ASPD.
12	SH	Alder Hey Children's NHS Foundation Trust	11	Full	4.4.1	Service user experience of services must include the experiences of parents in relevant services as a separate dimension.(page 76, line 19)	There is a section on family/carer experiences in this chapter (4.5). Our search of the literature did not identify any further studies.
13	SH	Alder Hey Children's NHS Foundation Trust	12	Full	4.4.3 and general	Experience of CJ settings: Should include the experiences of parents, visiting arrangements etc	There is a section on family/carer experiences in this chapter (4.5). Our search of the literature did not identify any further studies.

14	SH	Alder Hey Children's NHS Foundation Trust	13	Full	4.5	The experience of children, visiting arrangements and of the child's carer needs to be included here. People also felt that the way the guidelines were structured did not allow for the circularity of relationship patterns, e.g. there is a recommendation to consider the effect of the person with ASPD on the family, but there might be equal value in considering the effect of the family on the person with ASPD which is not considered at present. (page 88, line 29)	Thank you for this comment, but visiting arrangements and the needs of the child's carers as you have described are beyond the scope of the current guideline.
15	SH	Alder Hey Children's NHS Foundation Trust	14	Full	5 and general	Excellent inclusion of preventive approaches. We felt that the review by Hill (J. Hill; Early identification of individuals at risk for antisocial personality disorder, British Journal of Psychiatry, 2003, 182, suppl. 44, s11-s14) should be included. Several respondents identified the omission of ADHD as an established precursor of ASPD. The identification of antenatal risk was welcomed but identification/clarification of services that should deal with the parent thus identified would be helpful. Separating infants and parents as an intervention requires further clarification: should babies be put in nurseries, or should they be put up for adoption? CBT interventions for children with severe conduct problems: it would be helpful if there was an evidence based recommendation for whom such interventions would be tolerable (emotional and cognitive demand of CBT) and for whom they might be effective. The text in this section is sometimes written as if the parents do not display any of the characteristics that make their children identifiable as at risk of developing antisocial PD. This is clearly contrary to clinical experience and should be addressed in its full complexity.	Thank you for your comment. We consulted Hill's review you cited when reviewing the evidence. However, our review only included primary studies and not reviews of the literature. Thank you, we have now included literature on this in chapter 5. Thank you we will deal with this in our implementation of the guideline, this is beyond the scope of the guideline. This is referring to non-maternal care as a provision of nursery care rather than adoption; we think this is a standard term used in the literature. Thank you for your suggestion, however it is not possible from the evidence to make such specific recommendations. Thank you we agree this is an important issue but it is beyond the scope of the guideline.

						There was consensus that evidence for 'anger control' is limited and that it is not that helpful to identify 'anger' as a problem, rather than a communication of the problem. People felt strongly that the exclusion of young persons from services because of conduct problems should be identified as an issue here (mirroring adult services). Generally there was consensus that prevention needs to be delivered through a discourse of positive development rather than the pathologising language of disorder prevention, especially where the 'Disorder' is significantly related to contextual factors.	Thank you, we agree that the evidence for anger control is limited and have made this clear in chapter 5. Thank you, this is not a guideline on conduct disorder therefore this is beyond the scope of the guideline.
16	SH	Alder Hey Children's NHS Foundation Trust	15	Full	5.3.8	Interventions targeted at parents: some respondents felt that this review was not meaningful enough in terms of providing evidence for intervention. It would be more useful to differentiate which interventions included, or were based on, a needs assessment of the parent(s), and which were merely based on a problem assessment of the child and the child's parenting experience. (page 114, line 31) A comment was also made about attrition rates in parent training programmes: Attrition tends to be more related to parental factors than to the severity of the child's condition although the latter may reflect complexity in the family and the parent. With all these interventions for parents and for children it would be useful to identify where these interventions and by whom they might be delivered, especially if they are not yet universally available to all those identified as benefiting from them.	Although we agree this would be useful unfortunately such details were not included in the studies. Thank you for your comment, there is evidence for both parental and child factors predicting attrition (see Dadds and Hawes, 2007). Thank you, we have sought to address these in our recommendations in 1.2.5.3.
17	SH	Alder Hey Children's NHS Foundation Trust	16	Full	5.3.11 and general	While appreciating the separate review of interventions targeting families as a whole, we felt that this could not just be a preventive measure, and needed also including in the general picture of treating ASPD parents. (page 121)	Thank you for your comment, unfortunately there were no studies identified on family interventions to treat ASPD parents.
18	SH	Alder Hey Children's NHS	17	Full	5.31	People commented that the order of 'multi-component interventions' should be reversed, with MST first and treatment	Thank you for your comments. However, they are not listed in order of

		Foundation Trust				foster care second. (page 109. line 21)	priority so this shouldn't matter.
19	SH	Alder Hey Children's NHS Foundation Trust	18	Full	6.2.1	The following comments were made with respect to risk assessment and management: (page 138) • Violence risk should include specifically the parenting dimension and the risk to the child for ASPD parents, but also the risk of the ASPD parent to other staff e.g. in schools and other more universal agencies. • Families and children of ASPD parents should be included as 'risk assessors' in the text as they would often be the first to know that something is wrong and also be in need of intervention and management. • There should be some reference to psychological mindedness, cognitive ability and cognitive style as moderating variables re. risk. • Quality of social context and availability of social support in the current situation should be included as factors to be assessed. • CAMHS capacity for risk assessment needs to be considered and perhaps psychiatry & psychology should be included explicitly as contributors to a risk assessment process. • The increase of substance abuse in young people needs to be included in the guideline as an issue.	Thank you for these comments, which we carefully consider. However, we do not think that the specific points that you have raised warrant any significant adjustment of our current recommendations regarding the management of risk. For example we have already made reference to using families and others as potential sources of information, but do not think it at all appropriate to refer to them as "risk assessors". In addition we do not know of any specific evidence that would provide any further recommendations in relation to risk assessment, for example psychological mindfulness or cognitive style. The quality of social context in relation to support is built in to many risk assessments and risk management tools and this is already captured within our recommendations. We also make specific recommendations regarding the management of substance misuse issues and people with ASPD, but not in young people as this is outside the scope of our guideline, except to point out how they may influence treatment recommendations. For example specifically in relation to the recommendation for 1.2.8.2.
20	SH	Alder Hey Children's NHS Foundation Trust	19	Full	7.2.8	Health economics: We were not sure how much evidence there is available currently but felt that the inclusion of parenting interventions for parents with ASPD in principle would at least set a marker down. (page 175, line 4)	Thank you for your comment unfortunately there was not sufficient data to conduct health economic analyses in the area you suggest.
21	SH	Alder Hey	20	Full	7.4	We thought that there were therapeutic communities for whole	Thank you, this is beyond the scope of

		Children's NHS Foundation Trust				families in existence (e.g. the Cassel Service in West London). Presumably some of the families would have parental ASPD as an issue to contend with, possibly with antisocial tendencies in children. (page 191, line 34)	the guideline specifically in a section focusing on the treatment of adults with ASPD.
22	SH	Alder Hey Children's NHS Foundation Trust	21	Full	7	We found the tables (chapter 7) useful but thought they should be made more self-explanatory and easy to understand.	Thank you, we have tried to make these as self-explanatory as possible whilst trying to include the necessary data to make it informative.
23	SH	Alder Hey Children's NHS Foundation Trust	22	Full	General	People wondered whether it was appropriate for the drug industry to be accepted as stakeholders because of their vested interest in particular ways of conceptualising and treating 'disorder'. Should the criteria for stakeholder registration be more explicit in the guidelines?	We feel it is important to consider comments from a wide variety of stakeholders, including the drug industry.
24	SH	British Association of Art Therapists	1	NICE Full	General	The GDG is to be commended in synthesizing a large amount of complex research data and analysis into a much needed guideline, given the known history of poor service provision for this difficult to engage and treat client group. Alongside soon to be published NICE guidelines for the treatment of Borderline Personality Disorders, the therapeutic nihilism associated with Personality disorders should hopefully be consigned to history by the publication and implementation of these two significant guidelines.	Thank you for your comments.
25	SH	British Association of Art Therapists	2	NICE and Full	1.4.2.2	(Introduction)The guideline highlights the relatively small number of RCT's of interventions with shared outcomes in common and then generalises across populations in its recommendations for group cognitive and behavioural therapy, ie the clinical populations of offender/co-morbidity/drug & alcohol misuse? On p23 (short) on recommending treatment suggesting "Enhanced Thinking Skills" no such RCT is reported. You include in the short version that these interventions "have the potential to help" What is the scientific basis for this recommendation other than the fact it is common practice? Disparity in recommendations of psychological therapy between these two documents needs to be clarified or at least made more transparent in how recommendations are translated across editions and extrapolated across populations. Which mathematical extrapolation model was used across which population data?	Thank you for your comment, the recommendation refers to group cognitive behavioural interventions where there is moderate evidence for their effectiveness. Enhanced Thinking Skills was given as an example of this approach as this intervention shares much in common with the studies analysed in the review.

