ORIGINAL ARTICLE

Barriers and Facilitators to Implementing a Short-Term Transdiagnostic Mental Health Treatment for Homeless Persons

Soo Jeong Youn, PhD,* Shannon Sauer-Zavala, PhD,† Kaylie A. Patrick, MPH,‡ Emily M. Ahles, BA,‡ Yesenia Aguilar Silvan, BA,‡ Astrea Greig, PsyD,§ Luana Marques, PhD,* and Derri L. Shtasel, MD, MPH*

Abstract: Despite the significant mental health needs and comorbidity in homeless individuals, there is a "science-practice gap" between the available evidence-based treatments (EBTs) and their lack of use in community health centers servicing homeless populations. To address this gap, it is imperative to evaluate and attend to the contextual factors that influence the implementation process of EBTs before their integration into routine care. The study aims to evaluate the barriers and facilitators to implementing a transdiagnostic EBT in a community health center serving homeless individuals. The results of the thematic analyses (7 focus groups, 67 participants) yielded 8 themes for barriers and 10 themes for facilitators to implementation. The findings of the current study highlight common tensions faced by community programs and clinicians when working toward integrating EBTs across different types of populations, and those unique to homeless persons. Results can inform subsequent strategies used in implementing EBTs.

Key Words: Homeless individuals, transdiagnostic, implementation, qualitative methods, community health centers

(J Nerv Ment Dis 2019;207: 585–594)

Individuals with mental illnesses have a much higher risk of becoming homeless than the general population, and individuals who are homeless suffer from severe mental illness at rates higher than the general population (National Coalition for the Homeless, 2017). The prevalence rate of serious mental illness in individuals experiencing homelessness is 28% (US Conference of Mayors, 2014), compared with 4% in the general population (National Institute of Mental Health, 2017). Individuals who are homeless have also been shown to have higher rates of mental health illnesses, including anxiety, depression, and trauma, compared with housed individuals (Fazel et al., 2014; Whitbeck et al., 2015), with nearly 80% of individuals experiencing homelessness having had a life-altering traumatic event in their lifetime (Christensen et al., 2005). Co-occurring mental health disorders are exceptionally common as well, at rates 12 to 30 times higher than the general population (Center for Substance Abuse Treatment [US], 2013).

Nonetheless, despite their significant mental health needs and high rates of co-occurring disorders, there is a significant science-practice gap such that treatments with established efficacy in research settings are often not used in community health centers serving underserved populations, including persons who are homeless (Balas and Boren, 2000; DeLeon et al., 2003; Lilienfeld et al., 2015). This gap is pronounced despite the fact that evidence-based treatments (EBTs) have been developed for a variety of disorders pertinent to the homeless population, have been shown to be more cost-effective, lead to rapid improvement, and help prevent relapse (Lu et al., 2016). Providing training and consultation to clinicians in these EBTs has not been enough to address this gap (Shiner et al., 2013).

To address this gap, the field of implementation science provides a framework and systematic method for assessing the factors that impact the successful integration, uptake, and long-term sustainability of EBTs into routine clinical care, with the goal of providing quality and effective health care in community settings (*e.g.*, Brownson et al., 2012; Drake et al., 2001; Eccles and Mittman, 2006). To promote the effective translation of research and EBTs into clinical practice serving the homeless population, it is imperative to evaluate and attend to the contextual factors, such as barriers and facilitators, that influence the implementation process of EBTs before the actual integration of these evidence-based protocols into routine care (Bach-Mortensen et al., 2018; Berwick, 2003). To date, the existent implementation literature among the homeless population has focused primarily on the integration of systemic supports and evidence-based systemic interventions, such as supported housing, supported employment, case management models, and service delivery models (Kertesz et al., 2014; Perez de Leon et al. 2011; Rosenheck and Mares, 2007; Wallace et al., 2018). Although many of these interventions may improve mental health symptoms, they are not evidence-based psychotherapies developed specifically to target the complex mental health needs of this population. Thus, increasing our understanding of the implementation-related contextual factors that would impact the effective integration of EBTs and interventions for homeless populations is imperative.

The comprehensive assessment and identification of the relevant contextual factors that serve as barriers or facilitators to implementation of EBTs can only be conducted by systematically evaluating the multilevel factors that impact the successful implementation of an intervention, such as system-, clinician-, patient-, and intervention-level characteristics (Damschroder et al., 2009; Rapp et al., 2010; Southam-Gerow et al., 2012). This type of multilevel perspective ensures that we not only assess "what works" but also address the additional needed questions related to "what works where" (Damschroder et al., 2009).

In addition to assessing the multilevel barriers and facilitators to the successful implementation of EBTs, models of implementation science emphasize capturing these factors across a variety of perspectives from different stakeholders involved in the community settings, such as researchers, community stakeholders, patients, and clinicians. The inclusion of multiple perspectives helps the development of a comprehensive understanding of the factors impacting implementation and, thus, can enhance the successful integration of interventions into clinical practice. Thus, planning for the effective implementation of EBTs in community settings serving a homeless population requires an assessment of the resources, needs, and preferences of the specific setting where the intervention will be implemented, capturing diverse stakeholder perspectives. A few recent studies have examined the implementation of EBTs within community health settings (Creed et al., 2016, 2014), but no studies have focused on federally qualified community health centers that specifically serve persons experiencing homelessness. The aim of the current study was to evaluate the barriers and facilitators to implementing a transdiagnostic EBT in a federally qualified

community health center for individuals experiencing homelessness. Accordingly, we assessed the constellation of factors that impact the successful implementation of EBTs in addressing the science-practice gap. No previous studies have incorporated multiple perspectives when assessing the multilevel factors impacting the implementation process of an EBT for mental health in the homeless population. Therefore, we assessed the perspectives of various stakeholders relevant to this process, including patients, clinicians, and organization administrators.

