National Institute for Health and Clinical Excellence

Antisocial Personality Disorders scope consultation table

Type	Stakeholder	No	Section number	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	Association for Psychoanalytic Psychotherapy in the NHS (APP)	1	General	We welcome this guideline. The general diagnostic and background description of this condition is accurate, clear and comprehensive – we would like to see inclusion of how it feels from the patient's perspective, as well as something more about the strains and typical effects upon families and carers in trying to provide support and services to this group of patients, due to characteristic patterns of interpersonal functioning. This has implications for treatment and management in that support and supervision structures and management of relationships between clinicians and patients are key 'curative' factors. The scope should include models of clinical management which emphasise understanding and containment of the inevitable anxieties, tensions and conflicts generated in services between patients, clinicians, and the various layers of the organisation.	Thank for this comment – we think that our inclusion of service users on the guideline development group will ensure that the patient's perspective is addressed and we also believe that the issue of the impact on families and carers and the support they require is dealt with in 4.3. We have added the following item to 4.3 to address your last point: 'Support and supervision systems to facilitate the delivery of effective interventions.'
SH	Association for Psychoanalytic Psychotherapy in the NHS (APP)	2	3k o & p	Whilst these sections may reflect a realistic consensus of current professional opinion, they are unduly pessimistic for a guideline scope. The *potential* benefits of treatment should be stressed alongside the costs of unmet need and ineffective treatment. While there are useful sections on prevalence and distribution, there is little on the range of services available, treatment gaps across different sectors (primary, community, secondary, tertiary) and the need to identify these and make provision as part of the guideline task.	Thank you, but the guideline itself will include a review of the current treatment of the condition in the NHS.
SH	Association for Psychoanalytic Psychotherapy in the NHS (APP)	3	4.3d and 4.3j	We welcome inclusion of these important aspects in the scope.	Thank you.
SH	Association for Psychoanalytic Psychotherapy in the NHS (APP)	4	4.3c h and i	These 3 areas are particularly difficult to 'get right', and the balance of ethical, clinical and statutory duties requires ongoing scrutiny within services and across services, involving use of expert consultation, high quality supervision and support, and labour intensive service models. Cost effectiveness considerations in this area are often false economies, and more emphasis in the scope should be given to a rigorous and clinically informed cost-benefit analysis,	Thank you for this comment – we will draw it to the attention of the guideline development group. We have amended the scope to add support and supervision systems to facilitate the delivery of effective interventions, including team and individual professional functioning and how they

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				which will include criteria specific to this condition.	are influenced by working with this client group.
SH	Association for Psychoanalytic Psychotherapy in the NHS (APP)	5	4.3i	The inclusion of the support needs of families and carers is welcome and important, but the needs of professional staff are not adequately described in the scope. Models of reflective practice built in to all stages of the care pathway require that professionals are given adequate support and supervision structures to be able to sustain their work with this patient group over time, consistently, reliably, and without doing harm inadvertently through lack of experience and supervision.	Thank you for this comment – we have amended the guideline scope in light of this and other comments.
SH	Association for Psychoanalytic Psychotherapy in the NHS (APP)	6	General	There is acknowledgement of the lack of empirical evidence. The scope should include the option of the GDG referring for advice and consultation with an expert reference group made up of senior clinicians and service managers / leads. The scope should also seek to identify recommendations for further research and priorities (research questions) which this should address.	Thank you for this comment. We have in the past used external advisor but not in the way that you suggest which we do not think would be helpful to the process. However, as you will be aware we have an extensive consultation process which will allow for the views of relevant experts to be considered. The NICE process also requires that each guideline includes recommendations for future research.
SH	Association of Child Psychotherapists	1	3j	Families and carers experience impact of episodes - Should the Scope have more emphasis on the role of clinical treatment focusing on parental and familial support offered by CAMHS?	Thank you for this comment – we will be addressing both these issues and believe that these are clearly set out in the scope as it stands.
SH	Association of Child Psychotherapists	2	4.1.1b to make "recommendations about preventative interventions " with children and adolescents at	*a. Has scope sufficiently considered the presence and functioning of CAMHS as distinct from AMHS?* Point 4.2a) seems to be structured in relation to the settings of AMHS not CAMHS. The scope may need to clarify recent developments with in CAMHS that have progressed beyond the 'interface' of NHS with other services such as social and educational (4.2b): for example the shift of some CAMHS services into school settings and the relationship of the multi disciplinary CAMHS team to Children's services and CAMHS provision of supervision and consultation in settings both within and outside the NHS such as children's homes and foster carers. *b. How will the scope recognise the limitations of CAMHS*	Thank you; we will be addressing the issue of the relationship to CAMHS, and as you state the interface with education and social care is crucial – we will ensure these concerns are reflected in the membership of the guideline development group. Thank you; this will be a matter for

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			significant risk of developing ASPD	*services which are over-stretched, and under funded?* The ASPD scope indicates that to meet the challenges of offering consistent NHS based treatment for ASPD there will be a need to develop the capacity and skills within CAMHS. Specifically that there will be a need for increased capacity within CAMHS specialising in adolescence if effective preventative treatment PD interventions are to be provided on a national basis. *c. Will the NICE guidelines have access to audit data about CAMHS and specialist capacity within CAMHS for working with adolescents, particularly in the lead up to the transition into adult services at 16-17?*	commissioners and managers to address when the guideline is published. Thank you, but again we think this will be a matter for commissioners and managers to address when the guideline is published.
SH	Association of Child Psychotherapists	3	4.3	*Would it be more coherent for these sections (a)-j)) to separate out the points related to CAMHS from AMHS?* Currently points d) and j) relate to CAMHS.	Thank you; we have amended the scope.
SH	Association of Child Psychotherapists	4	4.3	*How will the ASPD Scope ensure that the strengths and experience within the CAMHS multi disciplinary team structure and its specialist approaches are recognised and nurtured in the context of what may well be an adult dominated expert group*	Thank you; we think that the issue you raise can be dealt with through clarity of scope, appropriate consultation and effective guideline development group members from CAMHS and other professional groups working with children.
SH	Association of Child Psychotherapists	5	4.3	There is a need for: "support for families and carers" to be reframed in relation to CAMHS. The current SCOPE emphasis downgrades the importance of working with parents of under 18s. This is important because CAMHS has specialist expertise and understanding of integrating clinical work with families and parents and also working in consultation with carers of disturbed and troubled children. *NB: A recent study by Trowell and Rhode, on treatment for severely depressed children, has demonstrated the importance of parent treatment taking place alongside individual once weekly psychoanalytic psychotherapy.*	Thank you, but we feel this is covered in 4.3 and in the membership of the guideline development group by a carer.
SH	Association of Child Psychotherapists	6	4.3 Areas not be covered by the	a**) treatments not normally available in the NHS or prison health** - *This exclusion suggests that the guidelines will not consider, or make recommendations, about the need for the development of clinical treatment approaches within CAMHS, such as: intensive focused therapeutic parent treatment and*	Thank you. The limitation of the scope at 4.3 will not have the effect of excluding interventions appropriate to ASPD just because they are new or not available widely or in appropriate

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			guideline:	*multi-systemic therapy; Please clarify does this limitation means that no new preventative approaches and treatments will be included in the guidelines unless they are commonly available?*	settings. For example see the recent NICE/SCIE technology appraisal on parent-training/education programmes in the management of children with conduct disorders.
SH	Association of Professional Music Therapists	1	General	The proposals which focus on this diagnostic group are broadly welcomed. We endorse an emphasis upon multi-disciplinary working, consideration of the links between medical, psychological, social and managerial issues, and suggest that these links should increase. Evidence should be explored that provides more weight to the need for treatments to be looked at collaboratively and from the individual patient's point of view, rather than professionally led. That being said, this document will focus on unique points illustrating that Music Therapy can contribute to the care of this population, assuming that many other responses will focus upon generic issues. These responses should be considered alongside those submitted by other professions, in particular BAAT, and alongside the submission from The Forensic Arts Therapy Advisory Group (FATAG), mentioned below. The Association of Professional Music Therapists (APMT) has over 400 qualified music therapist members in the UK. (500 members, but around 100 of these are in training or working in another country). Music Therapy is regulated by Health Professions Council in the UK, and a high percentage of music therapists registered with the HPC are employed in NHS settings (currently 50% of the membership, although these are not all full time posts. Consultation has been through attendance at the Stake Holders meeting on Dec 5th, a brief survey of all members of the APMT, and liaison with BAAT. Organisations such as BAAT and FATAG have shared ideas and discussed their	We will be including music therapy in the guideline and the scope has been modified to reflect this.

