Challenges and Potential Solutions to Implementing Phone Coaching in Dialectical Behavior Therapy

Sara J. Landes, *Central Arkansas Veterans Healthcare System, University of Arkansas for Medical Sciences*
Monica M. Matthieu, *Central Arkansas Veterans Healthcare System, Saint Louis University, College for Public Health and Social Justice, School of Social Work* Brandy N. Smith, *VA Palo Alto Healthcare System, National Center for PTSD*
Sacha A. McBain, *Central Arkansas Veterans Healthcare System, University of Arkansas for Medical Sciences*
Elizabeth S. Ray, *Central Arkansas Veterans Healthcare System*

Dialectical Behavioral Therapy (DBT) is an effective treatment for borderline personality disorder (BPD), yet many health care facilities struggle to implement one of the modes of DBT, phone coaching. The aims of this study were to present barriers and reported solutions regarding the implementation of DBT phone coaching. We conducted a sequential mixed methods national program evaluation that included a quantitative self-report survey completed by Department of Veterans Affairs (VA) facilities (N = 59) offering any of the four modes of DBT. Subsequent qualitative interviews using a semistructured interview guide informed by the Promoting Action on Research Implementation in Health Services (PARIHS) were completed with DBT providers and administrators from a subset (n = 16) of these VA sites. Four themes—the lack of tools and policies, compensation for phone coaching, clinician willingness to conduct phone coaching, and consistent program and leadership support—were identified and illustrated in a case study. This study also offered concrete recommendations for those health care organizations, managers, administrators, and clinicians who may be interested in implementing phone coaching at their health care facilities.

D eveloped to treat severe emotion dysregulation and suicidal behavior, research has demonstrated Dialectical Behavioral Therapy (DBT; Linehan, 1993) to be an effective treatment for borderline personality disorder (BPD; Koons et al., 2001; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan et al., 2006, 1999). In studies primarily with clients with suicidal behavior and BPD, DBT has been proven to reduce suicide attempts, nonsuicidal self-injury, drug use, symptoms of eating disorders, and to improve psychosocial adjustment and treatment retention (Linehan et al., 1999; Linehan et al., 2002; Linehan et al., 2006; McMain et al., 2009; Safer, Telch, & Agras, 2001; van den Bosch, Verheul, Schippers, & van den Brink, 2002; Verheul et al., 2003). In the Department of Veterans Affairs (VA) national health care system, DBT decreased male and female veterans' utilization and cost of mental health services, including hospitalizations (Meyers, Landes, & Thuras, 2014). Finally, in a meta-analysis of DBT, DeCou, Comtois, and Landes (2019) identified 18 controlled trials of DBT that demonstrated a reduction in self-directed violence as well as reduced frequency of psychiatric crisis services.

DBT is a complex evidence-based psychotherapy (EBP) with four treatment modes consisting of weekly skills groups, individual therapy, therapist consultation team, and phone coaching. DBT skills groups are taught in a classroom-like setting and the function is to increase the client's knowledge and skills in mindfulness, emotion regulation, interpersonal effectiveness, and distress tolerance. The function of individual therapy is to apply these skills to the client's life and enhance motivation to use skills and participate in treatment. Therapist consultation team meetings function as "therapy for the therapist" to assist providers in doing DBT, with a focus on making sure providers know what to do and are motivated to adhere to the treatment, as well as addressing any issues of burnout. The primary function of phone coaching is to increase the client's skill generalization to their daily life, which, according to the theoretical underpinnings of DBT, should thereby reduce suicidal and ineffective behaviors. Phone coaching can occur at any time of day (including outside of business hours), based on the needs of the client and with the prior agreement of the therapist. In general, DBT therapists provide access to phone coaching based on their individual personal boundaries or professional limits; some may offer 24/7 phone coaching, while

---

others may offer more limited access (e.g., no calls between 6–8 P.M.). If implementing all four modes of DBT, treatment generally lasts 1 year, resulting in approximately 182 hours of individual and group therapy per client (Landes et al., 2017).

As phone coaching, especially after hours, is a unique mode of treatment, a number of articles have been written to help providers use it effectively (Ben-Porath, 2011, 2014; Koons, 2011; Limbrunner, Ben-Porath, & Wisniewski, 2011; Linehan, 2011; Manning, 2011). Most recently, a comprehensive guide on phone coaching was published as part of a series of DBT practice books (Chapman, 2018). In general, providers who may be new to after-hours phone coaching often voice a reluctance or concern about what it entails, likely because after-hours contact with clients is not common in other treatment approaches. Providers worry that they will get constant crisis phone calls at all hours of the night and feel intruded upon. Training in DBT includes specific information about the function of after-hours phone coaching, the brief nature of calls, information on how infrequently calls generally occur, how to observe personal limits for calls (e.g., not taking calls from 6–8 P.M.), how to orient clients so they can use phone coaching appropriately, and how to deal with ineffective use of phone coaching.

When presenting the function of phone coaching, therapists emphasize that it is offered for three important reasons. These reasons include: (a) to decrease suicidal and nonsuicidal self-injurious behaviors, (b) to assist in generalizing the skills taught in treatment to everyday life, and (c) to provide an opportunity to make a repair in the therapy relationship if warranted (Linehan, 1993). It should be noted that phone coaching is an opportunity to engage in skill building before engaging in suicidal and nonsuicidal self-injury behaviors. The goal of phone coaching is, therefore, to help the client skillfully avoid these harmful behaviors. If a client engages in self-injurious behavior prior to utilizing phone coaching, they are required to wait 24 hours before contacting the therapist (Linehan, 1993). This rule must be clearly communicated to highlight that this is not a punishment; rather, once the self-injurious behavior has occurred, the opportunity for the therapist to provide coaching for skill use to avoid self-injury has already passed. When this rule is not adhered to, the behavior is treated as treatment-interfering behavior and discussed as such in the next therapy session.

