**ORIGINAL ARTICLE**

# Stakeholder Preferences on Transdiagnostic Psychosocial Treatment for Trauma-Exposed Veterans

Cassidy A. Gutner[1,2] · Caroline A. Canale[1,2] · Stephanie A. Vento[1,2] · Shannon Wiltsey Stirman[3]

**Abstract**

While modular and transdiagnostic approaches may address implementation challenges, there remains limited investigation into the fit within large healthcare systems. The current study examines qualitative interviews from patients, clinicians and administrative stakeholders in the Veterans Administration about experiences with, and views of, the Unified Protocol (UP; Barlow et al. in The unified protocol for transdiagnostic treatment of emotional disorders: therapist guide, Oxford University Press, New York, 2011) to understand potential for implementation. Qualitative interviews were conducted based on an established implementation framework and speak to implementation of transdiagnostic treatment in veterans, including insight into barriers, facilitators, intervention characteristics, patient characteristics, and system level variables. The UP demonstrated promise for improving efficiency, satisfaction and personalizing mental healthcare.

**Keywords** Transdiagnostic treatment · Routine care · Trauma exposure · Implementation

Over the past decade, there has been an increased call to consider a pivot away from single diagnosis protocols (SDPs) towards transdiagnostic and modular approaches to treatment (e.g., Barlow et al. 2014; Chorpita et al. 2005; Martin et al. 2018; McHugh et al. 2009). SDPs have moved the field of psychosocial intervention forward in enormous ways, yet they rarely provide guidance on treating multiple disorders, which ignores the overlap in the developmental and maintenance factors of these disorders. Furthermore, SDP implementation assume that providers have the time and capacity to be trained to deliver multiple SDPs effectively. However, we know comorbidity is common (Kessler et al. 2005), there are common developmental and maintenance factors responsible for emotional disorders (Barlow et al.

2014), and clinician training time and resources are limited (Ruzek and Rosen 2009). While SDPs serve an important role in specialty care, their limited uptake and penetration in large healthcare systems (Grubbs et al. 2017; Maguen et al. 2018), coupled with high dropout rates suggest a need for an alternative approach.

A shift towards thinking about psychosocial treatments from a modular and transdiagnostic approach has surged in the recent years (e.g., Chorpita et al. 2005; Chorpita and Weisz 2005; Sauer-Zavala et al. 2017). Within the child literature, extensive work has been done to develop and utilize modular treatments. These treatments, sometimes referred to as "common elements" approaches, infuse more prescriptive treatment approaches with the flexibility to incorporate systemic design decisions through treatment to improve fit to the context (Chorpita et al. 2005). The growth of transdiagnostic and modular approaches in the child literature is impressive, with widespread implementation and dissemination within some routine care systems (e.g., Chorpita et al. 2004; Hersh et al. 2016). Treatment interventions like the Modular Approach to Therapy for Children with Anxiety, Depression, or Conduct Problems (MATCH; Chorpita and Weisz 2005) utilize components of evidence-based treatments for commonly occurring problems into modules that can be individualized based on an individual patient, which directly incorporates consideration of context into treatment.

---

✉ Cassidy A. Gutner
   cgutner@bu.edu

[1] National Center for PTSD at VA Boston Healthcare System, Boston, USA

[2] Department of Psychiatry, Boston University School of Medicine, 720 Harrison Avenue, Boston, MA 02118, USA

[3] National Center for PTSD and Stanford University, Palo Alto, USA

Research in modular and transdiagnostic approaches has also been investigated in low- and middle-income countries with limited mental health infrastructure (Knapp et al. 2006; Murray et al. 2014; Patel et al. 2007; Saraceno et al. 2007) where implementing SDPs makes less sense in efforts to maximize treatment reach. Initial data supports its utility (e.g., Bolton et al. 2014; Murray et al. 2014), although often clinicians are still required to decide what to prioritize in treatment as modular approaches do target underlying developmental and maintenance factors. A transdiagnostic treatment for eating disorders (Fairburn 2008) has been used extensively in the United Kingdom, a system with substantial infrastructure, providing an efficient protocol to address eating disorders across a national healthcare system. While other transdiagnostic treatment protocols have emerged to treat the full spectrum of anxiety disorders (e.g., Creed et al. 2016; Lang et al. 2012, 2017; Norton 2012; Schmidt et al. 2012), many efforts to implement evidence-based psychotherapies (EBPs) for adults have focused on protocols that target single diagnoses. The reliance on diagnostic categories may restrict real world applicability due to diagnostic and statistical manuals' diagnostic constraints (Hofmann 2014) and negatively impact the efficiency of healthcare systems.

