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Evaluating Transdiagnostic, Evidence-Based Mental Health Care in a Safety-Net Setting Serving Homeless Individuals

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Homeless individuals experience higher rates of mental illness than the general population, though this group is less likely to receive evidence-based psychological treatment for these difficulties. One explanation for this science-to-service gap may be that most empirically supported interventions are designed to address a single disorder, which may not map on to the substantial comorbidity present in safety-net samples, and create a high training burden for often underresourced clinicians who must learn multiple protocols to address the needs of their patients. One solution may be to prioritize the dissemination of transdiagnostic interventions that can reduce therapist burden and simultaneously address comorbid conditions. The purpose of the present article is to describe the process of conducting a pilot study administering the Unified Protocol (UP), a transdiagnostic treatment for the range of emotional disorders, at a community-based organization that provides health care and other services to homeless individuals and families in Boston, Massachusetts. Therapists on a specialized behavioral health unit received didactic training in the intervention, followed by weekly consultation while they provided the UP to patients on their caseload. Qualitative and quantitative data were collected from both patients and therapists. Barriers to use of the UP by therapists, as well as to conducting research in this setting, will be discussed, along with the solutions that were used.

Clinical Impact Statement

Question: Can transdiagnostic cognitive–behavioral therapy be feasibly administered in a safety-net setting? ***Findings:*** Both patients and therapists found treatment with the Unified Protocol to be highly acceptable, though there were challenges to administration (e.g., provider turnover, patient attendance, and patient crisis) that impacted its delivery. ***Meaning:*** Transdiagnostic interventions, like the Unified Protocol, confer a number of advantages that may make dissemination of evidence-based practices for mental health in safety-net settings more feasible. ***Next Steps:*** A larger effectiveness study designed to address the remaining challenges is a necessary next step in assessing the fit of this intervention in a safety-net context.

Keywords: homelessness, transdiagnostic, cognitive–behavioral therapy, dissemination

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The critical research-to-practice gap in mental health care has long been recognized by researchers, clinicians, and policymakers alike (Institute of Medicine, 2001; Shafran et al., 2009; Sobell, 1996). Despite the progress made over the past quarter century in dissemination and implementation science (McHugh & Barlow, 2010; Wiltsey Stirman, Gutner, Langdon, & Graham, 2016), the available data suggest that evidence-based treatments (EBTs) are still not frequently used in mental health service settings (Garland, Bickman, & Chorpita, 2010). EBTs, also described as empirically supported treatments (APA Presidential Task Force on Evidence-Based Practice, 2006), are defined as clearly delineated (often manualized) interventions that have produced therapeutic change in controlled trials (Kazdin, 2008).[1] The relative lack of EBTs in usual clinical care, as well as recent findings indicating that most providers do not use research findings to inform their practice (Gyani, Shafran, Myles, & Rose, 2014), is problematic, as countless individuals in need never receive those interventions with demonstrated efficacy, time efficiency, and cost-effectiveness. Of course, it is important to note that decreased enthusiasm to use EBTs in routine practice may result from the fact that the efficacious interventions developed in academic settings are rarely tested in or adapted for community settings (Kerner, Rimer, & Emmons, 2005).

EBTs are often manualized protocols, and the successful dissemination of these interventions in routine practice in a similar manner to how they are delivered in academic settings typically requires relatively lengthy courses of one-on-one or group therapy (e.g., 12–16 sessions for a standard course of cognitive–behavioral therapy [CBT]), time-intensive and costly clinician training efforts, and expensive ongoing supervision from trainers (Wiltsey Stirman et al., 2010). Barriers to applying practices that promote sustainable dissemination have been identified and include limited funding for clinician training, high rates of staff turnover, and substantial comorbidity among patients that is not addressed by EBTs focused on single diagnostic categories (Barlow, Levitt, & Bufka, 1999; Foa, Gillihan, & Bryant, 2013; Mendel, Meredith, Schoenbaum, Sherbourne, & Wells, 2008). These barriers are particularly pronounced in safety-net settings, in which the research-to-practice gap is especially prominent (DeLeon, Wakefield, & Hagglund, 2003). Safety-net settings refer to organizations that provide access to health care and other services to uninsured, Medicaid, and other vulnerable and low-income individuals (Lewin & Altman, 2000). These settings tend to face a volume of high-need patients with trauma histories and multiple chronic psychiatric comorbidities (e.g., substance use and severe mental illness) marked with acute episodes, as well as significant financial hardship.

The lack of access to evidence-based mental health care is particularly concerning for homeless individuals, who make up a substantial proportion of those presenting for care in safety-net settings (Burt, Khadduri, & Gubits, 2016). For one, homeless individuals have significantly elevated rates of mental health disorders in comparison with the general population (National Coalition for the Homeless, 2009; National Institute of Mental Health, 2017). Additionally, data suggest that homeless individuals are four times as likely to have multiple mental health disorders than nonhomeless populations (National Institute of Mental Health, 2009). In particular, ~50% of homeless individuals in the United States are estimated to have a substance use disorder (Substance Abuse & Mental Health Services Administration, 2011), and a history of trauma is also common in this population (Christensen et al., 2005; Substance Abuse & Mental Health Services Administration, 2015). It is well established that comorbidity of mental health and substance use disorders is associated with poorer outcomes and higher utilization (Curran et al., 2008; Druss & Rosenheck, 1999; Mazza et al., 2009). Given the high rates of mental illness, substance use disorders, and trauma among the homeless, there is an urgent need for innovative, sustainable strategies to providing EBTs in safety-net settings that treat these individuals.

Newer, transdiagnostic treatment approaches may have the potential to address some of the common barriers to widespread dissemination of EBTs in safety-net settings treating homeless individuals. Specifically, their transdiagnostic nature may more adeptly handle the high rates of comorbidity reported among homeless patients, and they are purported to reduce therapist training burden, as one protocol can be used to treat most patients (McHugh, Murray, & Barlow, 2009).