Barriers to Implementing DBT and Phone Coaching in the VA Health Care System

Implementation of DBT that aligns with the full model of treatment with all four modes comes with a set of unique challenges (Landes & Linehan, 2012). As reported in Landes et al. (2017), skills group was the single most common mode of DBT implemented in VA settings (98% of respondents). It was followed by individual DBT (75%), phone coaching (in any form or amount; 61%), and therapist consultation teams (56%). Of the 35 sites that endorsed providing phone coaching in any form or amount, only four endorsed offering it 24/7 (i.e., with fidelity to the full DBT treatment model); that is, only 7% of all respondents were implementing phone coaching with fidelity.

When examining barriers to implementation of DBT in this VA program evaluation, 5 survey items out of 37 examined barriers specific to phone coaching (Landes et al., 2017). These included one item related to providers not being willing to take calls after hours, three items related to providers not being able or allowed to take calls, and one item related to lack of funding for calls. Overall, providers being unwilling or unable to take phone coaching calls during business hours were not identified as barriers. In contrast, the barriers related to personal time and resources being unavailable for calls outside of business hours, as well as funding to compensate therapists, were barriers experienced by many of the sites examined. In addition, the "three barriers rated as unable to overcome by the highest percentage of sites were all related to implementing phone coaching" (Landes et al., 2017, p. 837). A major limitation to these studies is that the survey results do not offer any additional reasons for why VA providers are unable to do phone coaching after hours.

To delve deeper into the reasons for this particular challenge in implementing phone coaching, the current study analyzed a subset of data from the VA national program evaluation noted previously. This subset of data included qualitative interviews that were subsequently conducted with VA providers to expand on and to clarify results that were identified on phone coaching from the previous quantitative survey. Therefore, the goal of this paper is to provide information regarding barriers to implementation specifically related to phone coaching and to describe solutions offered. Given that phone coaching is one of the least commonly implemented mode of DBT treatment, we focus here forward on its unique aspects and challenges. The purpose of this study is to provide concrete recommendations for those health care organizations, managers, administrators, and clinicians who may be interested in implementing the full model of DBT and want additional information to support phone coaching at their health care facilities.

Method

The design for the current study was a sequential mixed methods study of a national program evaluation that included a quantitative self-report survey and subsequent qualitative semistructured interviews (quan

→ QUAL) (Creswell, Klassen, Plano Clark, & Smith, 2011; Palinkas, 2014). The qualitative data presented here are a subset of the larger parent study focused on a national program evaluation of DBT treatment in VA health care settings. Because phone coaching is challenging at the organization and provider level, this study presents barriers and reported solutions specifically regarding the implementation of DBT phone coaching. A full description of the parent study, methods, and quantitative self-report survey results is available elsewhere (Landes et al., 2016), yet a brief overview will be provided here.

To guide the development of the interview questions and the analytic codebook, the Promoting Action on Research Implementation in Health Services (PARIHS; Kitson, Harvey, & McCormack, 1998) model was used as the overarching conceptual framework for this project. PARIHS describes successful implementation as a function of the nature and level of evidence for the practice, the context in which implementation will occur, and the way the implementation process is facilitated. Evidence includes research, provider clinical experience, and patient preferences. Context is defined as the environment or setting and includes setting characteristics and resources, leadership support, organizational culture, measurement, and perceived fit. Facilitation is defined as the process of helping individuals and teams to understand what they need to change and how they need to change it to implement the practice.[1] For example, interview questions focused on DBT implementation at each site and the context of that site (e.g., "what about the setting made it easier or harder to implement"; culture), the evidence used to decide to implement DBT (e.g., provider knowledge, patient request), and facilitation of implementation (e.g., "who moved implementation forward"; "what supports or resources were used").

Using a national program evaluation approach, the sampling frame included all VA facilities, herein called "sites," that (a) were identified to be utilizing DBT and (b) could be identified on an intranet DBT resource website. The study had no exclusion criteria. Once sites were identified, the research team employed a two-step, purposive, snowball sampling process to contact the listed point of contact for each site via their work e-mail address ($N = 59$). The research team subsequently requested that these providers share the invitation for study participation with others in their professional network who might be implementing DBT in any VA facility to expand the sample beyond those on the intranet site. Providers who agreed to participate were asked to complete a web-based survey related to their setting and implementation of DBT, including the use of DBT modes and strategies (e.g., frequency, length, and duration of each mode endorsed and offered at their VA facility), the type and amount of DBT training providers received, supporting resources preferred for using DBT, the barriers and facilitators to implementation of DBT in their setting, and the overall benefits of implementing DBT.

A subset of the sites ($n = 16$) that completed the quantitative survey were invited to participate in qualitative interviews. A clinical provider and administrator participated in interviews for each of the 16 sites (8 high-adopter sites, defined as implementing at least three modes of DBT, and 8 low-adopter sites, defined as implementing one or two modes of DBT). Qualitative data regarding clinical providers' and administrators' experiences with implementing DBT was collected using qualitative interviews informed by the PARIHS framework. (Kitson et al., 1998). As noted previously, interview questions were developed based on the PARIHS framework (e.g., context, evidence, facilitation) and DBT modes of treatment (e.g., skills group, phone coaching). Interviews were conducted by one member of the qualitatively trained research team (BNS) and transcribed verbatim. Another research team member checked the quality of the transcript against the audio file. Transcripts of the audio-recordings were entered into Atlas-ti, a software program that enables analysts to mark blocks of text with codes.

