University of Stirling

INDIVIDUAL STUDY PROJECT

DAS903 University Certificate in Drug and Alcohol Studies

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Title: Are staff training needs adequately addressed in Therapeutic Communities in relation to working with residents who have a diagnosis of Personality Disorder?

ABSTRACT

This study was conducted between March and April 2007 with three Therapeutic Communities in Australia. The research focused on identifying whether staff training needs were adequately addressed in relation to working with residents who have a diagnosis of either Borderline or Anti Social personality disorder.

By utilising a postal questionnaire the research attempted to elicit staff opinions and attitudes towards working with personality disordered residents and to establish whether they believed they had the necessary training and expertise.

In order to present the findings in context, a literature review pertaining to personality disorders, dual diagnosis and therapeutic interventions was incorporated into the report. The report gives an overall evaluation of the findings and offers recommendations to support the Therapeutic Communities in taking this research further.

ACKNOWLEDGMENTS

I would like to thank my Supervisor Rowdy Yates for his direction and initial introduction to the Australasian Therapeutic Communities Association without whom this study would have been impossible. My thanks in particular go to Lynne Magor-Blatch and Barry Evans from Karralika and The Buttery who went out of their way to facilitate me as I developed the study. I am grateful to all the staff who responded to the questionnaire and hope this study will stimulate further research and ultimately more funding and education.

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CHAPTER ONE

INTRODUCTION

The aim of the study is to examine whether staff training needs are adequately addressed in Therapeutic Communities in Australia in relation to working with residents who have a diagnosis of Personality Disorder.

1.1 Objectives

This study will examine the current situation regarding staff training and staff opinions relating to working with residents with a diagnosis of Personality Disorder in three Therapeutic Communities in Australia. The study will give a background overview of the rationale for the research and give a brief resume of each Therapeutic Community and the programmes offered. Attitudes and opinions of staff members will be sought, in an effort to determine whether any specific training needs can be identified that may facilitate treatment and assist staff in developing and enhancing their skills. It is hoped that this small study will facilitate the Australasian Therapeutic Communities Association in developing and maintaining an effective approach to treatment for this client group.

1.2 Definition of Terms

Substance Misuse

According to DSM IV (APA 1994) Substance Misuse is the maladaptive pattern of use not meeting the criteria for dependence that has persisted for at least 1 month or has occurred repeatedly over a long period of time.

Mental Disorder

DSM IV (APA1994) defines mental disorder as a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is typically associated with present distress (a painful symptom) or disability (impairment in one or more areas of functioning).

Personality Disorder

There are three main elements common to personality disorders:

1. they are primarily disturbances of behaviour, not symptoms
2. they are persistent
3. they create problems in social function both for the individual and society

It is evident that these feature are not confined to personality disorders and there has long been debate over the dividing line between mental state disorders (Axis I DSM Classification) and personality disorders (Axis II)

There are 10 personality disorders classified in DSM-IV (American Psychiatric Association 1994) and nine in ICD-10 (World Health Organisation 1992)

Axis II (DSM –IV 1994) disorders can be categorized into three Clusters A, B, C.

Cluster A are the odd eccentric group including Paranoid, Schizoid**,** Schizotypal**,**
Cluster B are the emotionally unstable Borderline, Histrionic, Narcissistic and Antisocial
Cluster C being the Avoidant, Dependent and Anankastic personality disorders.

Cluster B personalities are more associated with substance use perhaps due to their propensity for risk taking. This study will focus in particular on Borderline and Antisocial personality disorders. [Appendix i]

Dual Diagnosis

The term Dual Diagnosis has had a variety of meanings over time. Originally used as a term to describe people with a psychiatric disorder and a learning disability (Evans and Sullivan 1990) the definition has evolved to its current position which regards an individual with concurrent needs arising out of their mental disorder and their substance use past or present as having a Dual Diagnosis.

Dual Diagnosis can be defined as the concurrent existence of both substance abuse or dependency and one or more psychiatric disorders (NIDA 1991)

For the purposes of this study the term Dual Diagnosis will refer to the co occurring presentation of both a substance use disorder and a personality disorder.

Therapeutic Community

A Therapeutic Community offers drug free rehabilitative care for people with alcohol and other drug dependencies. The approach is based on the belief that an individual's dependence on alcohol or other drugs is a symptom of underlying personal difficulties. The focus is on assisting people in identifying the attitudes and behaviours that perpetuate their situation. According to Ottenburg et al (1993, p 51-62) "*Self-help and mutual help are pillars of the therapeutic process in which the resident is the protagonist principally responsible for achieving personal growth, realizing a more meaningful and responsible life, and of upholding the welfare of the community. The program is voluntary in that the resident will not be held in the programme by force or against their will*".

1.3 Background to Study

In 1999 the Australasian Therapeutic Communities Association (ATCA) was recorded as estimating that 70% of residential beds for drug and alcohol rehabilitation were provided by Therapeutic Communities; however few of them received state or federal funding (ATCA 1999). 2004 saw the publication of the National Drug Strategy: Australia's Integrated Framework (2004-2009) which is a joint venture between Australian State and Territory Governments and non Government sectors aimed at "*improving health, social and economic outcomes for Australians in preventing the risk of uptake of harmful drugs and for those who may experience harmful effects from licit and illicit drugs in our society*". With an increased level of funding, the role of some Therapeutic Communities has been developed and extended to include Family Services with crèche facilities and outreach work including other services such as Gambling and Sober Driver Programmes. The increasing pressure on Therapeutic Communities to provide these services has resulted in a heavy reliance on fund raising strategies by individual communities and on voluntary contributions.

As non profit making organizations recruitment and retention of staff can be challenging and wages are considerably less than can be expected from private and public health systems. Problems faced by some Therapeutic Communities in Australia include a lack of formal tertiary courses in substance use and mental illness which include mental disorders such as Axis II personality disorders. Therapeutic Communities are often geographically isolated and their remoteness contributes to a lack of training opportunities for staff.

In discussion with Janice Jones Executive Officer for ATCA it was identified that concern is raised for people with co occurring disorders as these are perceived as being the most vulnerable client group from a treatment perspective. These clients benefit from a holistic and multidisciplinary approach that offers a comprehensive, inclusive and coordinated service ensuring the risk of "falling through the gap" is minimized. The definition of co occurring disorders in this case arises from those clients with co-morbid mental health and substance use disorders.
This study perhaps serves to highlight the grey area in which personality disorders sit and questions whether they are included in the category of co morbidity. New South Wales does not acknowledge personality disorder as being a mental disorder requiring specialist treatment within the public system in the same way that the UK have recognized and are in the process of defining treatment approaches and services. This client group is frequently marginalized and excluded from mainstream public psychiatric services with the result that voluntary and charitable agencies are often left to support these individuals independently.

Whilst acknowledging that there are significant numbers of residents in Therapeutic Communities who experience co occurring disorders associated with both high and low prevalence disorders; ie anxiety and depression and serious mental illness alongside their substance use, this study will focus on those with a diagnosis of Borderline Personality Disorder and Antisocial Personality Disorder. The author recognizes that symptoms of

Axis I disorders are often overlooked due to the prominence of the Axis II disorder. It is therefore clear that there are numerous difficulties in working with this client group.

The author approached three Therapeutic Communities with a request to conduct a study on whether the staff felt adequately trained in working with residents with a diagnosis of personality disorder. The rationale for this being the authors' background in the United Kingdom as a Community Mental Health Nurse, with a particular interest in working with Personality Disordered clients. Personality disordered individuals frequently have significant substance use problems alongside their diagnosed personality disorder. The services currently available for this Dual Diagnosis client group in Australia seems to be limited and through the course of working in the Drug and Alcohol Service in Sydney it became a matter of interest as to what training staff had access to when working with this client group in what appears to be the major vehicle towards effective rehabilitation.

A proposal for this research was prepared and submitted for approval to the Department of Applied Social Science Research and Ethics Committee. [Appendix ii]

CHAPTER TWO

THERAPEUTIC COMMUNITIES

The Therapeutic Communities chosen for the study are:

- **The Buttery New South Wales**
- **Karralika ACT**
- **Mirikai   Queensland**

This study proposes to look at three Therapeutic Communities [Appendix iii] giving a description of their geographic location, fees, an overview of their programmes, resident numbers, complement of staff and background of experience and training opportunities available to staff.