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				submissions. In addition expert advice has been given by Stella Compton-Dickenson, Professional Lead for Arts Therapies at Rampton, an experienced music therapist, and her team. This evidence has been endorsed by senior staff at Rampton. A literature list is included, and other experienced practitioners from the multi-disciplinary team have contributed including Doctors, Mangers and Psychotherapists. The Forensic Arts Therapy Advisory Group (FATAG) is made up of experienced qualified Arts Therapists, and aims to provide support, advice and opportunities for continuing professional development for arts therapists working in forensic or secure settings and trainee arts therapists on clinical placement in forensics. The organisation has made a separate submission which APMT supports. A document entitled Guidelines for Arts Therapists Working in Prisons has been produced by members of FATAG in consultation with the four professional Arts Therapies Associations, The Standing Committee on the Arts in Prisons and the Prison Service Directorate of Healthcare (now renamed Healthcare Services for Prisoners). These Guidelines set out professional standards for arts therapists working in prisons and have been distributed throughout HM Prison Service, please contact us for details on how to obtain a copy	
SH	Association of Professional Music Therapists	2	2	The APMT welcomes the points made here, particularly the partnership with patients, and support for healthcare professionals. In the last decade there has been an increase in recognition of the benefits of modernisation of treatment approach, particularly the review of several secure NHS settings, the results of which included the increase of treatments which provide psychologically based treatments alongside medical and social care.	Thank you for your comment.
SH	Association of Professional Music Therapists	3	2a	According to the hierarchy of evidence, we understand that RCT trials and Cochrane review-type evidence will form a strong basis for the consideration of evidence. It will, however be important to take a historical perspective, and to take into	We will be including music therapy in the guideline and the scope has been modified to reflect this.

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				account the fact that some new research in both this area and BPD is only just emerging particularly owing to these diagnoses now receiving more government funding and medical attention. Pilot research in progress, some of it case study orientated in nature, may not be finally published by the end of the NICE process but will hopefully be considered. In terms of cost effectiveness, it is noticeable that in the last decade psychological treatments, including a diverse choice of more and less verbally based therapies and interventions, have expanded. This followed reviews of high secure hospitals, for example Rampton and Ashwoth, and this type of review evidence should be included in the process. Arts Therapies services have increased, and at the time of writing there are around 40 music therapists employed in Forensic mental health settings, comprising around 50% of the work load in the field of psychiatry, with a focus on high, and medium secure units. **An example of research in progress**: Pilot Music Therapy Project using a Cognitive Analytic Therapy (CAT) combined with music therapy approach, by a music therapist Stella Compton-Dickenson trained in both disciplines. Treatments were delivered to PD Patients: Completed six x 24 sessions of CAT Music therapy treatments with 3x monthly follow up sessions and before and after use of the Birtchnell Persons related to others PROQ2 evaluation. The aim is to register this by Easter with the IOP subject to completion of all ethical procedures One female patient/offender (BPD)had an 18 month treatment and has moved to medium security as a direct result of changes sustained. All the other patients are male. The latter psychopathic PD Patients,(some with BPD traits) have all indicated positive changes in relating to others. The current hypotheses consider that the degree of change is linked to the stage of the patients' treatment pathway: i.e. whether he had other psycho social interventions prior to	

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				treatment that have increased psychological mindedness and ability to use therapy. Treatments were given without overlap with other psychological therapies. The music therapy element within formalised CAT is different to CAT as it accesses the unconscious aspects of the psyche that CAT might not generally reach. The model used in this research is specific to high secure treatment. (Straight CAT is used in the women's directorate and on the DSPD Unit by the CAT Practitioners with the same monthly follow up plan. It is not the same in the community setting at St Thomas Hospital. (anecdotal evidence provided from Head Arts Therapist, Rampton High Secure Hospital.	
SH	Association of Professional Music Therapists	4	2a Evidence continued	**Pilot Research continued**: The best results have clearly indicated a reduction in psychopathology to a normal level whilst remaining in this enclosed hospital environment. In the first case this was not sustained when the patient moved from Rampton. He was returned and consideration has been linked to re- traumatisation and subsequent dissociation through loss of attachment figures developed at Rampton. With the most enduring patient who has been at Rampton for thirty years, and had not received previous psychological therapy; there were dynamic changes in his relating abilities from positions of upperness, neutrality and distance; but as yet no reduction in the PROQ2 score. All these patients have progressed to music therapy group work and the role of jointly created (improvised) music is central to development of the recognition of the value of learning new ways to relate in the individual work too. The APMT hope that case study based research will be used as best evidence such as the example given here.	We will be including art and music therapy in the guideline and the scope has been modified to reflect this.
SH	Association of Professional Music Therapists	5	3	There is a need for a review of current practice for ASPD	Thank you; this will be included in the guideline.
SH	Association of Professional Music Therapists	6	3d	We think it is important to consider the role of childhood or adolescent sexual abuse. This can be a key vulnerability factor in looking at how attachment may or not be internalised and sustained otherwise relapse may occur because of the	Thank you for this comment – we will draw it to the attention of the guideline development group. We are aware of the developmental nature of the

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				persistency of personality traits and learnt relating procedures. This case is to be published imminently (see bibliography).	disorder and this will be dealt with in the full guideline.
SH	Association of Professional Music Therapists	7	3e	It is noted reading these guidelines that depression and anxiety as part of ASPD are often sited as reasons for referral to Music Therapy, although much of the literature in the forensic setting concentrates on schizophrenia and music therapy. (Sloboda 2002, Glyn 2002). It is likely that for these people, personality disorder is an added sometimes unrecognised diagnosis, and dual diagnostic considerations must be emphasised in any guidelines. It is often through active psychologically based treatments that these aspects are picked up (Welldon & van Velson 1996, Sloboda (2002). In particular splits between action and thought, commonly found to be at the root of difficulty, can be attended to in music therapy, an action based treatment, a point which is expanded in 4e) below.	Thank you for this comment – we will draw it to the attention of the guideline development group.
SH	Association of Professional Music Therapists	8	4.3e	Please cross reference to the BAAT submission for points concerning the importance of less-verbally based therapies being taken into consideration. The long list of music therapy specific literature here will provide the detail about music therapy and its particular importance for people with PDA. Sloboda (1996) discusses how music, has a capacity to be both concrete and symbolic, which can be helpful in addressing the prevalent split between thought and action for this population. With it's here and now capacity for spontaneous engagement based upon innate musicality (Stern 1985), improvisation can work with aggression, allowing the physicality and creativity within very structured musical frameworks to enable patients to have some of these aspects understood. This happens in a setting where it is socially acceptable (ie expressing and giving meaning to this aggression through drumming for example), at the same time as creating a piece of music that can increase self esteem and help towards rehabilitation. Sloboda (2002) writes 'The musical activity can be pure, spontaneous, impulsive action, but can also (particularly if a recording is made) become and experience to be reflected upon'. (Sloboda 2002 p.134.	Thank you for this comment – we will draw it to the attention of the guideline development group.

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				Clearly in this preliminary document, space and time prevent more detail, but the APMT hopes that this response will result in the NICE teams examining established treatments such as Arts Therapies that are not listed in the Scoping document.	
SH	Association of Professional Music Therapists	9	4.3h	It should be noted that some particular research and case studies are included in the literature below which focus upon cultural diversity and the importance of attending to this through areas such as belief and ethnicity. Music Therapists are well versed in music of many cultures and there is evidence emerging that this way of working can be helpful in setting up relationships which enable patients to work within their own cultural idiom.	Thank you for this comment – we will draw it to the attention of the guideline development group.
SH	Association of Professional Music Therapists	10	General	***Music Therapy in Forensic Psychiatry*** **Compton Dickinson** S.J.(2001) *A case of work, rest and play: Music therapy in early onset psychosis* I.O.P. KCL Library London and Published in 10th World Congress of Music therapy, On line conference proceedings. **Compton Dickinson S.J**.(2003) *Community culture and conflict: the role of creativity.* BSMT Publications UK. ISBN0-85513-013-X **Compton Dickinson** (2003). *A comparative study of dynamic and cognitive analytic time limited therapy*. Cognitive analytic therapy project report (MSc) St. Thomas's. **Compton Dickinson S.J.** (2004) *Community culture and conflict. Part 2 Changes*. BSMT Publications UK and www.musictherapyworld.net **Compton Dickinson S.J.** (2005) *Beyond body, beyond words: cognitive analytic music psychotherapy with personality disordered offenders.* Association of cognitive analytic therapy. St Thomas's Hospital London. Reformulation magazine. September 05 issue. Full paper publication due through Anglia Ruskin University Publications. [Future publication: Compton Dickinson SJ *(2005) Rapping at the door: Songs of innocence and experience with ethnic minority offenders*.11th World Congress of Music Therapy] **Compton Dickinson, S**. (2006) Beyond Body, Beyond Words: Cognitive analytic music therapy in forensic psychiatry - New approaches in the treatment of Personality Disordered	Thank you.