A PARIHS-informed codebook was created a priori to analyze the interview transcripts. The codebook included implementation focused codes based on PARIHS and built on definitions from Stetler, Damschroder, Helfrich, and Hagedorn (2011), as well as DBT codes to identify DBT components being discussed (e.g., skills group, phone coaching, full program). Following a deductive approach guided by domains identified from PARIHS, we used a two-tiered coding strategy (e.g., top- and sub-level). The team followed the conceptual framework of the PARIHS model and used the interview guide to develop a preliminary codebook. The three-person coding team independently assigned top-level codes to one half of the transcripts using the preliminary codebook, paying attention to top-level codes of context, evidence, and facilitation, among others. To ensure coding reliability and consistency, the PI reviewed initial and all final coding by the other two coders and settled any disagreements in weekly coding meetings. In the second round, the team identified sublevel codes that were "grounded" (i.e., associated with many quotations) based on their knowledge of the interviews from top level coding. Sublevel coding followed a similar trajectory to that of top-level coding applying sublevels codes to quotes within the top level codes. For example, sublevel coding

---

[1] Of note, a more recent iteration of this framework (the integrated PARIHS or i-PARIHS framework; Harvey & Kitson, 2015) has been developed since completion of this project. We are reporting using PARIHS given that it was the framework used for the project.

of all quotations in evidence included the following categories: (1) research/published guidelines, (2) clinical experience, (3) patient needs/preferences/ experiences, (4) local practice information, and (5) other characteristics of DBT. After top- and sublevel coding was complete, the team selected codes for further analysis that illuminated a particular topic, wrote summary statements, and outlined overarching themes across questions and codes, noting any repeating patterns or divergent ideas. Only data specific to one mode of DBT, phone coaching, was used for this analysis. The research team, comprised of three qualitatively trained raters, utilized content analysis (Mayring, 2014) to initially identify and to extract any specific references to phone coaching from the interviews. Data were then analyzed independently using Microsoft Word to group quotes into categories that were thematically similar. These categories were then transformed into themes related to barriers and solutions to implement phone coaching with discrepancies identified and resolved in team coding meetings. Quotes were purposively selected by the research team to provide an illustration of the resulting categories and themes. Interpretation of the data was again completed in coding meetings with the research team who compared, contrasted, and developed these overarching themes into a final summary report presented here. Ethical approval for the study was obtained from the appropriate VA institutional review board.

Results

Participants in the qualitative interviews included providers (N = 20) and administrators (N =17) from 16 sites. See Table 1 for a summary of demographic information.

The results of this program evaluation are framed within the context of the national health care system for veterans—the VA. As background for this study, VA policies do not account for outpatient mental health providers to work beyond their established work schedule or "afterhours." Within outpatient mental health settings, clinical providers typically work a traditional 40-hour work week during business hours on weekdays (e.g., 8:00 A.M.–4:30 P.M., Monday to Friday). In VA, most clinical providers are salaried employees that are compensated by an hourly equivalent rate. Those who work irregular hours are paid a differential rate for evening or night hours, weekends, or holidays. Different types of compensation include overtime pay, compensatory time (e.g., an hour of time off for working an extra hour), monetary awards, and time-off awards. Except for psychiatrists who have on-call shifts that cover a 24-hour period, outpatient mental health providers are not expected to be on call or available to work during times when they are off duty. To fill the gaps when mental health providers are off duty,

the VA administers emergency rooms with psychiatric services available and offers the Veterans Crisis Line, a 24/7 crisis line available for veterans, service members, and their loved ones to access at any time via phone, text message, or online chat.

Within this context of outpatient mental health services in the VA, this study identified four broad themes related to VA clinician and administrators' perceived challenges to implementing DBT phone coaching. These themes include: (a) tools and policies; (b) compensation for phone coaching; (c) clinician willingness to conduct phone coaching; and (d) consistent program and leadership support. Each theme is presented below, first describing the theme, the provider-identified solutions to that barrier, and quotes to illustrate the theme. See Table 2 for a summary of the barriers and potential solutions. Following this, a case study is then presented to provide an in-depth analysis of all of the themes and issues inherent with phone coaching.

Barrier: Absence of Tools and Policies

Significant barriers to implementation of phone coaching included the absence of tools and policies to

Table 1
Participant Characteristics (n = 37)

	N	%
Gender		
Female	23	62.1%
Male	14	37.8%
Age		
30 – 39	13	35.1%
40 – 49	12	32.4%
50 – 59	5	13.5%
60 – 69	7	18.9%
Profession		
Psychologist	25	67.5%
Social Worker	10	27.0%
Psychiatrist	2	5.4%
Race		
Caucasian	31	83.7%
Asian	1	2.7%
Biracial	3	8.1%
Other	1	2.7%
Decline to State	1	2.7%
Professional Role		
Clinician/Provider	11	29.7%
Program Coordinator	9	24.3%
Supervisory/Leadership	13	35.1%
Other Role	4	10.8%
Treatment setting		
Specialty Mental Health Clinic	8	21.6%
General Mental Health Clinic	18	48.6%
Primary Care Clinic	4	10.8%
Other settings	7	18.9%

Table 2
Summary of the Barriers and Potential Solutions

Barrier	Potential Solutions
Absence of Tools and Policies	- Advocating to leadership for the approval for providers to use personal cell phones - Creating a clinical protocol for how to use personal phones - Obtaining permission to get a work cell phone
Compensation for Phone Coaching	- Overtime time pay - Time-off awards - Educating leadership and HR about phone coaching
Clinician Willingness to Provide Phone Coaching	- DBT training - Gradual implementation - Recommitment to phone coaching
Consistent Program and Leadership Support	- Educating leadership about the DBT model, core components, and research supporting DBT - Educating leadership about what was specifically involved in phone coaching and why it is needed and helpful for patient care - Collecting and presenting service utilization data and information on cost savings - Adopting language related to leadership goals to describe the treatment and show how DBT fits with leadership's goals

address barriers to DBT implementation. Tools in this context were defined as tangible things that clinicians used to conduct phone coaching, such as work cell phones and a laptop or other computer that would allow remote access to the electronic medical record to obtain client information and document the phone coaching clinical encounter. Policies are defined as organizational policies and clinical procedures that support employees to provide a range of clinical services within a health care organization.