2.1 The Buttery

Location

Binna Burra, New South Wales. The Buttery is located 759 kms from Central Sydney, driving time 10 hours 45 minutes.

Costs

The operating budget over 12 months is $800,000 with residents contributing 80% of Centrelink payments towards their board, lodging and treatment.

The Programme

Residents in the Buttery are guided through 2 programmes. Whilst the 12 step influence is significant as an aftercare component the programme runs on a biopsychosocial definition of addiction complemented by the 12 step concept.
Programme One works around the acceptance of the need to enter treatment and pursue an abstinence based lifestyle through a 12 week programme. According to the information available on the website www.buttery.org.au the course introduces the individual to the issues involved and provides a short term basic skills "survival" course.
Programme Two focuses on the core issues of recovery through a five month programme where the resident and their caseworker identify and explore relevant issues in depth. To be accepted on to this programme requires a community assessment of the individual's need and motivation and their capacity to complete the programme. Equally the individual is required to commit to the timescale and identify that they need long term residential treatment. Applicants with major mental illness are excluded.

A small education package is available for residents on food handling and safety in the kitchen but no formal education or job skills training is undertaken by the Therapeutic Community.

Residential Numbers

The Buttery is licensed for 30 adults. It does not accept families or children

Staffing

There are 20 Full Time Equivalent staff in total which includes Full Time Residential, Outreach, Part Time and Night Staff. Staffing consists of Psychologist, Nurse, AOD Cert 4 (This is a full time one year course at TAFE which is a basic qualification in Drug and Alcohol studies) and former residents of the Buttery.

Training Opportunities

There is no onsite routine training delivered. If funds allow, outside training is sourced. However, for non counselling staff there is the Accidental Counsellor Training which helps staff manage difficult referrals or requests for information. First Aid and IT training is given as an in house component and staff are given orientation training when joining the Buttery. Some of the staff have pursued Trauma Counselling, Narrative Therapy and training in Gestalt Therapy independently.

2.2 Karralika

Location

Karralika is in Tuggeranong, ACT and is 317 kms from Central Sydney, driving time 4 hours 15 minutes.

Costs

Centrelink payments contribute to board and lodging.

The Programmes

According to the literature available via www.adfact.org , the Adult Programme offers *comprehensive care and focuses upon individual personal growth to replace alcohol and other drug dependencies.* Emphasis is placed on preparation for future employment and includes education, lifestyle and job skills training together with individual and group counselling. The staff utilise a creative and therapeutic environment and are skilled in clinical practices providing strong role models for residents in treatment.
The Family Programme offers treatment for the whole family and the children's programme at Karralika is supported by a Child and Family Psychologist and Family Support Coordinator. Children are able to participate in full time daycare or after school care programmes whilst parents are also able to take part in parenting programmes and cognitive behavioural therapies (CBT) which aim to promote positive parent/child/family relationships.

Residential Numbers

The Karralika Therapeutic Community can accommodate up to 50 adults over the two programmes and they are licensed for up to 20 children. This can mean that the adult population may take between 30 – 40 at any one time.

Complement of Staff

Including the staff employed within the Family Services the total number working in a clinical role at Karralika is 20 plus casual and sessional workers and night supervisors. The team is multidisciplinary with some staff having themselves completed the programme, whilst all have completed professional training programmes with qualifications ranging from psychology, nursing, counselling to addictions studies and other disciplines.

Training Opportunities

ADFACT joined in partnership with the Canberra Institute of Technology to provide work based training for staff in the Certificate IV in Alcohol and other Drug Work. www.adfact.org.

2.3 Mirikai

Location
Mirikai is in Burleigh, Queensland which is 2,104kms from Central Sydney, driving time is 28 hours.

Costs
Centrelink payments contribute towards board and lodging.
The Programme

The Residential Programme is a five phase process of Orientation and Assessment, Safety Net, Transition, Pretreatment and Treatment. The client is assessed utilising the transtheoretical model of change (Prochaska and DiClemente's 1984). The treatment process takes around 8 months in total and is followed by the Re entry programme that allows residents to practice their psychosocial skills in preparation for leaving the community. There are three supervised halfway houses each housing up to five residents however residents are able to choose if they wish to access this facility.

Resident Numbers

Up to 34 residents with accommodation for 15 in three halfway houses

Complement of Staff

Clinical Manager, Dual Diagnosis coordinator, 4 weekday TC workers, nurse, welfare officer, 5 night time and weekend workers

Training Opportunities

This information was not available at the time this project was completed.

CHAPTER THREE

LITERATURE REVIEW

Although there is no universal agreement as to the aetiology of personality disorder, theorists generally accept that the origins lie in one or more of the following; genetics, behavioural mechanisms or traumatic life events. (Eurelings – Bontekoe et al 1998) With regard to both borderline and antisocial personality disorders, there is increasing evidence to suggest that they frequently exhibit Axis I disorders alongside the Axis II disorder which would correlate with the growing opinion that suggests personality disorder is associated with post traumatic stress disorder as well as anxiety and depression. Furthermore, Johnson et al (1999) propose childhood abuse or neglect places an individual at four times as much risk of developing personality disorder than those who were not abused or neglected. The paucity of research available specifically related to Dual Diagnosis associated with Personality Disorder in Australia, resulted in the review being gathered from literature around the world. However, the author would suggest the findings keenly illustrate the problems faced in Australia with regard to Dual Diagnosis.

3.1 Dual Diagnosis

Interest has grown regarding the high level of association between Axis II co morbidity and substance use disorders since DSM III (APA 1980). However, there remains an "*overall clinical pessimism about the prognosis and the difficulty in clinically managing the dually diagnosed patient*" (van den Bosch and Verheul 2007 p 67)

Australian data suggests co morbid mental health and substance use disorders range from 50% - 90% (Baigent et al 1995). Statistics indicate that substance use problems are evident for 28% of men and 14% of women with anxiety disorders and for 34% of men and 16% of women with affective disorders (Teeson 2000).

Personality disorders are considered to be more common in substance and poly-substance abuse subjects, particularly males with Antisocial personality disorder more commonly diagnosed in men and Borderline personality disorder in women Landheim et al (2003). According to Messina et al (1999) there is a 40 to 50% prevalence rate of antisocial personality disorders in male substance abusers with 90% of persons diagnosed with antisocial personality disorder being substance abusing criminal offenders.

The issue as to whether an Axis II diagnosis of personality disorder combined with a substance use disorder constitutes a Dual Diagnosis remains an area of debate and controversy. The UK perspective on Dual Diagnosis Guidelines (Department of Health 2002) regard Personality Disorder (PD) as a separate entity, which may co exist with a mental health or substance use problem, or both. The issue as to whether Personality Disorder constitutes a mental health problem rather than a mental disorder is contentious and therefore there is a failure to clarify a clear operational definition of the term Dual Diagnosis with regard to substance use and Personality Disorder. In the United Kingdom, and in response to the Department of Health (2003) national guidance

Personality Disorder: No Longer a Diagnosis of Exclusion the term Dual Diagnosis may be interpreted as including people with personality disorder.
The debate as to whether the co morbidity of Personality Disorder and Substance Use constitutes a Dual Diagnosis appears not to be limited to the United Kingdom. In New Zealand within the Odyssey House Therapeutic Community the Dual Diagnosis Service criterion is restricted to an Axis I diagnosis, whilst at the Windham Centre, Bellows Falls, Vermont, North America the criteria includes Axis I and Axis II (Magor-Blatch and Fleming 2007).