A prominent example of this approach is the Unified Protocol (UP) for the transdiagnostic treatment of emotional disorders (Barlow et al., 2018), which was explicitly designed to address a range of disorders by targeting shared vulnerabilities that contribute to their development and maintenance (Barlow, Sauer-Zavala, Carl, Bullis, & Ellard, 2014). There is mounting evidence that the UP meaningfully reduces symptoms of anxiety and depressive disorders (Barlow et al., 2017; Boswell, Anderson, & Barlow, 2014; Ellard, Fairholme, Boisseau, Farchione, & Barlow, 2010; Farchione et al., 2012), and there is preliminary support for its use with other diagnoses that are often present in homeless populations: posttraumatic stress disorder (Gallagher, 2017) and substance use disorders (Ciraulo et al., 2013). In fact, results of a recent equivalence trial indicate that the UP's transdiagnostic approach is just as effective at reducing symptoms of patients' primary diagnoses as targeted protocols designed to address those particular disorders (Barlow et al., 2017). In addition, the UP was recently adapted to be delivered across five sessions during brief inpatient stays on a crisis stabilization unit at an area safety-net hospital (Bentley et al., 2017). A substantial number of patients in this study were people who use multiple substances and also experience homelessness, and results suggest that UP principles can be feasibly implemented with this population.

Given the rationale for the use of evidence-based transdiagnostic approaches in safety-net settings, the goal of the present effort was to collect data on the feasibility, acceptability, and preliminary efficacy of an abbreviated version of the UP (Bentley et al., 2017), delivered by frontline clinicians, in a Boston-area health center, specifically designed to serve homeless individuals and families: Boston Health Care for the Homeless Program (BHCHP). This pilot study was conducted in the context of a two-phase research project; the first phase, described in detail elsewhere (Ahles et al.,

[1] Our use of EBTs (Kazdin, 2008) is consistent with the APA Presidential Task Force on Evidence-Based Practice's (2006) definition of empirically supported *treatments*. The definition of EBTs used in the present study represents a narrow form of the broader term *evidence-based practice*, which refers to clinical practice informed by evidence about interventions and patients' values, preferences, and needs. We have elected to focus on the more narrow term, EBT, as the present study evaluated the use of a specific, manualized intervention in a community setting.

2017; Marques et al., 2018) and briefly summarized below, was aimed at understanding the implementation climate at BHCHP, including factors that may influence successful dissemination of EBTs in this setting. The present article will describe the challenges we encountered conducting treatment outcome research in this routine practice setting, many of which were identified during Phase 1, along with our preliminary, data-based impressions on the feasibility, acceptability, and efficacy of using the UP at BHCHP.

Assessing the Fit of the UP at BHCHP Before Conducting a Feasibility Study

Before conducting our pilot feasibility study administering the UP at BHCHP, focus groups with various stakeholders (e.g., patients, providers, and administrators) were conducted that identified potential barriers and facilitators that might arise during this effort (for a detailed description of the overall implementation climate at BHCHP, along with the protocols guiding these focus groups, see Ahles et al., 2017; Marques et al., 2018). Qualitative findings indicated that there was agreement across stakeholder groups that the UP would meet the needs of patients at BHCHP, with particular regard to its ability to treat their most prevalent mental health concerns. Additionally, patients expressed positive views about learning new skills and felt that it could be helpful in the long term. However, the focus groups identified a number of barriers that might affect our ability to successfully carry out our pilot feasibility investigation of the UP in this context. For example, providers described heavy workloads and insufficient time to see all their patients as barriers to learning a new intervention. Similarly, administrators indicated that high staff turnover, staff burnout, and change exhaustion (e.g., recent transition to Epic digital medical records that continued to be difficult) may also compromise a rollout of a new intervention at BHCHP. However, in contrast to these barriers, providers and administrators noted that BHCHP staff are supported in receiving training relevant to their roles and that behavioral health providers routinely attend full- and half-day offsite trainings.

Additional feedback from stakeholders was relevant to how the UP skills could best be delivered at BHCHP. Specifically, providers noted that they often spent session time on crisis management and, thus, expressed skepticism toward finding time to introduce new, skill-based information. Using this feedback, we adapted the delivery of the UP so that providers could select which skill would be most relevant to each patients' current problem on the day of the session, rather than encouraging delivery in a prespecified order. This adaptation was possible given preliminary data that the UP treatment modules can be administered in a personalized order without negatively impacting treatment outcomes (Sauer-Zavala, Cassiello-Robbins, Ametaj, Wilner, & Pagan, 2018). Additionally, providers stated that many patients at BHCHP do not attend sessions regularly given the transient nature of their living situation. They suggested that the most feasible way to collect preliminary data on the effectiveness of the UP in their setting would be in the context walk-in groups for patients on a waiting list for individual care or the office-based addiction treatment (OBAT) program, in which patients are seen regularly for an extended period of time.

Overview of Planned Method

We aimed to train four BHCHP therapists, via a 1-day workshop and ongoing consultation, to provide the UP to two of their patients (in total, eight patient participants). Therapists were asked to complete brief questionnaires (described in detail below) before the UP workshop, directly following the training, and after they completed the delivery of the UP with their two study patients. Patients were initially asked if they would like to participate in a study assessing whether a new treatment would be a good fit for BHCHP by their therapists and, if interested, were consented by research staff. Patients completed brief symptom measures pre- and posttreatment (also described below), along with a UP Knowledge Acquisition Quiz and feedback form at posttreatment. Therapy sessions were audio recorded to assess therapist fidelity to the protocol. Providers were compensated a total of $90 in the form of Target gift cards for completing questionnaires and transferring each audio-recorded therapy session to our team. Patients were compensated $50 in the form of Target gift cards and $10 following each audio-recorded session. All procedures were approved by the Institutional Review Boards (IRB) at Boston University and Massachusetts General Hospital.

Study Intervention

As noted previously, the UP (Barlow et al., 2018) is a transdiagnostic, cognitive–behavioral intervention developed to address shared processes that maintain the range of anxiety, depressive, and related disorders. In its published form, the UP consists of eight modules that target aversive, avoidant reactions to emotional experiences that are typically delivered in the context of 16 outpatient sessions. The present study utilized a five-module adaptation that was used with a similar sample (Bentley et al., 2017). A detailed description of each UP module used in the present study can be viewed in Table 1. As described above, modules could be presented in any order at the discretion of the study therapist.

