Adapting standard Dialectical Behaviour Therapy (DBT) to a public community mental health program: Exploration of barriers and alternatives to 24/7 phone coaching

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Introduction

• Standard DBT is a comprehensive treatment for high-risk suicidal individuals with Borderline Personality Disorder, with 4 modalities (individual therapy, skills group, consultation team, 24/7 phone coaching).
• 24/7 phone coaching facilitates generalization of skills outside the therapy setting; it is usually the most challenging aspect of DBT to implement fully.
• Fraser Health Authority (FHA) is in process of implementing DBT but does not have resources for standard DBT.
• Research on less resource-intensive DBT adaptations is still limited, especially on 24/7 phone coaching alternatives.

Objective

• Understand FHA clinician perspectives on barriers and acceptable alternatives to 24/7 phone coaching.
• Promote DBT implementation throughout FHA’s geographically large and diverse region.

Methods

• Qualitative semi-structured interviews of FHA staff trained in and practicing DBT, recorded/transcribed.
• Questions from Consolidated Framework for Implementation Research1 (CFIR) interview guide tool2.
• Participants: 12 clinicians distributed across all 3 FHA regions (North: 5, South: 4, East: 3) and clinical disciplines (psychologists, nursing, social work, and counsellors).
• Analysis based on CFIR guidelines and informed by grounded theory.

Acknowledgement

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Results

Advantages:
• increased accessibility for clients
• generalization of skills in real-time
• diminished pressure on emergency health services

Motivation To Implement:
• Best care for clients: “We’d be able to say we are offering gold standard for most vulnerable and needy in society”.

Alternatives:
• coaching clients within working hours,
• group coaching/set hour clients can call,
• rotational phone coaching team,
• training crisis line staff in DBT skills,
• Hire casual staff to relieve DBT therapists from non-DBT work

Discussion

The interviews demonstrated that most of the barriers fall within the Inner Setting Domain. It is clear that leadership support is essential to sustain and further develop our DBT program. This is similar to findings in other public health systems3. 24/7 coaching is not feasible within current constraints, but some adaptations may be.

Somewhat unexpectedly, most participants agreed that running a pilot project for 24/7 phone coaching would be beneficial, and many were already doing some form of phone coaching.

Limitations: participants who volunteered may be the more passionate among 50+ eligible staff; we selected CFIR questions based on our knowledge of FHA; interviewees were from only 8/12 FHA communities (lack of volunteers from remaining 4), findings specific to FHA.

Implications

Our findings highlight a passion for DBT and strong interest in implementing some phone coaching in FHA despite serious challenges. Leadership can capitalize on this dedication by enriching educational opportunities and providing support in managing workloads.

Strategies FHA may consider to promote standard DBT:
• show how DBT can ENHANCE (not compete with) coping with high priority challenges (COVID-19 and opioid overdose pandemics)4.
• program evaluation and comparison of outcomes with other community programs that offer gold-standard DBT treatment to justify more staffing and financial support for the program.
• piloting extended hours or acceptable alternatives to phone coaching.
• increasing general awareness of DBT to garner support from stakeholders.
• motivate clinicians by attending to burnout and current workload stressors.

References

2. https://cfirguide.org/guide/app/#/