3.2 Personality Disorders

The prevalence of personality disorder in drug services and alcohol services was found to be 37% and 53% respectively compared to 10% in the general population in a study undertaken by Bowden-Jones et al (2004). They concluded that in both drug and alcohol populations not only were personality disorders poorly identified by staff but that there was a clear association between severity of the personality disorder and social morbidity and psychopathology. Whilst it is understandable that characteristic features of personality disorder may be evident in individuals during active periods of dependence a conclusive diagnosis is not usually made unless the traits either preclude the substance use or remain during and following recovery. Arguably, and from a positive perspective, there is perhaps a level of prudence within drug and alcohol services in the UK, in making early diagnoses in an attempt to limit the negative connotations ascribed to personality disorders that are suggested to have poor recovery outcomes in the substance use field. Notwithstanding this hypothesis, a raft of research highlights the epidemiological studies that indicate poor outcomes for personality disordered substance users. These outcomes include, higher rates of drop out from treatment, (Reich and Vasile 1993) poor social function (Darke et al 1994) and increased rates of criminal activity and offending (Hernandez-Avila et al 2000) Further, the characteristics of antisocial personality disorder which include irresponsibility, destructive behaviour and criminal activity (Blackburn 1993) together with an inability to self reflect suggests these subjects to be unsuitable for treatment in a Therapeutic Community as they lack the motivation to remain in long term treatment. (Forrest 1992)
In contrast, other studies have proposed that negative effects on outcomes are not necessarily accurate, particularly in relation to treatment in Therapeutic Communities (Brooner et al 1998, Messina et al 2002). In a comprehensive research study conducted by Messina et al (1999) in which a comparison was made between antisocial personality disordered clients and non antisocial disordered clients in two Therapeutic Communities managed by Second Genesis in the United States the results surprised researchers as there was no comparable difference in outcome. Further, they argued that antisocial personality disorders may indeed benefit from twelve month treatment programmes.

3.3 Therapeutic Interventions

Therapists working with dually diagnosed clients require extensive experience and professional training in psychotherapy, psychopathology, personality disorders and addiction, (van den Bosch and Verhuel 2007). Supervision is also an essential

requirement as the transference and counter-transference elements of therapy place a high demand upon the therapist (Konstantinos and Kaprinis 2006). Interestingly, the Therapeutic Communities provide a comprehensive approach to an individuals biopsychosocial functioning. They address not only psychological problems but deficits in social functioning, interpersonal skills and individual dysfunction. The core programme within a Therapeutic Community operates on the concept that the resident is not a passive recipient of treatment and that it is not the counsellors role to create the therapeutic milieu. The belief is that. Humans have the ability to psychologically help each other and that the strength of the community is reliant upon inclusiveness. The goal for the individual is to progress to enable the development of rewarding emotional bonds with others and to understand the principle of self determination and self awareness. The Therapeutic Communities in this study offer a rehabilitatory socio-dynamic approach together with a psychoanalytic focus. .

Studies indicate that problems in treatment approaches that utilise a confrontational and educational role may create difficulties in the development of the therapeutic relationship and may even be complicated by the clients denial and hostility in accepting they have a problem (Meier et al 2005) It is noted however, that successful engagement of the client in the process of treatment is indicative of a positive outcome (Simpson et al 1995). Successful outcomes for dually diagnosed subjects tend to occur in the context of relatively long term treatment programmes that deliver structure and safety together with skills training and relapse prevention programmes. Evidence from several studies indicates the need for therapy to target motivational, interpersonal and perceptual problems with dually diagnosed clients (Ball et al 2006)

Rosenthal (1989) proposes that Therapeutic Communities operate on a resident's existential reality promoting change in attitudes, self image and world view. He further suggests the demands and structure of the Therapeutic Community combined with peer influence facilitate a significant change in residents over a period of months in contrast to the years needed by individual psychotherapy to arrive at a point for attitudinal and behaviour change.

CHAPTER FOUR THE METHODS

In discussion with the Course Tutor and Clinical Directors of two Therapeutic Communities the author decided to formulate a simple questionnaire that would give the required information to elicit attitudinal and quantitative information yet be brief enough to encourage a response.

4.1 Design

In order to collect data the study will rely on a postal questionnaire as the most appropriate due to the geographical locations of the Communities around New South Wales, ACT and Queensland.

4.2 Instrument

In formulating the questionnaire the author will incorporate a set of 12 questions designed to elicit facts and opinions related to training programmes and perceived needs. By utilising closed questions with a Likert scale the survey will draw out any collectively held theories and opinions and give opportunity for both a subjective and objective analysis to the research.

4.3 Confidentiality

A covering letter will accompany the questionnaire assuring the respondent of confidentiality. As a further means to maintain anonymity due to the small sample size information on age, sex, gender and ethnic origin is not requested.

4.4 Reliability and Validity

The aim is to gather both attitudinal data surrounding the individual's feelings about training needs together with factual information. The limitations of using the Likhert scale mean that the depth of analysis is restricted however it will give an overall perspective for further research.

4.5 Sample and Setting

The sample group consists of 51 staff including professional and unqualified employees working with three Therapeutic Communities. Each potential respondent will be sent via the Clinical Director or Manager a questionnaire together with prepaid addressed envelopes for return to the researcher.

4.6 Data Analysis

Qualitative and Quantitative data will be discussed and analysed manually.

4.7 Distribution of Data

Research findings will be available for review by each Therapeutic Community

4.8 Ethical Considerations

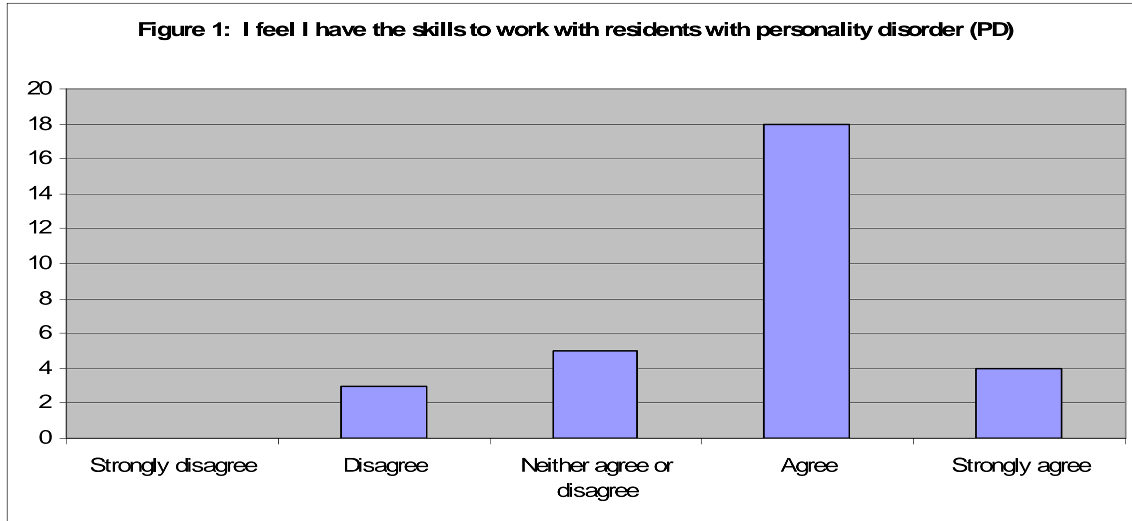
The benefits of identifying issues relating to working with residents with Personality Disorder through this survey may be regarded as contributing to the future needs of both staff and residents in Therapeutic Communities.

Whilst this study endeavors to maintain anonymity to encourage openness and honesty from the responders it is worth noting that whilst the results will generate commonly held opinions from the majority which may possibly indicate areas of discomfort that suggest some staff have concerns not necessarily verbalised. The small sample size results will not be delineated into the three communities in order to further safeguard confidentiality.

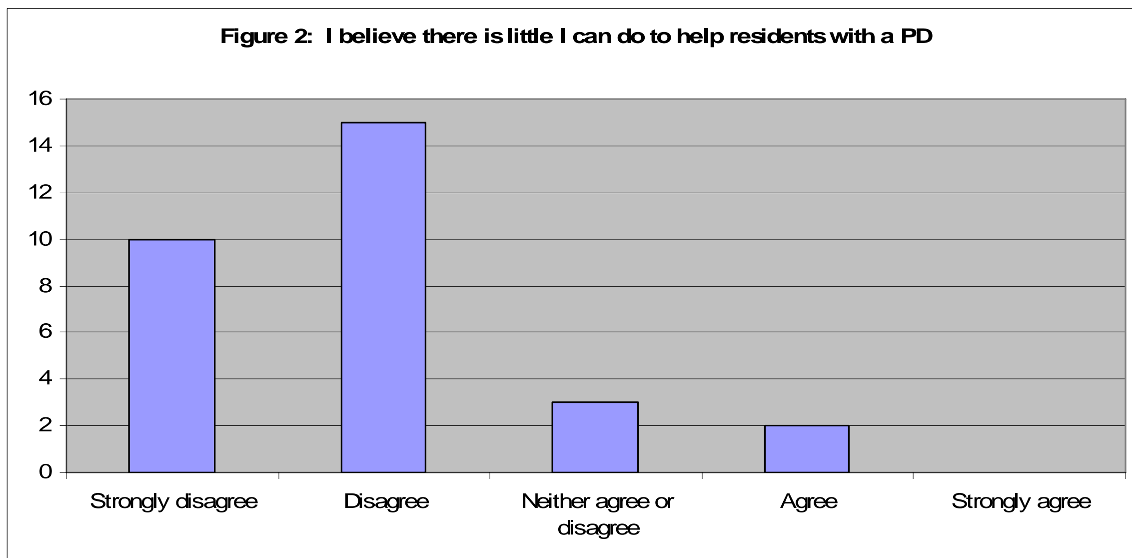
Approval for this study was sought from Stirling University Research and Ethics Committee.