Clinician Training Procedures

The standard 1-day UP workshop consists of a discussion of the rationale for transdiagnostic CBT, along with a detailed presentation of each UP-skill module; the workshop was modified to reflect the adaptations made when developing the five-skill version of the protocol. A detailed description of the material covered in the UP workshop delivered for the present study can be seen in Table 2. The didactic portion of the workshop was led by PhD-level psychologists (Shannon Sauer-Zavala and Kate H. Bentley) who are developers of the UP and created the five-session adaptation that had been previously used in clinical research (Bentley et al., 2017). In addition, advanced doctoral students (e.g., Julianne G. Wilner) certified in the provision of the UP via rigorous research standards (Barlow et al., 2017) assisted with role-play practice exercises. Providers at BHCHP had the support of leadership to attend our full-day offsite training, consistent with the facilitators to implementation identified during focus groups (described above). Following the training, the study therapists met with the lead trainer (Shannon Sauer-Zavala) for weekly 1-hr consultation calls for the duration of the time they had study patients on their caseload.

Table 1
Skills by Module in the Modified Unified Protocol

Skill	Skill target	In-session exercises	Home practice exercises
Setting goals and maintaining motivation	Identify treatment targets for change	Setting Goals Worksheet	Read associated handout
	Increase motivation to make changes	Decisional Balance Worksheet	Take steps identified in goal-setting exercise
Understanding emotions	Understand the adaptive nature of emotions	Breaking Down an Emotion Worksheet	Read associated handout
	Break emotions into thoughts, physical sensations, and behaviors		Complete Breaking Down Emotions Worksheet any time a strong emotion is experienced
Mindful emotion awareness	Observe emotions in a nonjudgmental/objective and present-focused manner	Meditation exercise	Read associated handout
		Anchoring in the Present Worksheet	Complete Anchoring in the Present Worksheet
Flexible thinking	Understand how thoughts can influence emotions	Ambiguous picture exercise	Read associated handout
	Generate alternative interpretations	Flexible Thinking Worksheet	Complete Flexible Thinking Worksheet
Countering emotional behaviors	Identify and counter behaviors that prevent the experience of strong emotions	Emotional Behaviors and Alternative Actions Worksheet	Read associated handout
		Facing Your Emotions Worksheet	Practice alternative actions discussed in session Complete Facing Your Emotions Worksheet

Study Setting

In coordination with BHCHP administration, the decision was made to initially test the UP in the OBAT program at BHCHP, which offers medications for addiction treatment, including buprenorphine and naltrexone, counseling, and case management to individuals diagnosed with substance use disorders. Counseling, provided by licensed social workers, is strongly encouraged for those receiving medications for addiction treatment, resulting in a patient population that attends therapy sessions regularly. Provision of the UP within the OBAT program increased the likelihood that the UP would be delivered in a manner similar to session frequency in UP efficacy evaluations (weekly or biweekly sessions). Although attendance is less consistent in the broader Behavioral Health Program at BHCHP, there are similarities across units such that findings may generalize across the program. Specifically, patients across BHCHP are characterized by substance use disorders, psychiatric comorbidities, and life stressors that are common in the OBAT program. Additionally, therapists on this unit routinely interface with other BHCHP clinicians, as well as leading groups outside of the OBAT program, allowing them to comment how their experiences with the UP would generalize to the broader BHCHP context.

Obstacles and Solutions to Implementation and Data Collection at BHCHP

Addressing Therapist Recruitment Challenges

The counseling team for the OBAT program consists of four providers, and the first step in pilot testing the UP in this clinic was to provide a didactic workshop to introduce the UP to these individuals. Unfortunately, but not surprisingly, as staff turnover was identified as a barrier during our focus groups, one therapist position in the OBAT program had not been filled at the time of the workshop, so only three providers were eligible to participate in this effort. The competing demands of providing care in a safety-net setting represented an additional challenge to recruiting therapists in this context; two therapists presented for the workshop, whereas the third eligible provider indicated that she could not spare the time away from her patients. This therapist's reluctance to participate in our study suggests that careful attention must be paid to minimizing burden with regard to research tasks that would be on top of already busy clinician schedules, as well as making clear the value that study-related training may, in fact, add to their clinical work. In this case, it may have been helpful to highlight how transdiagnostic interventions, like the UP, may increase efficiency (e.g., reduce planning time), as one set of skills may be applied across patient presentations.

In contrast, the remaining two therapists displayed strong enthusiasm for the training opportunity, along with participating in our implementation effort. They asked several thoughtful questions throughout the didactic portion of the workshop (e.g., how do you restructure negative thoughts that are true like: "I may never find affordable housing"?) and often requested additional time during role-play activities in order to gain more practice administering the skills. Notably, when they realized that, without the third provider present, our ability to recruit the number of patients originally proposed was compromised, they offered to each treat four patients (instead of two).

Addressing Patient Recruitment Challenges

Following the workshop, the BHCHP therapists remained at the training location for nearly an hour, discussing possible changes to proposed research procedures. This discussion highlights the importance of viewing collaborations with community practice sites as true partnerships. Although researchers may have expertise in

Table 2
Unified Protocol (UP) Training Procedures

Topic name	Main points covered	Role play exercises used
Theoretical rationale for treatment approach	History and limitations of *DSM* classification system; transdiagnostic case conceptualization; limitations of traditional single-disorder protocols; brief description of the UP and its empirical support; overview of adaptation for UP for BHCHP	—
Setting goals and maintaining motivation	How to increase self-efficacy by setting goals; building motivation for change with decisional balance exercise	Practice clarifying problems and setting goals using the Goal Setting Worksheet; practice running through the Decisional Balance form
Understanding emotions	The adaptive nature of emotions; emotions consist of thoughts, behaviors, and physical sensations; emotions have triggers and consequences	Practice Socratic questioning to explain how emotions are adaptive; practice describing the three interacting parts of an emotion and walk patient through three-component model
Mindful emotion awareness	Nonjudgmental awareness of thoughts, feelings, behaviors; increasing present-focused attention toward emotional experiences; practice applying these skills in response to emotional experiences as they occur by anchoring in the present	Practice explaining the rationale for being nonjudgmental toward emotional experiences; practice explaining the rationale for anchoring in the present and walk the patient through this worksheet
Flexible thinking	Reciprocal relationship between thoughts and emotions; how to question negative first impressions; generating alternative appraisals of emotion-eliciting situations	Practice describing the reciprocal relationship between thoughts and emotions and walk the patient through the ambiguous picture exercise; practice using the challenging questions to fill out the Flexible Thinking Worksheet with your patient
Countering emotional behaviors	Emotions are associated with urges to engage in behaviors that may/may not be helpful in the short/long term; provide examples of unhelpful emotional behaviors for different emotions; engaging in alternative actions can lead to different emotional consequences; facing your emotions intentionally can help you pursue goals	Practice describing emotional behaviors and alternative actions using the Alternative Action Worksheet; practice generating ideas for facing emotions with your patient and walking through the Facing Your Emotions Worksheet