						Of note a survey conducted in 2001 found that 84.5% of Dance Movement Therapists (Karkou, & Sanderson 2001) worked with teens with Behavioural disorders, sadly such work will fail to be acknowledged or recommended given the rigorous parameters set by the Guideline Development Process in recommending treatments. Treatment innovations within complex and difficult to treat populations may well be curtailed given the requirements for large cohort RCT studies. We would be happy to supply the GDG evidence of good practice from our special interest group of Forensic Art Therapists however, (See Reference list below) would it warrant an entry given that there exists no RCT involving the provision of Arts Therapies to this client group, sadly and rightly "No" <u>Selection of Literature for Arts Therapies that have potential to help individuals with Anti-Social Personality Disorders.</u> Karkou, V. and Sanderson, P. (2001) Report: Theories and assessment procedures used by dance movement therapists in the UK The Arts in Psychotherapy. 28, Gussack, D. (2004) 'Art therapy with prison inmates: a pilot study', *Arts in Psychotherapy,*31: 245-59. Liebmann, M. (1998) 'Art therapy with offenders on probation', in D. Sandle (ed.), *Development and Diversity: New Applications in Art Therapy.* London: Free Association. Riches, C. (1994) 'The hidden therapy of a prison art education programme', in M. Liebmann (ed.), *Art Therapy with Offenders.* London: Jessica Kingsley. Sarra N. (1998) Connection and disconnection in the art therapy group. Working with forensic patients on the locked ward. In: Skaife S, Huet V editor(s). *Art psychotherapy groups.*	It is commonly accepted that the best study design for assessing interventions are RCTs. We do not feel this will curtail treatment innovations. We feel the research recommendations in the guideline will improve innovations in this area. Thank you for your comment, we have considered this literature and as you suggest none of the studies were of sufficient quality to meet the criteria of our review.

						Between pictures and words. London & New York: Routledge, Springham, N. (1994) 'Research into patients' reactions to art therapy on a drug and alcohol programme', *Inscape, 1:* 36-40. Springham, N. (1998) The magpie's eye: patients' resistance to engagement in an art therapy group for drug and alcohol patients', in S. Skaife and V. Huet (eds), *Art Psychotherapy Groups: Between Pictures and Words.* London: Routledge. Springham, N. (1999)' "All things very lovely": art therapy in a drug and alcohol treatment Tamminen, K. (1998) 'Exploring the landscape within: art therapy in a forensic unit', in D.Sandle (ed.), *Development and Diversity: Neiv Applications in Art TJierapy.* London: Free Association. Teasdale, C, (1995) 'Reforming zeal or fatal attraction: why should art therapists work with violent offenders', *Inscape,* Winter: 2-9. Teasdale, C. (1997) 'Art therapy as a shared forensic investigation', *Inscape, 2* (2): 32-40. Teasdale, C. (2002) *Guidelines for Arts Therapists Working in Prisons,* London, Department for Education and Skills.	
26	SH	British Paediatric Mental Health Group	1	NICE and Full	1.1.1.14	The wording is not sufficiently emphatic to draw to the attention of professionals working mainly with adults the over-riding need to prioritise <u>any</u> risks apparent to <u>any</u> children. In the words of the Children Act 1989, “The needs of the child are paramount”. The word ‘safeguarding’ should probably be included. All staff working with adults with ASPD should have adequate training in child protection (this may need to go in a different section). (Third bullet point)	Thank you for this comment. We have revised the wording of this recommendation to say: The needs and risks to any children in the family and the safe guarding of their interests.
27	SH	British Paediatric Mental Health	2	NICE and	1.2.5.5 1.2.6.1	These two sections appear to contradict each other. Some clarification is needed if they do not; if they do, section 1.2.5.5	Thank you. We do not see a contradiction between 1.2.5.5 and

		Group		Full		should perhaps be omitted.	1.2.6.1. This reflects the evidence that there is little evidence of benefit for an additional psychosocial intervention for parents within a parent training programme (1.2.5.5). Whereas there is good evidence that family interventions, where there is a focus on the family and promoting positive interactions, is effective. We therefore feel it is clear as it stands.
28	SH	British Paediatric Mental Health Group	3	NICE and Full	4.3	I am a little puzzled by the recommendation of an RCT comparing MST to FFT. My understanding is that the sort of family therapy used in MST is very similar to FFT. The literature that I have read on MST suggests that for most adolescents with severe offending behaviour, family therapy (of whatever sort) is not enough, as the young person's relationships to other systems (such as peers, school and criminal justice system) need to be addressed at the same time. If this is true, then MST is bound to be superior to FFT, and there is no point in doing a trial to show this.	Thank you for your comments however MST has not yet been directly compared with FFT therefore this question would be better assessed empirically rather than by relying on assumption alone.
30	SH	College of Occupational Therapists	1	NICE and Full	1.2.5.3	It would be useful to include occupational therapists as an example of health professionals as they are often to be found in CAMHS delivering parent training programmes.	Thank you. Psychologists and social workers are given as examples, the list is not meant to be exhaustive. Given the wide variety of professional groups who deliver such interventions it is not possible to mention everyone of them.
31	SH	Department of Health	1	NICE and Full	2.8 and general	**Audience addressed** The summary guideline makes recommendations addressed to primary, secondary and specialist health services. The full document notes that a key conceptual problem regarding PDs is the belief that they exist in isolation from mental illness and other disorders; and that people with PDs present and are treated across all mental health services, substance misuse services etc. In our view, because many health practitioners and commissioners do not see PD as their business, an additional sentence in the Introduction to the short guideline identifying the services addressed might help to ensure that they read it. (page 29 lines 35 and 42)	Thank you very much for this comment. We have as you have suggested made a small adjustment to the introductory section of the NICE guideline.

32	SH	Department of Health	2	NICE	General	**Scope and implementation issues** The scope the NICE guideline limits the application of recommendations to the NHS. This, we feel, presents particular problems in relation to ASPD because of the crucial importance of joint work with other agencies which is recognised in the guideline. Two of the most important and valuable areas of advice (concerning the need for multi-agency ASPD networks; and preventative work with families and young people) cannot be effectively implemented without the willing participation of Criminal Justice System (CJS), social care and education agencies. Therefore, we feel, Implementation strategies need to address these difficulties. Would NICE please consider discussions with National Offender Management Scheme (NOMs) and social care (including children's services) so that the guideline is launched with the demonstrated backing/ownership of these agencies and disseminated accordingly. An aim might be advice that local implementation planning groups (as mentioned in the full version) should have membership from these specific agencies.	Thank you for drawing our attention to this. Though our recommendations are developed for clinical settings, we agree that it is important to link them to the CJS. We will take this into consideration when developing our implementation plan.
33	SH	Department of Health	3	Full	General	**Levels of severity** Generally levels of severity are not distinguished (for understandable reasons) other than sub-groups such as dangerous people with severe personality disorder (DSPD) or high risk of harm. Sometimes the guideline distinguishes the services (primary, secondary, specialist health care) to which specific recommendations or advice are addressed. However this is not always sufficient. Large numbers of people with less serious problems will be known only to primary care or perhaps substance misuse services. While the recommendations about treatment of comorbid conditions should apply to such sub-groups, should the recommendations about multi-agency working and agreements regarding pathways also apply to them? We would be grateful for clarification.	Thank you for your comments. We agree with this that services for this group extend beyond those of mental health, thereby spanning services from probation, education, social services, housing etc. The multiple disadvantages of this group are stressed in the introduction. We have revised some of the recommendations about multi-agency working and the role of networks in light of your and others comments but we think that the level of detail that you are suggesting in your comment is beyond the scope of the guideline and is really a matter for local agencies to determine when implementing the guideline.
34	SH	Department of Health	4	NICE and	1.1.1	**Access to services** In our opinion this remains a difficult issue and this has been	Thank you for this comment, but this is outside the scope of the current

				Full	4.2.4 4.4.6	the subject of Annual Assessment questions in the past but despite "ticking the boxes" services have a long way to go possibly because of thinking about people with PD as a separate client group. In the full version it is noted that many MSUs still decline to treat people with a primary diagnosis of ASPD and we have no information about community forensic services. We suggest that a tailored tool should be developed as part of the implementation materials with detailed questions to help local planning groups to recognise **all** the relevant services and to systematically review access and exclusion would be helpful.	guideline. We agree that issues of access are difficult and a tool to help identify access and exclusion would be helpful. This will be considered when developing our implementation strategy.
35	SH	Department of Health	5	NICE and Full	1.1.3	**BME populations.** While there is insufficient evidence to understand differential patterns of PD diagnosis and usage of services, there is some clinical comment about misdiagnosis applying to BME. In our opinion this is a major training issue for clinicians and practitioners. We feel that by regular monitoring of BME access to PD services through commissioning and Trust Boards would be an ideal to aim for but probably very difficult to achieve given the limitations of information systems. It would be helpful if the implementation materials mention both training and monitoring issues.	Thank you for this comment. We agree that there are some issues concerning the access of BME populations to personality disorder services. This may or as you suggest be an important training issue. We agree that regular monitoring and research in this area would be of interest and we will draw this to the attention of the NICE implementation team.
36	SH	Department of Health	6	NICE and Full	1.1.5	**Service user information** For many people a diagnosis of PD comes as a bewildering surprise sometimes after a succession of other labels. New PD services often find themselves developing leaflets and information packages for service users because they are so important but scarce. Is this an area where joint work with a service user organisation might result in some tailored tools that would substantially assist implementation?	Thank you for the suggestion, we will consider this when implementing the guideline.
37	SH	Department of Health	7	NICE and Full	1.1.6	**Needs of women** We feel that the statement about women should be strengthened. Unfortunately because numbers are so much smaller, and the male high harm group is a high priority, we feel the needs of women with severe and complex PDs are often overlooked both in the NHS and CJS.	Thank you for your comment; we have added detail to this recommendation.