Most central to this theme was the lack of after-hours access to a work cell phone. In the VA, employees must have a business rationale or a job description that authorizes the issuance of government-furnished equipment such as cell phones or laptops. Without this authorization, VA employees are not provided with technology or tools that can be removed from their official work location or VA office. The lack of access to a work cell phone that could be removed from the VA premises and used for phone coaching afterhours was a major barrier.

To address the absence of a dedicated work cell phone and to avoid giving out personal telephone numbers, some DBT providers reported utilizing an internet-based call-forwarding service like Google Voice, which provides a unique randomly generated telephone number that allows call forwarding to any other phone. Others reported using their personal cell phones. There is no existing formal policy against the use of personal phones within VA, although these means are less preferable by the providers than use of VA-furnished equipment.

For other participants, the lack of a laptop computer with remote access to the electronic medical record added another barrier. Participants noted that sometimes phone coaching calls involved a situation where they felt

that the patient needed assistance to be immediately sent to their location (e.g., a welfare check by police or an ambulance). If the client refused to voluntarily offer their address, the clinician would explain that they could not maintain confidentiality given the risk of harm to self, and that the previously agreed upon emergency crisis plan would be initiated. This crisis plan may necessitate access to information in the electronic medical record, such as their physical or residential address to be disclosed to local emergency response personnel. One participant reported dealing with lack of remote access by contacting staff at the hospital who were available after hours and whose job included access the medical record. They described:

"But even when you have the incentive, if you don't have the tools … Like, I don't have computer access on the weekends. So, when I get a coaching call, if [the patient is] in crisis, I have to call the [hospital] bed coordinator, get her to look up the person's … address … to send the police there…"

In addition to having emergency access to information such as addresses, upon the completion of a coaching call, some providers wanted remote access to the electronic medical record for the ability to document the clinical encounter. VA, like most health care systems, requires documentation of clinical encounters in the electronic medical record within 24 hours or the next business day. For those who cannot engage in electronic documentation right away due to being offsite, a paper log of telephone encounters was suggested. Clinicians who maintain a paper log of telephone encounters can subsequently enter these encounters electronically on the next business day.

Regarding after-hours crisis calls, clinicians utilize clinical judgment to decide if they need to report to their workplace to complete documentation before the next business day, which is standard practice, or call and communicate needed information to police or the emergency department.

To protect patient privacy, providers engaging in offsite phone coaching and any related clinical documentation should adhere to all organizational privacy policies. Within VA, the Department of Veterans Affairs Information Security Rules of Behavior dictates how VA employees are required to protect sensitive information. Per the Rules of Behavior, providers should ensure they are utilizing VA-approved encryption products, securing all written material (e.g., paper logs) when not in use in locked storage space, and only using the minimum necessary amount of information to perform the required duty. VA providers can only store VA sensitive information on non-VA systems or devices if specifically designated or authorized in advance by a VA supervisor, Information Security Officer, Information System Owner, local Chief Information Officer, or designee. Providers should address the possible risks to privacy associated with phone coaching in their informed consent process, create or adhere to organizational protocols regarding lost or stolen devices that may contain sensitive information, and use password protection and encryption wherever possible. Regarding the other aspect of this theme, organizational policies and clinical procedures to support phone coaching were lacking across all sites. This absence of policies or clinical protocols for conducting and documenting the phone coaching clinical encounter was a major barrier. Many participants stated there was a lack of existing guidance or a similar clinical after-hours situation regarding a phone coaching protocol that would be acceptable to the organization. The ambiguity and/or lack of training for how to develop a policy or clinical protocol made this barrier insurmountable for some sites. For example, given that after-hours clinical encounters by phone are not included in most providers' job descriptions, it was not clear what protocol would be appropriate.

Potential Solutions to Absence of Tools and Policies

Identified solutions to a lack of policy or clinical protocol included advocating to leadership for the approval for clinical providers to use their personal cell phones and creating a written clinical protocol for how to use personal phones for after-hours DBT phone coaching. This protocol outlined the purpose and parameters of the providers' use of personal cell phones, as well as the necessary documentation procedures and time line for the clinical encounter. Finally, this protocol also included specific guidance on the use of text messaging for clients to request after-hours phone coaching.

Another solution involved obtaining permission to get a work cell phone. One site was able to get permission for one work cell phone to be issued to the DBT team, so they created a schedule regarding who would carry the phone and provide after-hours phone coaching to all DBT patients. Providers on the DBT team agreed to carry the phone for 1 to 2 weeks at a time and also rotated who would have the phone during holidays. This arrangement was approved by their supervisors and clarified to DBT patients so that they understood that when they called the number for after-hours phone coaching they would be in contact with one of the DBT providers and not necessarily their individually assigned DBT provider. While this solution addressed the tangible challenge of needing the tool, participants identified that it was still perceived as a policy challenge, as one stated:

> "We have a cell phone that we take turns carrying for a week at a time, and so we've looked at a couple of different options. We've been doing that since 2008 and we're able to make it work, but it is really challenging and there's certainly no VA policy or rule that would be helpful in promoting that."