METHODS

Integrated Implementation Framework

To address the science-practice gap, implementation science relies on well-established conceptual models and frameworks to systematically guide the implementation of an intervention in routine clinical practice and assess if and how it can be successfully integrated within a specific setting (Proctor et al., 2011). The principles of implementation science recommend the systematic identification of the specific influencing factors, guided by empirically evaluated frameworks. Two of these implementation frameworks are the Consolidated Framework for Implementation Research (CFIR; Damschroder et al., 2009) and the Replicating Effective Programs (REP; Kilbourne et al., 2007), which have been combined for this study to create an integrated implementation framework.

First, the REP is a process model that was used to identify and plan for the stages of implementing the Unified Protocol (UP) in a homeless community health center. The four REP stages include preconditions (identifying setting needs and interventions that will meet these), preimplementation (customizing an intervention and training), implementation (support, evaluation, and refinement), and maintenance and evolution (sustaining an intervention; Kilbourne et al., 2007). The current study focuses on the barriers and facilitators identified during the first phase of the project, the preconditions phase.

Second, the CFIR is a "meta-theoretical" implementation framework developed specifically for research in health care, guiding the identification of important contextual factors that can act as barriers or facilitators to successful implementation outcomes. The four CFIR constructs included in the study's integrated implementation framework include a) characteristics of individuals (*e.g.*, clinicians' beliefs about an intervention), b) outer setting (*e.g.*, patient needs and resources), c) inner setting (*e.g.*, an institution's readiness for implementation), and d) intervention characteristics (*e.g.*, adaptability) (Damschroder et al., 2009).

Setting

Study participants were recruited from Boston Healthcare for the Homeless Program (BHCHP). BHCHP, a federally qualified community health center, providing services to thousands of patients in more than 60 locations to deliver the highest quality health care to some of Boston's most vulnerable citizens. In 2016, 2641 unique patients were seen for at least one behavioral health visit. The majority of the behavioral health patients at BHCHP are male (65.28%); the majority of patients identify as non-Hispanic white (43.77%), followed by non-Hispanic black (21.89%), Hispanic (18.74%), and less than 1% described themselves as Asian, American Indian, or Pacific Islander. Among the patients seen for at least one behavioral health visit, 66% were screened for depression and 33% for anxiety. On average, patients at BHCHP attend 5.04 mental health–related services (such as therapy appointments) in a given year.

Intervention

The intervention of interest in this study was the Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders (UP; Barlow et al., 2011), a behavioral treatment that has shown efficacy for reducing symptoms across a range of anxiety and depressive disorders, bipolar disorder, posttraumatic stress disorder, and borderline personality disorder (Ellard et al., 2010, 2012; Farchione et al., 2012; Gallagher, 2017; Sauer-Zavala et al., 2016). The UP encourages the reduction of negative reactions to emotional experiences as a means to eliminate reliance on avoidant coping strategies that paradoxically exacerbate symptoms (Farchione et al., 2012). By focusing on underlying common aspects of emotional processing and regulation that contribute to the development and maintenance of many disorders, the transdiagnostic UP approach has demonstrated equivalent symptom improvement across a range of disorders, as compared with more focused single-disorder protocols (Barlow et al., 2017).

In addition to the standard 16-session version, there is a 5-session version of the UP available, and its feasibility has been shown in the context of an inpatient setting for patients experiencing active suicidal ideation and comorbid substance use (Bentley et al., 2017). Patients treated with the five-session UP were highly satisfied with the UP skills and demonstrated promising improvements in depressive and anxiety symptoms. Given that the UP can address comorbid conditions and be delivered in an abbreviated format, it was hypothesized that the five-session UP could adequately address the mental health needs of homeless individuals and feasibly be delivered in the settings that provide treatment to this population. Thus, for this study, the barriers and facilitators impacting the implementation of the five-session UP were explored.

Participants

To obtain a diverse set of perspectives, the current study includes BHCHP patients, clinicians, and administrators. Twenty patients (out of 31 possible patients who were enrolled in the three BHCHP groups that were recruited for the study) participated in the focus groups. To reduce the patients' participation burden and maintain confidentiality, patient demographic information was not collected.

The administrator focus group included 16 of the 20 administrators who were recruited to participate and were from the research department, managerial positions, and directors of the clinical and nonclinical programs within BHCHP. The administrators who participated in the focus groups were mostly male (85.7%) and identified mostly as non-Hispanic or non-Latino (92.9%), followed by white (28.6%), black/African-American (14.3%), and more than one race (14.3%). The administrators reported working at BHCHP for an average of 13.2 years.

A total of 31 clinical staff participated in this study, including nonbehavioral health and behavioral health–trained clinicians. The nonbehavioral health clinicians who participated in the focus groups included 9 of the 15 nurses recruited to participate (8 nurses and a nurse manager), and 5 of the 20 case managers. The behavioral health staff included 17 clinicians (2 psychologists, 1 psychiatrist, 1 behavioral health case manager, 1 psychiatric nurse practitioner, and 12 other mental health clinicians and interns). At the time of recruitment for the focus groups, BHCHP employed the equivalent of 14.80 full-time employee staff in the behavioral health department. Clinician participants in the focus groups had, on average, 6.1 years of experience at BHCHP, and the majority (84.4%) was female; 78.1% identified as white, and 12.5% identified as ethnically Hispanic or Latino.