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				Offenders. Music Therapy Today (Online 22nd December) Vol.VII (4) 839-875. available at http://musictherapyworld.net **Glyn, John** (2003), *New York Mining Disaster.* British Journal of Music Therapy, vol 17, no 2 **Glyn, John** (2002), *Drummed Out of Mind – A Music Therapy Group with Forensic Patients.* Music Therapy and Group Work, ed Davies and Richards, Jessica Kingsley publications. **Hakvoort, Laurien** (2002), *A Music Therapy Anger Management Program for Forensic Offenders.* Music Therapy Perspectives, vol 20(2): 123-132 **Santos, Katie** (date not known). *Unlocking the Power – Creative Music Therapy with Mentally Disordered Offenders.(1988).* Broadmoor Hospital. **Sloboda A, and Bolton R (2002)** *Music Therapy in Forensic Psychiatry ; a case study with musical commentary*. In L Bunt & S. Hoskyns, (eds) The Handbook of Music Therapy: London & New York: Brunner-Routledge **Sloboda, A** (1997) *Music Therapy and Psychotic Violence.* From 'A Practical Guide to Forensic Psychotherapy' ed Welldon and Van Velsen, Jessica Kingsley Publishers	
SH	British Association for Counselling and Psychotherapy (BACP)	1	4.1.1c	It is certainly a good idea to comment on the management of common comorbid conditions in antisocial personality disorder (ASPD), as far as those conditions affect the treatment of patients with ASPD. It would also seem sensible to extend this through a consideration of the effects of ASPD on the management of these comorbid conditions (such as depressive illness and anxiety disorders) as this has not been covered in earlier NICE guidance.	Thank you, but we consider this to be outside the scope of the guideline.
SH	British Association for Counselling and Psychotherapy (BACP)	2	4.3c	When considering risk assessment in people with the diagnosis of ASPD, the risks of non-fatal self-harm and suicide should be discussed, in addition to the risks of violence towards others.	Thank you for this comment – we will draw it to the attention of the guideline development group.
SH	British Association for Counselling and Psychotherapy (BACP)	3	4.3f	As in the scope for the guidance on borderline personality disorder, when discussing the use of pharmacological interventions in the clinical management section, it should be recognised that sole reliance by the NICE working group on	Thank you for this comment – we will draw it to the attention of the guideline development group but should point out that the scope does not restrict

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				licensed indications would severely restrict the scope of this section and probably reduce its potential utility in clinical practice. It would be better for the working group to focus on the findings of published (and unpublished, but available) randomised placebo-controlled trials (RCTs) in ASPD, which represent the only reliable source for evaluations of the efficacy of psychotropic drug treatment. The group would need to focus on those RCTs that either exclude patients with primary comorbid conditions (such as major depressive disorder), or perform a sub-group analysis of the effects on treating ASPD in patients with or without comorbid conditions.	solely to licensed indications. If you are aware of as yet unpublished trials please draw them to our attention.
SH	British Association of Art Therapists	1	2a b, c	Clinical management, prevention and treatment is a huge ask, and would inevitable involve understanding many aspects of sociological, political, cultural contexts which contribute to such a debilitating condition. Whilst prevention is warranted this would involve many systemic reviews of social care, any recommendations would involve the political domain, at what point does NICE determine social policy whilst remaining un-elected?	Thank you for your comment. The scope of the guideline is limited to healthcare and the interface with related settings such as social care, education and the criminal justice system. We think your comment represents a misunderstanding of the role of NICE and the nature of the preventative interventions that we will examine, for example see the recent NICE/SCIE technology appraisal on parent-training/education programmes in the management of children with conduct disorders.
SH	British Association of Art Therapists	2	3	There is an undoubtedly a need for an appraisal of current practice and management of ASPD.	Thank you; this will be included in the guideline.
SH	British Association of Art Therapists	3	3n	How will these guidelines function alongside those being developed for the psycho-social treatment of drug abuse, a risk of contrary recommendations perhaps, should one subset of a diagnostic cluster take prominence/priority because of a risk to others rather than to self? In reaching to the prisons populations of ASPD is to be commended, current long-standing success stories (ie Grendon) should be obviously	Thank you for this comment. We can assure you that considerable care will be taken to integrate the recommendations from this guideline with other guidelines and technology appraisals that NICE is undertaking.

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				reviewed.	
SH	British Association of Art Therapists	4	3p	Is it possible that early intervention already takes place, At what point is it necessary to confirm a diagnosis without creating stigma through labelling of difficult children from within impoverished situations? Can you quantify in your review the amount of good practice that has already saved children and families through the work of CAMHs teams	Thank you. We are aware of the risk of labelling and stigma and this will be considered in relation to the potential harms and benefits of early identification and intervention. The purpose of the guideline is to review and recommend effective treatments – not to survey current good practice – and what you suggest is therefore outside the scope.
SH	British Association of Art Therapists	5	4.1.1	Why is it, that these guidelines cover adults with a diagnosis of ASPD in the NHS and prison system, whilst the BPD do not extend to include treatment in Prisons, BPD is equally a destructive condition, the suicide rates in prisons testify to this. (NSF?)	Thank you for your comment – the scope for the BPD guideline has been amended to include the care provided in prisons.
SH	British Association of Art Therapists	6	4 a	Is there a need for the widening of GDG's professional representation to ensure that GDG's are not biased by the initial composition of the GDG's.	The guideline development group will be broadly based to reflect the wide range of interventions to be covered.
SH	British Association of Art Therapists	7	4.3 e	Whilst there is no intent here it is disheartening to read constant references to the same modes of psychosocial treatments, which seem to reflect an evidence bias towards certain professions. Art therapists, (Art Psychotherapy) along with drama and music therapists are the only psychotherapies to have been granted State Registration with the Health Professions Council (HPC). Membership of this body demands high standards of education and clinical practice and ensures public protection. To practice as an art therapist practitioners are bound by law to be registered with the HPC. The British Association of Art Therapists (BAAT) is the professional organisation for art therapists in the United Kingdom and has its own Code of Ethics of Professional Practice. Comprising twenty regional groups and a European and International section, it maintains a comprehensive directory of qualified art therapists and works to promote art therapy in the UK. http://www.baat.org/art_therapy.html	We will be including art therapy in the guideline and the scope has been modified to reflect this.

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				As Art Therapists we work extensively with the clients group described within the scope, importantly we have extensive involvement within a variety of settings both primary care and secondary care: prisons, forensic and specialist, both for LD and within Adult mental Health. We are also work as part of Child and adolescent services. Part of the clinical specialism we contribute involves providing individual sessions and groups for clients with ASPD, notably contributing to risks appraisals where there remains a possibility of further offending behaviour. Art Psychotherapy is a standard intervention within these ranges of services. These people benefit from both individual and group art psychotherapy where, through the art, they begin to find a language to express themselves, think symbolically and reflect. The dynamics of shame and humiliation often dictate that such clients are often difficult to maintain working alliances with, the image can take some of the heat out of these feelings and make a therapeutic alliance feel safe. A recent survey of art therapists within the NHS and other settings found high percentage of severity within caseloads of arts therapists. Often this reflects maintaining chronic (co- morbid conditions ie drug and alcohol misuse) clients within the community and as such whilst no research has been undertaken we would suggest that this reflects a cost saving within these chronically presenting clients, who as it is known represent the second highest users of mental health beds. The image in art psychotherapy provides a unique therapeutic dimension beyond those encountered in purely verbal therapies. A recent evaluation of a unique initiative by the organisation Creative Expression who work with creative practitioners and arts psychotherapists in prisons is attached with this submission. Their latest evaluation for a short term clay workshop for severely dissocial offenders in the Vulnerable Peoples Unit (sex offenders) in HMP Channings Wood shows favourable results.	

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				See below for reading list and details of the specialist interest group in Forensic Arts therapy practice.	
SH	British Association of Art Therapists	8	General	**<u>Literature ASPD &Arts Therapies</u>** Report: Developing Principles and Policies for Arts Therapists Working in United Kingdom Prisons. Colin Teasdale, in **The Arts in Psychotherapy**, Vol.26, No.4, pp 265-270, 1999. **Art Therapy with Offenders** Marian Liebmann (ed), Jessica Kingsley Publishers, London 1994. Art Therapy as a Shared Forensic Investigation Colin Teasdale, in **Inscape (Journal of the British Association of Art Therapists)**, Vol.2, No.2, pp 32-40, 1997. Observing Offenders: The use of simple rating scales to assess changes in activity during group Music Therapy Sarah Hoskyns, in **Art & Music: Therapy and Research**, Andrea Gilroy and Colin Lee (eds) Routledge, London, 1995. **Using the Arts Therapies in Treatment of Sexual Offenders against Children in Vulnerable Populations, Vol 1** Sgroi, S M. (ed), Lexington Books, Massachusetts/Toronto 1988. **Challenging Experience - An Experiential Approach to the Treatment of Serious Offenders** John Bergman & Saul Hewish, Wood 'N' Barnes Publishing & Distribution, Oklahoma USA. 2003. **Drama Workshops for Anger Management and Offending Behaviour** James Thompson, Jessica Kingsley Publishers, London 1999. **Developing Principles and Policies for Arts Therapists Working in United Kingdom Prisons,** Teasdale, C. (1999),*Arts in Psychotherapy, Elsevier Science Publications, L.A. (California), pp. 265 - 270.* **Art Therapy Research and Evidence Based Practice,** A, Gilroy, Sage, London 2006 **Playing with Fire- Art Therapy in a Prison setting.** S . Delsahdian, *Psychoanalytical Psychotherapy*. Vol.17 No. 1. March 2003 pp. 68.84. **Psychodrama: Working Through Action- "My thank you is**	Thank you.