						The majority of specialist services for PD women are in the private sector. Would you please consider strengthening this point because commissioners, service planners and practitioners need reminding to effectively address women's needs?	
38	SH	Department of Health	8	NICE and Full	1.1.1.1 1	**Optimistic and trusting relationships** Given the wide range of staff who will be working with people with ASPD (not only in specialist services but also mental health services, voluntary sector, offender management services) there is a very significant training implication Knowledge and Understanding Frameworks for forensic and community PD services are in development and we feel should be referenced in implementation materials.	Thank you for your comment. The GDG viewed the ability to develop trusting and optimistic relationships as a core competency for staff working with people with ASPD. Thank you for the information on the Knowledge and Understanding Frameworks for forensic and community PD services.
39	SH	Department of Health	9	NICE and Full	1.1.1.1 2	**Engagement and motivation** Training in motivational techniques will be needed by a range of staff groups across secondary and specialist services. Implementation materials should mention this.	Thank you for your comment. However the recommendation simply refers to encouraging service users to engage in treatment and does not refer to specific motivational techniques.
40	SH	Department of Health	10	NICE and Full	1.3.1.1	**Assessment** For CMHTs, community forensic teams, substance misuse services, psychological therapies services, prison in-reach services, there will be a significant training requirement in order to ensure recognition and effective assessment of ASPD While this recommendation is addressed to mental health services, we feel many generalist primary care practitioners may be faced by people with ASPD. An assessment of the sort advised is unlikely to be possible without the help of specialist colleagues; recourse to advice/support in assessment from secondary care should be mentioned.	Thank you for this comment. We agree that specific training will be required. We have addressed this to some extent within the service style changes but it would be beyond the scope and remit to make specific recommendations for training. With regard to the need of mental health services for further assessments and support, this is precisely why we put forward the establishment of specialist personality disorder networks, as we believe that the knowledge and skills contained with specialist services need to be made more widely available to general services. The networks will provide the framework for doing this. However we did not feel we could be more specific than providing the

							framework in our recommendation. It would be for local services to determine the proper and correct means to implement this recommendation.
41	SH	Department of Health	11	NICE and Full	1.3.2.1 1.3.2.2	**Risk assessment in primary care and referral** As above, primary care practitioners will need specialist consultation, advice and support in assessing, managing and referring people with ASPD who may be violent; referral or request for advice from secondary care services in assessment should be mentioned. In our view, many local mental health services will struggle to provide such assistance to primary care. To implement this recommendation, PCTs and mental health Trusts need to ensure that mental health training courses provided for primary care practitioners routinely address PD and risk. Should this be suggested in implementation materials?	Thank you, we agree that there are significant training issues contained within this guideline. We made recommendations regarding the potential value of personality disorder networks in promoting this and also describe some core elements of the training programme. However it is beyond the scope of the guideline to consider the details of how such a programme should be implemented.
42	SH	Department of Health	12	NICE and Full	1.3.2.3	**Risk assessment in secondary care** These recommendations we feel need to be incorporated within the framework for implementing revised CPA guidance and monitoring regimes at Trust and PCT level. In our opinion both the summary and implementation materials need to make reference to the new CPA guidance.	Thank you for this comment. We have added further text to the introduction of this section to make clear that any assessment should take place in the overall framework adopted for the integration of assessment and materials.
43	SH	Department of Health	13	NICE and Full	1.3.3.1	**Risk management – ASPD high risk clients** A multi-agency approach with probation in the lead role is valuable advice. However this cannot be achieved without a joint NHS/CJS approach to implementation. ***See comment 2 above.*** There is also likely to be a training implication for probation and other CJS staff.	Thank you for the comment regarding National Health Service and criminal justice systems approach to implementation. We agree with you that greater co-ordination with the two would very much support implementation. In addition we agree training that would be likely to follow from an effective implementation programme would be very helpful. However we must point out that the details are beyond the scope of the guideline. We will however draw this to

							the attention of the NICE implementation team.
44	SH	Department of Health	14	NICE and Full	1.4.1.1	**Treating comorbid disorders** There are implementation issues for the design and delivery of psychological therapies services, and prison in-reach services to ensure that needs of people with ASPD are recognised and appropriately addressed. In our view there are likely to be training issues for low intensity psychological therapies workers, prison in-reach staff and for prison staff in recognising PD and what to do in ensuring people access appropriate treatment. Therefore, we feel that Implementation materials should alert PCTs/Trusts to service design issues; training issues and staff groups affected; and explain the NICE guidelines that apply.	Thank you for your comment; it is beyond the remit of the guideline to determine how other NICE guidance should be implemented in general. However in relation to ASPD, there is little evidence to suggest people with ASPD respond different from other groups. Where differences are likely to occur (for example, in relation to engagement with treatment) recommendations in 1.4.1.2 and 1.4.1.3 have been made on how staff may modify the intervention.
45	SH	Department of Health	15	NICE and Full	1.6.1	**Multi-agency care, pathways and networks** These recommendations are very valuable and it is in the interest of all agencies to see them implemented. These networks could also include CAMHS to ensure that early identification and transition issues are addressed. Nonetheless the current level of practice in many areas is a long way from our aspirations and therefore implementation will be difficult and take time; getting pathways “agreed” can be a lengthy process. There are also practical problems in that such inter-agency arrangements could cover a multiplicity of agencies and several different client sub-groups. In our view, implementation advice needs to be supportive and possibly advocate a staged approach to developing inter-agency arrangements. We would suggest that focussing on the high harm clients (see comment 13 above); and on women with severe PD and complex need; might provide a limited and therefore achievable first stage of development.	Thank you for your comment. We agree the specific details on multi-agency working, including whether to use a staged approach and the role of CAMHS needs to be discussed and addressed when working on implementing the guideline. We also agree that this will be a challenging and lengthy process.
46	SH	Department of Health	16	NICE and Full	1.1.1.1 1	**Key Priorities for Children with conduct problems** In terms of a key focus for implementation it is unclear why individual intervention for over 8s is selected when elsewhere the key role of parenting work and multi-level intervention is recognised.	Given that parenting work and multilevel interventions have already been noted elsewhere it is particularly important to highlight individual cognitive problem solving skills as this

							has tended to be neglected despite similar strength of evidence for effectiveness.
47	SH	Department of Health	17	NICE and Full	1.1.1.14	**Engaging families and carers** Mention of impact on children is welcomed but there will be a training need for adult services to implement this fully.	Thank you, we agree this will need to be considered when implementing the guideline.
48	SH	Department of Health	18	NICE and Full	1.2.1	**General principles when working with Ch & F** In our opinion the legal framework should also include the Children Act 2006	Thank you for this information, we have added this.
49	SH	Department of Health	19	NICE and Full	1.2.2	**Identifying Children…..** It is not clear which services this part refers to. There is no reference to the role of health visitors, early years provision, children's social workers or schools for example. Also no link is made with existing assessment of children and families e.g. Common Assessment Framework and the Child in Need assessment and how these guidelines might inform those processes. Would you please clarify?	Thank you for these comments. We have made some adjustments to the recommendations in light of these comments to make a reference to the established assessment frameworks.
50	SH	Department of Health	20	NICE and Full	1.2.3 1.2.3.2	**Early Intervention** We are unable to see a link with existing service structures. I am unsure of the evidence base for non-maternal care but if it is to be included some reference needs to be made to the quality/characteristics of alternative care e.g. a reference to Children's Centre provision which might offer care for the child but also parenting input too. We feel that this recommendation sits separately from those on parenting interventions and so is confusing to make sense of. Reference to parenting interventions are scattered in different places and it would be clearer to identify the strength of the evidence for each age group of child. For example the section on conduct problems follows the one on under 3s which leaves the reader wondering how to deal with the 3-8 group (although this is covered later). It might be useful to cross refer to the NICE/SCIE guidance on parenting programmes for children with conduct disorder at an earlier point in this section. Whilst there is a different evidence base for conduct problems and disorders, in implementation terms the suggestion seems to be to start with individual work with the child and only	Thank you for these comments. On the first point we think it neither appropriate or possible that we try and fit all our recommendations with existing service structures – we think it best left for local services to determine where certain forms of care can be provided – this of course will be influenced by current service policy and configurations. We have re-structured the recommendations to address the problems you raise but in general feel that our current classification is the best compromise that could be achieved.