CHAPTER FIVE QUESTIONNAIRE RESULTS AND ANALYSIS

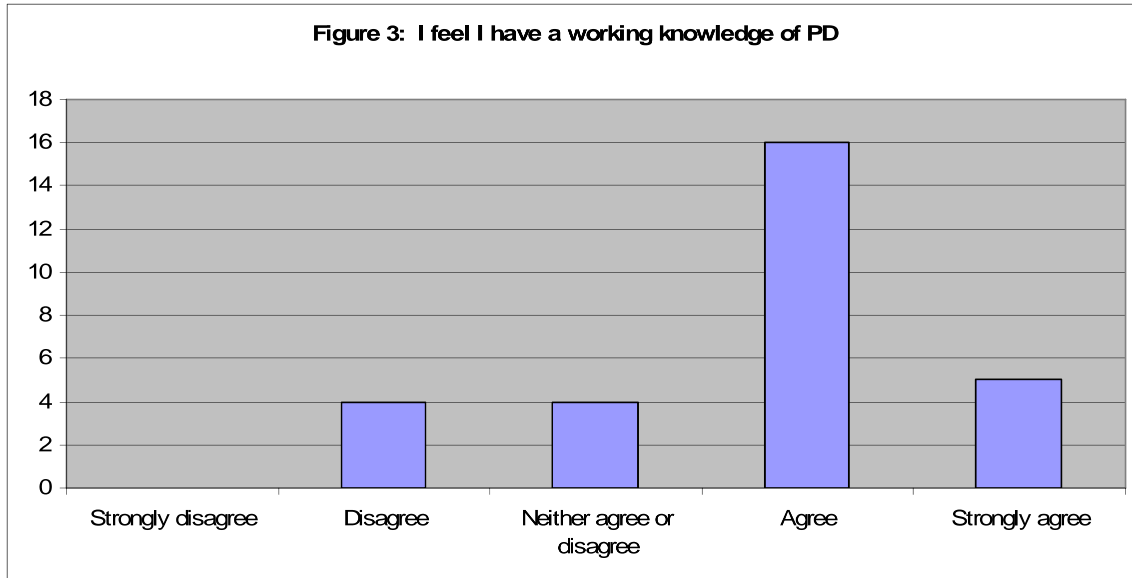
Fifty one questionnaires were distributed with a total of 30 returns representing an overall response rate of 58.82%.



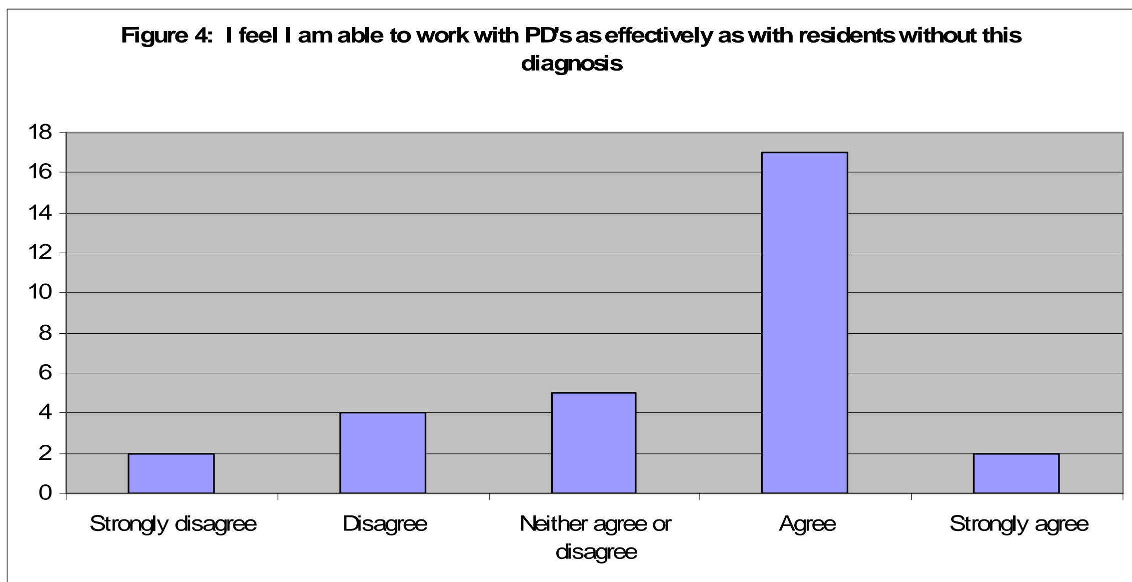
As highlighted by Question 1 (Figure 1) the majority of responders reported they believe they have the skills to work with personality disordered residents. Analysis of the respondents who neither agree nor disagree is open to supposition. It may be argued that limited knowledge of personality disorder characteristics influenced a neutral result as the responders may not have been confident in their understanding of what skills are required.



The majority of responders felt that they could help residents with a personality disorder Question 2 (Figure 2) with a third holding strong opinions to this effect.

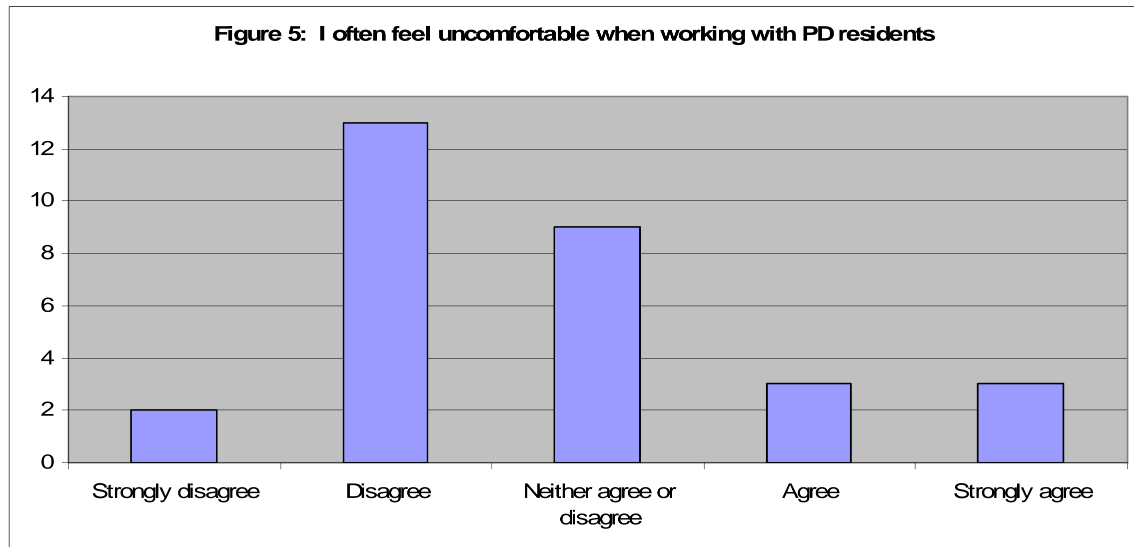


In terms of knowledge about personality disorder Question 3 (Figure 3) the results compare favourably with the responses from Question 1 (Figure 1) with twenty one responders feeling they have a working knowledge of the disorder. However, it is apparent that eight individuals equating to almost a third disagreed or were neutral in their opinion.