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				for your concern" *Group Analysis* Vol. 38 No.3 pp371-379 2005. Jinnie Jeffries : HMP Grendon. Jeffcote, N and Watson, T (2004) **Working Therapeutically with Women in Secure Mental Health Settings,** London: Jessica Kingsley Publishers Ltd. **Art Therapy within a prison therapeutic community**, ATC Windsor Conference 2004, Bill Wylie. BIGSPD Conference 2004. **'Art Therapy in a High Secure Hospital'** (Rampton) at the ISPS Conference 2004, Bill Wylie. '**Working with Trauma in a Prison T C: An Essentially Social and Integrative Approach**.' S.Tucker & B Wylie , Windsor Conference 2005. Published in the International Journal of Therapeutic Communities 27,3. Autumn 2006.	
SH	British Association of Art Therapists	9	General	The Forensic Arts Therapy Advisory Group (FATAG) is a voluntary organisation which aims to provide support, advice and opportunities for continuing professional development for arts therapists working in forensic or secure settings and trainee arts therapists on clinical placement in forensics. A document entitled **Guidelines for Arts Therapists Working in Prisons** has been produced by members of FATAG in consultation with the four professional Arts Therapies Associations, The Standing Committee on the Arts in Prisons and the Prison Service Directorate of Healthcare (now renamed Healthcare Services for Prisoners). These Guidelines set out professional standards for arts therapists working in prisons and have been distributed throughout HM Prison Service, please contact us for details on how to obtain a copy.	We will be including art therapy in the guideline and the scope has been modified to reflect this.
SH	College of Occupational Therapists	1	4.1.1c	We are pleased to see this included, as common comorbidities, such as substance misuse, are often used as a way of excluding people from treatment for ASPD.	Thank you for your comment.
SH	College of Occupational Therapists	2	General	We have concerns that the environment and the service setting have not been included for this client group, as these are considered to be so important as a factor in the treatment of ASPD. We feel the environment cannot be separated from the treatment of people with ASPD.	Thank you; we have added the nature of the therapeutic environment to the areas that will be covered by the guideline.
SH	College of Occupational	3	4.3e	We would like to see occupational therapy listed in the	Thank you for this comment . In a

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	Therapists			psychosocial interventions especially as 4.3h refers to issues of social exclusion and the condition is associated with, amongst other things, social impairment.	clinical guideline we specify which interventions are found to be most effective, not the names of the professional groups. The psychological and psychosocial interventions listed are examples, not an indication of the limits to the types of intervention that will be considered.
SH	College of Occupational Therapists	4	General	We would welcome a comment about the importance of supervision/support for staff working with this group as this is integral to many of the treatment approaches.	Thank you; we have amended the scope in light of your comment. See 4.3(h)
SH	College of Occupational Therapists	5	4.1.1b	We would welcome a reference to which settings these preventative interventions for children at risk will come from as we have noted in the appendix that the DoH included education in its referral.	Thank you – education is included in the scope. Settings are addressed at 4.2 and include the interface with educational services. Educational interventions are referred to in relation to preventative interventions with children and young people at significant risk of developing ASPD (see 4.3 Clinical management).
SH	College of Occupational Therapists	6	General	Would welcome a comment/report on research that looks at the impact on individuals receiving diagnosis of ASPD and how this is viewed by primary care and many mental health settings.	Thank you; addressing this issue will be part of the guideline development group's work.
SH	College of Occupational Therapists	7	General	Further acknowledgement of the significance of people's histories in ASPD would be welcome.	Thank you; addressing this issue will be part of the guideline development group's work.
SH	College of Occupational Therapists	8	General	Because of the complexity of this diagnosis we would welcome an emphasis on an integrative approach to treatment and a holistic approach.	Thank you for this comment – we believe the scope will allow us to achieve this.
SH	Department of Health	1	General	We welcome this scope as there is a shortage of expertise within the health service and that this patient group is likely to be over-represented in those who present a challenge to services and who present in a violent and aggressive manner.	Thank you for this comment.
SH	Department of Health	2	General Guideline Title	In our opinion, the scope title should include reference to treatments or treatment intervention. In terms of ASPD management interventions to the individual can be considered	Thank you; we have changed to the title to: Antisocial (Dissocial) Personality Disorder: Treatment,

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				as essential aspects in improving clinical/ symptomatic outcomes.	Management and Prevention.
SH	Department of Health	3	3a	Would you please consider adding at end of sentence..... 'particularly substance misuse (including alcoholism) and offending behaviours'. Also would you please add..... 'attachment disorders'	Thank you we have added offending behaviours.
SH	Department of Health	4	General	if the scope is to include prevention we feel it should mention the need to consider evidence for early intervention with specific high risk groups e.g. Young Abusers with ASPD: (vizzard.E. et al) Overall the scope appears a little too health/medically focused. The social and environmental aspects of the disorder need to be strongly identified. Issues of emotional, physical, and sexual abuse as well as early trauma and deprivation are all indicated on current evidence as major factors in the development key personality disorders and particularly ASPD. In addition the provision and management of the appropriate psycho social environment is an important therapeutic feature and needs to be considered as an aspect of treatment/management intervention in particular ASPD. Responding to ASPD is of cross-governmental importance and needs to engage agencies of education, the NHS, social care and criminal justice. It is significant to	Thank you; we agree – this is included in the scope (see 4.3). We will be addressing the identification of high risk subgroups and interventions which specifically address those groups. We are aware of the developmental nature of the disorder and this will be dealt with in the full guideline. We have added the nature of the therapeutic environment to the areas that will be covered by the guideline. We intend that the membership of the guideline development group should reflect a broad approach to responding to ASPD, with membership for example from the probation service, prison services, CAMHS, social care and education.
SH	Department of Health	5	4.2 Healthcare setting	Would you please consider including "National Offender Management Services (NOMS)" and adding 'care and management' in prisons	Thank you; we have amended the scope to include care in prisons and young offender institutions in the section on health care settings (4.2). The scope also includes the interface with the criminal justice system, which includes the National Offender Management Service along with prisons, young offender institutions, and the probation service.

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SH	Department of Health	6	4.3	Would you please consider adding..... 'other offence related treatment' interventions Finally, '**in areas not covered**', we are uncertain as to the relevance of this section. In most of NHS and NOMS services interventions appropriate to ASPD are not currently available in any form where they need to be. Is this an unnecessary limit to the guidance.	Thank you; we consider that offence related treatment interventions are adequately covered under psychological and psychosocial interventions. The limitation of the scope at 4.3 will not have the effect of excluding interventions appropriate to ASPD just because they are not available widely or in appropriate settings.
SH	Forensic Arts Therapies Advisory Group	1	General	FATAG is an organisation dedicated to the understanding, clinical development and support of arts psychotherapists who work with offenders. One of its principal aims is to promote and share best practice amongst its members, through the examination and presentation of relevant theoretical advances. This is primarily done via regular conferences that have taken place twice yearly over the past 10 years. In 1997 it produced the 'Guidelines for Arts Therapists Working in Prisons' (currently available through www.fatag.org.uk) in consultation with the four professional Arts Therapies Associations, The Standing Committee on the Arts in Prisons and the Prison Service Directorate of Healthcare (now renamed Healthcare Services for Prisoners). First line evidence for the efficacy of the arts therapies with personality disordered clients is hard to come by: as arts therapists we rigourously examine our practice through case presentation and in-depth discussion and it is with this in mind that the FATAG conferences are designed. Since their inception, many of the key presentations have been concerned with the treatment of personality disordered clients and the unique opportunities that are presented through the use of the arts therapies. There are currently something like 90 arts therapists who work with adults in forensic settings: prisons, high secure hospitals, and medium and low secure units both in the NHS. To a	Evidence on the efficacy of interventions for ASPD is sparse and we will consider evidence that satisfies relevance and quality criteria appropriate to the clinical questions addressed by the guideline – the review will not be limited to RCTs. We will be including art therapy in the guideline and the scope has been modified to reflect this.