Procedure

Between February and March 2017, a total of 67 participants were recruited to participate in seven focus groups. Each focus group included participants from each specific participant level to minimize any undue bias or influence on the focus groups discussions (*i.e.*, patient focus groups only included patient participants) (Onwuegbuzie et al., 2009). Participants were eligible to participate if they were older than 18 years and either worked at or received services at BHCHP.

Patient participants were recruited from several existing support groups at BHCHP. Two groups, one of only men and a second of only women, were recruited from weekly medication-assisted treatment for

opioid use disorder support groups. The third group of patients, a mix of both men and women, was recruited from a daily support group at the medical respite care facility that provides short-term medical and re-cuperative services for homeless people who are too sick be on the streets or in a shelter and often recently discharged from local hospitals. The focus groups were conducted during preexisting patient groups at the organization so as to reduce burden on the organization and the partici-pants, and also to leverage existing group dynamics to facilitate easy dis-cussion and sharing of patients' thoughts, experiences, and ideas (*e.g.*, Gill et al., 2008; Stewart and Shamdasani, 2014). All patients gave verbal consent to participate in the focus group and to have the focus group ses-sion audio-recorded in a deidentified manner. Patients were remunerated with breakfast and a $10 drugstore gift card for their participation.

Clinicians and administrators were recruited through an e-mail from the Director of Behavioral Health at BHCHP. One focus group was held with each of the three groups of clinicians: behavioral health cli-nicians, nurses, and case managers. One additional focus group was held with administrators. Standing weekly meetings for the clinicians and ad-ministrators were used for the focus group sessions to reduce scheduling burden. All clinicians and administrators gave verbal consent to partici-pate in the focus group, have the focus group sessions audio-recorded in a deidentified manner, and completed a few brief self-report question-naires. Clinicians and administrators were remunerated with lunch for their participation, and one $50 retail gift card was raffled off at each cli-nician and administrator focus group session. All research procedures were approved by the Boston University Institutional Review Board.

Interview Guide Development

One semistructured focus group guide was developed for each stakeholder population of interest: administrators, clinicians, and pa-tients (see Appendices for interview guide questions). Focus groups have been shown to be an effective strategy for collecting qualitative data for exploratory studies (Krueger and Casey, 2014), especially con-ducive to gathering varying perspectives across participants. The focus group guides were developed by the research staff in collaboration with leadership from BHCHP. The development of questions was guided by the four constructs from the CFIR (Damschroder et al., 2009) to provide domains of interest to inform the identification of organizational and contextual factors related to the implementation of the UP. For example, within the "characteristics of individuals" CFIR construct, we devel-oped questions to examine subconstructs related to "knowledge and be-liefs about the intervention" and "self-efficacy." Within "outer setting," we focused on "patient needs and resources"; within "inner setting," we examined domains related to "implementation climate, compatibility, relative priority, learning climate, leadership engagement, and available resources." Finally, within the "intervention characteristics" CFIR con-struct, we focused on "adaptability" (Damschroder et al., 2009). Focus group questions broadly assessed for potential barriers and facilitators to implementing the brief five-session UP at BHCHP, patient needs, and clinician characteristics using the CFIR as a guide.

Data Collection, Transcription, and Analyses

Data were collected through 60-minute focus groups with the pa-tients, clinicians, and administrators. All focus groups ($n = 7$) were dig-itally recorded and transcribed verbatim by undergraduate research assistants. The software NVivo 10 was used for data management (QSR International, 2014). The coding team consisted of one master's-level laboratory manager and one postdoctoral-level fellow, supervised by the principal investigator, a doctoral-level clinical psychologist. Fol-lowing the recommendation of Hill (2012), the coders discussed biases and experiences that could influence their data analyses before commenc-ing the data coding process, including their attendance at or absence from the focus groups, previous work with the target population, and levels of clinical knowledge.

The data were coded using qualitative analyses and, specifically, using the principles of thematic analysis in psychology (Braun and Clarke, 2006). Thematic analysis is a specific approach within qualitative analyses that focuses on identifying patterns, or themes, within the data. The coding team began the process of data familiarization, whereby they read the transcripts and noted initial ideas in the margins. An initial data an-alytic codebook was created from the themes and subthemes that emerged during data familiarization. Minor changes to the codebook were made un-til data saturation was achieved, and the coding team agreed the codebook was inclusive and comprehensive. Afterward, the two coders indepen-dently coded the transcripts, meeting weekly to discuss coding decisions, discrepancies, and reach consensus, until all focus group transcripts were coded using the most updated version of the codebook.

RESULTS

Results of the qualitative analyses are grouped by themes that emerged as barriers or facilitators to implementing the UP at BHCHP. The coding process yielded 8 themes for barriers and 10 themes for facil-itators. Data were not coded if they included introductions between partic-ipants, logistical discussions, procedural conversations, and, in rare cases, inaudible data. Table 1 includes exemplar quotes for each of the themes.