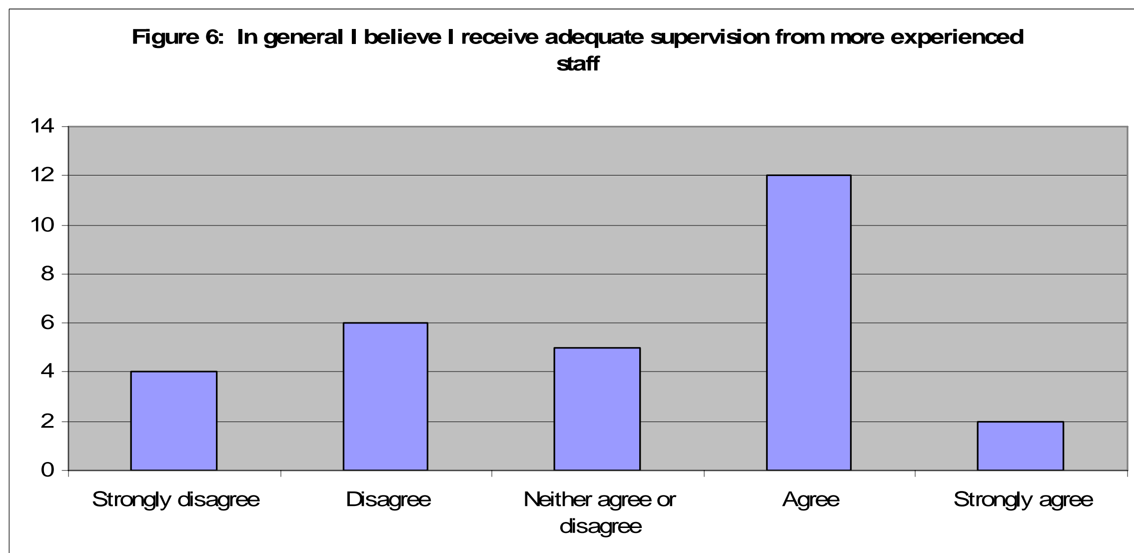


Question 4 (Figure 4) highlighted varying opinions over the whole range of responses suggesting a small but significant number holding the belief that they are unable to work with personality disordered residents as effectively as they can with those without the diagnosis. Whether this is related to the staff members' personal skill base or opinion is unclear. It may be speculated that there is a perception that personality disordered

residents are unable to function and progress as effectively as residents without the diagnosis within the therapeutic community milieu.

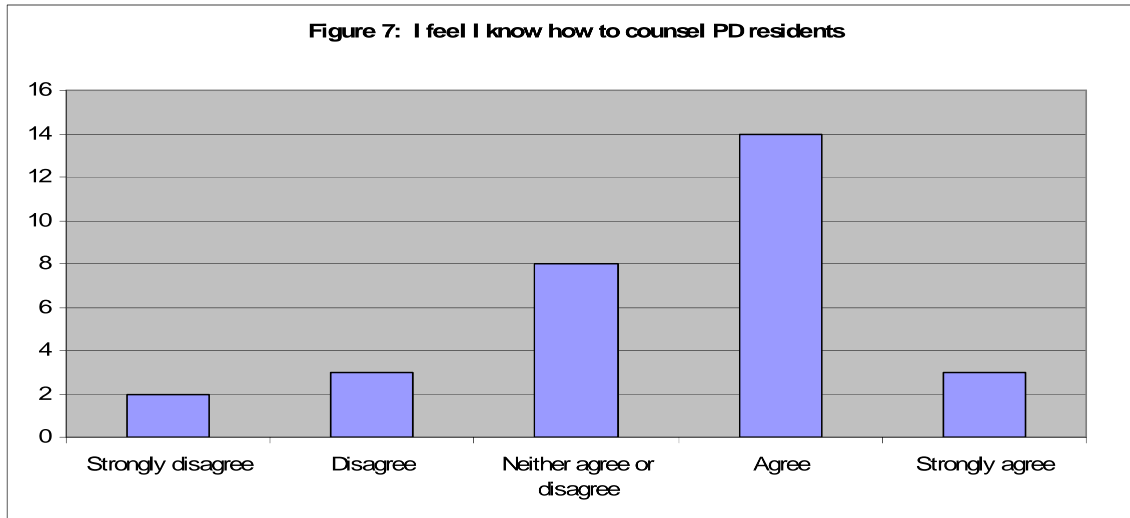


Question 5 (Figure 5) once again elicited responses over the whole range with a significant number choosing to remain neutral with regard to personal feelings about working with personality disordered residents. Whilst fifteen respondents felt they were comfortable, nine were neutral and six admitted feeling uncomfortable. It is difficult to analyse neutrality as the author interpretation may be influenced by personal opinions giving rise to value judgments and assumptions. Does neutrality equate to ambivalence or alternatively might it signify a non judgmental stance that offers positive regard to all residents?

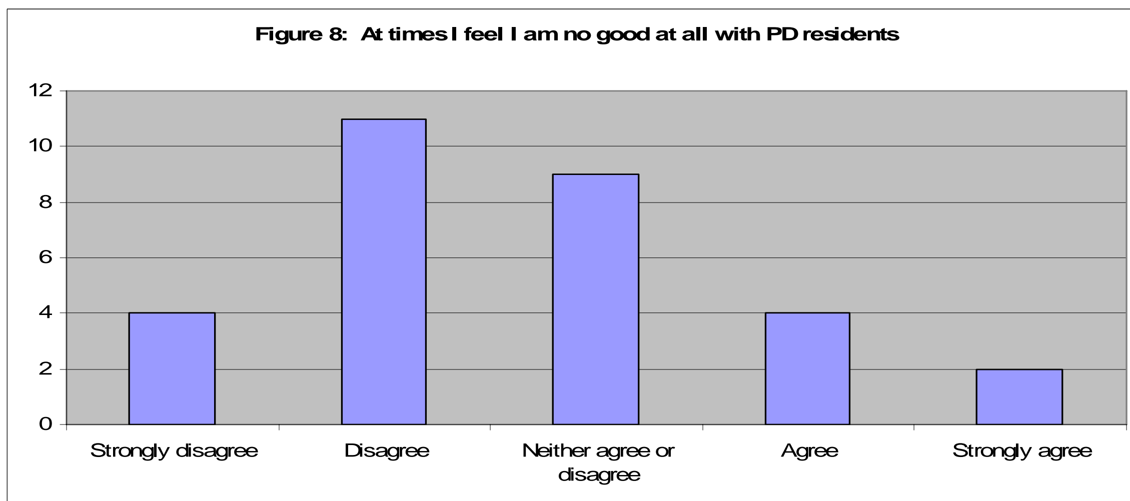


The responses to Question 6 (Figure 6) gave a strong result in terms of staff indicating they had differing opinions relating to supervision in working with personality disordered residents. Just under half the respondents felt they were adequately supervised with ten

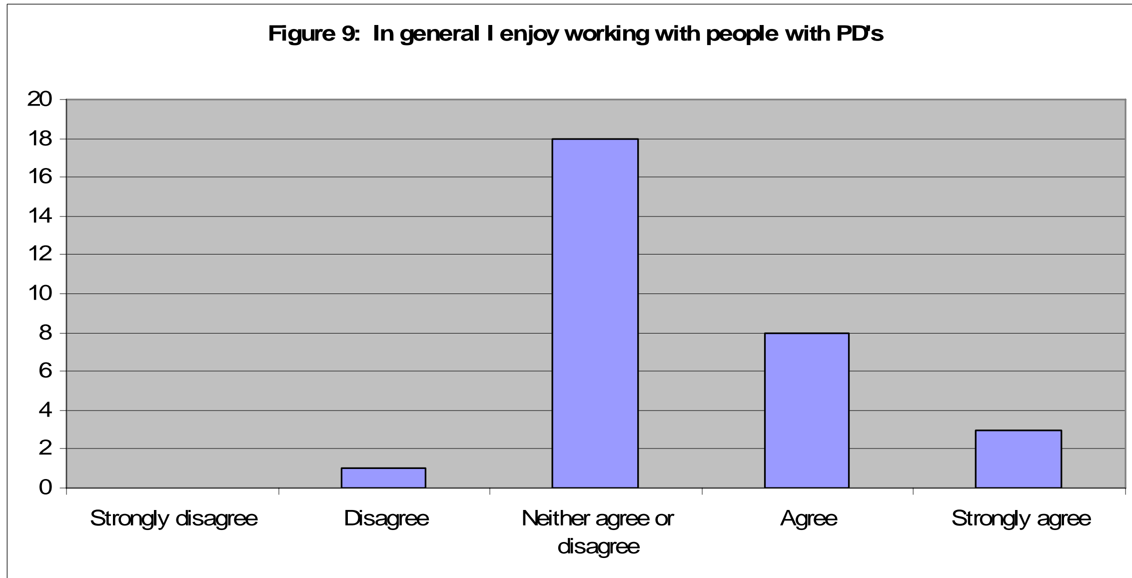
believing they were not. A further five were neutral in their response. Speculation may suggest these five responders did have an opinion but were cautious in the level of honesty of their response perhaps due to potential ramifications. Alternatively, they may have not felt supervision to be a necessary component in working with personality disordered residents.



