
Executive summary

Health Council of the Netherlands. Prevention and treatment of the antisocial personality disorder. The Hague: Health Council of the Netherlands. 2006 publication no. 2006/07.

Request for advice

Antisocial personality disorder (ASPD) is a psychiatric disorder characterised by a long-standing pattern of egocentricity, impulsivity and aggressiveness. Affected individuals lack a sense of responsibility and guilt. People with an ASPD therefore almost always have social problems, cause much damage and distress, and become a nuisance to society. They are also convicted of offences relatively frequently. Between one and two percent of the general population in Western countries have an ASPD. In prisons and TBS* clinics, this percentage is much higher. It is thought that ASPD may be eight times more common among men than among women.

People with an ASPD are often themselves unaware that they are suffering from a disorder and, consequently, they rarely seek help. And if they receive a prison sentence or are ordered to attend a TBS clinic, they are not usually motivated to cooperate with the treatment. They frequently also have an additional psychiatric disorder, such as a serious alcohol or drug addiction, for which they do sometimes submit to treatment.

People with an antisocial personality disorder pose a problem for society on account of the trouble that they cause and their limited motivation to undergo treatment. Furthermore, there is a lack of knowledge among care providers about

* *Terbeschikkingstelling* (TBS): detention under a compulsory treatment order.

how ASPD can best be prevented and treated. Consequently, the Minister of Health, Welfare and Sport, acting on behalf of the Minister of Justice as well, has requested the Health Council to review the current level of knowledge with regard to prevention and treatment. The Council has also been asked to indicate what practical implications this body of knowledge should have.

The development of ASPD

Antisocial personality disorders have their origins in childhood and adolescence. The disorder arises after a process lasting many years and involving a synergistic interaction between various types of risk factors.

This process always begins with some degree of genetic predisposition. When combined with such environmental factors as a lack of parental supervision, abuse or growing up in a deprived area, this predisposition gives rise to neurobiological and psychological risk factors. Examples of neurobiological factors are reduced excitability of the autonomic nervous system or a limited reaction to punishment. Psychological risk factors include a marked need for excitement and a heightened tendency to regard other people's behaviour as hostile.

The greater the number of such risk factors present in children, the more likely they are to develop a behaviour disorder. Behavioural problems among toddlers are often the first warning signals that a child is at increased risk of developing a behaviour disorder. Conduct disorder, in particular, is an important precursor of antisocial personality disorder. The fact that the antisocial behaviour and the lack of a sense of responsibility and guilt have become long-standing is a hallmark of personality disorder.

Prevention

Since antisocial personality disorder results in a great deal of distress, it is important to prevent it from occurring. This is best achieved by preventing and treating behaviour disorders during childhood and adolescence.

From the standpoint of effectiveness and efficiency, research shows that it is important to intervene at the earliest possible stage in circumstances where there is increased risk. The longer the delay, the greater the likelihood that a behaviour disorder will emerge, or that this condition will become chronic and escalate – in which case interventions will usually need to be more intensive and prolonged in order to have an effect. Furthermore, the chances of preventing an ASPD will then diminish. Nevertheless, even prevention by treating a behaviour disorder

during adolescence probably still offers a better prognosis than treating an ASPD during adulthood.

Scientific evidence from a number of interventions shows that they can help to reduce behaviour disorders. In infants, toddlers and children of primary-school age, this can be achieved by providing parents with educational support, improving conditions for development within the family, stimulating the young child's cognitive development and providing the parents with behaviour training. For adolescents, cognitive behavioural therapy, functional family therapy and multi-systemic therapy have proved effective.

The various possibilities for the prevention and treatment of behaviour disorders are not being fully exploited at present. This is partly due to a lack of expertise in the detection, diagnosis and treatment of behaviour disorders within the youth care services. Consequently, children with problems are frequently not identified. Furthermore, the treatments are often not tailored to the particular characteristics of the child and those of its family. Moreover, the effectiveness of many of the treatments has not been scientifically established. In addition, cooperation between different institutions is frequently poor.

Similar problems arise in youth custody centres, where a large proportion of the youngsters have a behaviour disorder. These conditions frequently go undetected and are therefore also not treated.

Treatment

There is still insufficient good research to be able to say with any certainty whether antisocial personality disorder can be effectively treated in adulthood. Nor, however, can it be said as yet that the disorder is *not* treatable. Until more research has been done, one can only draw provisional conclusions about the treatability of ASPD.

The most important of these provisional conclusions is that there is no prospect of a cure for ASPD at this point in time, but it is possible to combat certain symptoms of the disorder. There are indications that cognitive behaviour therapy and pharmacological therapy can be used to reduce a person's impulsivity and aggression. Furthermore, there is some scientific evidence that alcohol or drug addiction can be effectively treated in a person with an ASPD by means of psychotherapy, 'contingency management' (conditioning whereby desired behaviour is rewarded) and pharmacological therapy. This can also help to reduce symptoms of the disorder.