						progress to parenting work if problems are more severe. In our opinion this doesn't fit well with the broader evidence base for early intervention with children or with the current policy direction of both CAMHS & schools, where there is a strong emphasis and necessity to work with parents alongside any individual work with children	
51	SH	Department of Health	21	NICE and Full	1.2.6.3 1.2.7	**Multi-component interventions** Whilst the reference to evidence based manualised programmes, such as FFT, MST & Treatment Foster care is welcomed, in terms of implementation these are all licensed programmes which can only be implemented with a high investment in training and consultation. Although a growing number of these programmes exist, it might be helpful to make it clear that these are specific licensed programmes and possibly also to identify the key characteristics of these evidence based programmes. In our view, CAMHS & children's services could not just set these up easily without appropriate training.	Thank you for your comments. NICE produces implementation tools for each guideline that are posted on the NICE website at the time of the guideline publication these will seek to address your concerns.
52	SH	Department of Health	22	NICE and Full	1.2.7.2	Age range for MST is 12-17 years not 13 + MST involves structural family therapy, CBT & behavioural work with family and young person. Would you please consider amending?	Thank you. We have amended as suggested.
53	SH	Department of Health	23	NICE and Full	1.6.2	**Transition** Transition from child to adult services is mentioned on p. 27 but it would be helpful to move this to p18, the end of the C & F sections as CAMHS & other children's services e.g. those working with Care leavers, need to work on transition protocols with adult colleagues. There are significant problems in relation to young people leaving care who at the same time are in transition from CAMHs to adult services; with frequent dislocations in provision and disputes between services. Such young people are also often reluctant to use statutory services and more flexible, youth-friendly models are needed. Could this group be mentioned?	Thank you for this comment. We have moved the recommendation to a different point in the NICE guideline as you have suggested.
54	SH	Department of Health	24	NICE and Full	General	We were unable to find reference to community Youth Offending Services. For young people these are key services for early identification of emerging A-S PD and they have a key role in assessing and treating young people. The guidelines will	Thank you for your comment; this will be addressed in the implementation strategy.

						need to be made available and understandable to both health workers and other YOS staff e.g. social workers, who run programmes for young people and parents.	
55	SH	Department of Health	25	NICE and Full	1.6.4	**Staff training** There are significant training implications as many staff groups will be working with people with ASPD; community mental health practitioners; secure services staff; A&E staff; substance misuse staff; psychological therapies staff within the NHS, many of whom will be non-professional workers. And also social care and probation staff in hostels and community services; prison staff; voluntary sector offender rehabilitation services staff etc.	Thank you for your comment this will be considered when developing implementation materials.
56	SH	Department of Health	26	Full	General	**General** The DH is committed to the overall direction of the guidance and will work to: • pick up the implementation issues at a policy level • publish PD commissioning guidance in line with the BPD/ASPD guidance • support a joint launch of the BPD/ASPD NICE guidance(s) • initiate cross departmental collaboration on implementation,; in particular with the Criminal Justice Services and MoJ	Thank you for your comments. We appreciate that the DH is committed the overall direction of the guidance. We also support the DH's action points.
57	SH	Greater Manchester West Mental Health NHS Foundation Trust	1	Full	2	In the Introduction section, the Guideline Development Group presents a comprehensive account that highlights the complexity surrounding the ASPD concept. The discussion of historical, diagnostic, contextual and ethical issues is welcomed and orients the reader to important considerations of which it is important to be aware when assessing/treating this population.	Thank you for your comments. We agree that the ASPD concept is complex and we appreciate that you think the introduction has done this topic justice.
58	SH	Greater Manchester West Mental Health NHS Foundation Trust	2	NICE	Introduction	The introduction section that appears in the full guideline might be regarded as essential reading. It might be worth highlighting this in the brief guideline, with a suggestion that the full guideline is referred to.	Thank you for your comment, the full guideline is referred to in the brief guideline.
59	SH	Greater Manchester West Mental Health NHS Foundation Trust	3	NICE and Full	1.1.1.6	The brief guideline highlights a need to consider higher incidence of comorbid Axis I and II disorders in women, and to adapt interventions in the light of this. The full guideline does mention potential gender specific pathways to antisocial and violent behaviour, however this question is not explored in	Thank you for your comment. There is a lack of data on ASPD in women, therefore it is difficult to draw further conclusions for this group. We have drawn attention to the lack of data on

						great depth. Does the group consider that this issue might need to be given greater prominence, or that reasonable questions may exist about the generalisability of the guideline recommendations to a female population?	women in for example chapter 7.
60	SH	Greater Manchester West Mental Health NHS Foundation Trust	4	Full	6.2.1 6.3	It is encouraging to see that important points are made regarding the purpose and process of violence risk assessment in clinical practice. An emphasis on understanding risk in order to appropriately manage it, rather than to make statistically derived statements of probability, is central to the endeavour of services. (page 142, line 7-22) The full guideline refers to the DoH 2007 guidance, wherein a formulation of risk is a key element of the risk management process. Might the brief guideline benefit from highlighting this practice point in more detail than it does in its present form? (page 160, line 26 onwards)	Thank you for this comment. We believe that the use of instruments such as the HCR-20 does involve implicitly a careful formulation and quantification that are appropriate to the degree of risk.
61	SH	Greater Manchester West Mental Health NHS Foundation Trust	5	Full	7.2.2	In the review of psychological interventions that may be of value, the group indicate that research on populations with diagnoses of serious mental illness, including schizophrenia, was excluded. It is acknowledged that, in both the brief and the full guidelines, a need to consider co-morbid Axis I and II disorders is highlighted. However, do the group consider that any further clarification might be warranted with regards to implementation of the guideline within populations where co-morbid serious mental illness and antisocial personality disorder are present?	Thank you we agree this is an important issue but unfortunately it is beyond the scope of the guideline.
62	SH	Hampshire Partnership NHS Trust	1	Full	General	On the whole, I think the guidelines are sensible without too much of significant contention. However, one thing I'm not happy about is the recommendation that the PCL-R should be considered for routine use in risk assessments in specialist and tertiary care (which effectively means doing it on all patients in medium secure units). I think there are ethical issues surrounding use of PCL-R that are not adequately addressed in the antisocial PD proposals. I would not be happy to see this recommendation about PCL-R go ahead.	Thank you for this comment. We understand the concerns that you raised about the PCLR as others have. We have added a specific comment in the ethics section to deal with this, but we do not think that a proper indication of the severity of the disorder such as that achieved through the use of the PCLR is simply unethical as you appear to imply. Rather we think that accurate and proper management of the severity of a disorder has important implications not only for identifying

							those who present a significant risk but also for identifying those who after careful assessment may well be assessed and viewed as presenting a less significant risk, than was the case prior to that assessment.
63	SH	Hampshire Partnership NHS Trust	2	NICE	1.3.1	Assessment: due to the particular risk of violence in people with APD the guidance should emphasise the importance using of safe interview techniques.	Safe interviewing is a general point best covered in guidelines on managing acute risk of violence. It is not specific to ASPD.
64	SH	Hampshire Partnership NHS Trust	3	NICE	1.3.2	Risk assessment: Obtaining the service user's consent to obtain and share or relevant information when making a risk assessment is good practice, but the guidance should indicate that there are circumstances in which the need to obtain / share information (e.g. risk of serious, imminent violence to a named individual, or where not doing so would hinder the detection or prosecution of a serious offence) justifies over-riding the service user's consent. Another circumstance in which it is justifiable to proceed without the service user's consent is if discussing the issue with them in order to obtain consent would necessarily involve the need to disclose sensitive, third party (e.g. victim) information.	Thank you for this comment. This is concerned with a wider issue within health care services and is beyond the appropriate guidance rules for the disclosure of information in the circumstances that you described. We consider that this guidance is better dealt with elsewhere in properly formulated department of health and home office policy and it is beyond the scope of the guideline.
65	SH	Hampshire Partnership NHS Trust	4	NICE	1.3.3	Risk management: Probation will only take the lead role in risk management planning where they have a defined / statutory role (e.g. the individual is subject to a community order or a period of licence following release from prison). In other cases this role / responsibility rests with the police. Guidance in this section should refer to guidance on MAPPA (such as that produced by the RCPsych).	Thank you for your comments. This section has been amended.
66	SH	Hampshire Partnership NHS Trust	5	Full	General	I do not believe it is accurate to describe the PCL-R as a tool for measuring antisocial personality disorder. PCL-R is a tool to diagnose psychopathy as defined by the PCL-R. That is not to say that the PCL-R may be more or less useful than the clinical diagnoses of dissocial or antisocial personality disorder by	Thank you but we disagree. We have dealt with cut-off scores versus dimensional use of the scale, though not at great length.