Note. *DSM* = *Diagnostic and Statistical Manual of Mental Disorders*; BHCHP = Boston Health Care for the Homeless Program.

rigorous design methods, as well as the treatment protocols under study, clinicians represent the "boots on the ground" with valuable knowledge regarding site logistics and the patient population necessary for studies to be successful. For example, a major concern was how the therapists would select patients to participate in the study. Given that patients were to be compensated for their participation, therapists did not feel comfortable hand-picking them for this opportunity; they did not want the responsibility of unfairly advantaging a few individuals on their caseloads, for whom the small amount of study compensation could be quite beneficial. Thus, the decision was made to assess patient interest starting with the first patient of the week and proceeding through their schedules until all four patients were recruited.

An additional concern was whether Spanish-speaking patients could participate in the study, as sessions at BHCHP are offered both in English and Spanish. Given the high number of Spanish-speaking patients receiving services at BHCHP, the generalizability of pilot data to the larger organization would have been enhanced by the inclusion of Spanish-speaking patients; however, our IRB protocol stipulated that only English-speaking individuals would be recruited, and our timeline precluded the submission of an amendment to change this procedure. One of our therapists' caseload consisted of mostly Spanish-speaking patients, and, ultimately, was only able to recruit two (of the proposed four) eligible patient participants into the study. Although not utilized as part of this research study, the five-session UP protocol adapted for BHCHP was translated into Spanish following initial provider feedback during the UP workshop; this translation was given to clinicians about 8 weeks into the pilot study for use with nonstudy patients. In hindsight, our team should have been prepared at the outset of our pilot feasibility study to accommodate the large Spanish-speaking population at BHCHP, and a larger test of the UP's effectiveness at this organization must be equipped to address the range of patients that present for treatment in this setting.

Another challenge to recruiting patients at BHCHP was identifying personnel to consent patients to participate. Although therapists could assess the interest of their patients, in the context of our study, they could not consent them for two reasons: (a) Only study staff had IRB-approved informed consent and, as study participants themselves, they could not fulfill this role, and (b) we did not want patients to feel coerced to participate by having their therapists recruit them. BHCHP has a research department and, originally, we had proposed to have their full-time research assistant join sessions of interested patients to review consent procedures. Unfortunately, staff turnover in the research department precluded their use in this capacity. As a result, a research assistant

from our team traveled to BHCHP several days a week during our recruitment period to conduct informed consent procedures. Study therapists communicated with him to identify days on which multiple eligible patients would likely be attending scheduled sessions and provided him with desk space to work while he waited; however, despite the fact that most patients were interested in participating after being asked by their therapists, frequent no-shows made it difficult to recruit in a timely manner and, as noted above, we were only able to recruit six (of eight) patients. Future research may benefit from exploring options to allow study therapists to fulfill multiple roles, including serving as IRB-approved study staff capable of obtaining their patients' consent to participate, along with being participants themselves.

Addressing Challenges to Patient Engagement

Once patients were recruited, the provision of the UP proceeded smoothly, though several challenges were identified during weekly consultation calls. First, all participating patients had been attending sessions with their therapists on an ongoing basis before the initiation of the study; despite expressing interest in learning UP skills, patients often wished to spend ample time seeking support for events of the past week in accordance with how sessions were previously carried out. Accordingly, therapists reported difficultly redirecting their patients to UP content, making it difficult to get through the planned material for each skill in one session. Compounding this issue was the fact that patients often arrived late to the session (a common barrier in this population due to difficulties with transportation, committing to last-minute work opportunities, etc.) or were pulled out by the unit's nurse, such that sessions ranged from 15 to 50 min. Each of the five UP skills consists of two to three exercises lasting ~15–20 min and, on average, therapists could get through one exercise per session. As a result, it was difficult for therapists to cover the five UP skills in the proposed five sessions; in fact, the number of sessions to complete all five skills ranged from five to eight sessions. Therapists suggested retaining all five skills, but that it would be more feasible to choose a single exercise within a given skill to be completed within a particular session. Fortunately, there was flexibility in our research design allowing therapists to see patients beyond the five planned sessions to completely administer UP content. However, based on this feedback, future effectiveness efforts with the UP at this program will need to plan for 20 min of content per session.

Therapists also noted that hypothetical examples tended to seem inapplicable with their patients (e.g., imagine you are walking down the street and a friend does not say hello to you), suggesting that more concrete examples would be beneficial for this population (e.g., when you told me you felt anxious after that interaction, what were you thinking at the time?). Finally, as a testament to the providers' enthusiasm for these skills, they both noted that they had been using the UP skills with several nonstudy patients; specifically, they had adapted it for use in group format and had been translating it for use with their Spanish-speaking patients before study staff provided the full translated patient workbook. Throughout our consultation calls, both therapists also expressed gratitude for the opportunity to receive training on the UP.

Summary of Pilot Findings

As noted above, the primary aim of the pilot study at BHCHP was to assess the acceptability and feasibility of administering the UP in this context. Acceptability was assessed, for therapists, by examining postworkshop and posttreatment feedback on the use of the UP with their patients. Additionally, patient feedback following the receipt of the five UP sessions was also considered. The feasibility of using the UP at BHCHP was assessed by examining therapists' preworkshop attitudes about learning a new intervention, in general, along with their understanding of UP concepts (using a Knowledge Acquisition Quiz) and ability to carry out the UP with fidelity (using adherence ratings of session audio recordings). Feasibility was also assessed using patient-level data, including the patient's understanding of UP concepts (also using a Knowledge Acquisition Quiz) and rates of treatment completion. Finally, the initial efficacy of the UP at BHCHP was explored by computing pre- to posttreatment (within condition) effect sizes for change in anxiety and depressive symptoms.