Finally, other solutions appeared gradually over time, as teams often solved these tools and policy barriers in a series of progressive steps. These steps included first training providers in the DBT style of phone coaching to increase the number and expertise of DBT-trained staff. Once a critical mass was identified and trained, then the addition of tools such as a rotating phone and documentation strategies to support phone coaching were utilized. Other DBT teams experimented with various tools and strategies. Once they identified a site-specific manner of phone coaching, they would then develop a policy to support DBT-trained providers who were committed to providing this clinical service. One study participant stated this progression from training to policy in this way:

> "They started taking coaching calls after that [intensive DBT] training. So that was the first thing that happened, was 'We're going to offer coaching calls.' Then the second thing was, like, 'Okay, so what phone number do we give the patients?' And so, we were using Google Voice for a while, and then that got really complicated. And then some people started using their personal cell phones. And then we wrote an SOP [standard operating procedure] about coaching calls."

Barrier: Compensation for Phone Coaching

A second frequently identified barrier to implementation of phone coaching was lack of provider compensation for after-hours phone coaching. Numerous sites identified lack of appropriate financial alternatives to compensate for after-hours phone coaching or the lack of available funds in the operating budget for compensation as barriers. Participants described working with leadership (e.g., clinic or mental health service leadership) and human resource (HR) offices to determine the organizational parameters that impacted how and if they could be compensated for working after-hours to offer phone coaching.

Potential Solutions to Compensation for Phone Coaching

Participants described HR solutions such as providing overtime pay (i.e., 15 minutes of overtime pay) and time off awards (i.e., accruing leave that can be used later based on time spent on calls). One site was concerned with inadvertently reinforcing longer calls by paying for the exact amount of time, especially when phone coaching calls are designed to be brief calls. To address this, they offered overtime at a flat rate. They described it as follows:

> "So, afterhours coaching calls, we get one hour of overtime for every coaching call we take. It's, like, a flat rate. If the same patient calls us three times in one day after hours, we'd get three hours of overtime for that, no matter how long the call lasted."

In addition to this proposed compensation solution, participants described needing to educate leadership and HR to help them understand what phone coaching included. This was critically important as turnover in leadership and HR could result in changes to agreements. Participants at one site identified that turnover in HR leadership after establishing a staff compensation solution resulted in having to change the system for compensation for phone coaching calls. Regarding educating leadership, one participant stated:

> "What we proposed was two hours of leave time to take the phone a week, four hours on a holiday week to increase the incentive for holidays. And then, 30 minutes per call, and if it was a particularly complicated call, you could get 60 minutes. So, that's kind of how we proposed it… Leadership thought it was reasonable. However, the way it went through HR was they were going to pay us overtime for the entire time we had the phone, which would have been a huge bill and we knew that wouldn't work. I mean, once they realized how much money that was going to be, they would sink the whole deal. So, we actually argued against that because we thought they

really didn't understand what they were doing, and that would never fly, and we ran it by administration and they said, 'Oh yeah, no, that would break the budget. We couldn't do that.' So, how we did it … was that they would give us awards every six months. So, we would keep track of the time awarded to each staff person. And then every six months we'd get time off work."

Participants also described in detail the perceived limitation of funds available for overtime compensation. One site described working with leadership to pilot compensating providers for phone coaching. They used a temporary fund, collected data, and were able to demonstrate that the practice was useful and worth spending money on. This site's ability to demonstrate the need for and evaluate outcomes produced a business case for the value of phone coaching. They described it as follows:

> "We wanted to incentivize the phone coaching piece . . . so we worked with local leadership to get a fund established and it was a temporary fund. We were beta testing it, pilot testing it for a little while and then after about a year or so, it was clear that it was a useful expenditure of money and, again, we compared, again, the inpatient stays for those who were in the program versus before they were in the program and things like that, so the cost-benefit analysis was, again, kind of brought to leadership's attention."

Barrier: Clinician Willingness to Provide Phone Coaching

The third barrier to implementation was a lack of clinician willingness to provide phone coaching after hours. However, this barrier was less prevalent than the lack of the tools or policies to support phone coaching.

Potential Solutions to Clinician Willingness to Provide Phone Coaching

A common solution identified by participants was to increase clinician willingness to engage in phone coaching through DBT training. The training allowed for education of providers, team building, and an opportunity to recommit to DBT and the phone coaching requirements. One participant described it this way:

> "They were able to send eight providers to the two-week intensive [training], and so we went to that and it was a great kind of team-building experience and, once we completed that, we really kind of renovated [the program], so we had providers commit. That was when we had providers commit to at least two years and carrying three to five people at a

time, or clinical units at a time, and then that was also started the afterhours phone coaching."

As described in the quote above, some sites described using a gradual implementation process to get a full DBT program model established at their facility. For example, some participants reported that their team had started with offering phone coaching during business hours and then expanded the service to after hours over time. This measured change approach impacted clinician willingness in both directions, as some DBT teams' practices and personnel changed over time such that a provider may have agreed to do DBT with phone coaching during business hours and was not willing to do after-hours coaching when the program changed. To address clinician willingness in the context of extending phone coaching to after hours, the solution was to orient providers to the new expectations and allow providers to choose to recommit to phone coaching or to opt out. One participant described the gradual implementation and recommitment to phone coaching as follows:

"We talked to the existing staff really about the idea of upping their commitment [to the team] for two years, their willingness for two years to do this. And then along with that, it was time to do the 24-hour phone coaching, and would they be willing. . . . So, that was a hard sell, and we lost some staff but . . . there were some new staff that came on board and made the two-year commitment."

Barrier: Consistent Program and Leadership Support

The fourth and final barrier to implementation of phone coaching was lack of leadership support. For some sites, lack of leadership support appeared related to leadership perceptions that the resources (e.g., compensation, staffing) were not available or that after-hours coaching was not needed. As described by participants, those in leadership positions may not have been aware of the staff support of and the patient-level benefit of after-hours coaching.