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				lesser extent we also support those practitioners who work with offenders in the community settings. This figure does not include arts therapists who work on locked wards that do not carry 'forensic' status. Despite this relatively small number, arts therapists in these settings attract a high proportion of referrals for clients with personality disorders. This seems to be because of the very difficulty that clinicians from other professions have in finding effective treatments programs for them. The arts therapies are, by the very nature of creative activity, fundamentally patient-focussed. It is for this reason, together with the fact that we are comparatively small professional groups, that empirical research such as the use of random control trials do not translate well to work with the arts therapies.	
SH	Forensic Arts Therapies Advisory Group	2	General	Why the use of arts therapies? The use of arts media in with this client group plays a vital role in regulating and containing the anxiety that they face when attempting any sort of therapy that addresses the nature of their personal relationships. The timely and judicial use of a third element in the therapy, (the image or other artistic expression) allows the client to engage in therapy at a pace and in a form that is at their own command. The creative element of the therapy, together with the strict boundaries demanded by our training, in effect encourages the client to tell his or her own story often for the first time in their lives. This becomes a starting point for developing strategies and treatment plans that can be picked up by or worked by staff with expertise in other areas. The arts therapies encourage a fundamentally integrated approach both with respect to working with the 'whole person' and with colleagues from other disciplines. It is perhaps for these reasons that anecdotal evidence suggests that, where they are available, the arts therapies are a highly popular choice amongst our clients with personality disorders. Our experience shows that the active use of the art in the context of a psychodynamic psychotherapy can have a highly significant impact on the development of our clients' capacity to	Thank you for this comment. We will be including art therapy in the guideline and the scope has been modified to reflect this.

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				reflect, particularly with those who have 'acted out' in their offending. In addition, these therapies are frequently offered as group work. The verbal and creative interaction promotes the ability for each group member to look at group and social norms, a regard for others and an understanding of their impact on others. The arts therapies provide a setting in which it become possible to check out owns perceptions against those of the group ones through the arts medium and through personal interactions. This clinical approach will be familiar to many clinicians who work in therapeutic communities. Several FATAG members have developed working strategies and methods that dovetail with those used in TCs, (most notably at HMP Grendon at the Henderson Hospital).	
SH	Forensic Arts Therapies Advisory Group	3	General	The importance of the management of clients with personality disorders cannot be stressed enough. The understanding gained by these therapeutic interactions provide an alternative means by which ongoing assessment can be achieved. In forensic hospital or prison settings in particular, the focus on the transference relationship, both within the art form and to the group or therapist, can provide a unique source of information with regards to the team's understanding of the patient's (or inmate's) risk. Despite the lack of a large amount of outcome research within the arts therapies in prisons and secure hospitals, (see the separate submissions from the four arts therapies professional associations) we would wish that NICE would make a significant reference to the fact that, in many forensic settings, they are at the forefront of the effective management and treatment of both anti-social personality disorder and borderline personality disorder. In the experience of many of us, they have often been the only treatment to have made any observable impact on some of our clients.	Thank you for this comment. We will be including art therapy in the guideline and the scope has been modified to reflect this.
SH	Henderson Hospital	1	4.1.1c	There will need to be some cross-referencing with the GDG on Borderline Personality Disorders, and consideration of other PD diagnoses, as there is much co-morbidity amongst the different categories of PD, particularly with increased severity e.g. at Henderson Hospital research has consistently shown	Thank you for your comment. Arrangements are in place to ensure good communication between the two GDGs during the development of the guidelines. It is clear in the scope that

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				that residents have an average of over 7 different PDs using the PDQ.	we will address relevant issues of comorbidity.
SH	Henderson Hospital	2	4.3a	This needs to include the setting in which the treatment takes place i.e. the psychosocial milieu; the attitudes and responses from staff to patients with guidance on what has been found to be effective in making the environment therapeutic rather than detrimental e.g. supervision, sociotherapeutic activities.	Thank you; we have amended the guideline scope in light of your and other similar comments.
SH	Henderson Hospital	3	4.3e	There is no consensus on what indicates severity e.g. number of PD diagnoses, type of PD, severity of symptoms, lack of insight, lack of responsibility, effect on range of areas of functioning, risk to others, risk to self. It would be useful if the guidance could look at severity and how this might relate to different clinical needs and types, intensity, length and setting of treatment. This also applies to heterogeneity of the diagnosis and co-morbidity.	Thank you for this comment – we will draw it to the attention of the guideline development group.
SH	Henderson Hospital	4	5	Service users have commented that they should be more equally represented on the GDG. The process of selection onto this group is not transparent. The group needs to be diverse and to include providers of specialist treatments. This is particularly important if expert opinion is to be used as different experts have different opinions and all need to be heard.	Thank you, but we do not agree that NICE processes for recruiting service users and carers are not transparent. Information for service user selection can be found here: http://www.nice.org.uk/page.aspx?o=PatientPublic
SH	Rethink Severe Mental Illness	1	4.1.1	Individuals with a diagnosis of ASPD who have become involved with the police or courts, or are in prison may also have some form of psychotic symptoms or substance misuse problems. They may be refused help on the grounds that their condition is untreatable. Individuals with dual diagnosis (PD and substance misuse) will have complex needs and are more at risk of suicide and violent behaviour.	Thank you for your comment. It is clear in the scope that we will address relevant issues of comorbidity.
SH	Rethink Severe Mental Illness	2	4.2.c	Rethink is anxious that problems with diagnosis be addressed in the guideline. People with diagnosis of PD will often have had their diagnosis changed. This may partly be due to the lack of consistency in support professionals. We are concerned that a diagnosis of PD is given to facilitate discharge of patients or to deny someone access to services, especially if they have assaulted a nurse. Sudden discharge with no where	Thank you; we will address the issue of assessment but will not be focusing on the matter of differential diagnosis with other disorders – it is outside of the scope. However we will be identifying the features which should trigger the use of this guideline.

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				to go can lead directly to crisis.	
SH	Rethink Severe Mental Illness	3	General	People with a diagnosis of PD, and their carers, must be provided with information so that they understand what it means, and also why diagnosis can change. Rethink has produced information on this but health professionals should also be providing information.	Thank you for this comment – we will be addressing the needs of carers in this guideline.
SH	Rethink Severe Mental Illness	4	General	Rethink would also recommend some sort of guidance be produced on diagnosis of PD for mental health professionals. There is variation in the interpretation of diagnostic criteria – for example, some psychiatrists deem hallucinations to be 'pseudo-hallucinations' if the person has insight into their symptoms, and change a diagnosis of schizophrenia to one of PD. It is possible for a person with schizophrenia to have insight, and it is not good practice for a diagnosis to be changed due to misinterpretation of diagnostic criteria.	Thank you, but we consider the matter of the general diagnosis of personality disorder outside the scope to the guideline.
SH	Rethink Severe Mental Illness	5	General	There is also confusion amongst service users, carers and health professionals between ASPD and psychopathy, the latter being a term used within the legal system. Differentiation between ASPD, psychopathic disorder and psychopathy should perhaps be outlined.	Thank you; this will be clarified in the guideline.
SH	Rethink Severe Mental Illness	6	General	Rethink is concerned that not all psychiatrists are aware that a person may have both PD and a mental illness. Also, some people receive a PD diagnosis when in fact they have a psychotic illness which has not yet responded to any treatments.	Thank you; this will be clarified in the guideline. It is clear in the scope that we will address relevant issues of comorbidity.
SH	Rethink Severe Mental Illness	7	4.2 c	Rethink's National Advice Service has noted from experience that the common characteristics shared by people who become involved in the criminal justices system are: - change in diagnosis, usually from some form of psychosis to an unspecified type of PD (the large majority of prisoners have a diagnosis of PD) - lack of 'insight' and refusal to accept any diagnosis - little or no treatment, usually because of 'non-compliance' - use of street drugs or alcohol (dual diagnosis) often from an early age - a chaotic lifestyle - usually young, male and white	Thank you for this comment – we will draw it to the attention of the guideline development group.
SH	Rethink Severe Mental Illness	8	General	Rethink is aware of inappropriate assessments being made by	Thank you, technically the FMEs are

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				Forensic Medical Examiners when people are taken into custody. At this stage a correct assessment is crucial as a person with a psychotic disorder may be incorrectly diagnosed with PD and will not be diverted to a hospital setting.	not part of the NHS however we will be touching upon assessment.
SH	Rethink Severe Mental Illness	9	General	Many prison staff will not have knowledge of Personality Disorder or mental illness and we recommend that training requirements are addressed so that prisoners may be properly supported. Similarly, staff should also be properly supervised and supported by staff group and a senior practitioner. An outside facilitator to chair the staff group can be helpful.	Thank you, but we consider the detail of staff training in prisons to be outside the scope of the guideline.
SH	Rethink Severe Mental Illness	10	General	Community Mental Health Teams should do inreach in prison and ensure that continuity of care is provided, though in practice we are not sure of the regularity of this. Hopefully guidelines will address pre-release care plans. It is worth noting that prisoners with PD may be deemed (possibly incorrectly) as untreatable and released from prison with no accommodation.	Thank you for this comment – we will be addressing care provided in prisons and at discharge from prison.
SH	Rethink Severe Mental Illness	11	4.3h	Rethink notes that few people from Black and Minority Ethnic groups receive a diagnosis of PD, and are often more likely that non BME people to receive a diagnosis of psychosis. We suggest that stereotyping of BME groups can influence diagnosis.	Thank you for this comment – we will draw it to the attention of the guideline development group.
SH	Rethink Severe Mental Illness	12	4.3i	Rethink has experience of working with service users and carers and believes that it is beneficial for everyone involved for carers to be involved in support in a structured way where possible. We are aware that health professionals do not always understand confidentiality and may use this as an excuse not to communicate with family members. It is essential that carers are informed about the diagnosis and sources of support for themselves, which is not often the case. Rethink has produced an information factsheet on PD for carers.	Thank you for your comment – we will draw it to the attention of the guideline development group.
SH	Royal College of General Practitioners	1	4.2c	Prison Health is now provided within the NHS (by PCTs in my area), so I cannot see the point in separating it in this way. These might be value in highlighting it (e.g. "including prison	Thank you; this is emphasised to make it clear that we will be covering services in prison.