						ICD10 or DSM.	
67	SH	Hampshire Partnership NHS Trust	6	NICE	General	This was very useful to receive, I have read the summary and found it very useful .I would have valued more guidance on making diagnosis, but perhaps that is available elsewhere .I would also value a greater sense of who (or what domains of symptoms) is more likely to respond to psychological therapies, particularly in forensic settings i.e. who to prioritise for psychological interventions in terms of sentence planning etc	Thank you for your comment. Unfortunately though guidance on making a diagnosis is important it is beyond the scope of this guideline. In response to the second part of your comment, we were unable to find good evidence for groups more likely to respond to psychological therapies.
68	SH	Hampshire Partnership NHS Trust	7	Full	2.1	I liked the efforts to highlight the developmental pathway of ASPD from conduct disorder, but wondered whether this could be made more explicit via a subheading or the use of the expression like "the developmental pathway to ASPD invariably starts in early childhood"? I liked importance given to identifying at-risk groups and how to identify them. (page 15, line 35 onwards)	Thank you, however as it stands the title is sufficient as it is simply an introduction. The developmental pathways of ASPD from conduct disorder are dealt with in other parts of the document in more detail.
69	SH	Hampshire Partnership NHS Trust	8	NICE and Full	1.3.1.2	Is the PCL:R used to assess the severity of the disorder? Or is this one of many assessment tools? Using the PCL:R as a routine assessment toll may need wider discussion. P19 says it should be used routinely, whereas P22 only recommends it. More discussion about the contentious nature of the PCL:R may need to be given, particularly as a high score will be excluded from some interventions and services. Not to mention the high concern that is generated around high scorers.	Thank you for your comment on the PCL-R; we can only reiterate what we have previously stated that we consider the PCLR to be an effective measurement of severity and therefore one which potentially informs a comprehensive assessment programme. We feel that an objective and quantifiable measurement contributes to thoughtful and effective risk management plans. Further information has been added to section 6.2.5 in reference to the PCL-R assessment.
71	SH	Hampshire Partnership NHS Trust	10	NICE	1.4.2	The use of psychological interventions: should this section mention the significant problems associated with motivation to engage with therapy. Should clinicians assess motivation first? Those with ASPD are not normally the ones who request the help. Such people are usually within secure hospital, prison, or referred via the court for "anger management work". Such	Thank you for your comments. Engagement with treatment is dealt with in recommendation 1.4.2.4 and we feel this is dealt with sufficiently.

						people often have conflicting levels of motivation when the work is prescribed or ordered and this can lead to a situation where people with ASPD can sham their way through an intervention in order to tick a box. This is clearly an area of high concern and needs further consideration. Those with a degree of psychopathy are particularly adept at doing this. What about making a good individual formulation of the difficulties?	
72	SH	Hampshire Partnership NHS Trust	11	NICE	General	Can the shorter guidance (42 pages) make reference to Borderline PD (I think the full guidance does discuss this, but people are unlikely to read the long one). There are many overlapping characteristics between BPD and ASPD but the guidance does not mention this. It is often seen that women are given the dx of BPD and males ASPD, where as the reverse can often be true and the interventions are different. Can the document acknowledge the difficulties in making accurate dx in the first instance and contain some more discussion relating to BPD in males, particularly in relation to difficulties in managing interpersonal relationships and dysregualted affective states (e.g. anger)?	Thank you for your comment, we agree there is important overlap with borderline personality disorder and reference to this guideline is made on both p5 and p38 in the shorter NICE guideline version.
73	SH	Hampshire Partnership NHS Trust	12	NICE	General	Finally, How do the ASPD Nice Guidelines relate to HM Prison service and how they would deliver the recommended interventions, as it is they who have the majority of the ASPDs. Prisons have very limited scope to deliver the interventions outlined and wondered what the implications of this document would be for them and what the resorting issues would be?	Thank you for your comments however we have already emphasised the contribution of the prisons to 'offender management programmes' to those with ASPD. We will seek to address the issue of implementing the guideline in prisons in our implementation strategy.
74	SH	NHS Direct	1	Full	General	The consultation document has been considered by NHS Direct and no comments made.	Thank you for considering the document.
75	SH	Nottinghamshire Healthcare NHS Trust	1	Full	7.2.3	Authors should have included Evershed, et al (2003). (Criminal Behaviour and Mental Health, 13, 3, 198-213). This study of DBT treatment has a control TAU group, and evidenced significant change in terms of aggressive behaviour and anger. A large proportion of the study group (forensic patients) had ASPD (but also other personality disorders). Study should meet inclusion criteria as per Table 26.	Thank you for drawing our attention to this paper. However, it does not meet the criteria of the review. Firstly, it was not randomized. Secondly, there was no indication in the paper that they were selected for that basis.

76	SH	Nottinghamshire Healthcare NHS Trust	2	Full	4.4.4	There is a literature on personality disorder in intellectual disabilities and this should be referred to here (eg Alexander & Cooray, 2003; Lindsay, et al, 2006), There are also papers on ID and psychopathy, and ASPD specifically (eg Morrissey, et al 2005, International Journal of Forensic Mental Health, 4, 2, 207-220), and Morrissey & Hollin (in press) ("Antisocial and Psychopathic Personality Disorders in Offenders with Intellectual Disabilities: What do we know so far"? Psychology, Crime and the Law). Treatment/intervention studies in this population are, however, few. They may want to consider a study by Taylor & Novaco, et al (2004), and RCT, which examined anger management treatment in a forensic population, a high proportion of whom are likely to have had ASPD (forensic unit for people with ID). This study could also be included in Chapter 7, Table 26.	Thank you for drawing our attention to this literature. We have included some literature in the introduction discussing people with comorbid learning disabilities. However, in terms of intervention studies, Taylor and Novaco (2004) is not an RCT therefore doesn't meet the criteria of the review.
77	SH	Nottinghamshire Healthcare NHS Trust	3	NICE and Full	1.6.3.2	Paragraph 2 "rarely, if ever". Unclear as to meaning.	We think this is clear.
78	SH	Nottinghamshire Healthcare NHS Trust	4	NICE	4.2	Research should also be considered on outcomes of adapted CBIs for those of significantly sub-average intelligence.	Thank you for your comment. The evidence base for ASPD is very limited therefore there are many areas requiring further research. The key areas requiring further research, in the judgement of the GDG, are provided in section 6 of the NICE guideline.
79	SH	Partnerships in Care	1	Full	2.10.4	Within this section on risk assessment there is reference to the VRAG and the PCL-R. The PCL-R is not a risk assessment – it is a diagnostic tool allowing the identification of individuals who fit this model of psychopathy. The PCL-R psychopath presents a high risk of offending and for this reason whether or not the individual scores above a certain level on this test is incorporated in several risk assessments. (page 34, line 8) There is specific mention of one actuarial risk assessment tool (VRAG). There is no reference to the much more commonly used tools such as the HCR-20, SVR-20, RSVP etc (these are structure clinical assessments). However, the guidance on risk assessment at 6.2.8.7 does	Thank you for your comment, the VRAG and PCL-R were used in 2.10.4 as examples and therefore were not intended as a comprehensive list of available risk assessments. However in chapter 6, as you allude to, a more detailed consideration of risk assessment tools was reviewed. We have also added an additional sentence to clarify a primary purpose of the PCL-R was as a measure of severity and not intended to be used primarily as a diagnostic tool on page 171 of the full guideline.

