Not Drowning, Making Waves: ACT for BPD & SUD
Kate Hall1, Angela Simpson2, Jane Morton3, Jean Popomilkov2, Ann Mills2, Margret Petrie2, Michelle Sharky2 & Petra K. Staiger1, 2013.

Background
While population surveys reveal that around 1-2% of the general population meet criteria for Borderline Personality Disorder (BPD) (Lenzenweger, Line, Loranger, & Kessler, 2007), up to 66% of users in treatment meet criteria for BPD (Trull, Steer, Monroe-Brown, Durkin, & Bun, 2000). Such figures are concerning, as clients with co-occurring Substance Use Disorder (SUD) and BPD present considerable challenges for Alcohol and Other Drug (AUD) treatment services, given their association with higher levels of psychosocial impairment, psychopathology, substance use, unsafe injecting, self-harm and suicidal behaviour (Brown-Jones, et al., 2004). Treatment studies also highlight that clients with co-occurring SUD and BPD have higher rates of relapse, treatment noncompliance and poorer outcomes than those with either diagnosis alone (Ball, 2007; Gregory, et al., 2008), while SUD significantly reduces the likelihood of clinical remission of BPD (Zanarini, Frankenburg, Hennen, Reich, & Silver, 2004). A recent systematic review of the literature investigating current treatment options for co-occurring SUD and BPD examined RCTs of psychological interventions and found that there is currently insufficient evidence to recommend a best practice model of treatment (Penn, et al., 2011). Moreover, all effective psychological treatment options were unlikely to be implemented with fidelity in community AOD treatment settings due to the long-term and resource intensive nature of the intervention, and the specialist training required of staff. This highlights a significant need for further examination of treatment options for BPD and SUD which are adaptable to the real life clinical setting.

These observations, along with the fact that these clients may represent the majority of AOD treatment seekers, prompted Turning Point Alcohol and Drug Centre to implement Making Waves, a project funded by the Department of Health and Ageing that aims to increase the capacity of the AOD sector to deliver evidence-based treatment to clients with co-occurring BPD and SUD. The current paper outlines an exploratory pilot of Acceptance and Commitment Therapy (ACT) with clients with BPD and SUD which describes the feasibility of implementing ACT informed treatment into AOD treatment settings and whether client outcomes improve after receiving ACT. Technology transfer took the form of a training workshop combined with ongoing coaching, and client-based clinical reviews and role plays of ACT techniques in a group supervision model to minimise implementation errors.

Aim
The aim of Making Waves was to implement ACT for BPD and SUD in a community AUD treatment service with minimal implementation errors to improve client outcomes.

Method
Implementation model: Systematic implementation methods were informed by the Consolidated Framework for Research Implementation (CFIR) (Crosby & Hagedorn, 2011; see Figure 5).

Clinician training and coaching: Sixteen clinicians from across two services (Turning Point and Eastern Health Drug and Alcohol Service) underwent 40 hours of staff training and consultation in ACT from a Spectrum consultant consisting of attendance at a 1-day workshop and 4 2-hour supervision sessions held fortnightly. They implemented a 12 session ACT treatment developed by Spectrum, a specialist public sector service for people with BPD symptoms which is described in the treatment manual. Wise Choices (Morton & Shaw, 2012) available from www.spectrumact.org.

Client intervention: Once written informed consent was obtained, clients completed baseline measures in the areas of: borderline symptoms (BEST); feelings of hopelessness (BHS); drug and alcohol use (ATOP); quality of life (WHOQOL-brief); emotion regulation (ERQ); acceptance and values-based action (AAQ II); and treatment engagement, motivation, and readiness (TCU scales). Clients received 12 sessions of ACT-consistent treatment, from Wise Choices (Morton & Shaw, 2012). Measures were re-administered after the 6th and 12th session. Comparison between the three time points were conducted through paired sample t-tests as an indication of treatment outcomes.

Results
Client demographics
Fifteen clients completed evaluation measures at three time points. Most of the sample (n = 14; 93%) were women. Ages ranged from 21 to 52 years (M = 30.6, SD = 8.5). Most participants (n = 14; 93%) had not previously attended an AOD treatment service. All 15 (100%) clients were re-consent to participate in the study after Time 1, and 2 (14%) withdrew after completing the baseline measures, and 4 (29%) withdrawing after 6 sessions.

Client outcomes
The 15 clients who completed the 12 sessions maintained high levels of treatment satisfaction and counselling rapport (Figure 4) with a statistically significant increase in treatment satisfaction from Time 1 to Time 3 (t(14) = 3.40, p < .05). Significant reduction in scores on the Acceptance and Avoidance Questionnaire (AAQ-II) were also recorded. The group mean score on the Acceptance and Avoidance Questionnaire (AAQ-II) decreased from Time 1 to Time 3 (t(14) = 3.40, p < .05). The group mean score on the Acceptance and Avoidance Questionnaire (AAQ-II) decreased from Time 1 to Time 3 (t(14) = 3.40, p < .05).

Clinician outcomes
Clinician outcomes included increased confidence in implementing ACT (t(15) = 5.86, p < .001) and increased likelihood that they will continue to use ACT and recommend this treatment approach to colleagues (see Figure 6). Qualitative results indicated that clinicians found ACT useful with complex client presentations and the techniques were a ‘good fit’ within a AUD setting.

Qualitative clinician outcomes
“Most important to me was the practical application of ACT strategies using specific client examples. It was also beneficial to have the opportunity to role-play ACT approaches and explore the more practical elements.”

“... it is the first time I have seen ACT applied to highly complex clients who represent our key demographic and manuals don’t typically do that. When we are dealing with people with both BPD and SUD, it can be the most effective therapy.”

Conclusion
ACT is a feasible intervention for AOD services in treatment of clients with complex psychosocial needs if implemented using methods informed by evidence for technology transfer. ACT offers an alternative treatment to CBT and DBT within this setting.

Acknowledgments: Funded by The Department of Health and Ageing, Canberra.

Contact details
Dr Kate Hall: kath@turningpoint.org.au
Dr Angela Simpson: angelas@turningpoint.org.au
Ms Jane Morton: mortonbj@outlook.com

www.easternhealth.org.au