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				health services")	
SH	Royal College of General Practitioners	2	4.2b	There is considerable integration at service provision level of Social Services with the NHS – especially in Mental Health: for example in my own substance misuse service there are Local Authority-employed social workers engaged in treatment activities fully integral with the NHS staff. Perhaps more flexibility here?	Thank you – we expect that the guideline will apply to staff working in CMHTs, including social care staff.
SH	Royal College of Nursing	1	General	With a membership of over 395,000 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. The RCN promotes patient and nursing interests on a wide range of issues by working closely with 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 the opportunity to review the draft scope for this guideline.	Thank you for this comment.
SH	Royal College of Nursing	2	General	There are no specifics in relation to Primary Care settings and the impact of ASPD. For example guidelines are required for staff in primary care settings who deal with ASPD clients who are violent towards their children. Such guidelines need also to look at how health care personnel should interface with other agencies e.g. probation, social work and guidance is required in relation to which aspects of the disorder should be dealt with by which agencies.	Thank you. Primary care is included in the scope (4.2 a), as is the interface between healthcare and other services such as social care services, educational services and the voluntary sector (4.2 b). We have amended the scope to include the interface with the criminal justice system (this includes probation), housing and the police. We will also liaise with SCIE in relation to their

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					current work on children whose parents have a mental disorder, which has relevance to the point you raise.
SH	Royal College of Nursing	3	General	ASPD is not a discrete condition and the scope appears to minimise the acknowledgement of this. Co-morbidities are common and impact greatly e.g. when there is a presence of more than one PD and when psychosis is also an issue. The guidelines must attempt to deal with these issues otherwise there is potential to produce a guideline which, in reality, is relevant only to a small percentage of ASPD clients. Likewise it is important that this guideline or a separate one examines DSPD in light of the minimal but growing evidence base.	Thank you; we intend to address both these issues – the scope includes the management of common comorbidities in people with ASPD as far as these conditions affect the treatment of ASPD and we have added specific reference to DSPD at 4.1.1 (a). We will draw the attention of the guideline development group to your comments.
SH	Royal College of Nursing	4	General	The guideline needs also to consider the environmental factors germane to this patient group e.g. treatment modalities, staff competencies, staff clinical supervision and support Without this the guideline will fail to acknowledge the huge significance that therapeutic milieus and relationships have upon the behaviours of the ASPD patient.	Thank you; we have added the nature of the therapeutic environment and support and supervision systems to the areas that will be covered by the guideline.
SH	Royal College of Nursing	5	4.1.1b	The guideline will need to examine how to define and identify 'at risk'. In addition examination as to how to prevent labelling and stigma of identified groups requires careful consideration. Also, clear demarcation is required between notions of 'early identification' and 'prevention' - the two are not necessarily the same thing.	We agree – at 4.3 the scope includes the 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. Early identification and prevention are addressed in separate points in section 4.3. We are aware of the risk of labelling and stigma and this will be considered in relation to the potential harms and benefits of early identification.
SH	Royal College of Nursing	6	General	There is no specific mention on the care and management of the ASPD patient in for example general medical wards. This is a particular concern since these patients and related self harming behaviours are particularly likely to be misunderstood and/or seen as threatening by non mental health nurses/staff	Thank you; we believe this comment has more relevance for the borderline personality disorder guideline and we will draw your comment to that group's attention. The scope includes

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				and as such the therapeutic approach implemented by such staff may well be counter productive	the care provided by the full range of NHS settings and is not limited to specialist services.
SH	Royal College of Nursing	7	General	There is no mention about including patients with a learning disability. Whilst it might be argued that it is difficult to diagnose ASPD to learning disabled patients some are considered as such one cannot ignore the severe challenging behaviour that such patients present to services.	Thank you; we will be addressing the issue of intellectual functioning broadly in the guideline, and also its impact on treatment and management.
SH	Royal College of Nursing	8	General	The ways in which individuals are chosen to be on the guidelines development groups need to be made much more transparent. In addition the so called multi disciplinary nature of these groups is not particularly apparent and the professions of medicine and psychology are over represented. There are now many allied health professionals such as nurses, art therapists, OT's with the relevant academic qualifications to undertake review work. The absence of such people within the ASPD guideline development group is shocking and unjustifiable.	Thank you for this comment, but we do not accept your observation which does not represent accurately the composition of current guideline development groups where OTs, nurses and other professions are present.
SH	Royal College of Nursing	9	4.2 a	Will the guideline cover care provided in tertiary settings?	Yes; we have amended the scope to make this clear.
SH	Royal College of Nursing	10	4.2 c	Will the guideline include secondary/tertiary interface?	Yes; we have amended the scope to make this clear.
SH	Royal College of Nursing	11	4.2 c	Will care in young offenders' institutions be addressed or is this included when referring to prisons? This seems pertinent due to risk indicators in childhood.	Yes; care in young offender institutions will be addressed and we have amended the scope to make this clear.
SH	Royal College of Nursing	12	4.3	Whilst risk factors are being identified and risk assessed there is no mention of risk management.	Thank you – we have added 'and management'.
SH	Royal College of Nursing	13	4.4.2	The Royal College of Nursing has a wealth of expert and experienced mental health nurses within its membership and we are in a position to nominate suitable candidates to be considered as members of the guideline development group. The RCN looks forward to actively participating in the development of this guideline.	Thank you.
SH	Royal College of Paediatrics and Child Health	1	4.3j	We welcome the inclusion in the scope of preventive and protective measures (4.3 (j)). We would like this to include specific mention of looked after children as well as young offenders.	Thank you for this comment. We will draw your concerns to the attention of the guideline development group, but we have not added specific mention

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					of looked after children as during the scoping process we did not identify evidence that being in care is a specific risk factor for ASPD.
SH	Royal College of Paediatrics and Child Health	2	General	The scope appropriately focuses on the treatment and prevention of ASPD/BPD, but should also specifically mention the need to safeguard the children of such adults from the effects these conditions can have on parenting and family life. This comment was made by several members	Thank you; we think this issue is addressed in the guideline scope (the scope includes the assessment of risk and we have added the management of risk). We will also liaise with SCIE in relation to their current work on children whose parents have a mental disorder, which has relevance to the point you raise.
SH	Royal College of Psychiatrists	1	General	The document appears to be limited to primary and secondary health services. As is acknowledged, much of the morbidity from this conditions is found in the offending population. Where there is significant risk to others, they may be managed by forensic in-patient or community services – tertiary level services. We consider that guidelines should be extended to this group where possible	Thank you for this comment; section 4.2 notes that the guideline will address care in prisons and the transition from Prison Health to NHS services.
SH	Royal College of Psychiatrists	2	General	Whereas the borderline document appropriately mentions the overlapping population who suffer this PD and a Learning Disability, we did not see the same in the ASPD paper. We assume the omission to be deliberate, but consider this to be regrettable as there is urgency for services to address the needs of offenders with ASPD whose level of intellectual functioning means that they are excluded from typical cognitive programmes in prison and health settings.	Thank you; we will be addressing the issue of intellectual functioning broadly in the guideline, and also its impact on treatment and management.
SH	Royal College of Psychiatrists	3	General	We note that comment about guidance on pharmacological treatment only being given in "off-licence" situations in exceptional circumstances – this will limit the value of guidelines in this conditions unless exceptional is broadened as there is extensive and diverse prescribing at present for these conditions, and clinicians are in great need of guidance even if the evidence base is less sound than for mental illness	Thank you, but our experience suggests that it is possible to develop effective guidance within the framework set out in the scope.
SH	Royal College of Psychiatrists	4	General	We feel that meeting plans should involve patient and carer input, and be consistent across community/ IP domains.	Thank you for this comment; it is NICE policy that each guideline development group includes patient