Barriers

Patient-Level Characteristics

Several patient-level characteristics were identified as barriers to implementing the UP at BHCHP. First, all participants identified pa-tients' needs not addressed by the UP as a barrier to implementing the UP, which included needs or areas of difficulties that the UP does not have evidence supporting its effectiveness. For example, all participants discussed substance use, such as opioid addiction, as a significant mental health challeng impacting the BHCHP patients. Clinicians added that the patient population also experience psychosis and auditory hallucinations. Other patients' needs not addressed by the UP include the population's sig-nificant physical health difficulties, including but not limited to diabetes, hypertension, pneumonia, and cancer. Participants also noted the daily challenges faced to attend to their basic necessities, including challenges obtaining food, clothing, money, and stable housing. Clinicians and ad-ministrators noted that these competing needs often meant that patients had to balance receiving services at BHCHP, returning to their shelter for lodging and food at prespecified times, and/or attending to their daily crises that arose in attempting to manage these competing needs.

Another barrier to implementation of the UP was patients' irreg-ular attendance at BHCHP. Clinicians and patients both identified low attendance at both behavioral health groups and individual sessions. Both clinicians and patients noted conflicting appointment times with patients' medical appointment as a possible reason for low attendance to mental health services. Clinicians also suggested the lack of incen-tives to attend behavioral health groups (such as food provision), whereas patients described environmental triggers to their substance use surrounding the location of BHCHP as additional factors that hin-der their attendance.

Patients' engagement, or their active participation in treatment or ac-tivities, at BHCHP also emerged as a barrier to the implementation of the UP. For example, clinicians stated patients' different beliefs impacting their engagement with behavioral health services at BHCHP, including stigma related to mental health, and their ambivalence regarding the effectiveness of treatment.

Clinician-Level Characteristics

At the clinician-level, two barriers to implementing the UP were identified within the data. First, clinicians expressed concerns about having nonbehavioral health clinicians, such as nurses, involved in the implementation of the UP. Specifically, clinicians noted a lack of

TABLE 1. Exemplar Quotes for the Barriers and Facilitators Identified by Different Stakeholders

Code	Definition	Exemplar Quote
Barriers		
Needs not addressed by the UP	The participant identifies needs or areas of difficulties not addressed by the UP (*e.g.*, physical disability, substance use, competing needs)	*When it comes to time and what I mean by that because certain times they have to be at a shelters for a bed, or for lunch, or for dinner, and timing here, it's hard to us to find a room because so many meetings and group times, all the people… it's hard.* – Clinician
Attendance	The participant describes patients' irregular attendance rates as a challenge for a variety of reasons	*Depending on when they had appointments, and when they were out, and when they weren't feeling well, and just their ability to consistently come to a group or even an individual session would make it a little bit more challenging because we have patients that might be really interested in coming to a group five times in a row to get whatever information, but something comes up with the medical appointment…* – Clinician
Engagement	The participant identifies the patients' active (or lack thereof) participation in treatment or activities	*I have had patients that have said, I've told so many people this I'm sick of telling people and nothing's any different.* – Clinician
Nonbehavioral health involvement	The participant expresses concerns about nonbehavioral health clinicians becoming involved with the implementation of the UP	*Yeah I mean I also have like a, you know, a concern too cause we're not – I mean I think this piggybacks on it or maybe repeating it a little bit but a lot of times as a nurse, like they know I'm not a behavior health specialist so therefore they'll kind of try and use me like a therapist sometimes and I'm also really careful of being appropriate with my scope of practice.* – Clinician
Clinicians' perceptions of the UP	The participant describes clinicians' beliefs about the UP that may be barriers to implementation	*I guess it's just, one of my initial responses, is that, um, what I always try and do is make sure that what I'm doing is client-centered, not my agenda. And so my initial responses is that "gee, that sounds like my agenda to run the therapy" and I am not sure I feel comfortable with that.* – Administrator
Organizational resources and services	The participant expresses limited organizational resources (*e.g.*, lack of time, space, tools) and/or services (*e.g.*, lack of clarity, lack of individualization)	*Yeah they're supposed to spend an hour with you but he spends like maybe, I don't know, maybe it's because I'm doing so good, I don't know but, like, 15 [minutes] if that, sometimes less. That's the only problem I have.* – Patient
Organizational structural change and clinician burnout	The participant identifies change as a construct that may negatively affect the implementation of the UP (*e.g.*, turnover, changes that would need to be made at the organization) as well as clinicians feeling burnout	*I mean I think that change is scary for many people. I think that we also have had a lot of, like, change exhaustion. Right, so we just moved to EPIC, that's our new electronic health record… There's a number of new clinicians. Um, there's just, there's been, just lots of change.* – Administrator
Existing organizational structures	The participant describes existing organizational structures (*e.g.*, established groups or meeting times) that may hinder implementation of the UP	*Within the respite program, we don't have long-term relationships with the patients in the same way an outpatient case manager would, um, because people can stay as few as a few days or you know our average stay is about two weeks so it doesn't mean we don't have recurrent inpatient relationships, but it's just a different nature of – like our timeframe to work with a patient is different.* – Clinician
Facilitators		
Needs addressed by the UP	The participant identifies needs or areas of difficulties addressed by the UP (*e.g.*, trauma, anxiety, depression, anger, comorbid psychiatric disorders)	*I have real bad anxiety, and I get like this, that it's taken me a long time to understand that it's not a bad thing to be around a lot of people, and it is not supposed to be scary, or upsetting, to be around a lot of people who care and stuff. So it's taken me a lot of steps to get to where it's okay.* – Patient

(Continued on next page)

