NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

SCOPE

1 Guideline title

Personality disorder: the management and prevention of antisocial (dissocial) personality disorder

1.1 Short title

Antisocial Personality Disorder / ASPD

2 Background

(a) The National Institute for Health and Clinical Excellence ('NICE' or 'the Institute') has commissioned the National Collaborating Centre for Mental Health to develop a clinical guideline on Antisocial Personality Disorder for use in the NHS in England and Wales. This follows referral of the topic by the Department of Health (see Appendix). The guideline will provide recommendations for good practice that are based on the best available evidence of clinical and cost effectiveness.

(b) The Institute's clinical guidelines will support the implementation of National Service Frameworks (NSFs) in those aspects of care where a Framework has been published. The statements in each NSF reflect the evidence that was used at the time the Framework was prepared. The clinical guidelines and technology appraisals published by the Institute after an NSF has been issued will have the effect of updating the Framework.

(c) NICE clinical guidelines support the role of healthcare professionals in providing care in partnership with patients, taking account of their individual needs and preferences, and ensuring that patients (and their carers and families, where appropriate) can make informed decisions about their care and treatment.

3 Clinical need for the guideline

a) Personality Disorders are long-standing and maladaptive patterns of perceiving and responding to other people and to stressful circumstances. Antisocial Personality Disorder (ASPD) is characterised by a gross disparity between behaviour and the prevailing social norms and a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood. It is one of the most common of the personality disorders and is strongly associated with social impairment and increased risks of both mental and physical health problems, particularly substance misuse (including alcoholism).

b) General diagnostic criteria for a personality disorder must be met for a diagnosis of ASPD. There are two main sets of diagnostic criteria in current use, the International Classification of Mental and Behavioural Disorders 10th Revision (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders fourth edition (DSM-IV). General criteria for personality disorders are similar in IDC-10 and DSM-IV. Both require an individual to have an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of their culture, is pervasive and inflexible across a range of situations, leads to significant distress or impairment, is stable and of long duration (with onset in childhood, adolescence or early adulthood), and cannot be explained as a manifestation or consequence of other mental disorders, substance use, or organic brain disease, injury or dysfunction.

c) Diagnostic criteria for ASPD are broadly similar in both IDC-10 and DSM-IV, although the latter has a heavy emphasis on criminality. ICD-10 uses the term Dissocial Personality Disorder, which is characterised by at least three of the following features: a disregard for the feelings of others and social norms, rules and obligations; gross and persistent irresponsibility; incapacity to maintain relationships; a low tolerance to frustration and a low threshold for aggression and violence; incapacity

to experience guilt or learn from experience (including punishment); and a tendency to blame others or offer rational explanations for antisocial behaviour. Additional criteria included in the DSM-IV definition of ASPD are repeatedly performing acts that are grounds for arrest, deceitfulness, impulsiveness, and a disregard for the safety of others. DSM-IV criteria do not include lack of concern for the feeling of others and incapacity to maintain relationships or profit from experience.

d) ASPD can only be diagnosed in adults. In ICD-10 the specific personality disorders come within the overall grouping of disorders of adult personality. In DSM-IV ASPD cannot be diagnosed in those under 18 years of age, although a number of juvenile criteria (i.e. features present before the age of 15) are specified that must be met in addition to abnormal behaviour in adulthood.

e) ICD-10 notes that people with personality disorders may have other coexisting or superimposed mental disorders, behavioural syndromes and developmental disorders. In DSM-IV common comorbidities in people with ASPD include anxiety and depressive disorders, mood disorders, substance-related disorders, somatisation disorder, pathological gambling and other disorders of impulse control. DSM-IV also notes that while the personality disorders have overlapping features and must be distinguished from one another by their distinguishing features, they can (and often do) co-occur.

f) Antisocial, aggressive or criminal behaviour that does not meet the full criteria for ASPD is described as Adult Antisocial Behaviour in DSM-IV, with the diagnosis of ASPD only applying to those whose antisocial personality traits are inflexible, maladaptive and persistent, and a cause of significant impairment or distress. ASPD is distinguished from criminal behaviour for gain where the characteristic features of ASPD are absent.

g) The aetiology of ASPD is uncertain. ASPD may be the consequence of the accumulation and interaction of multiple factors through development, including temperament, childhood and adolescent experiences, and other environmental factors. The risk factor most predictive of adult antisocial personality is the severity and extent of child and adolescent conduct symptoms and a history of childhood or adolescent Conduct Disorder is common in people with ASPD (and is one of the diagnostic criteria in DSM-IV). Other childhood and adolescent risk factors for adult ASPD include other psychopathology (particularly depression, oppositional disorder, and substance misuse) and callous temperament.