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					and carers as full participating members. We routinely include 3 such people in each group.
SH	Royal College of Psychiatrists	5	General	We are concerned that the Youth Justice Board is not included as a stakeholder. As the main provider of care and treatment for adolescents who are developing ASPD, they should have a substantial involvement.	Thank you for your comment. It is up to individual agencies to register their interest as stakeholders for NICE guidelines. If you know someone from the Youth Justice Board to draw their attention to the stakeholder registration process, please do so. The information can be found here: http://www.nice.org.uk/page.aspx?o=shregistration
SH	Royal College of Psychiatrists	6	General	We are concerned that NSCAG, which currently commissions Medium Secure Psychiatric Adolescent Inpatient Services for England, is not included as a stakeholder.	Thank you for your comment. It is up to individual agencies to register their interest as stakeholders for NICE guidelines. If you know someone from the NSCAG to draw their attention to the stakeholder registration process, please do so. The information can be found here: http://www.nice.org.uk/page.aspx?o=shregistration
SH	Royal College of Psychiatrists	7	4.3b + d	The risk factors are well researched and identified. Suggest you see "Structured Assessment of Violence Risk in Youth" (Borum, Bartel and Forth, 2000) This needs to be more specific as to the skills required of those assessing and treating children and adolescents. Many decisions are made through courts, either family or criminal. Too often the "experts" in these cases have little knowledge of likely outcomes and do not identify risk in their recommendations.	Thank you for this comment – we will draw it to the attention of the guideline development group.
SH	Royal College of Psychiatrists	8	4.2b	Quite simply inappropriate as regards children and adolescents. This is the area where the biggest impact of guidelines could be realised. It is essential that Health, Education and Social Care is subject to the same guidelines. I regularly see the consequences of missed opportunities in the failure of these agencies to work together. Your scope does	Thank you. We have amended the scope in light of this comment, which we will draw to the attention of the guideline development group. 4.2b now states: 'This guideline will comment on the interface with a

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				not accord with the direction of travel in the Children's NSF.	range of other settings, services and agencies, such as: social care services, educational services, the criminal justice system, the police, housing and residential care, and the voluntary sector. The guideline may include recommendations relating to these settings, services and agencies where those recommendations are relevant to the prevention, treatment, care and management of ASPD.'
SH	Social Care Institute for Excellence (SCIE)	1	3j 3 k , 3L	ASPD management in the community: there are many social problems here; amongst them: working with the police and criminal justice system around threats and in some cases incidents of actual violence to staff / members of the public/other users of service; working with housing departments and Homeless Persons Unit regarding issues to do with eviction and homelessness; working with Children and Families services where children are involved. Any guideline addressing the management of a diagnosis with this range of presenting social problems has to address how community mental health staff work in this area, as the guideline will not be comprehensive otherwise.	We agree and the membership of the guideline development group will reflect the issues you have set out. The scope includes the interface between healthcare and other services such as social care services, educational services, and the voluntary sector, and we have added housing, the police and the criminal justice system.
SH	Social Care Institute for Excellence (SCIE)	2	4.2 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 …" Community mental health services include mental health social workers who are not health care professionals but are seconded to work under Mental Health Trust management. How will the guidelines address their work as Care Co-ordinators and Approved Social Workers as the definition does not include their role.	Thank you – we expect that the guideline will apply to staff working in CMHTs, including social care staff.
SH	Social Care Institute for Excellence (SCIE)	3	4.2 b	"This is an NHS guideline" Interface with other services including voluntary sector, social services and education." This should also crucially include interface issues with the police, housing and residential care.	We agree and this will be reflected in the work of the guideline development group. We have amended the scope in light of this and other comments.
SH	Social Care Institute for Excellence (SCIE)	4	4.3e	"psycho social interventions": the definition of this needs to be broader. Every intervention made by care professionals has a	Thank you – these are offered by way of example, although we would

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				psycho social dimension. For instance, how a care co-ordinator explains to a user the grounds for whether they meet the eligibility criteria for secondary service under CPA is a very sensitive issue with this user group as services can at times define people out of service on the grounds that the individual presents with problems that are not 'treatable'.	consider the example you offer as outside of the scope and more a broader competence that has importance beyond that of ASPD.
SH	Social Care Institute for Excellence (SCIE)	5	4.3h	Issues of diversity and social inclusion and working with carers are all areas where a social perspective needs to be included.	Thank you, but these issues are included in the scope at 4.3. We intend that the membership of the guideline development group should reflect a broad approach to responding to ASPD, including an awareness of the social perspective.
SH	Social Care Institute for Excellence (SCIE)	6	General	What is the rationale for having 2 guidelines? Would it be more economical to combine them, to avoid repetition of key messages which apply to both ASPD and BPD?	Thank you, but we believe there is sufficient distinction between the scopes to warrant two guidelines.
SH	Social Care Institute for Excellence (SCIE)	7	General	Given the range of social problems that people with PD present, as reflected in the above comments, could a joint guideline or close collaboration with Social Care Institute for Excellence be considered?	Thank you. The scope includes the interface between healthcare and social care services, educational services, and the voluntary sector, and we have added housing, the police and the criminal justice system. As indicated in the response to other stakeholders, another guideline that will be a joint guideline with SCIE will address children whose parents have a mental health problem. Work with SCIE in relation to this other guideline may inform the ASPD guideline.
SH	Tavistock and Portman Foundation Trust	1	3	Anti-social PD is a psycho-social condition that impacts on interpersonal relationships and so inevitably impacts on the relationship of the patient to the clinician, the treatment setting and the provision of care itself. The diagnostic model outlined has a medical emphasis and risks neglecting taking account of this interpersonal dimension.	Thank you for this comment – we will draw it to the attention of the guideline development group.
SH	Tavistock and Portman Foundation Trust	2	4	The documents risks neglecting the impact on carers or professionals of working with patients with ASPD. It is in the nature of this condition that a low tolerance for frustration and a	Thank you, but we do not think this is the case – the needs of families and carers is in the scope and we have

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				low threshold for aggression, coupled with the potential risk of violent enactment, have the potential to evoke a strong affective reaction in the clinician, either more negative or inappropriately positive towards the patient.	amended the scope to take account of the matter of support for professionals. There will also be a carer on the GDG.
SH	Tavistock and Portman Foundation Trust	3	4	Patients with ASPD pose a conflict for service providers between the provision of care and the exercise of control in the delivery of all services. It is essential that neither is neglected at the expense of the other.	Thank you for this comment – we will draw it to the attention of the guideline development group.
SH	Tavistock and Portman Foundation Trust	4	4	The guidelines should take account of the needs of professional carers. It is not sufficient to delimit these as "training needs"; the ongoing impact and conflicts inherent in service delivery should be addressed, as this relates to individual clinicians or carers, the clinical team, and the organisation and organisational milieu. Such 'reflective practice' opportunities are likely to capture some of the ways in which ASPD patients interact with others in their environment and hence offer an opportunity to address this aspect of the condition.	Thank you, but we do not think this is the case – the needs of families and carers is in the scope and we have amended the scope to take account of the matter of support for professionals. There will also be a carer on the GDG.
SH	Tavistock and Portman Foundation Trust	5	General	The document refers to "treatments" and "management" but it would be important that the model of clinical management encompassed both the subjective experiences of patients, the anxieties and conflicts aroused in staff, and the means (supervision / consultation) to address and contain these.	Thank you for this comment – we have amended the guideline scope (4.3) in light of this and other related comments. We think that our inclusion of service users on the guideline development group will ensure that the patient's perspective is addressed.
SH	Tavistock and Portman Foundation Trust	6	General	Whatever treatment is offered to these patients proper reflective attention to how these patients and their carers relate to each other in the treatment setting is itself potentially therapeutic, and potentially anti-therapeutic if not taken into account.	Thank you for this comment – we have amended the guideline scope in light of this and other comments.
SH	The Cassel Hospital	1	General	It is reassuring to note that guidelines will be developed based on the best available evidence.	Thank you for your comment.
SH	The Cassel Hospital	2	General	RCTs are usually not a good measure of complex interventions. The treatment of ASPD requires complex interventions or perhaps simple interventions delivered as part of a complex programme.	Thank you, but we disagree; there are many successful and helpful RCTs on complex interventions in the health care field.
SH	The Cassel Hospital	3	4.1	The number of co-morbid diagnoses of PD usually reflects the	Thank you for this comment – we will

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				severity of a person's difficulties. Each inpatient at the Cassel had on average 3.9 different diagnoses of PD (Chiesa et al). Which PD diagnosis will be taken as the priority to treat? Will treatment of people with increasing numbers of differing PD diagnoses need to be reflected in the setting (ie inpatient TC setting) of the treatment offered?	draw it to the attention of the guideline development group. We will need to review the evidence before being able to address your question.
SH	The Cassel Hospital	4	4.2	It is important to highlight the place of managed clinical networks in the delivery of care, even if part of the network is to be delivered in non NHS settings.	Thank you for this comment – we will draw it to the attention of the guideline development group.
SH	The Cassel Hospital	5	4.3	Who suffers from ASPD? Often it is the partners, children, families, professionals who suffer the consequences of this disorder. How will this be reflected in the guidelines?	This is covered in 4.3.k and in the membership of the guideline development group by a carer.
SH	The Cassel Hospital	6	4.1	I fully support the recommendations in this guideline addressing preventative interventions with children and adolescents at significant risk of developing ASPD.	Thank you for your comment.
SH	Welsh Assembly Government	1	General	Thank you for giving the Welsh Assembly Government the opportunity to comment on the above appraisal. We are content with the technical detail of the evidence supporting the consultation and have no further comments to make at this stage	Thank you.