						urge consideration of the use of the HCR-20.	HCR-20 is described in detail in section 6.2.5.
80	SH	Partnerships in Care	2	NICE and Full	**1.3.1.2** 4.2.4.2	Here the PCL-R is correctly described as a structured assessment of personality. There are other assessments which test wider concepts of personality. These include the MCMI-3 (based on self report) and the IPDE (less influenced by self report) which provide evidence of ASPD which does not also meet the PCL-R criteria and other PDs such as paranoid, borderline, narcissistic (MCMI only) etc	Thank you for this information we have made a number of adjustments to the chapter of risk in light of this and other comments. I would like to point out that our concern here is with the assessment of various ASPD and not with other forms of personality disorders as you have listed in your comments.
81	SH	Partnerships in Care	3	Full	General	Broadly, the recommendations are welcomed as a balanced articulation of good practice that will help to drive up standards in this difficult area of practice.	Thank you for your comments, we appreciate your feedback regarding recommendations.
82	SH	Royal College of Nursing	1	Full	General	With a membership of over 400,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations. Mental health nursing is represented in all its diverse forms. This embraces clients across the life span and in settings as diverse as high security hospitals, statutory care settings and the community. Mental health nurses are engaged in these diverse areas engaging with service users, carers and families in promoting well being and recovery. The RCN welcomes this guideline. It is comprehensive.	Thank you for your comments and your positive feedback.
83	SH	Royal College of Nursing	2	Full	General	We welcome the work of the guideline development group particularly the consideration given to the development of antisocial personality disorder over the lifespan.	Thank you for your comments regarding our consideration given to the development of antisocial

						It is useful that the guidance goes through the early detection and treatment of at risk children to adults with antisocial personality disorder. We welcome the clear articulation of the principles of practice through the Ten Essential Capabilities and the development of skills for practice through the use of the Knowledge and Skills Framework (KSF) and Supervised practice.	personality disorder and our guidance on early detection and treatment.
84	SH	Royal College of Nursing	3	NICE	General	The RCN represents practice nurses and school nurses. These groups of staff and their role in the early recognition and treatment of the 'at risk' children is not specified in the summary document and the guideline development group may wish to review how they include this important group of staff. The nature and effectiveness of educational interventions that promote the early detection of the 'at risk' children by nurses and other professionals working closely with children and families could have featured as a research stream.	Thank you for your comment. We have included research in the guideline on the work of nurses and other professional working with 'at risk' children in chapter 5.
85	SH	Royal College of Nursing	4	Full	General	The guidelines on the assessment and management of risk run parallel with good practice documentation on risk produced by the Department of Health (see below) and it would aid readers of the guidelines if this was referenced in a similar way to the Ten Essential Capabilities. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_076511?IdcService=GET_FILE&dID=143719&Rendition=Web	Thank you, we have made reference to the DH good practice document on risk in detail in Chapter 6 of the full guideline.
86	SH	Royal College of Nursing	5	Full	4.3	With regard to training the document would benefit from including diversity training in preparation of practitioners working with this group of individuals.	Thank you; we will consider this in developing our implementation strategy.
87	SH	Sussex Partnership NHS Trust	1	NICE	Person-centred care	"If the service user agrees, families and carers should be involved": should there be guidance on when confidentiality can be breached due to risk? (page 6)	Thank you. It would be clinically evident as to when this ought to be done and does not need additional emphasis.
88	SH	Sussex Partnership NHS Trust	2	NICE and	1.1.1.2	1.1.1.2 "avoiding unnecessary transfers between institutions wherever possible during an intervention": this seems to be just	Although this may appear common sense, the GDG concluded that this is

				Full		commonsense, unless the guidance specifies when clinical and therapeutic decisions cannot be overridden by financial pressures.	an important problem in everyday practice and so should be tackled in the recommendations.
89	SH	Sussex Partnership NHS Trust	3	NICE and Full	1.1.1.10 1.1.1.12	1.1.1.10 working with the "…aim of developing their autonomy and encouraging choice…" is at odds with 1.1.1.12 "…people with antisocial personality disorder are vulnerable to premature withdrawal from treatment and supportive interventions." These two statements reflect a general expectation that workers take responsibility for achieving a therapeutic alliance, often without the necessary resources and neglecting the potential for service user to meet their own needs in a recovery model.	We have stressed all along that this is a difficult group to engage so that those who offer interventions for this group ought to be aware of that.
90	SH	Sussex Partnership NHS Trust	4	NICE and Full	1.3.1.1	1.3.1.1 "When assessing a person with a possible antisocial personality disorder, healthcare professionals in secondary and specialist mental health services should conduct a full assessment of:….domestic violence and abuse": should there not be some advice here on the use of Safe-Guarding Vulnerable Adults?	Thank you for this comment. The reference that you make around safeguarding vulnerable adults is beyond the scope of the guideline. We expect these issues to be taken up with the routine care practices and policies of individual NHS organisations responsible for the implementation of the guideline.
91	SH	Sussex Partnership NHS Trust	5	NICE and Full	1.3.2.3	1.3.2.3 "the use of additional information from written records or families and carers, as the service user may not always be a reliable source of information; this is subject to the service user's consent and right to confidentiality.": should there not be some guidance here on when risk overrides a service user's right to confidentiality and some advice on the duty of services to maintain contact with distressed family members and offer support in a way that does not break confidentiality (i.e. a dedicated carer support worker).	Thank you for this comment. We have drawn attention in the discussion of ethics to the difficulties that you allude to in your comment. However we think providing specific advice on the issue of confidentiality is beyond the remit of this guideline.
92	SH	Tavistock and Portman Foundation Trust	1	Full	General	The focus on prevention, early intervention and treatment of childhood antecedents of ASPD is to be welcomed. The absence of a child and adolescent psychiatrist with experience in the treatment of conduct disorder or a suitably qualified expert from child and adolescent mental health is hard to understand or justify. If, as seems to be the case, Professor Hill is no longer a member of the GDG, a replacement should be found.	Thank you for your comments. The GDG did consider a replacement for Prof Hill, unfortunately by the time it was clear he was not able to join the group it was felt the GDG was too far advanced and felt it not appropriate to recruit another psychiatrist. However the GDG were fortunate in having as a

							member Professor Peter Fonagy who is a leading international expert In the development and evaluation of childhood disorders. In addition, we have written to a number of national and international experts in the field of child and adolescent mental health/psychiatry. Further, a range of stakeholders in this field have responded to the document during the NICE consultation period. In our judgment this level of consultation is sufficiently thorough.
93	SH	Tavistock and Portman Foundation Trust	2	Full	5.3 onwards	The heterogeneity of the samples involved in the conduct disorder studies should be addressed. Potential predictors of response to treatment such as the presence of callous/unemotional traits and biological predictors need further studies.	Thank you for your comment, we agree this is an important issue and have added a research recommendation on this (see section 6 of the NICE guideline).
94	SH	Tavistock and Portman Foundation Trust	3	Full	5.3.7	The long term evidence for sustained benefit from parent training is not available and it is therefore not possible to assert that the pathway to adult ASPD is altered. Knowledge about developmental trajectories as opposed to risk factors is generally weak and further research is indicated.	It was the judgement of the guideline development group that the evidence was sufficient to conclude the impact of parent training is likely to alter the pathway of adult ASPD. There is clear evidence from the trial data that parent training reduces conduct problems (see Chapter 5). In addition, we have added data showing the strong association of conduct problems with the later development of ASPD (see also chapter 5).
95	SH	Tavistock and Portman Foundation Trust	4	Full	5.3.	Many of the multimodal or family interventions are for young people identified via the criminal justice system or other offending behaviour – again, a heterogenous population from which it is dangerous to draw conclusions about the pathway to	The aim of the review was to draw conclusions on the pathway to ASPD not PD in general. There is good evidence that contact with the criminal

						adult PD (page 130)	justice system and offending behaviour are strong predictors of ASPD and are central to a future diagnosis of ASPD. Therefore the judgement of the guideline development group was that changing such behaviour would have an impact on the development of ASPD.
96	SH	Tavistock and Portman Foundation Trust	5	NICE	4	The research recommendations appear somewhat idiosyncratic. There is a need to evaluate structured early interventions in high risk groups such as the FNP or triple P models in UK settings. Some of this work is underway but more is required. Studies such as the one suggested about enhancing sensitivity are indicated to tease out the effective components of early intervention programmes. Studies of interventions addressing interparental discord are also indicated. There is a need for more basic research to characterise the children with severe disruptive behaviour problems to inform targeted interventions. If such studies are to address the issue of pathways to ASPD they maust have long term follow up built in.	Thank you for your comment, the GDG has developed further research recommendations. Research on ASPD is severely limited therefore since research is already underway on FNP and triple P models in populations and settings you suggested this means research recommendations should be highlighted at areas where there is much less research attention. A research recommendation has been added on characterising children with severe behaviour problems (in relation to showing callous and unemotional traits).
97	SH	Tavistock and Portman Foundation Trust	6	Full	General	There is a discrepancy between the overall tone of the report which recognises the complexity and multi-faceted nature of ASPD and the “need to challenge therapeutic pessimism”, and the narrowness of the treatment recommendations. This is particularly evident in the research recommendations in the short report, which focus on extending existing knowledge of CBT, rather than broadening knowledge of a range of possible treatments.	Thank you for your comments. We have made recommendations where the evidence supports such recommendations. We are however recognising that there are considerable areas for further development in therapeutic interventions for children and people with ASPD. We have addressed these not through recommendations unfortunately as we have little evidence but through making clear research recommendations.