h) Childhood and adolescent risk factors associated with the broader category of adult antisocial behaviour include individual characteristics such as an undercontrolled, impulsive, aggressive or hyperactive temperament, low IQ and poor educational achievement; family factors such as having an antisocial parent, poor supervision, abuse and violence between parents; and wider societal factors such as an antisocial peer group and high levels of delinquency in school. Risk factors for antisocial behaviour are often correlated with one another. A number of childhood factors are protective against the development of later antisocial behaviour, including temperamental characteristics such as shyness and inhibition, intelligence, a close relationship with at least one adult, good school or sporting achievement, and non-antisocial peers.

i) Neurobiological mechanisms for ASPD and antisocial behaviour have also been proposed and there is evidence that there is a genetic component in the development of antisocial behaviour. It has been proposed that a genetic predisposition may increase the likelihood that exposures to adverse environmental influences and life events will lead to the development of ASPD.

j) The Personality Disorders are associated with a significant burden to the individual, those around them and society as a whole, with the

impact of the disorder generally being greatest in early adulthood and diminishing with age. Their families commonly endure episodes of explosive anger and rage, a callous and unemotional behavioural pattern, depression, self-harm, and suicide attempts. ASPD is also associated with significant drug and alcohol misuse, with further attendant costs to the individual, their family and society.

k) The antisocial, violent and offending behaviour associated with ASPD has a negative impact across society and results in a range of costs to society including those to victims of the behaviour (including physical harm and the impact of intimidation and fear), the costs of policing and other national and local measures to curb antisocial behaviour, and general costs to the criminal justice system including the costs of detention and other punitive measures.

l) People with personality disorders tend to make heavy but dysfunctional demands on services, having frequent contact with mental health and social services, A&E, GPs and the criminal justice system, and may be high-cost, persistent, and intensive users of mental health services.

m) The prevalence of ASPD in the general population of Great Britain has been estimated at 0.6%, with the rate in men (1%) five times that in women (0.2%). Surveys conducted in other countries report prevalence rates for ASPD ranging from 0.2% to 4.1%. Higher prevalence rates for personality disorders appear to be found in urban populations and this may account for some of the range in reported prevalence – the estimate of 0.6% for the prevalence of ASPD in Great Britain was based on data gathered from a survey covering a range of locations.

n) ASPD is common among drug and alcohol misusers in both treatment and custodial settings. The prevalence of personality disorders, and ASPD in particular, is particularly high in the prison population. In England and Wales 78% of male remand prisoners, 64% of male sentenced prisoners, and 50% of female prisoners have personality disorders, with the prevalence of ASPD being 63% among male

remand prisoners (just over half of whom have ASPD plus another personality disorder), 49% among sentenced male prisoners (two fifths of whom have ASPD plus another personality disorder) and 31% among female prisoners (two thirds of whom have ASPD plus another personality disorder).

o) Many clinicians are sceptical about the effectiveness of treatment interventions for personality disorder, and hence often reluctant to accept people with a primary diagnosis of personality disorder for treatment. Established ASPD is difficult to treat and evidence on the effectiveness of therapeutic interventions is sparse.

p) The diagnosis of ASPD requires evidence that the features of the disorder onset in childhood or adolescence (ICD-10) or evidence of Conduct Disorder with onset before age 15 years (DSM-IV) and this, combined with the difficulty of treating adult ASPD, has led to a focus on preventative interventions with children and young people at risk of later ASPD. Early prevention during childhood may be desirable, but many individuals who go on to develop adult ASPD are not identified before adolescence.

4 The guideline

a) The guideline development process is described in detail in two publications which are available from the NICE website (see 'About NICE' » 'How we work' » 'Developing NICE clinical guidelines' » 'Clinical guideline development methods'). *An overview for stakeholders, the public and the NHS (2006 edition)* describes how organisations can become involved in the development of a guideline. *The guidelines manual (2006 edition)* provides advice on the technical aspects of guideline development.

b) This document is the scope. It defines exactly what this guideline will (and will not) examine, and what the guideline developers will consider. The scope is based on the referral from the Department of Health (see Appendix).

c) The areas that will be addressed by the guideline are described in the following sections.

4.1 Population

4.1.1 Groups that will be covered

The recommendations in this guideline will address the following:

a) The treatment and management of adults with a diagnosis of ASPD in the NHS and prison system.

b) Preventative interventions with children and adolescents at significant risk of developing ASPD.

c) The treatment and management of common comorbidities in people with ASPD as far as these conditions affect the treatment of ASPD.