SH	Adults Strategy and Commissioning Unit	This organisation was invited to comment, but did not respond	
SH	Afiya Trust, The	This organisation was invited to comment, but did not respond	
SH	Arts Psychotherapies Services	This organisation was invited to comment, but did not respond	
SH	Association for Improvements in the Maternity Services	This organisation was invited to comment, but did not respond	
SH	Association of Dance Movement Therapy UK	This organisation was invited to comment, but did not respond	
SH	Association of Therapeutic Communities	This organisation was invited to comment, but did not respond	
SH	Avon and Wiltshire Mental Health Partnership NHS Trust	This organisation was invited to comment, but did not respond	
SH	Barnsley PCT	This organisation was invited to comment, but did not respond	
SH	Bedfordshire & Hertfordshire NHS Strategic Health Authority	This organisation was invited to comment, but did not respond	
SH	Berkshire Healthcare NHS Trust	This organisation was invited to comment, but did not respond	
SH	Borderline UK	This organisation was invited to comment, but did not respond	
SH	British Association for Psychopharmacology	This organisation was invited to comment, but did not respond	
SH	British Association of Drama Therapists	This organisation was invited to comment, but did not respond	
SH	British National Formulary (BNF)	This organisation was invited to comment, but did not respond	
SH	British Psychological Society, The	This organisation was invited to comment, but did not respond	
SH	Broadmoor Hospital	This organisation was invited to comment, but did not respond	
SH	Cambridgeshire & Peterborough Mental Health Trust	This organisation was invited to comment, but did not respond	
SH	Cambridgeshire Neurological Alliance	This organisation was invited to comment, but did not respond	
SH	CASPE	No comment	
SH	CIS'ters	This organisation was invited to comment, but did not respond	
SH	Commission for Social Care Inspection	This organisation was invited to comment, but did not respond	
SH	Connecting for Health	This organisation was invited to comment, but did not respond	
SH	Conwy & Denbighshire Acute Trust	This organisation was invited to comment, but did not respond	
SH	Counsellors and Psychotherapists in Primary Care	This organisation was invited to comment, but did not respond	
SH	Counsellors and Psychotherapists in Primary Care	This organisation was invited to comment, but did not respond	
SH	County Durham & Darlington Priority Services NHS Trust	This organisation was invited to comment, but did not respond	
SH	Critical Psychiatry Network	This organisation was invited to comment, but did not respond	
SH	Cumbria Partnership NHS Trust	This organisation was invited to comment, but did not respond	
SH	Department for Education and Skills	This organisation was invited to comment, but did not respond	
SH	Derbyshire Mental Health Trust	This organisation was invited to comment, but did not respond	
SH	Eastern Specialised Mental Health Commissioning Group	This organisation was invited to comment, but did not respond	

SH	Gloucestershire Partnership NHS Trust	This organisation was invited to comment, but did not respond	
SH	Hampshire Partnership NHS Trust	This organisation was invited to comment, but did not respond	
SH	Health and Safety Executive	This organisation was invited to comment, but did not respond	
SH	Health Commission Wales	This organisation was invited to comment, but did not respond	
SH	Healthcare Commission	This organisation was invited to comment, but did not respond	
SH	Heart of England NHS Foundation Trust	This organisation was invited to comment, but did not respond	
SH	Hertfordshire Partnership NHS Trust	This organisation was invited to comment, but did not respond	
SH	Home Office	This organisation was invited to comment, but did not respond	
SH	Humber Mental Health NHS Trust	This organisation was invited to comment, but did not respond	
SH	King's College Acute Trust	This organisation was invited to comment, but did not respond	
SH	Leicestershire Partnership NHS Trust & Managed Clinical Network for PD	This organisation was invited to comment, but did not respond	
SH	Liverpool PCT	This organisation was invited to comment, but did not respond	
SH	London Development Centre for Mental Health	This organisation was invited to comment, but did not respond	
SH	Lundbeck Ltd	This organisation was invited to comment, but did not respond	
SH	Medicines and Healthcare Products Regulatory Agency (MHRA)	This organisation was invited to comment, but did not respond	
SH	Mental Health Act Commission	This organisation was invited to comment, but did not respond	
SH	Mental Health Nurses Association	This organisation was invited to comment, but did not respond	
SH	Mersey Care NHS Trust	This organisation was invited to comment, but did not respond	
SH	Merton CAMHS	This organisation was invited to comment, but did not respond	
SH	National Institute for Mental Health in England (NIMHE)	This organisation was invited to comment, but did not respond	
SH	National Patient Safety Agency	This organisation was invited to comment, but did not respond	
SH	National Public Health Service - Wales	This organisation was invited to comment, but did not respond	
SH	National Treatment Agency for Substance Misuse	This organisation was invited to comment, but did not respond	
SH	NCCHTA	This organisation was invited to comment, but did not respond	
SH	NCCHTA	This organisation was invited to comment, but did not respond	
SH	NHS Health and Social Care Information Centre	This organisation was invited to comment, but did not respond	
SH	NHS Plus	This organisation was invited to comment, but did not respond	
SH	NHS Quality Improvement Scotland	This organisation was invited to comment, but did not respond	
SH	North Staffordshire Combined Healthcare NHS Trust	This organisation was invited to comment, but did not respond	
SH	Northwest London Hospitals NHS Trust	This organisation was invited to comment, but did not respond	
SH	Nottinghamshire Acute Trust	This organisation was invited to comment, but did not respond	
SH	Nursing & Supportive Care Collaborating Centre	This organisation was invited to comment, but did not respond	
SH	Nutrition Society	This organisation was invited to comment, but did not respond	
SH	Oxfordshire & Buckinghamshire Mental Health Trust	This organisation was invited to comment, but did not respond	

SH	Oxleas NHS FoundationTrust	This organisation was invited to comment, but did not respond	
SH	Peninsula Primary Care Psychology & Counselling Services	This organisation was invited to comment, but did not respond	
SH	PERIGON (formerly The NHS Modernisation Agency)	This organisation was invited to comment, but did not respond	
SH	Regional Public Health Group - London	This organisation was invited to comment, but did not respond	
SH	Scottish Intercollegiate Guidelines Network (SIGN)	This organisation was invited to comment, but did not respond	
SH	Service for People with Personality Difficulties	This organisation was invited to comment, but did not respond	
SH	Sheffield PCT	This organisation was invited to comment, but did not respond	
SH	Sheffield Teaching Acute Trust	This organisation was invited to comment, but did not respond	
SH	South London & Maudsley Acute Trust	This organisation was invited to comment, but did not respond	
SH	South West London & St George's Mental Health Trust	This organisation was invited to comment, but did not respond	
SH	Staffordshire Moorlands PCT	This organisation was invited to comment, but did not respond	
SH	Stockport PCT	This organisation was invited to comment, but did not respond	
SH	Surrey and Border Partnership Trust	This organisation was invited to comment, but did not respond	
SH	Surrey PCT	This organisation was invited to comment, but did not respond	
SH	Sussex Partnership NHS Trust	This organisation was invited to comment, but did not respond	
SH	Sustain: The alliance for better food and farming	This organisation was invited to comment, but did not respond	
SH	Tees, Esk & Wear Valleys NHS Trust	This organisation was invited to comment, but did not respond	
SH	The Association for Cognitive Analytic (ACAT) Therapy	This organisation was invited to comment, but did not respond	
SH	The College of Mental Health Pharmacists	This organisation was invited to comment, but did not respond	
SH	The David Lewis Centre	This organisation was invited to comment, but did not respond	
SH	The Howard League for Penal Reform	This organisation was invited to comment, but did not respond	
SH	The Royal Society of Medicine	This organisation was invited to comment, but did not respond	
SH	The Survivors Trust	This organisation was invited to comment, but did not respond	
SH	UK Council for Psychotherapy	This organisation was invited to comment, but did not respond	
SH	UK Psychiatric Pharmacy Group	This organisation was invited to comment, but did not respond	
SH	UK Specialised Services Public Health Network	This organisation was invited to comment, but did not respond	
SH	Welsh Scientific Advisory Committee (WSAC)	This organisation was invited to comment, but did not respond	
SH	West Glam&West Wales AD/HD Family Support Group(U.K.) Wales	This organisation was invited to comment, but did not respond	
SH	West London Mental Health NHS Trust	This organisation was invited to comment, but did not respond	