The Veterans Administration (VA) has spent substantial effort implementing several SDPs, two of which have specifically focused on posttraumatic stress disorder (PTSD) and three on depression, which is commonly comorbid with PTSD (Stander et al. 2014). Although these SDPs have been shown to decrease symptoms to subclinical levels when utilized (Eftekhari et al. 2013; Karlin et al. 2012), they also have some drawbacks. First, training clinicians to implement SDPs is costly (McHugh et al. 2009), particularly when it is necessary to train providers to treat a variety of symptom presentations and co-occurring disorders. Comorbidity is the rule rather than the exception (Brown et al. 2001; Kessler et al. 1995) with rates of comorbidity in veterans estimated to be between 25 and 35% (Forman-Hoffman et al. 2005; Seal et al. 2007). Second, research has demonstrated that these SDPs are not used frequently in routine VA mental healthcare (Sripada et al. 2018; Sripada et al. 2018). One study demonstrated that only 20.2% of veterans with PTSD received at least one session of an SDP for PTSD over approximately 15 years (Maguen et al. 2018). Furthermore, veterans presenting to community-based outpatient clinics for PTSD treatment are rarely receiving an SDP for PTSD (Grubbs et al. 2017) which suggests that they are underutilized. This may be in part due to veterans' refusal of trauma-focused treatments, and to the presence of comorbidity and complex symptom presentations, which can make clinicians feel unprepared to effectively use evidence-based interventions (Osei-Bonsu et al. 2017; Zubkoff et al. 2016). As a result, there is room for an alternative,

perhaps transdiagnostic, approach to treating trauma-related psychopathology.

Given the potential barriers to SDPs in routine care, it is possible that transdiagnostic treatments may be a beneficial option within the VA system. Transdiagnostic treatments, which aim to decrease symptoms across a variety of domains, may minimize clinician training costs by offering one flexible protocol applicable to a broad range of symptom presentations rather than requiring clinicians' proficiency in multiple SDPs. Furthermore, the results of the recent Acceptance and Commitment Therapy study demonstrating modest effects (Lang et al. 2017) paired with the high rates of comorbidity in trauma-exposed veterans, suggest a need for further research into understanding the potential of a transdiagnostic treatment within routine care. The utility of a transdiagnostic treatment that targets underlying mechanisms, as opposed to universally applying principles across symptom presentations (see, Sauer-Zavala et al. 2016), is an understudied path that may yield important information in routine care.

Taking stakeholder needs and preferences into account when implementing a new protocol into a healthcare system is essential (Vastine et al. 2005). In fact, understanding local context and putting in place a bidirectional flow of information is crucial for successful implementation and is recommended by the National Institute of Health (2017). Implementation frameworks provide a structure for evaluating system-, provider-, and patient-level needs. Including patient preference in this process is often overlooked given the structure of many implementation frameworks; however, it is important for successful translation into routine care (Rosen et al. 2016). The Consolidated Framework for Implementation Research (CFIR; Damschroder et al. 2009) is a widely used framework to study these factors as it provides guidance on assessment of variables at various levels, and includes consideration of patient needs and resources. CFIR guided interviews are utilized in the current study to guide assessment of a variety of factors that may influence a decision to implement the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (UP; Barlow et al. 2011) including feasibility, tolerability, satisfaction, perceptions of clinic and patient fit, and barriers and facilitators. The current study, guided by CFIR constructs of inner and outer setting, focuses on examining and understanding local context and intervention feasibility and acceptability through pre-implementation research. Following Pettigrew et al. (2001) and Damschroder et al. (2009) inner setting includes aspects of structural, political and cultural context in which the implementation process is being studied. Additionally, outer context includes the economic, political, and social context that the organization resides in. The aim of the study is to examine qualitative data from interviews with patients, clinicians and stakeholders in the VA about experiences with,

and views of, the UP, a mechanistic approach to emotional disorders, to better understand factors impacting potential future implementation within the larger system.

## Methods

### Treatment

The UP is a transdiagnostic, emotion-focused treatment that is grounded in traditional cognitive behavioral therapy with the goal of treating underlying negative affect. The flexible protocol, which takes place over 12–16 sessions, allows clinicians to utilize traditional therapeutic techniques, including cognitive therapy and behavioral exposures. Rather than focusing on a specific diagnosis, the UP focuses on the broader emotional experience and the impact it has on the patient's daily life, which allows for comorbidities to be treated simultaneously. The UP has demonstrated promising results in several studies with community samples seeking treatments at university clinics, covering a wide range of primary anxiety disorders, including posttraumatic stress disorder (Barlow et al. 2017; Ellard et al. 2010; Farchione et al. 2012).