TABLE 1. *(Continued)*

Code	Definition	Exemplar Quote
Engagement and attendance	The participant describes patients' attendance and engagement with treatment	*We always have, when we leave group, we always positive… think positive and in a great mood. There's been plenty of times when I've come in here and just didn't even wanna come to group, you know, and just like ugh group again, but then once you're here, yeah, you start talking and you, you vent and just, feel awesome by the time you leave.* – Patient
Experiences, organizational	The participant describes positive experiences with/at the organization (*e.g.*, liking that there are groups to attend; the organization is helpful)	*This place basically saved my life. That's the way I look at it. When I-, I was on the streets for uh, just about four years, and I was just a wreck and I don't even know how I ended up in their-, in this lobby. I don't even remember, that's how bad it was. But they worked with me, you know what I mean, and it did, it turned out for the best. 'Cause like I'm not, I got too much to lose this time, I can't, I can't lose what I have. Took me a long time to get everybody's, you know, trust back.* – Patient
Experiences, clinician	The participant describes a positive and engaging relationship, or trust, between patients and clinicians	*It's the trust that you've got on your clinician. That will hold you back from really telling them what's going on. And because in my case, I love my doctor… I got, treated me with respect, with understanding, and I would share anything I want with them.* – Patient
Patients' perceptions of the UP	The participant identifies patients' beliefs about the UP (*e.g.*, UP is a good fit for their needs)	*Hearing about your description of it, I'd be open to it, like if they were to, you know, suggest like, you know different techniques, or like focus on the emotional help or health.* – Patient
Experience with existing treatment	The participant identifies clinicians' experiences with existing techniques/treatments (*e.g.*, mindfulness, motivational interviewing)	*You know, to me, so a couple years ago I have attended some disaster relief CBT training through DEA, it sounds like the protocol is very similar to what they were doing there, and based on the cognitive therapy, so I like it.* – Clinician
Clinicians' perceptions of the UP	The participant describes clinicians' beliefs about the UP (*e.g.*, UP is a good fit for patient population)	*The long-term payoff is if you would find a way to regularly implement the intervention then it should reduce the amount of time that that people are in crisis.* – Clinician
Institutional support	The participant identifies the effect of organizational support (*e.g.*, buy-in, distribution of financial resources), not including training	*I was just also thinking that when we have been most successful, I am sure this is everywhere, there just there needs to be a cheerleader, someone to really drive that agenda forward.* – Administrator
Training	The participant describes training (*e.g.*, protected time, including different staff) as a factor in implementation	*I think it would be really important for probably nurses, in particular, to have this specific training, cause they often see our patients more than anyone else, and nurses have such the opportunity to teach patients, it would be so nice if they were involved in these same types of meetings and interventions and then also practicing of the skills, in a way that is not nurses and behavioral health, but in a combined way, in an integrated way.* – Clinician
Existing organizational structures	The participant describes existing organizational structures (*e.g.*, established groups or meeting times) that may facilitate implementation of the UP	*So, one of the things, you know, each department has their own regular meetings. We can try to, you know, I know that behavioral health has every week rounds that are 90 minutes. And we have looked at how we can bring more educational topics there. So that's a dedicated time.* – Administrator

time during nonbehavioral health visits, which would make it difficult to include the delivery of the UP as part those appointments, as well as a lack of support, such as structured supervision, within nonbehavioral health teams. Nonbehavioral health clinicians also expressed concerns about the possibility of delivering the UP, stating discomfort in delivering an intervention that they did not feel equipped to do. For example, several of the nonbehavioral health clinicians noted not asking

patients emotionally charged questions so as to not trigger the patients, as they did not feel comfortable managing their reactions.

In addition, the clinicians' perceptions of, or beliefs about, the UP itself were noted as a barrier to implementation. Clinicians expressed concerns as to whether the UP would differ and possibly impact how they were already practicing. For example, they stated that delivering the UP would require them to shift their treatment approach from supportive in

nature to a structured, possibly rigid, manualized treatment protocol. In addition, they asked several questions as to whether the UP would alter the client-centered approach to their treatment and, thus, the therapeutic relationship with their patients. Clinicians also described the complexity of their patients' presentations and needs, including their mental health and life circumstances, and expressed uncertainty as to whether the UP would be able to address all of these. Last, others noted the similarities between the UP and other treatments that were already in place at BHCHP and, thus, were unsure what the UP would be able to provide in addition to what they already had available.

Organizational-Level Characteristics

Several organizational characteristics were identified as barriers to the implementation of the UP. Both patients and clinicians identified limited organizational resources and services as potential barriers, specifically limited time. Patients expressed wanting more individualized time with their clinicians at BHCHP, and clinicians also stated needing more time to address all of their patients' needs during their visits, including managing emerging crises and being able to deliver new interventions, such as the UP. Patients, clinicians, and administrators all described a shortage of staff, which increased the patients' wait times and shortened available visit times. Clinicians also noted a scarcity of available space at BHCHP, which at times made it difficult to find space to hold meetings or run groups. Furthermore, participants commented on the complexity of the services and organizational structure at BHCHP and expressed concern about adding yet another new service, such as the UP, to an already saturated system. For example, patients noted learning about new services and resources available at BHCHP despite having been part of the organization for years, and clinicians wondered how the UP would be incorporated into the existing organizational infrastructure, such as their electronic medical record system.

Another barrier to implementation was the organization's frequent structural changes, which were already occurring at BHCHP. For example, administrators noted having to adjust to many changes that had already occurred, such as adjusting to the new electronic medical record software. Staff turnover was identified as a challenge, with patients describing difficulties meeting and having to trust new clinicians, and clinicians discussing the impact that frequent staff turnover would have on the implementation and sustainability of the UP at BHCHP.