4.1.2 Groups that will not be covered

The guideline will not cover:

a) the separate management of comorbid conditions

b) the management of criminal and antisocial behaviour in the absence of a diagnosis of ASPD

4.2 Healthcare setting

a) The guideline will cover the care provided by primary, community and secondary healthcare professionals who have direct contact with, and make decisions concerning, the care of adults with ASPD and the care of children and young people who are at significant risk of developing adult ASPD.

b) This is an NHS guideline. It will comment on the interface with other services such as social services, educational services, and the voluntary sector, but it will not include recommendations relating to the services exclusively provided by these agencies; except insofar as the

care provided in those institutional settings is provided by NHS healthcare professionals or NHS supported services.

c) The guideline will include:

- care in general practice and NHS community care
- hospital outpatient and inpatient care, including secure hospitals
- primary/secondary interface of care
- care in prisons and the transition from Prison Health to NHS services.

4.3 Clinical management

Areas that will be covered by the guideline

a) The full range of care routinely made available by the NHS and Prison Health (including care and interventions with offenders serving non-custodial sentences).

b) Assessment both before and after diagnosis.

c) The assessment of risk in people with diagnosed ASPD

d) Identification of risk factors for adult ASPD in children and young people, including the early identification of child and adolescent behaviour disorders that are precursors or risk factors for ASPD.

e) All common psychological and psychosocial interventions currently employed in the NHS and Prison Health and related criminal justice services including, psychotherapy, cognitive-behavioural treatments, anger/violence management, and therapeutic communities.

f) The appropriate use of pharmacological interventions, for example initiation and duration of treatment, management of side effects and discontinuation.

(Note that guideline recommendations will normally fall within licensed indications; exceptionally, and only where clearly supported by

evidence, use outside a licensed indication may be recommended. The guideline will assume that prescribers will use a drug's Summary of Product Characteristics to inform their decisions for individual patients.)

g) Combined pharmacological and psychological treatments.

h) Sensitivity to different beliefs and attitudes of different races and cultures, and issues of social exclusion.

i) The role of the family or carers in the treatment and support of people with ASPD (with consideration of choice, consent and help), and support that may be needed by carers themselves.

j) Preventative / protective measures and interventions with children and young people who are at significant risk of developing adult ASPD, in particular those with a diagnosis of Conduct Disorder, including educational interventions and interventions with young offenders serving custodial and non-custodial sentences.

Areas that will not be covered by the guideline

a) Treatments not normally available in the NHS or Prison Health.

4.4 Status

4.4.1 Scope

This is the first draft of the scope, which will be reviewed by the Guidelines Review Panel and the Institute's Clinical Practice Associate/Director.

The guideline will incorporate relevant technology appraisal guidance issued by the Institute, including: *Conduct disorder in children - parent-training/education programmes* NICE Technology Appraisal (Publication expected [TBC])

The guideline will incorporate relevant clinical guidance issued by the Institute, including: *Schizophrenia: core interventions in the treatment and management of schizophrenia in primary and secondary care* (2002);

Depression: the management of depression in primary and secondary care (2004); *Anxiety: management of generalised anxiety disorder and panic disorder* (2004); *Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary* (2004); *Post Traumatic Stress Disorder; Management of post-traumatic stress disorder in adults in primary, secondary and community care* (2005); *Obsessive Compulsive Disorder: Core interventions in the treatment of obsessive compulsive disorder and body dysmorphic disorder* (2005); *Violence: The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments* (2005); *The treatment and management of bipolar disorder* (2006); *Drug misuse: Opiate detoxification of drug misusers in the community and prison settings* (expected publication 2007); *Drug misuse: Psychosocial management of drug misusers in the community and prison settings* (expected publication 2007); *Attention deficit hyperactivity disorder: pharmacological and psychological interventions in children, young people and adults* (expected publication 2008).

4.4.2 Guideline

The development of the guideline recommendations will begin in March 2007.

5 Further information

Information on the guideline development process is provided in:

- *An overview for stakeholders, the public and the NHS (2006 edition)*
- *The guidelines manual (2006 edition)*

These booklets are available as PDF files from the NICE website (http://www.nice.org.uk/page.aspx?o=guidelinesmanual). Information on the progress of the guideline will also be available from the website.

Appendix – Referral from the Department of Health

The Department of Health asked the Institute to consider preventative and treatment interventions for Antisocial Personality Disorder in education, in primary health care and in specialist services including prisons for adults and children and adolescents and to consider which treatment settings are most appropriate for which intervention.