### Participants

Clinician participants at VA Boston and VA Puget Sound Healthcare Systems were recruited (N = 18) and enrolled (N = 15) in the study. Clinician participants identified as serving a primary clinical role (N = 7), primary research job with a small amount of clinical work (N = 1), clinical trainees (N = 3), a clinic director (N = 2), a VA Local Evidence-Based Practice coordinator (N = 1), and an administrator (N = 1). There were no notable differences among those serving as clinicians versus the varying administrative roles. Veteran participants (N = 7), were part of the intent-to-treat sample for the UP and attended at least four sessions prior to participation in the qualitative interview. Two additional veteran participants participated in the parent study, but did not provide qualitative interviews as they did not completed more than four sessions of the UP. Four veteran participants completed 16 sessions of the UP. One participant dropped out after session 4, one after session 5, and one after session 9. Four participants were male and three were female, with an average age of 44.14 (SD = 15.48) and the majority identified as White (N = 5).

### Procedure

Data were collected as part of an IRB-approved pilot Hybrid I open trial assessing pre-implementation and effectiveness of the UP in trauma-exposed veterans. The parent study identified the UP as a protocol that had potential to target comorbid presentations frequent in trauma exposed individuals, a frequent presentation in the VA, and one that has been understudied outside of efficacy trials. Given the pilot nature of this study and the limited scope, the study was presented to one site, which accepted, and one other site approached the PI about participating in the study. The current study focuses on the CFIR-based qualitative interviews (Damschroder et al. 2009) in two groups: clinicians and administrative stakeholders, and veterans. Purposive sampling (participants selected based on characteristics that could speak to the objective of the study) was used to recruit for in-depth, semi-structured qualitative interviews from VA Boston and VA Puget Sound Healthcare Systems clinician and administrative stakeholders with the intention of collecting data on personnel perspectives on the UP, training experiences, and contextual factors that influence key implementation outcomes related to inner and outer setting. Stakeholders were recruited and interviewed until theoretical depth was reached (Nelson 2017). A subset of these clinician participants from VA Boston Healthcare System also delivered the UP as study therapists (N = 4) in an open UP trial. After providing informed consent, clinician and administrative stakeholder participants completed a 1-h qualitative interview to examine factors such as feasibility, acceptability, perceived fit and satisfaction in clinic settings, using an interview guide that was based on CFIR constructs. Interviews were conducted in person when feasible or over the phone. Stakeholder participants from the VA Boston Healthcare System were compensated with a gift card or a small gift (e.g., book, magazine subscription for the waiting room) valued at up to $50. Stakeholder participants from the VA Puget Sound Healthcare System were not compensated for participation due to IRB regulations.

All treatment-seeking veteran participants that participated in qualitative interviews were enrolled in the open trial at VA Boston Healthcare System and were recruited through clinician referrals from routine care. Veteran participants were compensated with $50 cash for participation in the post-treatment assessment session that included the qualitative interview. Veteran participants were interviewed regarding their perception of, and satisfaction with the UP at their post-treatment assessment using a CFIR interview guide that was tailored to assess patient perspectives. Veteran participant interviews were designed to evaluate potential fit of the UP for this population and the individual being interviewed. Specifically, it inquired about constructs relevant to the success of potential future implementation efforts, including the intervention (perceptions of evidence strength and quality), outer setting (patient needs and resources), characteristics of the individuals potentially implementing the UP, and potential treatment manual modifications. Process was not the primary focus of these interviews given the overall aim

of the study was to assess effectiveness of the UP in a new context, and to gather pre-implementation data to inform future implementation efforts. The CFIR interview guides were created from the CFIR wiki page interview generator and edited to best fit the study content. Notably, not all of these participants completed a full course of the UP, but all participated in the final assessment.