The last barrier to implementing the UP that was identified was related to BHCHP's existing organizational structures or the systems and procedures that are already in place within the organization. For example, clinicians described short patient stays within some of the BHCHP programs and, thus, were unsure whether it would be feasible to complete a full five-session protocol with these patients. In addition, both administrators and patients identified existing organizational structures within BHCHP leading to a potential for lack of continuity in care as a barrier to implementing the UP. Administrators noted that BHCHP has a walk-in or open access policy to their daily operational system, in which patients are assigned same-day appointments based on clinicians' availability. They expressed concern that this might be a barrier to implementing the UP as patients see a multitude of clinicians, which might lead to difficulty coordinating which modules had already been delivered, and uncertainty about whether the full five-session protocol had been completed. Patients also stated they had to wait a certain period before being able to return for services, which might make it difficult to retain the knowledge they acquired when learning the UP skills.

Facilitators

Patient-Level Characteristics

Several patient-level characteristics were identified as facilitators to implementing the UP. First, all participants noted convergence between the BHCHP's patient population's mental health needs and the areas that the UP has been shown to have established evidence for its effectiveness and efficacy. These included anxiety and depression, with patients specifically describing social anxiety, fear, racing thoughts, self-doubt, general sadness, and anger. Significant incidents of trauma in patients were also an important need mentioned by all participants. All participants also highlighted the high comorbidity of psychiatric conditions in the BHCHP patients. In addition, administrators noted the similarities in the patient population at BHCHP and those served in crisis stabilization units, where the UP has been shown to have preliminary efficacy (Bentley et al., 2017).

Another patient-level facilitator to the implementation of UP relates to patients' engagement and attendance, including how often they present for services and engage with treatment and other activities at BHCHP. For example, patients stated attending treatment groups weekly or biweekly, rarely missing meetings, depending on their treatment schedule and describing feeling better when they engaged with services at BHCHP, both at individual and group sessions. Group engagement was especially highlighted as being helpful as the patients felt welcomed and feeling like they could relate to the other members' life circumstances, which they described as helpful in their recovery. In terms of what aided patients' attendance, patients identified having access to transportation to and from BHCHP as a significant help in increasing their attendance to services. Clinicians suggested that giving patients input in their own care might increase engagement as they promote patients' buy-in to treatment.

Patients also highlighted their past positive experiences at the organization as a facilitator to the UP implementation. Patients expressed feeling like the organization as a whole had provided them with services and help across all areas of their lives, in a quick manner, and that they especially liked the multiclinician teams at BHCHP (*e.g.*, composed of behavioral health, case management, medical care), who included them as integral parts in their own care.

In addition to their experiences with the organization, patients' experience with clinicians at BHCHP was identified as a facilitator to the implementation of the UP. Patients expressed positive and engaging relationships with their clinicians, including trusting them, feeling it is safe to talk to them, and feeling that their clinicians treat them with respect and understanding. Patients even described coming to BHCHP to receive services on specific days of the week to match their clinicians' limited availability and that they were open to this due to the relationship they had with them. In group settings, patients described feeling that clinicians ensured that all members had time to participate and that they led helpful discussions. Patients also noted several instances where they felt their clinicians had gone above and beyond their responsibilities to help them, such as helping patients coordinate a cab when they were physically injured and going to see patients outside of BHCHP to check up on them or bring them food. Clinicians described promoting a collaborative relationship with their patients by encouraging feedback, promoting empowerment, and helping them identify and achieve tangible goals.

Furthermore, patients also reported positive perceptions toward the UP, including their openness to learning new skills and beliefs that the UP was a good fit with their needs and it would be beneficial to them in the long term.

Clinician-Level Characteristics

Two specific clinician-level characteristics were identified as possible facilitators to implementing the UP. First, clinicians described their experiences with existing treatments, including interventions or treatment modalities that they already use with their patients, as possibly aiding their learning and delivering the UP content. For example, clinicians described having had experience with cognitive-behavioral therapy, cognitive therapy, skill-based therapy such as dialectical behavioral therapy, mindfulness, motivational interviewing, and trauma-informed

care. In addition, clinicians expressed previous experiences with client-centered treatment, de-escalation techniques, crisis management, stress management, psychosocial support, and assessment as facilitating their learning and implementation of the UP.

In addition, clinicians' positive perceptions of the UP were identified as a facilitator to its implementation. Clinicians described believing that the UP would be a good fit with their patient populations' various needs and treatment schedules, including for those seen for brief sessions, patients who attend treatment semiweekly, and those who are in long-term treatment. Clinicians also noted that the UP would be a great bridge for patients who previously had not had contact with behavioral health and for those who had been wanting additional skill-based treatments. Last, the clinicians stated that the UP would help reduce the instances of crises in their patient population.

Organizational-Level Characteristics

Several organizational characteristics were identified as facilitators to implementing the UP. First, clinicians and administrators highlighted the importance of having institutional support, or organizational buy-in, as an important facilitator to implementation, such as protected time to learn and practice the UP, as it would allow for the uptake and penetration of the intervention across the organization. Administrators noted that BHCHP had already been dedicating more resources to behavioral health and, thus, believed that the institution would be supportive of a new behavioral health–oriented intervention. Administrators also identified the need for a "cheerleader" or champion to drive the agenda of implementing the UP to facilitate its implementation and sustainability.