98	SH	Tavistock and Portman Foundation Trust	7	Full	7.2.9	While rigorous standards of evidence are applied that eliminate consideration of all but selected CBT approaches to treatment, there is then a leap of inference in assuming that findings from studies undertaken in the CJS, with an undefined offender population, and re-offending as the outcome criterion, can be extrapolated to an ASPD population in health and community settings, where criminal behaviour will not be the only relevant outcome criterion. To be consistent the applicability of findings from CBT/ CJS studies should be presented with more caution. The draft could be more open to the value of a psychodynamic orientation to this area of work. The Fallon Enquiry (1999) for example concluded that the Ashworth Hospital PD Unit "lacked highly experienced psychodynamic contributions to the assessment and treatment of its patients. This would compliment the other approaches to assessment and would help a vigilant awareness of the depth of the patients' psychopathology" (4.2.29)	Thank you for your comment, we agree that applying the data on group cognitive behavioural interventions to people not in CJS is an extrapolation, the limitations of the data are clearly stated in Chapter 7. However, it was the view of the guideline development group that this was a justified extrapolation. We felt more confident in recommending cognitive behavioural interventions where there is data in populations likely to have a higher prevalence of ASPD. Unfortunately we were not able to identify literature from a psychodynamic orientation in this field or in related populations.
99	SH	Tavistock and Portman Foundation Trust	8	NICE and Full	**1.3.1.1** 4.2.4.1	While history is given due weight in the section on risk assessment, the assessment recommended in the section on service provision neglects personal and offending history, which may be crucial in risk assessment, in appreciating the meaning and likelihood of recurrence of antisocial acts, and in anticipating the relationship to services and help. (page 66)	Thank very much for this comment. This is not our intention and as you point out we do require that offending history is taken into account as part of risk assessment in primary, secondary and tertiary care. History of offending is also considered as part of many interventions. We also feel that we cover issues for example about the relationship to services in a range of other recommendations, such as 1.1.1.10, 1.1.1.11 & 1.1.1.12.
100	SH	Tavistock and Portman Foundation Trust	9	NICE and Full	**1.3.1.2** 4.2.4.2	The use of structured methods of assessment will only increase the validity of the assessment if the practitioner is aware of the limitations of such instruments in risk prediction in the individual case. If misinterpreted, such instruments may decrease the validity of an assessment.(page 66)	Thank you for this comment. You are correct in what you say and of course it is also the case that the measures used for example the PCL-R or the HCR-20 have an association with specific training courses, which will not

							only point out the potential benefits but also the limitations of any such instrument. Regarding the details of this training, this is for the NHS to consider when implementing the guideline.
101	SH	Tavistock and Portman Foundation Trust	10	NICE and Full	**1.1.1.4** 4.2.4.7	The complexities of providing psychological or other interventions in the person's own language or through interpreters may be glossed over here; with a "treatment rejecting" group with severe interpersonal difficulties the use of interpreters might facilitate or impede engagement.	Thank you for this comment. The intention here is to draw attention to the need to provide interventions in a range of languages. Specific details of their implementation may present challenges but we think these are for local services to determine.
102	SH	Tavistock and Portman Foundation Trust	11	Full	4.3	Section 4.3. On Training, supervision and support for staff is particularly welcome and recognises the difficulty for staff of dealing with hostility and aggression, and issues of values and attitudes. Staff and institutions may also benefit from supervision and consultation to deal with other impacts of the client's pathology – most notably poor attachments, social and emotional deprivation and a childhood history of abuse, and the traumatic impact of knowledge of serious offences on both the offender and staff. The Fallon Enquiry into Ashworth Hospital (1999) made reference to the need for systematic and well organised clinical supervision of ward based staff (4.2.28) recognising the need to manage the '"toxic emotional processes"' active in Special Hospitals (4.4.23). The Portman Clinic was funded for a number of years to offer such supervision (see Ruszczynski, S. {2008}) and research evidence (Blumenthal {in preparation}) indicates that such supervisory/consultative intervention, using an approach based on the application of psychodynamic principles, benefits the ward staff team in their work with patients.	Thank you for your comments. This level of detail is beyond the scope of the document. However, the Department of Health will be developing materials that will deal with these in more detail. In addition we will be developing implementation materials and will take this into account.
103	SH	Tavistock and Portman Foundation Trust	12	Full	General	We welcome the references throughout the draft to the need for staff supervision and support for those working with this patient group but would suggest that specific reference be	Thank you for your comment. We agree institutional dynamics are important but are beyond the scope of

						made to attention being paid to group and institutional dynamics as well as to individual support and supervision. Alongside the reference in a number of places to develop 'optimistic and trusting relationships' with these patients, the draft should make reference to the fact that ASPD patients, because of the emotional deficits in their histories, often find it very difficult to trust people in authority and therefore there should be an expectation that this dynamic will inevitably emerge in the treatment process and it should be recognised as part of the psychological make up of the patient rather than as an expression of treatment resistance.	the guideline. This is stated in a number of places in the guideline for example chapter 4.
104	SH	The Association for Cognitive Analytic (ACAT) Therapy	1	Full	General	ACAT welcomes this draft guideline and thanks the GDG for their expertise in assessing the field.	Thank you for your comments.
105	SH	The Association for Cognitive Analytic (ACAT) Therapy	2	Full	General	ACAT is fully supportive of an approach to assessment and treatment that recognises individual needs, preferences, choice and the views of families and carers. The link between ASPD and childhood abuse and trauma is rightly recognised as the most important aetiological factor and it is valuably stated that the aim of treatment should be recovery-based.	Thank you for your comments we appreciate your positive feedback.
106	SH	The Association for Cognitive Analytic (ACAT) Therapy	3	NICE	General	**Limited Expectations:** ACAT is disappointed that the recommendations have set limited expectations and scope for treatment for adults with ASPD. It is acknowledged that the RCT evidence base is extremely limited but the danger of forming recommendations almost solely on the basis of the quantitative evidence base is to prematurely narrow the field to treatments focussed on damage limitation and inhibit the development of more exploratory approaches that look at people with ASPD in a more holistic and developmental context.	Thank you, but we disagree with your comments that the recommendations set limited expectations for the treatment of ASPD. We have recommended a variety of different approaches including interventions for at risk children, interventions for offenders, as well as therapeutic communities for people with ASPD and substance misuse problems. The GDG made such decisions on the basis of the best available evidence and their expert opinion and clinical judgement.
107	SH	The Association for Cognitive Analytic (ACAT) Therapy	4	NICE	1.3	**Lack of Aetiological/Developmental perspective in Assessment:** The recommendation should include the need to assess clients in the context of their childhood development and histories of	Thank you for your comment. The guideline development group felt there was sufficient detail in the recommendations.

						abuse and trauma. Without asking the question 'why' as part of the overall assessment, ACAT feels that people with ASPD are being overlooked in terms of their unmet emotional needs, which would seem important in any relationship building and treatment approach. This omission is not in keeping with the earlier emphasis on trauma in the aetiology of ASPD.	
108	SH	The Association for Cognitive Analytic (ACAT) Therapy	5	NICE	1.4	Omission of literature around Cognitive Analytic Therapy Approach to Treatment ACAT is very concerned that the GDG has not considered the literature on CAT and work with offenders including those with ASPD, although CAT is mentioned in the full guidance as a treatment approach used clinically. ACAT would strongly request that the GDG consider: **<u>CAT and Offenders / ASPD key references:</u>** • Pollock, P H, and Belshaw, T (1998) *Cognitive Analytic Therapy for Offenders*, Journal of Forensic Psychiatry 9, No 3 pp 629-642. • Pollock, P H, Stowell Smith M, and Gopfert M (Eds.) (2006) *Cognitive Analytic Therapy for Offenders*. Pub:Routledge. (Book). Pertinent chapters in above: • *Stowell-Smith,* States and Reciprocal Roles in the Wider	Thank you for your comment. We have considered these papers, but none of these studies were RCTs therefore they did not meet the criteria of our review.