Participants

Two BHCHP therapists with master's degrees in social work participated in this study. Both therapists reported relatively large caseloads (i.e., ~30 scheduled sessions per work, though no-show rates are high), consisting of patients with a range of mental health conditions (e.g., anxiety, depressive, personality, bipolar, and substance use disorders). They noted that their work is relatively long term, lasting 20 to more than 40 sessions, and includes components from a variety of orientations (i.e., cognitive, behavioral, psychodynamic, humanistic, supportive, motivational interviewing). Both therapists had limited exposure to the UP before the study, one having seen protocol outlines and handouts (sent out in advance of the workshop) and the other having attended a UP focus group in Phase 1 of the study. Although additional information about study therapists was collected (e.g., demographics, years of experience), we did not include it in this article at the request of our community partner; given the small sample and the fact that we identify the specific unit at BHCHP, it became clear that providing this information would likely identify our participants. Of course, detailed therapist information is extremely valuable for understanding best practices for implementing EBTs in community settings, and we consider this an additional obstacle to conducting research in routine practice where samples may be limited by the structure of the organization being studied.

Six BHCHP patients participated in this study. Providers were asked to pull demographic and diagnostic data from the medical record for each of their patients; unfortunately, data were only provided for four patients, as one of the therapists left BHCHP before sending this information to research staff. Of the patients with data, three identified as male and one identified as female, with an average age of 52 years ($SD = 3.37$). One patient declined to provide racial and ethnic data; the three remaining patients identified as White, with one also identifying as Latino. On average, patients were assigned 3.75 diagnoses ($SD = 0.5$). All patients received a diagnosis of opioid use disorder and major depressive disorder, three met criteria for generalized anxiety disorder, and one met criteria for posttraumatic stress disorder. Three of the patients also had one additional substance use disorder, which

included stimulant use disorder (cocaine), stimulant use disorder (unspecified), and sedative use disorder.

Measures

Preworkshop Therapist Measures

In addition to a demographic questionnaire, therapists completed two validated measures assessing their attitudes toward learning new, empirically supported psychological treatments. First, the Evidence-Based Practice Attitudes Scale (Aarons, 2004) assesses individuals' perceptions about various aspects of evidence-based practice, including interest and openness to using new interventions, opinions about the usefulness and importance of research-based and manualized interventions, level of consistency in clinical practice, and different or contrasting attitudes to the use of evidence-based practice. Additionally, therapists completed the Motivation to Learn Scale (Machin & Fogarty, 2004), which measures clinicians' level of desire to gain new therapeutic skills (e.g., commitment to learning, willingness to expend effort, and perceived usefulness of skills) and their intentionality to learn the new skills (e.g., goals of mastery and expertise).

Postworkshop Therapist Measures

Directly following the UP workshop, therapists completed a brief, multiple-choice UP Knowledge Acquisition Quiz to test their understanding of important treatment concepts. This measure was created for the present study and can be viewed in Appendix A. Additionally, therapists were also asked to provide information on their initial impressions of the UP via a workshop feedback form. In addition to open-ended questions (e.g., What parts of the treatment do you think will be most/least helpful for your patients), therapists rated the extent to which they agreed with several statements about the UP (e.g., The skills and concepts in the UP does [or will] make sense to my patients; The UP is [or will be] straightforward to use).

Posttreatment Therapist Measures

Following the completion of the five UP sessions with all of their study patients, therapists completed a treatment feedback form to provide additional impressions on the use of this intervention with their population. Example items include the following: "In your own words, please tell us what you thought of the treatment overall," and "What parts of the treatment did you find least helpful?"

Fidelity Ratings

Previous UP trials have used adherence checklists and competency ratings to ensure that study therapists were adequately providing the UP according to published guidelines (Barlow et al., 2017; Farchione et al., 2012). The UP adherence checklists used in these trials were modified for the present study to reflect our five-skill adaptation (Appendix B). Study therapists audio recorded all of their sessions and, at the completion of the study, expert raters certified in the provision of the UP (see Farchione et al., 2012, for a description of this certification process) reviewed all session tapes. Expert raters in the present study were advanced doctoral students (Amantia A. Ametaj and Julianne G. Wilner).

Patient Measures

At pre- and posttreatment, patients completed brief self-report measures of anxiety and depressive symptoms. Specifically, the Patient Health Questionnaire (PHQ)-9 (Kroenke, Spitzer, & Williams, 2001) is a nine-item depression severity measure that assesses each of the *Diagnostic and Statistical Manual of Mental Disorders*, *Fourth Edition* (*DSM-IV*; American Psychiatric Association, 2000), criteria for depression, with scores in the 10–15 range, indicating moderate/moderate severe depression. The PHQ-9 has been established as a reliable and valid measure of depression (Kroenke et al., 2001). The Generalized Anxiety Disorder (GAD)-7 is a seven-item measure that assesses the severity of GAD symptoms in the past week (e.g., "feeling nervous, anxious, or on edge," "worrying too much about different things"), with scores above 10 indicating clinical severity. The GAD-7 has demonstrated good reliability and validity within primary care settings (Spitzer, Kroenke, Williams, & Löwe, 2006). Additionally, patients also completed a UP Knowledge Acquisition Quiz to assess their understanding of treatment concepts (Appendix C). Patients also completed a posttreatment feedback form. The example items include the following: "In your own words, please tell us what you thought of the treatment overall," and "What parts of the treatment did you find least helpful?"

Acceptability of the UP at BHCHP

As noted above, the acceptability of the UP at BHCHP was assessed via therapist and patient impressions of this intervention. Therapist data were collected directly following the workshop and after completing UP treatment with their study patients. Perceptions of the UP after the workshop were quite positive. Both therapists "strongly agreed" that the UP was a good addition to their repertoire of treatments available for patients, would be straightforward to use, and that the skills and concepts made sense to them. Of note, they both identified aspects of mindfulness (i.e., anchoring in the present, observation of emotions, and acceptance) as likely to be most helpful for their patients. Therapist feedback remained largely positive following the administration of the UP with patients at BHCHP. In general, therapists found the UP to be acceptable (i.e., approach and activities made sense and were reasonable). Also, both reported feeling very satisfied with the treatment throughout delivery. Furthermore, each therapist independently elected to use the UP with five to 10 additional patients (~20–25% of caseload) beyond those specified for study procedures.