Clinicians and administrators identified training as an important factor in the implementation of the intervention, including dedicated time for training and time to practice the UP. In addition to UP-specific training, clinicians and administrators identified the need to provide training to other nonbehavioral clinicians, such as nurses and case managers, in behavioral health interventions more generally, as they believed this would improve integration across departments and facilitate patient's contact with behavioral health.

Finally, several existing organizational structures were described as possible facilitators to implementing the UP. For example, clinicians and administrators discussed leveraging the existing open groups at BHCHP, as the content (*e.g.*, encouraging participants to focus on emotions) would be similar to the UP materials. Clinicians additionally identified the hour-long visits with case managers as potential visits where the UP could be implemented, or its content reinforced, as the length of the appointment was longer than other types of sessions. Administrators and clinicians also noted including discussions and supervision related to the UP in regularly scheduled meeting times, such as case conferences or during weekly rounds.

DISCUSSION

The aim of the present study was to identify the barriers and facilitators to implementing the UP, a transdiagnostic EBT in a community health center setting serving homeless individuals, as a first step in addressing the gap in the implementation and dissemination of EBTs for this population. Findings reflect data gathered via focus groups with 67 diverse participants, including patients, clinicians, and administrators, during the preimplementation phase of a larger implementation trial of the UP. This is the first study that we are aware of that assessed multilevel implementation–related contextual factors impacting the integration of behavioral health interventions for homeless individuals across different levels of participants and stakeholders.

The results of the current study highlight tensions faced by community health settings when working toward integrating EBTs across different types of populations. For example, all participants in the study discussed the positive match between the UP and the mental health

needs of the population served at BHCHP, describing the fit between the areas targeted by the transdiagnostic nature of the UP, such as mood and anxiety symptoms, and the areas of high rates of comorbidity faced by the patients. However, despite the transdiagnostic nature of the intervention, there were still needs identified that would not be directly addressed by the UP, including the patients' substance use, physical ailments, and competing needs such as food, housing, and basic necessities. This is consistent with previous literature that show the homeless population's complex presentation (*e.g.*, Baggett et al., 2010; Corrigan et al., 2015) and the difficulties faced by behavioral health clinicians in balancing their various needs during treatment (Hwang et al., 2005). Therefore, it is important to continue to evaluate and implement initiatives that would help other areas of needs not attended to by traditional mental health–focused EBTs, such as supported housing and employment (*e.g.*, Kertesz et al., 2014), as well as programs that promote the integration of behavioral health and primary care through collaborative care models to simultaneously address the patients' various behavioral and physical needs (*e.g.*, Alford et al., 2011).

Given the complexity of the psychosocial functioning in this population, participants also reported sporadic patient attendance and engagement with treatment. One way that was identified as helping increase patients' engagement and attendance to treatment was providing solutions to their competing needs, such as the provision of transportation to patients to attend treatment. This finding is in alignment with other work examining barriers of homeless clients in engaging with mental health services (Johnson and Zlotnick, 2009). Another significant facilitator that arose in this population was the strong therapeutic relationship between the patients and clinicians. Given that the alliance has been shown to be a predictor of clinical outcome and increased use of outpatient mental health and substance use services in this population (*e.g.*, Martin et al., 2000; Tsai et al., 2013), participants reported being open to new interventions and treatments if delivered in the context of the relationship with their clinicians.

To facilitate the inclusion of a new intervention in a setting, implementation science urges attending to the organizational factors that would impact its implementation. The organizational composition of BHCHP led participants to consider training nonbehavioral health specialists, such as nurses and case managers, in delivering behavioral health interventions. This consideration was viewed not only as a facilitator, because it would increase patients' access to behavioral health interventions like the UP and improve coordination across departments, but also as a barrier, as it would require additional training and session time for nonbehavioral health specialists to learn the intervention and deliver it to patients. This reflects a reality and tension faced by community health settings, where there is an overall lack of specialized trained behavioral health interventionists (Wang et al., 2005). Thus, there has been a recent focus and push to train nonspecialists in the delivery of mental health interventions (*e.g.*, Dawson et al., 2015; Murray et al., 2011), with recent evidence supporting its feasibility (*e.g.*, Valentine et al., 2019). Not surprisingly, all participants noted limited resources and time as significant barriers to implementing the UP at BHCHP. This difficulty is a struggle faced by all community health settings (*e.g.*, Vale et al., 2007). Dedicating time and resources to train clinicians in new treatment interventions, even when these have been shown to be evidence based, requires significant commitment from both the clinicians and the organizations (Creed et al., 2016; Youn et al., 2019a). This is particularly relevant when the community organizations are already resource constricted due to changing policies and practices. Thus, the importance of having the institution's "buy-in" and support was highlighted as a significant facilitator in the effective implementation of a new intervention, such as the UP. This is consistent with previous findings (Creed et al., 2016; Youn et al., 2019a), as high-level organizational support translates to practical changes that enable clinicians to learn and practice new EBTs. These include dedicated time and leveraging existing organizational structures to facilitate the seamless

implementation of the intervention. In addition, the presence of a champion was argued to be an important factor to ensure the long-term sustainability of the intervention (Youn et al., 2019b). This echoes the results of other studies exploring the factors that impact implementation of EBTs in community health settings such as frequent, tailored, and supportive EBT consultation (Creed et al., 2014, 2016).