Potential Solutions to Consistent Program and Leadership Support

A frequent solution included educating leadership about the DBT model, the research supporting the therapeutic approach, the core components of DBT, what was specifically involved in phone coaching, and why phone coaching was needed and helpful for patient care. Other solutions included challenging leadership beliefs through the collection and presentation of service utilization data, information on cost savings, and adopting language related to leadership goals to describe the treatment and therefore show how DBT's treatment

model fits with leadership's goals (e.g., patient-centered care). One participant described how a champion of DBT at their site collected data to demonstrate that after-hours coaching was helpful to patients and the organization:

"She did a pretty thorough job of collecting data. … and then she was able to hand that up to the supervisors who brought it to other higher up administrators, and basically that data covered [the] amount of … inpatient hospital visits, both for medical and mental health reasons. And then, (Name) got some data [about]… cost savings. And so, when we pitched it that way of, you know, if we start this program we can reduce the amount of visits, etc., etc., save costs... At that point, there was this terminology of veteran centered care that was just kind of gaining momentum. And so, it was used as, 'Hey, this is a veteran centered treatment. It's a way to save money.' So, those two aspects were [what] really pushed [it] forward."

Case Example

A description of one site's implementation process is provided now as a case example of how to approach the common challenges related to implementing phone coaching. This site, the Southern Arizona VA Health Care System, was chosen for the example because they identified a unique solution to implementing phone coaching that addressed all of the most common barriers to implementation. The site and site champion, Christine Way, LCSW, had attempted to advocate for tools and policy solutions within the outpatient mental health setting and was unable to obtain approval for compensation for the providers offering phone coaching after hours or access to phones or pagers. They described being committed to offering phone coaching and continued to work to determine how to do it within the constraints of the organization. They described their commitment and how they engaged with leadership of different clinical services to help solve the problem:

"The team was really clear that they were not going to do a full program without phone coaching, and so was kind of figuring out how we would do it. We proposed having our staff carry a pager. Due to monetary cost they would not allow it, so we just kind of turned the tables to them and said, 'So what are you willing to do to support it?' So, I guess my chief kind of talked to his supervisors and said, 'Okay, so how are we going to do this?' Like, we look at our Psychiatry residents carrying pagers, we have a Mental Health Intensive Case Management program that carries pagers, and then our inpatient providers. So the inpatient nursing director at that time stood up and said, 'We want these patients off the unit in a healthy way, like out in a good community getting treatment versus being

on our unit three or four times a year, so we'll do that to help get them off the unit.'"

With support from the inpatient nursing director, this site implemented after-hours phone coaching for outpatient mental health DBT patients using the inpatient nursing staff. They did this by identifying a unit that already possessed the staffing and tools needed to meet the function of phone coaching (e.g., 24/7 staff support and access to work phones).

The site worked with their facility leadership and nursing leadership to get buy-in from nursing staff who would provide the coaching. They did this by identifying the benefit of after-hours phone coaching to the inpatient unit —namely, that it could help patients use DBT skills and prevent or reduce readmission to the inpatient psychiatric unit. They also highlighted that the timing was for after-hours phone coaching, not 24/7 coaching, as the DBT providers could do phone coaching during business hours.

"At first we had contact with the director of the nurses there. So we went sort of to their administration as well as the administrative supervisor over [inpatient unit], because it was a different supervisor that we had. And so, our supervisors were talking to that supervisor who was on board. And then, Christine communicated with the nurse there, who then talked to her staff and again kind of pitched it as, if we can prevent a lot of these people from coming to us by doing a 10 or 15 minute phone call … the hours that they were going to be manning the phone were kind of off-peak hours anyway, when a lot of their patients are sleeping and they're not doing a lot of direct patient care. They were willing to do it."

They described some ambivalence from some of the nursing staff, which was addressed with education and training on DBT, DBT skills, how to do phone coaching, and the overall benefit for the inpatient nursing service.

"It was a little bit of probably hesitation on the part of some of the nurses. And then, when Mrs. Way (a mental health provider trained in DBT) went over there and did some training, they warmed to the idea pretty quickly once they saw that it wasn't going to be as labor-intensive as they thought."

Like other participants in this study, this site described the challenges that arose when there was turnover in the nursing leadership position. They used orientation, education, and worked to establish recommitment with new leadership in hopes of preventing potential future barriers related to lack of leadership buy-in.

"The only pushback we got, I think, was … when the nurse that we had the relationship with left, took another job. A new person came on, said, 'Yeah, we're not doing this. This is ridiculous.' So, it was kind of just the same approach again of Mrs. Way (a mental health provider trained in DBT) going back to the supervisor and saying, 'Hey, this is something we have set up. If we don't keep it going, the DBT team is going to be debunked… In order to do the full program, we need the phone coaching.' And then the supervisor talked to the nurse, and then I think Mrs. Way had an opportunity to sort of educate the new person in there. And again, I think a lot of the assumptions on the front end from her as well as early on from some of the nursing staff was that it was going to be a crisis line, where people were just going to call and you wouldn't be able to get them off the phone. So I think, again, once the education and training was done, there haven't really been any problems."

Discussion

The aims of this study were to present barriers and reported solutions to implementing DBT phone coaching. The barriers and solutions were grouped into four themes: the lack of tools and policies, compensation for phone coaching, clinician willingness to conduct phone coaching, and consistent program and leadership support. These challenges have been identified in other DBT implementation studies (Carmel, Rose, & Fruzzetti, 2014; Herschell, Kogan, Celedonia, Gavin, & Stein, 2009; King, Hibbs, Saville, & Swales, 2018), as well as in implementation research in general. All four themes of barriers identified in this analysis were related to the PARIHS construct of context (e.g., policies available, compensation, provider perspective, and leadership support), while the solutions described included addressing the context providing evidence, and additional examples of facilitating the implementation process. This study is innovative as there is limited data available about the implementation of phone coaching in DBT. The data presented here identify barriers and offer practical solutions to one of the most frequently reported barriers to implementing a DBT program.