Additionally, similar to the responses of their therapists, patient impressions of the UP content were positive overall. Specifically, the acceptability and satisfaction of the UP treatment were high, with average item-level responses of 4.6 ($SD = 0.55$) on both scales of 1 (e.g., *not at all acceptable, not at all satisfied*) to 5 (e.g., *extremely acceptable, extremely satisfied*). For those who offered qualitative feedback, patients described "utilizing CBT skills . . . getting more off my chest" and "how to deal with anxiety" as the most important things learned from this treatment.

Feasibility of Disseminating the UP at BHCHP

With regard to feasibility, questionnaires assessing therapist perceptions on EBTs, as well as on learning new treatments in general, were administered before the UP workshop, and average scores can be seen in Table 3. These ratings are consistent with favorable impressions of research-based care and willingness to learn new techniques in the service of helping one's patients (Aarons et al., 2010), suggesting that, in general, therapist attitudes are promising for disseminating a new intervention at BHCHP.

Additionally, both therapists demonstrated excellent understanding of treatment concepts, demonstrated via 100% correct answers on the Knowledge Acquisition Quizzes directly following their training workshop ($M = 7$ [out of 7 possible points], $SD = 0$). Fidelity ratings gleaned from the audio-recorded treatment sessions also suggest that the UP is feasible to implement at BHCHP. Two expert raters certified in the UP rated all sessions for adherence and competence. Ratings indicate good-to-excellent fidelity to the UP for sessions in which UP content was delivered, with the average session percent adherence being 93.35% across all sessions for one therapist, and 84.39% for the second therapist. Additionally, the therapists were given overall ratings per session, evaluating the competence of treatment delivery (i.e., effectiveness of presenting key treatment elements, meeting session goals), to which they received average scores of 3.2 and 3.7 on a scale of 0 (e.g., *poor*) to 5 (*excellent*). It is important to note, however, that there were several instances in which therapists recorded sessions, intending to cover UP content, but were unable to do so due to crisis management; these sessions were not included in the fidelity ratings (see below for more information regarding the percent of sessions in which UP content was covered). Overall, of the sessions rated for both therapists, mean adherence was 88.82% ($SD = 4.53\%$) and mean competence was 3.45 ($SD = 0.25$).

With regard to treatment completion (Table 4), three out of six patients received all five UP skills; for completers, the number of sessions needed to cover all of the UP content ranged from 5 to 8. The noncompleters received between two skills (delivered in two sessions) and four skills (delivered in six sessions). Of the noncompleters, one was withdrawn due to a serious substance use relapse and two were unable to complete the skills during the study window (4 months) due to missed appointments and patient refusal to "do skills" during a given session. Across all patients, therapists planned to cover UP content in a total of 34 sessions, but were able to do so in 29 sessions (85.3%) due to crisis management or patient refusal to engage with UP content. Despite the difficulties administering the UP as planned, patients[2] demonstrated strong understanding of UP concepts, evidenced by their average score of 82.86% correct ($SD = 13.80$) on the UP treatment Knowledge Acquisition Quiz following the receipt of UP skills.

Table 3
Therapist Treatment-Related Factors

Measures	*N*	*M*	*SD*
Evidence-Based Practice Attitude Scale (EBPAS) Total[a]	2	3.27	0.00
EBPAS Requirements	2	2.67	0.47
EBPAS Appeal	2	3.38	0.53
EBPAS Openness	2	3.50	0.35
EBPAS Divergence	2	0.65	0.53
Motivation to Learn Scale	2	53.5	7.78

Note. Item anchors range from 0 (*not at all*) to 4 (*to a very great extent*); higher scores on the total score and Requirements, Appeal, and Openness subscales, and lower scores on the Divergence subscale indicate positive attitudes toward evidence-based practice.
[a] EBPAS total score reflects an average of 15 item-level scores following reverse-scoring of negatively worded items (i.e., Divergent subscale).

Preliminary Efficacy of the UP at BHCHP

Finally, a preliminary examination of the efficacy of the UP was explored via patients' pre- and posttreatment responses on measures of anxiety and depression. At pretreatment, average scores on measures of generalized anxiety (GAD-7; Spitzer et al., 2006) and depression (PHQ-9; Kroenke et al., 2001) were 15.33 ($SD = 4.27$) and 16.33 ($SD = 4.37$), respectively, reflecting significant anxiety and moderately severe depression. At posttreatment, average generalized anxiety decreased and depressive symptoms increased to 13.17 ($SD = 5.71$) and 17.50 ($SD = 7.15$), respectively. Within-condition effect sizes demonstrated that these pre- to posttreatment changes in anxiety (Hedges' $g = 0.57$, $SE = 0.60$, confidence interval [−0.60, 1.74]) and depression (Hedges' $g = -0.18$, $SE = 0.58$, confidence interval [−1.32, 1.74]) were not significant. It is important to note that there was variability in the extent to which patients improved and, given the small sample, it is important to report scores for individual patients (Table 4). With regard to pre- to posttreatment changes in anxiety symptoms, three patients evidenced raw reductions in symptoms (each completed at least four skills), one patient's scores remained the same (completed five skills), and two demonstrated worsening anxiety (each completed three or fewer skills; one was withdrawn due to clinical deterioration). In terms of pre- to posttreatment changes in depressive symptoms, two patients evidenced raw reductions in symptoms (each completed all five skills), one patient's scores remained the same (completed five skills), and three demonstrated worsening depression (each completed four or fewer skills; one was withdrawn due to clinical deterioration).

Conclusions

Our experience administering the UP at BHCHP, along with our preliminary data, yielded mixed results with regard to the intervention's acceptability and feasibility in this setting. Specifically, data suggest that therapists possess positive attitudes toward learning new EBTs, in general, and reported beliefs that the UP, specifically, would be feasible to administer and helpful to their patients following their training workshop that persisted after they implemented this intervention with their patients. Postworkshop knowledge acquisition quizzes indicated that therapists can quickly learn the UP concepts, and fidelity ratings for audio-recorded sessions suggest that they can teach the skills as designed by developers. It is, of course, important to note that these promising therapist-level findings represent a very small sample ($N = 2$) as the therapist census for the OBAT unit is 4, and an additional therapist on the unit refused study participation (one therapist

[2] Follow-up data were collected for all participants, regardless of treatment completion status; however, Knowledge Acquisition Quiz scores are based on data from five (of six) participants as one patient was lost to follow-up before completing this measure.