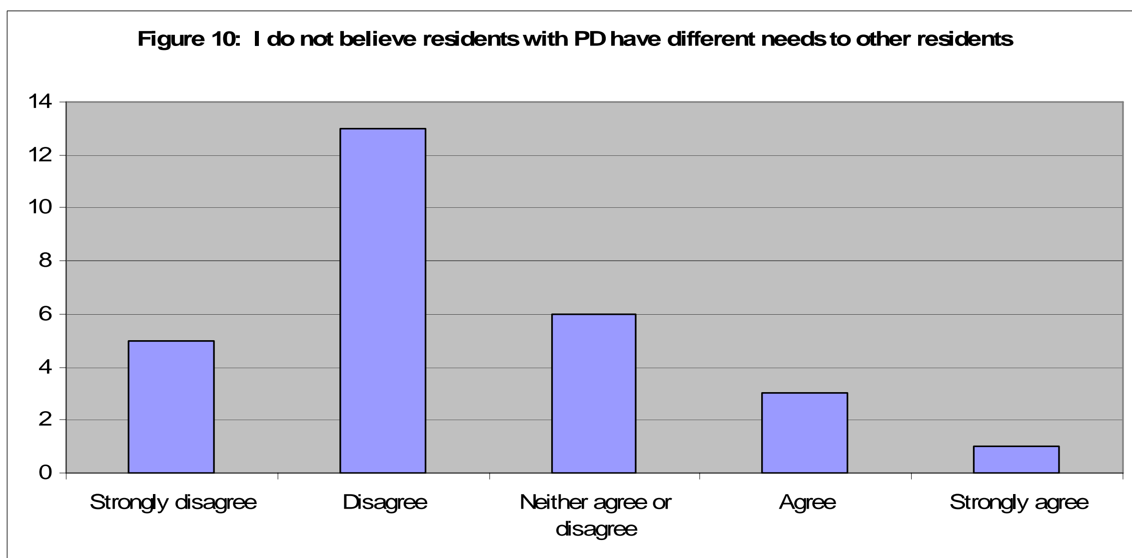
The responses to Question 7 (Figure 7) indicated just over half the respondents felt confident in their counselling skills. It is worth mentioning that a number of respondents are not employed as counsellors which may be reflected in these figures.



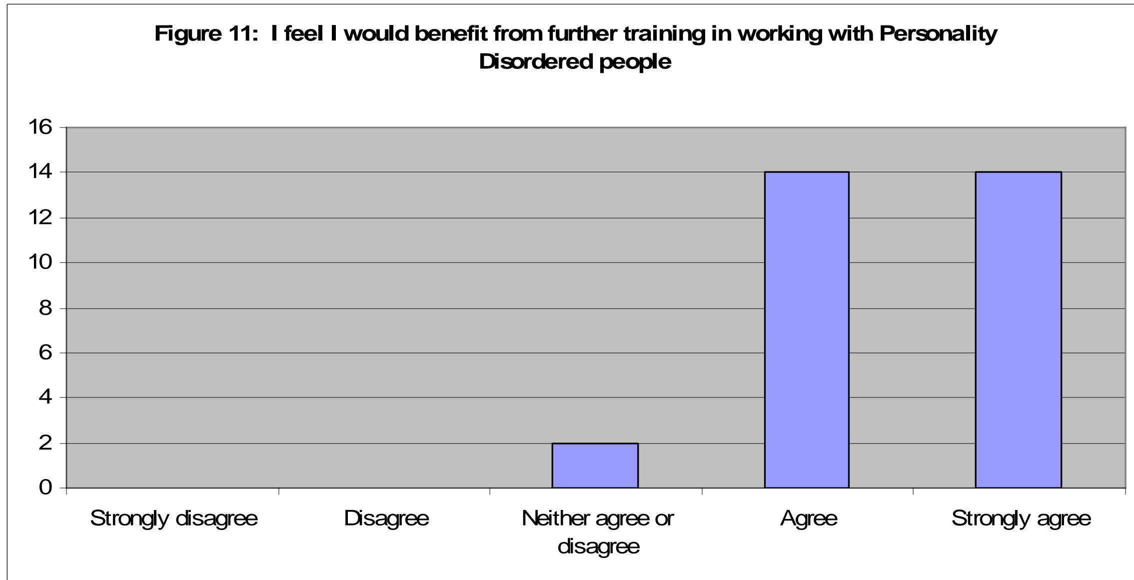
Question 8 (Figure 8) elicited a fifty per cent positive response from staff suggesting they have confidence in working with personality disordered residents. The responders who believed they were no good with these residents together with the neutral responders may be either unqualified staff or perhaps unsure of their skills. Controversially, it could be suggested that these residents are too difficult to help.



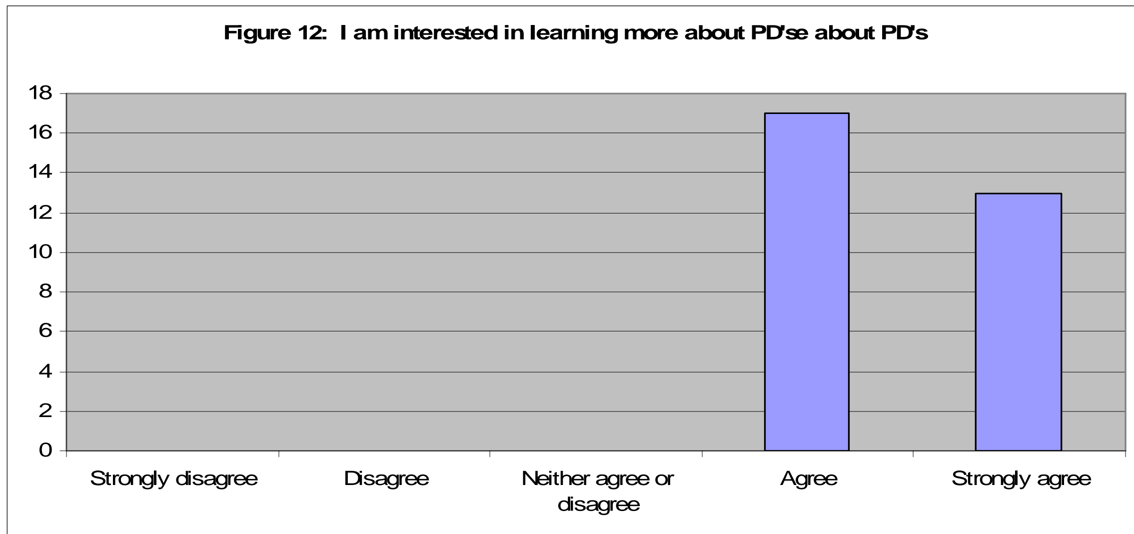
Question 9 (Figure 9) brought a resounding neutral response with eighteen responders being neutral with regard to enjoying working with personality disordered residents. It is widely acknowledged that this client group can be manipulative, demanding and frustrating to work with yet the responders gave a noncommittal response. One may ask in what way personality disordered residents behave differently, if at all, to residents without the diagnosis to elicit such a response.



Most of the responders to Question 10 (Figure 10) felt that these residents have different needs to other residents. In terms of the treatment and management of these residents this response may indicate a need for a clearer recognition of what specifically is required to support them.



In support of Question 10 the responses to Question 11 (Figure 11) overwhelmingly suggest that staff would benefit from further training in working with personality disordered residents. Only two responders had no opinion.