These treatment options provide some pointers for risk management (i.e. the reduction and containment of the risk that someone with an ASPD poses to his

surroundings). It is not possible to reduce this risk permanently by means of temporary imprisonment alone.

For one specific group – people with psychopathy – the prospects for risk containment are less favourable. Psychopathy is a severe form of ASPD which is characterised in part by personality traits as callousness, lack of empathy, pathological lying and manipulation. Psychopaths frequently either try to withdraw from treatment or to disrupt it through aggressive behaviour. Group therapy may even have the opposite effect from that intended in these individuals, since it enables them to learn from each other's experiences and hone their manipulative skills.

In the course of their lives, people with an ASPD often come into contact with the mental health services, the prison system and the TBS sector. In all of these areas, better use can be made than at present of the opportunities for risk management. People with an ASPD may sometimes be treated for an addiction or depression within the current mental health system, but they are hardly ever treated for personality disorder. The prison system does not itself possess sufficient knowledge, experience and resources to treat offenders who have an ASPD. And the treatment given to people with an ASPD who are placed under a TBS (compulsory treatment) order suffers from the isolated position that the TBS clinics occupy in relation to the mental health services. This situation is a contributory factor to the low scientific underpinning of the working practices in the clinics and hinders the desired channelling of people with an ASPD into the mental health system once the threat of reoffending has been reduced to an acceptable level. This isolated position is caused in part by a disinclination on the part of the mental health services to treat patients who are considered to be untreatable and potentially dangerous.

Recommendations

Prevention

Since it is mainly children who have a behaviour disorder (or are at increased risk of developing one) who are likely to develop an antisocial personality disorder, it is desirable that the prevention of ASPD should be embedded within the prevention and treatment of behaviour disorders during childhood and adolescence. This requires timely detection of risk factors and early characterisation of behavioural problems and disorders, expert diagnosis, and the implementation of scientifically proven interventions.

Within the youth care services and the juvenile justice system, in particular, improvements need to be made in these three areas. First of all, expertise in recognising risk factors and making them a subject for discussion, as well as in diagnosing behavioural disorders needs to be improved. Furthermore, greater use should be made of scientifically proven treatment methods. The interventions that are adopted should preferably always be subjected to scientific evaluation so as to avoid the use of ineffective methods wherever possible. Moreover, the effectiveness and efficiency of treatments can be enhanced by developing guidelines for detection, diagnosis and treatment.

Finally, the Committee recommends that more statutory options should be created in order to motivate children with a behaviour disorder who have not been convicted of an offence by applying pressure to undergo treatment.

Treatment

The opportunities for risk management can be made better use of than at present when dealing with people with an antisocial personality disorder. According to the Committee, the mental health services should also accept responsibility for preventing people with a psychiatric disorder from slipping back into criminal behaviour or reoffending after having served a prison sentence or having been placed under a TBS order. With this in mind, it recommends fostering expertise within the mental health services as far as the recognition and treatment of ASPD are concerned.

In the TBS sector, the Committee feels that more attention should be focused on the scientific underpinning and evaluation of treatment options and on quality assurance. Due to the low scientific content of the way of working in the clinics, it is possible that ineffective forms of treatment are currently being retained for too long. At the same time, forms of treatment that are, in fact, effective are not being adequately tailored to individual patient characteristics.

Because the prospects for risk management are less favourable in people with psychopathy, it is important that care providers in the TBS sector recognise psychopathy. Admission to a long-stay unit is an obvious option in cases where people with psychopathy have been issued with a TBS order and treatment has indeed proved ineffective, provided the proportionality between the seriousness of the offence committed and the duration of the TBS order is taken into consideration

If risk management is to be effective, the Committee perceives a need for better cooperation between the mental health services, the prison system and the

TBS clinics. This is not only important because risk management frequently requires continuity of care (possibly in the form of assertive outreach), but also because the institutions in question can learn from one another about how people with an ASPD can be treated. An initial step in establishing this cooperation might be to draw up common guidelines for diagnosis and treatment. The Committee believes that universities should also be involved in this process.

Finally, one should consider whether more statutory options are needed outside of the criminal justice framework in order to motivate people with an ASPD by applying pressure to undergo treatment.

Research

Considerable uncertainty still surrounds the development of antisocial personality disorder and the possibilities for prevention and treatment. Whereas we have a reasonably clear picture of the risk factors at the population level, little is known as yet about factors that may have a protective effect, for example. Consequently, it is not possible to draw any firm conclusions about the likelihood of an individual developing an ASPD, thus making targeted prevention more difficult. Nor is much known as yet about the effectiveness of preventive interventions in the long term, and, owing to a lack of good research, little can be said with much certainty about the treatability of antisocial personality disorder. The effectiveness of many of the treatments that are currently being applied in practice remains unproven.

The Committee therefore recommends that more research should be performed into the development of ASPD and into the long-term effects of prevention. In order to select effective and efficient treatments, more research is needed into interventions that are tailored to the specific characteristics of people with an ASPD.