Table 4
Patient Outcome Data

Patient	Number of skills completed	Anxiety		Depression	
		Pre	Post	Pre	Post
1	5	21	21	21	21
2	5	17	8	17	8
3	5	13	7	20	9
4	2	11	18	9	25
5	4	19	10	17	21
6	3	11	15	14	21

Note. Anxiety was measured with the Generalized Anxiety Disorder-7, and depression was measured with the Patient Health Questionnaire-9. Patient 4 was withdrawn due to clinical deterioration.

position remained unfilled), suggesting that significant variability in willingness to adopt the UP may exist in the larger BHCHP context.

Patient acceptability and feasibility data were also mixed. Knowledge acquisition data suggested a promising uptake of the skills, and patients also reported strong satisfaction with this treatment approach. However, despite finding the treatment acceptable, only three of six patients completed all five skills within the 4-month treatment window. Additionally, preliminary effect sizes for the full sample showed limited movement on psychological symptoms following the presentation of the five UP skills, though there was significant variability in response among individual patients and our limited sample size precluded drawing conclusions.

Overall, the use of the UP at BHCHP shows promise in addressing the research-to-practice gap that exists for safety-net settings, though numerous challenges remain. The transdiagnostic nature of intervention is responsive to some of the barriers that have historically prevented the use of established EBTs in these contexts (e.g., high rates of comorbidity and underresourced therapists). Additionally, enthusiasm from the providers and patients in our study suggests that the UP may be an acceptable form of care across more than one stakeholder level. Of course, it is important to note that the attitudes expressed by the participants in our pilot study may not be representative of BHCHP as a whole. Only two therapists were trained, as the third eligible clinician chose not to attend the workshop despite having institutional support to do so. Additionally, patient enthusiasm did not translate to uniform treatment compliance, with only 50% of sample completing all five skills over the course of 4 months. Further, therapists had difficulty covering planned session material, suggesting the need to design exercises that can be completed in ~20 min. Finally, to be successful, interventions used at BHCHP must be translated in to Spanish to accommodate the high number of Spanish-speaking individuals that receive care at this organization. A larger scale effectiveness effort that addresses these barriers and compares the UP with the treatment as usual is needed to understand whether the results from this pilot study can be improved upon at BHCHP.

In conclusion, conducting research in routine practice settings provides a richness of information about necessary adaptations to interventions developed in academic settings that increase the likelihood that these efficacious treatments are adopted more widely. Although maintaining the same level of experimental control as is expected in academic settings is difficult to achieve in community practice, these efforts should still be undertaken and their results published. Not only do pilot studies, like the one described above, serve as stepping stones in achieving the external funding needed to conduct larger scale effectiveness studies, their more valuable function may be to provide information to treatment developers in academic settings who can begin to tailor their approaches to the clinicians who will ultimately be using them right from the start.

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Appendix A

Therapist Knowledge Acquisition

We are interested in your understanding of treatment principles in the unified protocol (UP).

(1) What are the core deficit(s) targeted by the UP?

a. Inability to pursue important goals

b. Frequent negative emotions, coupled with aversive reactions to them

c. Lack of motivation to engage in activities

(2) What is the overarching goal of the UP?

a. To cultivate a more willing, accepting attitude toward emotions

b. To learn how to successfully stay away from situations that bring up strong emotions

c. To use the patient−therapist relationship to help the patient understand the impact his/her interpersonal responses have on other people

(3) How does the UP view negative emotions like anxiety or sadness?

a. It is important to dampen negative emotions to the extent possible

b. All emotions, including "negative" ones, are essentially adaptive

c. Negative emotions are signs that someone is ignoring valued actions

(4) What are the three components of the three-component model?

a. Antecedents, behavior, and consequences

b. Emotion avoidance, behavioral avoidance, and emotion-driven behaviors

c. Psychoeducation, skills learning, and implementation

d. Thoughts, physical feelings, and behaviors

(*Appendices continue*)

(5) What are the key components of mindfulness in the UP that make it a useful skill to practice? (select two).

a. Relaxation

b. Present-focused awareness

c. Nonjudgment of experience

d. Quieting the mind of thoughts

(6) What is the purpose of the cognitive work in the UP?

a. To increase flexibility in thinking and generate alternative explanations

b. To eliminate incorrect ways of thinking

c. To help patients experience positive thinking

(7) What is the purpose of Alternative Actions for emotional behaviors?

a. To help the patient find more effective ways of staying away from upsetting situations

b. To adopt a pattern of approach instead of avoidance

c. To intentionally provoke emotions so that habituation can occur.

Appendix B

Therapist Adherence Rating Scale

Therapist ID _____ Patient ID _____ Rater ID _____

Introduction to Treatment (Start of Session 1)

☐ Yes ☐ No (1) The goal of treatment, building healthy coping strategies for strong emotions, is described
☐ Yes ☐ No (2) Rationale for being more accepting of emotions, rather than pushing them away, is described

Setting Goals and Staying Motivated

_____ session number(s) in which this skill was presented, _____ Duration of session(s)
☐ Yes ☐ No (1) Therapist acknowledges that facing problems can be overwhelming but is the first step to addressing them
☐ Yes ☐ No (2) Therapist completes Goal Setting Worksheet with patient
☐ Yes ☐ No (3) Therapist acknowledges that change is hard and patients likely feel conflicted about making changes
☐ Yes ☐ No (4) Therapist completes Decisional Balance Worksheet with patient
☐ Yes ☐ No ☐ N/A (5) Therapist assigned homework

Non-UP interventions delivered.

☐ Yes ☐ No Therapist implemented interventions that are not included in this manual or model of treatment?
If Yes, describe: _____

Adherence summary score.

_____ % Overall Adherence—calculate the percentage of *applicable* items that were completed, including the session duration item at the top of this page

(*Appendices continue*)

Overall session rating.

_____ Please provide an overall rating for the delivery of this treatment skill, taking into consideration how effectively the therapist presented key treatment elements and met the primary goals of the session.

0	1	2	3	4	5
Poor	Marginal	Fair	Adequate	Good	Excellent

Comments:

Understanding Emotions

_____ session number(s) in which this skill was presented, _____ Duration of session(s)

☐ Yes ☐ No (1) Therapist highlights the functional, adaptive nature of emotions

☐ Yes ☐ No (2) Therapist emphasizes that breaking an emotion down into its three components can make the experience feel more manageable

☐ Yes ☐ No (3) Therapist completes Break Down Emotions Worksheet with patients

☐ Yes ☐ No ☐ N/A (5) Therapist assigned homework

Non-UP interventions delivered.