Limitations and Future Directions

There are some limitations to this study that are inherent to qualitative research. For example, our study's methodology precludes drawing conclusions regarding causal relationships and makes it difficult to generalize to other clinics and populations. In addition, despite data collection across multiple levels, this study may still be limited by the small number of participants from each population and the data having been collected from one clinic. The full range of experiences of homeless individuals and the perceptions of community health clinicians and administrators may not be represented in our data, and the results may not be generalizable to other clinics. Specifically, because the patients included in this study were actively receiving care at BHCHP, our data may not be generalizable to individuals experiencing homelessness whose care is provided outside of community health centers (*e.g.*, hospital-based outpatient clinics or episodic treatment in hospital emergency departments and inpatient units rather than continuous ambulatory care). Future studies should explore which structural modifications (time, incentives, clinician roles, and expectations) are likeliest to promote implementation of EBTs in these settings, as these are challenges faced by community health centers broadly and not limited to those primarily serving homeless populations. In addition, studies identifying remedies to address the unique needs of homeless persons (immense burden of social determinants of health and balancing the therapeutic need to promote attachment with the need to implement skill-focused EBTs) will be very important. Likewise, examining the efficacy of transdiagnostic EBTs for use with substance use disorders is also of great need.

CONCLUSION

This study provides an important initial examination of the barriers and facilitators that may impact the effective implementation of an EBT within a community health center serving homeless individuals. The study was conducted within the context of a broader implementation study, and as such, the results presented informed the subsequent strategies used in the implementation of the UP (Sauer-Zavala et al., 2018). Stakeholders overall were in agreement that the UP was a good fit with the mental health needs of the patients at BHCHP and also suggested adaptations for the delivery of the intervention within the setting. For example, given the time and resource constraints faced by staff, it was suggested that a few clinicians be trained first and serve as "champions" of the implementation and feasibility testing process before an organization-wide integration.

Studies such as this one that consider and attend to contextual factors that impact implementation of interventions are important in increasing clinician uptake and sustainability of the EBT in that setting (*e.g.*, Brownson et al., 2012) and, most importantly, address the science-practice gap that exists in mental health treatment. For the effective integration of EBTs for homeless individuals, the results of the study highlight the importance of selecting interventions that address the complex and highly comorbid mental health presentation in this population, such as interventions that are transdiagnostic in nature. This allows for addressing relevant mental health needs of the patients served and helps reduce the cost and resources needed for training, as clinicians can be trained in one transdiagnostic protocol rather than several EBTs.

ACKNOWLEDGMENTS

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APPENDIX A

Administrator Focus Group interview guide questions.
1. As part of the management team, what do you believe your role is in supporting new mental health initiatives?
2. Can you describe a time within BHCHP where you have observed or experienced attitudes that inhibited the implementation of a new mental health initiative?
3. Can you think of a factors or resources that may have helped to improve the process of implementation?
4. What are some financial barriers to implementing new mental health initiatives?
5. How many of you have heard about the Unified Protocol (UP)? [Brief description of the UP provided]
6. Can you describe in what ways UP may meet a need for of patients at BHCHP? Can you think of more pressing needs that would get in the way?
7. Is BHCHP set up so that you can easily integrate the UP into clinical practice? If not, can you describe specific barriers?
8 How do you envision using the space and personnel available to support its delivery?
9. Do you believe you have the capacity to support the implementation of the UP in your daily work?
10. Are the right people supportive of the UP? Are key individuals thinking about what would be involved?
11. Can you describe a successful implementation of recent new intervention?
12. How do you envision program evaluation?

APPENDIX B

Clinician Focus Group interview guide questions.
1. What do you believe your role is in supporting new mental health initiatives?
2. Can you describe any more pressing needs than mental health services that would get in the way of implementing a new mental health treatment?
3. What factors might facilitate, or help, the implementation of new mental health initiatives?
4. Tell me about the types of training you've received in the past.
5. What do you currently do with your clients/patients?
6. What do you think leads to change with your clients/patients?
7. What are your experiences implementing evidence-based treatments (EBTs) at BHCHP?
8. Prior to today, had you heard about the Unified Protocol (UP)? If so, what do you know about this intervention? [Brief description of the UP provided]
9. In what ways might the UP meet a need for your clinic/your patients?
10. Based on your knowledge and experience, is there any aspect of the UP that doesn't fit with your patients' needs?
11. Is your clinic set up so that you can easily integrate the UP into clinical practice?
12. Do you believe you have the knowledge to implement/support the UP in your day-to-day practice?
13. Is there space and adequate personnel to support its delivery?
14. Do you believe BHCHP leadership would be engaged if a new initiative was implemented?
15. How successful has your clinic been in implementing new interventions in the past?

APPENDIX C

Patient Focus Group interview guide questions.
1. When you come to BHCHP, what services are most important for you to get?
2. What sort of mental health services have you been offered here at BHCHP?
3. What do you hope to get out of your mental health care visits?
4. How do you know the care that you're receiving is quality?
5. Can you describe a positive experience when receiving mental health care at BHCHP?
6. Do you feel there's always someone to talk to at BHCHP? [Brief description of evidence-based treatments provided]
7. If one of your providers here at BHCHP told you about a new mental health treatment, would you be interested in receiving treatment? Are there any reasons you would, or would not, be interested?
8. Is there anything that makes you NOT want to receive mental health treatment?
9. How do you access information about mental health treatment at BHCHP? What about outside of BHCHP? [Brief description of the UP provided]
10. In what ways do you think this treatment would be beneficial to you?
11. What other resources would you want to improve your mental health?