Question 12 (Figure 12) highlighted that without exception all responders were interested in learning more about personality disorders.

CHAPTER SIX DISCUSSION

Of interest to the study is the issue that not all Therapeutic Communities accept personality disorder and substance use as being a dual diagnosis. In this study, however, they are accepted without discrimination. The Buttery interestingly excludes those with major psychiatric problems due to the demands of the programme. This study will not comment or criticise any particular community, it serves merely to bring into focus the debate as to whether having a personality disorder is less debilitating than an Axis I diagnosis. It further raises the question as to whether having a personality disorder impedes the opportunity for recovery in the same way a mental illness might? Perhaps having a personality disorder is, for some resident's, part and parcel of having a substance use problem and as such there is an expectation from staff that many residents, but not all, will demonstrate characteristics attributable to personality disorders? Indeed staff attitudes as to the effectiveness of interventions with personality disordered residents indicated a high level of confidence.

Although the general consensus is that this client group has different needs, the limitations of the survey did not allow for an in depth analysis to determine precisely what these may be. Nevertheless, it may be proposed that Post Traumatic Stress Disorder has significant relevance when considering the needs of these residents. It is unclear as to whether staff receive training in this area.

The majority of responders appeared to have a neutral opinion regarding working with these residents despite evidenced based research which suggests they are difficult, demanding and challenging leading to reluctance from health professionals to provide a service. Findings from the survey also suggest that some staff feel uncomfortable working with residents with personality disorder which perhaps questions the majority response from Question 9 inferring staff have neutral opinions regarding working with these residents.

Whilst the majority of staff felt confident in working with and counselling these residents there were a number who raised concern regarding the level of supervision available from more experienced staff. This may possibly relate to staff feeling unsupported or out of their depth and would correlate with the responses of those who reported feeling uncomfortable. Evidence based research emphasises the importance of a team approach to working with this client group and advocates the implementation of effective clinical supervision to avoid staff burn out, transference, counter transference and splitting.

The survey established that the consensus of opinion supported the view that staff can help residents with personality disorders and there appears a general belief that staff have the skills, knowledge and confidence overall to support and work with the residents.

Without question all respondents requested further training and education to facilitate their practice and it is assumed that this opinion is shared by professional and untrained members of staff collectively.

6.1 Conclusion

This study has attempted to investigate whether the training needs of staff are adequately addressed in relation to working with residents with a diagnosis of personality disorder.

The research failed to ascertain the depth and breadth of knowledge already held by staff in this specialist area.

The results of the survey indicate that whilst the majority of staff are confident and feel appropriately skilled there are others who appear less confident in their knowledge base; with some feeling uncomfortable and commenting on a lack of supervision. Training opportunities vary in each setting and this may be reflected in the responses which have been combined to safeguard anonymity.

6.2 Recommendations

The limitations of this study in terms of both the depth of analysis feasible due to word allowance and the data extrapolated from the Likert scale indicate the potential for further, more detailed research. Without exception, all respondents requested further education and training to facilitate working with personality disordered residents. Further research into training opportunities specifically targeting the needs of personality disordered residents is recommended.

The grey area of co morbidity, in particular substance use and personality disorder is gaining global recognition and this study has attempted to highlight the valuable work undertaken in Therapeutic Communities with this vulnerable and fragile client group.

Words used 5,357

Appendix i

Characteristics of Personality Disorder

The framework of the 1995 Department of Health document *Building Bridges* (DoH 1995 p 11) suggest the term Personality Disorder falls within the parameters of being a serious mental illness.

Working with this client group can be frustrating, challenging and stressful requiring supervision and support for staff (Brooker and Repper 1998 p 190). People with Borderline Personality Disorders frequently demonstrate emotional instability with highly impulsive behaviour resulting in antisocial activities such as misuse of drugs or alcohol, self harming or self mutilation, overdosing, eating disorders, sexual promiscuity (Norton 1992) According to Alarcon and Foulks (1998 p 8) "*the socialization process and socio cultural background play a significant role in the construction of self-concept and self-image – the origins and dynamic interactions of personality."* Whilst no universally accepted agreement has been reached on the aetiology of personality disorder theorists have debated the origins as arising from genetics, behavioural mechanisms and traumatic life events (Mombour and Bronisch 1998). Environmental factors included serious abuse including emotional, physical and sexual at an early age and abandonment or betrayal by carers or adults in positions of trust. Childhood abuse or neglect places an individual at four times as much risk of developing personality disorder than those who were not abandoned (Johnson et al 1999). Coid (1999) proposes that people diagnosed with personality disorder have had their behaviour shaped and reinforced over long periods of time by environmental adversity which results in rigid patterns of behaviour which are resistant to change.

Characteristics of Borderline Personality Disorders include:

- frantic efforts to avoid real or imagined abandonment
- a pattern of unstable and intense interpersonal relationships
- unstable self image or sense of self
- impulsivity in at least two areas that are potentially self damaging eg substance use, reckless driving, spending, binge eating
- recurrent suicidal behaviour, gestures or threats
- affective instability due to a marked reactivity of mood usually lasting a few hours and rarely more than a few days
- chronic feelings of emptiness
- inappropriate intense anger
- transient stress related paranoid ideation

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, (American Psychiatric Association 1994)

Characteristics of Antisocial Personality Disorder include:

According to Zanarini et al (1998) 23% of people with antisocial personality disorder also meet the criteria for borderline personality disorder. Under ICD – 10 (1992) the definition of antisocial personality disorder is characterized by:

- callous unconcern for the feelings of others and lack of the capacity for empathy
- gross and persistent attitude of irresponsibility and disregard for social norms, rules and obligations
- incapacity to maintain enduring relationships
- very low tolerance to frustration and a low threshold for discharge of aggression, including violence
- incapacity to experience guilt and to profit from experience, particularly punishment
- marked proneness to blame others or to offer plausible rationalizations for the behaviour
- persistent irritability

International Statistical Classification of Diseases and Related Health Problems: Tenth Revision; World Health Organisation (1992)

DSM IV (APA 1994) further elaborate on these characteristics suggesting evidence of conduct disorder with onset before age 15 is indicated along with a pattern of irresponsible and antisocial behaviour.

University of Stirling **Appendix ii**

DEPARTMENT OF APPLIED SOCIAL SCIENCE

DAS903 – University Certificate in Drug & Alcohol Studies (Drugs, Alcohol & Nursing).

Individual Study Project – Proposal & Ethical Approval Form

This form should be completed in consultation with your tutor. You should not commence fieldwork until you have been notified that your project is approved.

Student name	Stephanie Stace
Approved dissertation topic	Are Staff Training Needs adequately addressed in Therapeutic Communities in relation to working with residents who have a diagnosis of Personality Disorder
Tutor's name	Rowdy Yates

Project Description: Please provide a brief description of your Individual Study Project. Explain here what it is you are intending to do and how you intend to go about it. Include details of how you intend to collect any data required and how this data will be analysed. Explain how your study will be structured and what it is you are hoping to ascertain.

The project will look at three Therapeutic Communities in New South Wales, Australia and determine whether the training received by staff adequately addresses their needs in relation to working with residents diagnosed as having a personality disorder.

The study will identify and examine the grey area of co morbidity and focus specifically on personality disorder attempting to exclude in this research residents with severe and enduring mental illness (low prevalence disorders) and milder mental health issues such as anxiety/depression/psychosomatic disorders (high prevalence disorders).

Whilst acknowledging that Personality Disordered residents experience some or all of the above symptoms this research will look at the skills required that assist and support the staff in managing Personality Disorder and determine any shortfalls.

The project will describe the three TC's in terms of the programmes offered, number of residents and difficulties encountered by staff in terms of how the service accommodates and retains residents with co morbidity. Current training programmes will be examined, how they are delivered and by whom ie in house or external training.
A small questionnaire will be distributed to the staff based on a Likert Scale which will determine both attitudinal data surrounding the individual's feelings and perceptions together with information seeking data.

The study will analyse the results manually highlighting significant areas of research that may suggest a need for a more detailed investigation.