Regarding solutions for tools and policies, some sites reported developing their own policy, clinical protocol, or standard operating procedure (SOP). In VA, creating a local SOP or policy is appropriate to fill gaps in national policy and guidelines. There is a formal process for approving these local policies that includes approval at various levels of leadership within the facility. For example, in mental health at one facility this included approval by the Associate Chief of Staff for Mental Health, the Facility Chief of Staff, and the Facility Director.

It is also possible to identify and adapt existing policies or clinical protocols that include after-hours and on-call shifts for mental health clinicians. While participants in our interviews stated that there were no available existing

policies that could be adapted, we have since identified some. For example, within VA, Residential Rehabilitation Treatment Programs are structured so that clinician duties include rotating on-call responsibilities, which include carrying a work cell phone and being available to on-site staff for assistance after hours. This on-call work is in addition to their traditional daytime work schedules. These clinicians are compensated for this type of work as part of their pay. The national policy that supports this practice is a good example of one that could be adapted for outpatient mental health clinicians doing DBT. Other examples of roles that include access to a work cell phone and offsite or after-hours work include intensive case managers or home health providers. These policies not only allow for a template to follow, they provide needed structure and information to inform compensation, allow clinicians to understand and commit to phone coaching, and engage leadership support.

Given that a policy might address the other identified barriers, addressing the gap in VA policy for outpatient mental health services regarding after-hours phone coaching may be a critical solution to support DBT phone coaching across the health care system. The policy could describe what is appropriate, types of providers appropriate for this work, protocols for implementing and conducting phone coaching, and type of compensation to provide (or options). This could then inform revision of position descriptions for VA providers who will provide DBT and therefore make a business case for having a work cell phone (or access to one on the team) and remote access to the electronic medical record.

Limitations to this study include that it only included sites in VA implementing DBT. VA is a national health care system and while it may generalize to other large health care systems, not all aspects are generalizable, especially the process for creating or augmenting organizational policies. Participants in the qualitative interviews did not include anyone in the position of authority regarding VA-wide policies.

Future research on how to implement DBT and, more specifically, phone coaching, may benefit from including patient-level perspectives, as the individual-level perspective from clients and their decision making for utilization is key to understanding implementation as well. For example, when phone coaching is offered, patients may have difficulty using it for a variety of reasons (e.g., not wanting others to hear, cost of phone or minutes, shame or stigma in needing to ask for help). In addition, once implemented, providers may have difficulty doing phone coaching due to inadequate knowledge, lack of skill, or having negative perceptions of phone coaching. Additional research on how to best equip providers to use phone coaching effectively is needed. Finally, client difficulties and provider difficulties with phone coaching

likely interact, such that a provider struggling to introduce phone coaching may result in a client struggling to use it and vice versa. Additional work is needed to understand these interactions and how to best apply DBT principles and skills to implementation of phone coaching.

Conclusion

The aims of this study were to present barriers and reported solutions to implementing DBT phone coaching. This study provided concrete recommendations for those health care organizations, managers, administrators, and clinicians who may be interested in implementing phone coaching at their health care facilities. Finally, a case study that illustrated all four themes—lack of tools and policies, compensation for phone coaching, clinician willingness to conduct phone coaching, and consistent program and leadership support—was presented. These solutions could be implemented in a variety of settings and may be useful in other large health care organizations.

References

Ben-Porath, D. D. (2011). Introduction. *Cognitive and Behavioral Practice*, *18*(2), 165–167. https://doi.org/10.1016/j.cbpra.2010.06.001.

Ben-Porath, D. D. (2014). Orienting clients to telephone coaching in dialectical behavior therapy. *Cognitive and Behavioral Practice*. https://doi.org/10.1016/j.cbpra.2014.02.004.

Carmel, A., Rose, M. L., & Fruzzetti, A. E. (2014). Barriers and solutions to implementing dialectical behavior therapy in a public behavioral health system. *Administration and Policy in Mental Health and Mental Health Services Research*, *41*(5), 608–614. https://doi.org/10.1007/s10488-013-0504-6.

Chapman, A. L. (2018). *Phone Coaching in Dialectical Behavior Therapy.* New York, NY: Guilford Press.

Creswell, J. W., Klassen, A. C., Plano Clark, V. L., & Smith, K. C. (2011). *Best practices for mixed methods research in the health sciences.* Bethesda (Maryland): National Institutes of Health Retrieved from https://tigger.uic.edu/jaddams/college/business_office/Research/Best_Practices_for_Mixed_Methods_Research.pdf.

DeCou, C. R., Comtois, K. A., & Landes, S. J. (2019). Dialectical behavior therapy is effective for the treatment of suicidal behavior: A meta-analysis. *Behavior Therapy*, *50*(1), 60–72. https://doi.org/10.1016/j.beth.2018.03.009.

Harvey, G., & Kitson, A. L. (2015). *Implementing evidence-based practice in healthcare: A facilitation guide.* New York, NY: Routledge.

Herschell, A., Kogan, J., Celedonia, K., Gavin, J., & Stein, B. (2009). Understanding community mental health administrators' perspectives on dialectical behavior therapy implementation. *Psychiatric Services*, *60*, 989–992. https://doi.org/10.1176/ps.2009.60.7.989.

King, J. C., Hibbs, R., Saville, C. W. N., & Swales, M. A. (2018). The survivability of dialectical behaviour therapy programmes: A mixed methods analysis of barriers and facilitators to implementation within UK healthcare settings. *BMC Psychiatry*, *18*, 302. https://doi.org/10.1186/s12888-018-1876-7.

Kitson, A., Harvey, G., & McCormack, B. (1998). Enabling the implementation of evidence based practice: A conceptual framework. *Quality in Health Care*, *7*(3), 149–158.