						Understanding of Forensic Mental Health. • Shannon, Willis, Potter, *Fragile States and Fixed Identities: Using CAT to Understand Aggressive Men in Relational and Societal - terms.* • *Pollock,* Cognitive Analytic Therapy of a Rapist with Psychopathic Personality Disorder. CAT provides a rich understanding of people in terms of their relational development, is popular clinically and may be a promising approach that offers clients an opportunity to develop a trusting therapeutic relationship and explore the underlying issues around abuse, neglect and offending behaviour.	
109	SH	The Association for Cognitive Analytic (ACAT) Therapy	6	NICE	4	Research Recommendations ACAT would like to see the recommendations for further research demonstrating a greater degree of vision and to look beyond the very limited current evidence base. RCTs of approaches for community based clients with ASPD are always going to be very difficult to conduct but this does not mean that out-patient psychotherapy treatments recognised as promising in the treatment of other personality disorders (eg: Borderline Personality Disorder) should not be further developed and researched in people with ASPD. ACAT intends to engage in an RCT in this area in the way that it has overcome the challenges of such a trial in BPD (Chenen et al in press). ACAT feels that consideration of the literature around CAT (see 5 above) merits CAT's inclusion as an approach needing further evaluation.	Thank you for your comment. We agree there are many limitations in the evidence base on ASPD. There are many possible options for research recommendations but only a limited number can be made. Although it may be the case that CAT interventions are promising, the GDG judged there were other areas which required more attention.
110	SH	The Cassel Hospital	1	NICE	Introduction	This is an excellent introduction to and overview of ASPD. I appreciate the emphasis on patient centred care on the inclusion of families and carers with the patient's agreement.	Thank you for your comments.

111	SH	The Cassel Hospital	2	NICE	Introduction	The key priorities for implementation are clear and concise.	Thank you.
112	SH	The Cassel Hospital	3	NICE and Full	1.1.1.14	I am pleased that the needs of and risks to any children in the family are recognised. This section could usefully be worded more strongly by reminding readers of the importance of involving child protection services/social services in any situation of significant risk to a child. I believe it is also important here to highlight the need for an awareness and appropriate use of services that specialise in work with parents with ASPD and their children in a range of settings, including specialised residential work for the most worryingly at risk children and their parents.	Thank you for this comment. We have drawn attention to the specific needs of children in our general introductory recommendations (1.2.1.1).
113	SH	The Cassel Hospital	4	NICE	1.2	The evidence for many of the interventions listed in this section is recognised to be week. There is some evidence now of effective outcomes for children of parents with ASPD who engage in a residential assessment and/or treatment programme in the Cassel Residential Family Service. The future safety and well being of the children in families admitted is ensured either within the family or in appropriate permanent placements elsewhere. (Jones B, 2008. Therapeutic Communities Journal).	Thank you for your comment, unfortunately this matter is beyond the scope of the guideline.
114	SH	The Cassel Hospital	5	NICE	general	Congratulations. This is a well thought out and clearly written draft guideline. It is refreshing to see an important place given to early interventions and prevention.	Thank you for your positive feedback regarding our emphasis to early interventions.
115	SH	The Sainsbury Centre for Mental Health	1	Full	General	The Sainsbury Centre welcomes the guideline for the treatment, management and prevention of ASPD	Thank you for welcoming the guideline.
116	SH	The Sainsbury Centre for Mental Health	2	Full	General	We are particularly impressed by the emphasis on early intervention and work with young people and their families	Thank you for your comments regarding early interventions and work with young people and their families. We think that this is an important aspect.
117	SH	The Sainsbury Centre for Mental Health	3	NICE and Full	1.4.2 7.2.10	The guideline development group described the dearth of evidence relating to effective psychological interventions for the treatment of the condition, but emphasised the importance of cognitive and behavioural interventions (particularly group work) aim at reducing the maladaptive behaviours associated with the condition - there may be the potential for more	Thank you for your comment; we have added further research recommendations on therapeutic communities and pharmacological interventions.

						research to determine the efficacy of other psychological approaches in treating the underlying condition	
118	SH	The Sainsbury Centre for Mental Health	4	Full	General	The research recommendations are welcomed, although they could be extended (as above)	Thank you for your feedback on our research recommendations.
119	SH	The Sainsbury Centre for Mental Health	5	Full	General	We are pleased that there is an emphasis on working with staff as well as individuals with the condition -this is particularly important, especially in prison settings	Thank you for your comments. We also agree that there are important issues regarding working with staff in this population.
120	SH	University of Liverpool	1	Full	General	There is an inherent bias in the current guideline development process which excludes by default issues such as Old Age, Parenting, and to a lesser degree perinatal issues. We could not find any reference to ASPD in adults of non-working age, yet clinically it sometimes does present for the first time at the point of retirement from work. It also presents clinically as an issue in many services for non-working age people including care homes. There was limited reference to parents with ASPD and peri/post-natal issues for patients with ASPD. Because of the clinical significance of these dimension we feel that this should be included more prominently in the guidelines.	Thank you. There is good evidence that the prevalence of ASPD reduces with age (e.g. Black et al. 1995). However, studies were not excluded on the basis of age.
121	SH	University of Liverpool	2	Full	1.1.1	This promises research recommendations in the guideline. We were particularly interested in these but could not find any throughout the whole text. Maybe we overlooked some in the full text?	Thank you for noticing this. All research recommendations found in the NICE guideline should have/will also appear in the full guideline.
122	SH	University of Liverpool	3	Full	General	The question of responsibility of the person with ASPD for their actions is a key issue. It involves forensic, justice and treatment dimensions as well as ethics issues and motivation. Because of the common dilemma whether 'responsibility' for offences committed should be considered reduced on grounds of mental disorder or not this needs further clarification in the guidance. It is a very important practical point.	Thank you for your comments. The traditional psychiatric stance on responsibility is the Orwellian 'Mental illness – Good; Personality Disorder – Bad' as far as responsibility is concerned. That is, those with PD are deemed 'responsible' for their behaviour, irrespective of the misbehaviour of their amygdala etc. Therefore we feel it should remain as it stands.
123	SH	University of Liverpool	4	Full	2.6.3	We were concerned that the 'absence of convincing evidence' for therapeutic community treatment dismissed too cursorily a	Thank you for this comment. In light of your comment and the comments of

						complex and established treatment method that addressed very explicitly the issue of responsibility in personality disorder. Maybe the evidence base is more complex, and more research would be required to distil what has been good about the TC treatment methods? We agree that the evidence for the effectiveness of TC treatment in ASPD specifically is more limited than the general evidence for the value of TC treatment. However this could be due to a number of reasons, e.g. the particular mix of diagnoses e.g. putting people with Borderline Personality Disorder and histories of abuse together with people with ASPD who more traditionally then get identified as potential abusers. In a group situation this might not work optimally.	other stakeholders we have reviewed further evidence to the effectiveness for therapeutic communities. This is contained in section 7.4.
124	SH	University of Liverpool	5	Full	4.2.4	The requirement for structured assessment methods has training implications that are not fully addressed in the recommendations. There is an issue of practicality that needs further detailed attention. How should this be done? What are the ethics of 'diagnosing' when adequate services are not readily available? Should this be done by CMHTs? Or in primary care? Should it be a specialist task? How can other services who might have involvement with an ASPD person get help with the diagnosis and treatment?	Thank you for this comment. You raise a number of questions which we felt are in fact dealt with within the guidelines. For example we have a specific discussion of the ethics concerning ASPD in the introductory chapter. We also make clear differential responsibilities requiring assessment between primary care, secondary, and non-specialist service's and specialist services such as forensic personality disorders services. The specific methods which might be used are described in Chapter 6.
125	SH	University of Liverpool	6	Full	4.3.6	Maybe it would be helpful to specify which training should be provided in professional core trainings. The current recommendations only address service based skills training but it would be helpful for medical education if the question of professional core training, especially medical training, could be included in the guideline in general.	Thank you for this comment, but commenting on the detail of Medical Training is beyond the scope of this guideline.
126	SH	University of Liverpool	7	Full	5.2.8	We felt that there is an identifiable gap in the evidence here: to our knowledge there is no study addressing the outcome of mother-child relationships of unwanted pregnancies resulting from rape that do not lead to termination. This is a very wide-	Thank you for your comment, although this is an important research need, the GDG felt there were many other research recommendations that were

						spread issue worldwide, a high-risk issue for psychological development, and warrants study. While most of the wide-spread and systematic rape seems to happen outside the UK at present, it does come into the UK by way of pregnant asylum seekers (often underage and unaccompanied minors) and will become more prominent in the future as these children grow up.	of greater priority.
127	SH	University of Liverpool	8	Full	5.3.8	We were wondering whether there were any studies specifically addressing the mental health issues of parents with ASPD? (page 118, line 20)	The literature on ASPD is very limited in general and even more limited on the specific needs of parents with ASPD.
128	SH	University of Liverpool	9	Full	2.1	We felt that the issue of diagnosis needed more attention. At present some people who work clinically with ASPD would not be able to formally diagnose with certainty. There is a need for the development of valid ways of identifying the presenting condition (s) of ASPD in a way that is pragmatic, less stigmatising to the service users, maybe more helpful than current diagnostic procedures for treatment planning and acceptable to professionals (rather than intensifying dissent and splits) – should this be identified as an important research issue?	Thank you for this comment. However the issue of diagnosis and specifically how staff could be trained in the diagnosis of ASPD is outside the scope of the guideline. We note your comment about a possible research recommendation but are unclear precisely how such a question may be formulated and developed.