The Buttery

The Buttery Inc. is an independent community based charitable organization. It operates on a not for profit basis and became incorporated under the Anglican Church of Australia (Bodies Act) 1938 in 1990. It was originally operating as a Christian Community between 1972 and 1977 caring for individuals with drug problems (Rawlings and Yates 2001) Funding through the New South Wales Drug and Alcohol Authority assisted the Buttery in expanding and evolving towards the hierarchical end of the continuum. The hierarchical structure encourages a sense of progress as increased responsibilities signify a step forward. Information about the Buttery is taken from communications with Barry Evans, Director and the web www.buttery.org.au

According to ATCA (1999) the Buttery has been influential in the development of many subsequent therapeutic communities. The Buttery currently offers a **Residential Programme** for which there are 30 beds, a proportion of which are allocated to the MERIT Programme which is Magistrates' Early Referral Into Treatment. There is also an **Outreach Programme** and a **Gambling Service.**

Basic requirements for entry to the Buttery are that the applicant has a problem drug using history greater than two years, they are over 20 years of age and are not facing legal proceedings for which application to the Buttery may be considered as a mitigating factor in court proceedings. The applicant is also required to be motivated to stop using and has undergone a detox prior to admission. Worthy of mention is that staffing constraints and the demands of the programme also necessitate the exclusion of applicants with major psychiatric problems. The Buttery have a **halfway house** situated in Artarmon a suburb in Sydney.

Karralika

Karralika was established in 1978 in the Australian Capital Territory at Tuggeranong in the Southern area of Canberra as a Therapeutic Community and is part of the ADFACT network of services.. According to the information available on the web from www.adfact.org and in communication with the Clinical Director Lynne Magor-Blatch the programmes offered by Karralika include the Karralika Adult Programme and the Karralika Family Programme. Each offers separate treatment facilities with a capacity to accommodate up to 50 people over the two programmes. They are licensed for up to 20 children so the adult population may take 30 – 40 at any one time. Following successful completion of the programme residents move on to the Community Programme called the Nexus Programme.

The Karralika **Adult programme** accepts applications from those aged over 18 years and who wish to address their alcohol or drug dependent lifestyle**. The Family programme** offers treatment for the whole family which gives the opportunity for young children to remain within the family whilst the parents undertake the Karralika programme. Karralika also have a **transition house** to assist residents in their move back into their

own accommodation. As with the Buttery the social structure is a simple hierarchy of positions with increasing degrees of responsibility.

Referrals are accepted to the intake programme from the general community, other agencies, Corrective Services and other legal systems and self referrals are welcomed. The typical length of treatment in total is nine to twelve months.

Mirikai

Information regarding the history of Mirikai has been available from contact with the Clinical Directors Personal Assistant and through the web link. Mirikai opened as a Therapeutic Community in 1971 and offers the **Mirikai Residential Programme** and a **Community Programme**. It is part of the Gold Coast Drug Council Inc. www.gcdrugcouncil.org.au which is a non profit, non government organization that offers support to people experiencing problems with alcohol or drugs. The residential programme can accommodate up to 34 young people who are experiencing problems associated with their substance use.   The residents are between the ages of 16 and 29 years.   The focus of the programme is to support the residents in developing their personal and social functioning free from harmful drugs. The staff and residents are active in a variety of community projects related to harm reduction and community support for young people. Mirikai offers three transitional house for graduates of the programme which are also available to young people aged 17 to 29 who have a history of drug dependence and mental health problems.

Appendix iv

March 2007

Dear Staff Member

I am a Registered Nurse working for Sydney West Area Health Service within the Drug and Alcohol Team.

As part of the Certificate in Drug and Alcohol Studies I am undertaking with Stirling University in Scotland I am looking at whether staff training needs are adequately addressed in Therapeutic Communities in relation to working with residents who have a diagnosis of Personality Disorder.

This questionnaire has been distributed to the Buttery, Karralika and Mirikai in a small scale study.

Your reply to the questionnaire will be completely confidential and you need not identify your name.

Whilst acknowledging that a significant proportion of residents with co occurring disorders experience symptoms ranging from anxiety and depression to severe mental illness this study will attempt to focus on those residents who have either a Borderline Personality Disorder or Antisocial Personality Disorder diagnosis.

I would be grateful if you would complete the questionnaire and return it to me in the stamped addressed envelope by April 15th.

May I take this opportunity to clarify that this research is a personal project and thank you in anticipation of your response.

Should you require further information please do not hesitate to contact me via your Clinical Director with whom I am in regular communication.

Yours Faithfully

Stephanie Stace

Appendix v

QUESTIONNAIRE TO DETERMINE WHETHER STAFF TRAINING NEEDS ARE ADEQUATELY ADDRESSED IN THERAPEUTIC COMMUNITIES IN RELATION TO WORKING WITH RESIDENTS WHO HAVE A DIAGNOSIS OF PERSONALITY DISORDER

Please indicate how much you agree or disagree with each of the following statements about working with residents with a diagnosis of personality disorder by circling the number that corresponds with your opinion.

	Strongly disagree	Disagree	Neither agree nor Disagree	Agree	Strongly Agree
1. I feel I have the skills to work with residents with personality disorder (PD)	1	2	3	4	5
2. I believe there is little I can do to help residents with a PD	1	2	3	4	5
3. I feel I have a working knowledge of PD	1	2	3	4	5
4. I feel I am able to work with PD's as effectively as with residents without this diagnosis	1	2	3	4	5
5. I often feel uncomfortable when working with PD residents	1	2	3	4	5
6. In general I believe I receive adequate supervision from more experienced staff	1	2	3	4	5
7. I feel I know how to counsel PD residents	1	2	3	4	5
8. At times I feel I am no good at all with PD residents	1	2	3	4	5
9. In general I enjoy working with people with PD's	1	2	3	4	5
10. I don't believe residents with PD have different needs to other residents	1	2	3	4	5
11. I feel I would benefit from further training in working with Personality Disordered people	1	2	3	4	5
12. I am interested in learning more about PD's	1	2	3	4	5

Appendix vi

METHOD

RESEARCH DESIGN

Design

In order to collect data the study will rely on a postal questionnaire as the most appropriate rather than semi structured interview questions due to the geographical locations of the Communities around New South Wales, ACT and Queensland.

Instrument

In formulating the questionnaire the author will incorporate a set of 12 questions designed to elicit facts and opinions related to training programmes and perceived needs. By using closed questions with a likert scale the survey will draw out any collectively held theories and opinions and give opportunity for both a subjective and objective analysis to the research

Confidentiality

A covering letter will accompany the questionnaire assuring the respondent of confidentiality. As a further means to maintain anonymity due to the small sample size information on age, sex, gender and ethnic origin is not requested.

Reliability and Validity

In developing the questionnaire the aim is to gather both attitudinal data surrounding the individual's feelings about training needs together with factual information.

Sample and Setting

The sample group consists of 50 staff including professional and unqualified employees working with three Therapeutic Communities. Each potential respondent will be sent via the Clinical Director or Manager a questionnaire together with prepaid addressed envelopes for return to the researcher.

Pilot Study

Due to time limitations it is unrealistic to undertake a stratified sample questionnaire.

Data Analysis

Qualitative and Quantitative data will be discussed and analysed manually.

Distribution of Data

Research findings will be available for review by each Therapeutic Community

	Details of arrangements
Consent procedures	Introductory telephone call to each Therapeutic Community Clinical Director discussing my background rationale for the study and ideas followed by email outlining intention. Following permission, questionnaire distributed to Team Leaders for dissemination to staff.
Access to respondents	Via Clinical Directors/Managers of Therapeutic Communities
Confidentiality	Confirmation that the research is for personal study and is not for public disclosure
Data storage, archiving and destruction	Data will be collected and stored in a locked filing cabinet. The intention is to shred the data at the end of the study.
Prevention of harm to respondents	There is no sensitive information within the questionnaire that would lead to risk of harm to respondents and no information/data gathered will be discussed outside of the tutorial environment
Safety of researcher	Geographical boundaries reduce any element of risk to the researcher and there is no direct contact with staff or residents at the Therapeutic Communities
Disclosure Scotland etc.	Not applicable
Note of any other relevant issues	

DECLARATION

I recognize that by submitting this form, I am agreeing to conform to the appropriate ethical procedures (see above) and to inform participants in any fieldwork that the research forms part of a degree programme. In addition, if further ethical issues arise during the course of my research I agree to raise these with my tutor.

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