Koons, C. R. (2011). The role of the team in managing telephone consultation in dialectical behavior therapy: Three case examples. *Cognitive and Behavioral Practice*, *18*(2), 168–177.

Koons, C. R., Robins, C. J., Lindsey Tweed, J., Lynch, T. R., Gonzalez, A. M., Morse, J. Q., & Bastian, L. A. (2001). Efficacy of dialectical behavior therapy in women veterans with borderline personality disorder. *Behavior Therapy*, *32*(2), 371–390. https://doi.org/10.1016/S0005-7894(01)80009-5.

Landes, S. J., & Linehan, M. M. (2012). Dissemination and implementation of Dialectical Behavior Therapy: An intensive training model. *Dissemination and Implementation of Evidence-Based Psychological Interventions* (pp. 187–208). New York, NY: Oxford University Press.

Landes, S. J., Matthieu, M. M., Smith, B. N., Trent, L. R., Rodriguez, A. L., Kemp, J., & Thompson, C. (2016). Dialectical behavior therapy training and desired resources for implementation: Results from a national program evaluation in the Veterans Health Administration. *Military Medicine*, *181*, 747–752. https://doi.org/10.7205/MILMED-D-15-00267.

Landes, S. J., Rodriguez, A. L., Smith, B. N., Matthieu, M. M., Trent, L. R., Kemp, J., & Thompson, C. (2017). Barriers, facilitators, and benefits of implementation of dialectical behavior therapy in routine care: Results from a national program evaluation survey in the Veterans Health Administration. *Translational Behavioral Medicine*, *7*(4), 832–844. https://doi.org/10.1007/s13142-017-0465-5.

Limbrunner, H. M., Ben-Porath, D. D., & Wisniewski, L. (2011). DBT telephone skills coaching with eating disordered clients: Who calls, for what reasons, and for how long? *Cognitive and Behavioral Practice*, *18*(2), 186–195.

Linehan, M. M. (1993). *Cognitive-Behavioral treatment of borderline personality disorder*. New York, NY: Guilford Press.

Linehan, M. M. (2011). Dialectical behavior therapy and telephone coaching. *Cognitive and Behavioral Practice*, *18*(2), 207–208.

Linehan, M. M., Armstrong, H. E., Suarez, A., Allmon, D., & Heard, H. L. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry*, *48*(12), 1060.

Linehan, M. M., Comtois, K. A., Murray, A. M., Brown, M. Z., Gallop, R. J., Heard, H. L., & Lindenboim, N. (2006). Two-year randomized controlled trial and follow-up of Dialectical Behavior Therapy versus therapy by experts for suicidal behaviors and borderline personality disorder. *Archives of General Psychiatry*, *63*, 757–766.

Linehan, M. M., Dimeff, L. A., Reynolds, S. K., Comtois, K. A., Welch, S. S., Heagerty, P., & Kivlahan, D. R. (2002). Dialectical behavior therapy versus comprehensive validation therapy plus 12-step for the treatment of opioid dependent women meeting criteria for borderline personality disorder. *Drug and Alcohol Dependence*, *67*(1), 13–26.

Linehan, M. M., Schmidt, H., Dimeff, L. A., Craft, J. C., Kanter, J., & Comtois, K. A. (1999). Dialectical behavior therapy for patients with borderline personality disorder and drug-dependence. *American Journal on Addictions*, *8*(4), 279–292. https://doi.org/10.1080/105504999305686.

Manning, S. Y. (2011). Common errors made by therapists providing telephone consultation in dialectical behavior therapy. *Cognitive and Behavioral Practice*, *18*(2), 178–185.

Mayring, P. (2014). *Qualitative content analysis: Theoretical foundation, basic procedures and software solution.* : Klagenfurt.

McMain, S. F., Links, P. S., Gnam, W. H., Guimond, T., Cardish, R. J., Korman, L., & Streiner, D. L. (2009). A randomized trial of dialectical behavior therapy versus general psychiatric management for borderline personality disorder. *The American Journal of Psychiatry*, *166*(12), 1365–1374. https://doi.org/10.1176/appi.ajp.2009.09010039.

Meyers, L. L., Landes, S. J., & Thuras, P. (2014). Veterans' service utilization and associated costs following participation in dialectical behavior therapy: A preliminary investigation. *Military Medicine*, *179*(11), 1368–1373. https://doi.org/10.7205/MILMED-D-14-00248.

Palinkas, L. A. (2014). Qualitative and mixed methods in mental health services and implementation research. *Journal of Clinical Child & Adolescent Psychology*, *43*(6), 851–861. https://doi.org/10.1080/15374416.2014.910791.

Safer, D. L., Telch, C. F., & Agras, W. S. (2001). Dialectical behavior therapy for bulimia nervosa. *American Journal of Psychiatry*, *158*(4), 632–634.

Stetler, C. B., Damschroder, L. J., Helfrich, C. D., & Hagedorn, H. J. (2011). A guide for applying a revised version of the PARIHS framework for implementation. *Implementation Science*, *6*(1), 99.

van den Bosch, L. M. C., Verheul, R., Schippers, G. M., & van den Brink, W. (2002). Dialectical behavior therapy of borderline patients with and without substance use problems: Implementation and long-term effects. *Addictive Behaviors*, *27*(6), 911–923.

Verheul, R., Van Den Bosch, L., Koeter, M. W., de Ridder, M. A., Stijnen, T., & Van Den Brink, W. (2003). Dialectical behaviour therapy for women with borderline personality disorder 12-month, randomised clinical trial in The Netherlands. *The British Journal of Psychiatry*, *182*(2), 135–140.

Address correspondence to Sara J. Landes, Ph.D., Central Arkansas Veterans Healthcare System, 2200 Fort Roots Drive, North Little Rock, AR 72114; e-mail: sara.landes@va.gov.