☐ Yes ☐ No Therapist implemented interventions that are not included in this manual or model of treatment?

If Yes, describe: _____

Adherence summary score.

_____ % Overall Adherence—calculate the percentage of *applicable* items that were completed, including the session duration item at the top of this page

Overall session rating.

_____ Please provide an overall rating for the delivery of this treatment skill, taking into consideration how effectively the therapist presented key treatment elements and met the primary goals of the session.

0	1	2	3	4	5
Poor	Marginal	Fair	Adequate	Good	Excellent

Comments:

Mindful Emotion Awareness

_____ session number(s) in which this skill was presented, _____ Duration of session(s)

☐ Yes ☐ No (1) Therapist highlights the consequences of judging emotions

☐ Yes ☐ No (2) Therapist leads patient in mindfulness exercise

☐ Yes ☐ No (3) Therapist highlights the consequences of focusing on the past/future

☐ Yes ☐ No (4) Therapist teaches the steps for anchoring in the present

☐ Yes ☐ No ☐ N/A (5) Therapist assigned homework

Non-UP interventions delivered.

☐ Yes ☐ No Therapist implemented interventions that are not included in this manual or model of treatment?

If Yes, describe: _____

Adherence summary score.

____ % Overall Adherence—calculate the percentage of *applicable* items that were completed, including the session duration item at the top of this page

Overall session rating.

_____ Please provide an overall rating for the delivery of this treatment skill, taking into consideration how effectively the therapist presented key treatment elements and met the primary goals of the session.

0	1	2	3	4	5
Poor	Marginal	Fair	Adequate	Good	Excellent

Comments:

(*Appendices continue*)

Flexible Thinking

_____ session number(s) in which this skill was presented, _____ Duration of session(s)
☐ Yes ☐ No (1) Therapist describes the reciprocal relationship between thoughts/emotions
☐ Yes ☐ No (2) Therapist uses ambiguous picture to highlight that we tend to trust our first impressions
☐ Yes ☐ No (3) Therapist highlights the importance of being flexible in our thinking and introduces challenging questions
☐ Yes ☐ No ☐ N/A (4) Therapist assigned homework

Non-UP interventions delivered.
☐ Yes ☐ No Therapist implemented interventions that are not included in this manual or model of treatment?
If Yes, describe: _____

Adherence summary score.
_____ % Overall Adherence—calculate the percentage of *applicable* items that were completed, including the session duration item at the top of this page

Overall session rating.
_____ Please provide an overall rating for the delivery of this treatment skill, taking into consideration how effectively the therapist presented key treatment elements and met the primary goals of the session.

0	1	2	3	4	5
Poor	Marginal	Fair	Adequate	Good	Excellent

Comments:

Countering Emotional Behaviors

_____ session number(s) in which this skill was presented, _____ Duration of session(s)
☐ Yes ☐ No (1) Therapist defines emotional behaviors
☐ Yes ☐ No (2) Therapist highlights how behaviors that create short-term relief from strong emotions may make things worse for us in the long-term
☐ Yes ☐ No (3) Therapist defines Alternative Actions and indicates that these behaviors may increase negative emotions in the long term but may bring us closer to long-term goals
☐ Yes ☐ No (4) Therapist completes Emotional Behaviors and Alternative Action worksheet with patient
☐ Yes ☐ No (5) Therapist describes rationale for Facing Your Emotions
☐ Yes ☐ No (6) Therapist completes Facing Your Emotions Worksheet with patient
☐ Yes ☐ No ☐ N/A (7) Therapist assigned homework

Non-UP interventions delivered.
☐ Yes ☐ No Therapist implemented interventions that are not included in this manual or model of treatment?
If Yes, describe: _____

Adherence summary score.
_____ % Overall Adherence—calculate the percentage of *applicable* items that were completed, including the session duration item at the top of this page

Overall session rating.
_____ Please provide an overall rating for the delivery of this treatment skill, taking into consideration how effectively the therapist presented key treatment elements and met the primary goals of the session.

0	1	2	3	4	5
Poor	Marginal	Fair	Adequate	Good	Excellent

Comments:

(*Appendices continue*)

Overall Therapist Ratings (To be Completed After Rating All Tapes for This Patient)

(1) Rate the quality of the therapist's rapport with the patient (e.g. warmth, openness, respect, humor):

0	1	2	3	4	5
Poor	Marginal	Fair	Adequate	Good	Excellent

(2) Rate the extent to which the therapist engaged in interactive exchange with patient and tried to involve them in the treatment (e.g. use of Socratic questioning, checked the patient's understating or recall of information, worked collaboratively on assignments, sought the patient's opinions or suggestions, used patient relevant examples):

0	1	2	3	4	5
Poor	Marginal	Fair	Adequate	Good	Excellent

(3) Rate the therapist's ability to manage the session (e.g. kept the patient on task, used time effectively, proceeded logically, made smooth transitions):

0	1	2	3	4	5
Poor	Marginal	Fair	Adequate	Good	Excellent

(4) Rate the therapist understanding of treatment concepts and their ability to deliver information at a level the patient can understand:

0	1	2	3	4	5
Poor	Marginal	Fair	Adequate	Good	Excellent

Appendix C

Patient Knowledge Acquisition

(1) Making changes to your life is easy and doesn't require much motivation. __*F*___

(2) There is no point to having negative emotions like fear, anger, anxiety, and sadness. _*F*__

(3) The three parts of an emotion are thoughts, physical sensations, and behaviors. __*T*___

(4) It is important to judge your emotional experiences as good or bad. ___*F*__

(5) Anchoring in the Present allows us to determine whether what you're worried about is actually happening in the here and now. __*T*__

(6) The way people think about situations does not affect how they feel. _*F*___

(7) Flexible thinking involves generating other interpretations for the situations we face. __*T*___

(8) Strong emotions are usually accompanied by the urge to DO something. _*T*____

(9) Alternative Actions should involve avoiding your emotions. __*F*___

(10) The purpose of Facing your Emotions is to show you that they are temporary and that you can cope with them. ___*T*___

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