## Data Analysis

All interviews were digitally recorded, transcribed, and checked for accuracy. Eleven hours and 23 min of qualitative interviews were collected. There was a total of 9 h and 42 min of qualitative interviews from 15 clinician participants and a total of 1 h and 41 min of qualitative interviews from seven veteran participants. Clinician interviews averaged 39 min and veteran interviews averaged 15 min. We employed a directed content analysis, which entailed both deductive coding based on an a priori set of codes defined by our conceptual model, and inductive coding to capture emergent themes outside our existing framework (Hsieh and Shannon 2005). A preliminary codebook to operationalize a priori codes based on the CFIR framework was developed. Codes were derived deductively by identifying categories at the beginning of the research (e.g., elements of the CFIR framework to inform research questions) and inductively by identifying those that emerged gradually from the data. We developed a codebook with operational definitions of each code. Using constant comparison, we updated the coding model to reflect further refinement. Using NVivo10 software, three raters coded the transcripts and identified additional codes where needed through consensus. Transcripts were coded using open coding followed by focused coding, with disagreements in assignment of codes resolved through discussion and consultation between raters with the codebook. Central themes were determined through triangulation across stakeholders and the frequency with which codes were identified.

## Results

Qualitative interviews were conducted with 83% of the clinicians contacted to participate in the study, and 100% of the veteran participants contacted to participate in an interview, with an overall study response rate of 88%. Analysis from the qualitative data obtained from the semi-structured interviews with clinicians and administrative stakeholders revealed critical information that might impact potential implementation of the UP. Overall, data demonstrate a consistency in responses across CFIR constructs of inner and outer setting. More specifically, the interviews highlight overlap between local- and system-level factors that impact

the perceptions of the UP. Perceptions of the innovation fall under three broad categories: perceived efficiency/cost-effectiveness, perceived compatibility, and perceived alignment with VA priorities. Key themes across stakeholders revealed the overwhelming impression of a need and good fit for the UP within the VA. Several potential organizational barriers were also identified.

## Characteristics of the Intervention

### Perceived Efficiency and Cost-Effectiveness

The perception of the UP as potentially more efficient and cost-effective treatment intersected with perceptions of the VA system's priorities. The increased number of veterans seeking mental health treatment in the VA was commonly noted throughout interviews and the UP was consistently viewed as a protocol with potential to decrease the number of courses of treatment an individual needed, which may yield overall cost saving for the VA. One participant stated: "I think, especially in these settings where they're understaffed…they're all about wanting to be cost effective, so if you can cut down on the amount of different episodes of care or sessions or whatever, then that's cost savings for VA and for the federal government" [provider]. This quote highlights the widely held view that the UP is packaged in a way to promote efficiency in care by providing one intervention for use across a variety of mental health concerns and its financial benefit to the larger system. Improving effectiveness and efficiency is also valued at the clinic level, "We are really trying to figure out how we can balance effectiveness of care and efficiency and the UP seems to be a potentially good route" [provider]. A theme across interviews was a perception that there was a need for the UP, specifically to increase efficiency in clinics, "…there's a push for increased evidence-based care in the mental health clinics, which is wonderful. This [the UP] seems like a good place to start. We are already providing evidence-based groups for disorder-specific presentations, but I think, in terms of increasing efficiency, there seems to be a lot of openness [to the UP]" [provider].

### Patient Needs and Perceptions

Patient perspective has not been prominently captured in most studies (Rosen et al. 2016) despite being a critical factor in successful implementation. Veteran participants overwhelmingly had a positive experience with the UP. All of them identified finding it helpful, especially having the ability to discuss multiple mental health concerns with one provider rather than having to seek multiple people either simultaneously or sequentially. Interviews consistently revealed commonly-held belief that the components of the

UP allowed veterans to discuss all their concerns, while each treatment component built off of one another. The general consensus was that the same skills carry over into multiple parts of life and that going through the treatment enabled them to see how the treatment components and difficulties with their mental health, regardless of diagnosis, were interconnected. Streamlined mental health treatment was important to the veterans we interviewed. One participant captured the overall theme that there is a benefit to the treatment package being efficient by discussing the UP as a way to support veterans' willingness to initiate treatment, "I know a lot of veterans sometimes feel… like it's a weakness to have to go to a psychologist at all … I think more Veterans, if you could give them …more bang for their buck in treatment per hour they spend here, I think that they would appreciate the fact that they're actually getting more than [treatment for] just one thing. And I think that would be a good selling point, would be that you know, 'we can treat you for this, but why don't we do the entire process'" [patient]. These interviews supported the notion that the UP holds potential to guide mental health treatment effectively and efficiently while helping support veterans working with one clinician for their mental health needs rather than needing to seek multiple providers across clinics.

## Perceived Compatibility

Given the number of VA hospitals, culture (e.g., norms, values, and basic assumptions of the organization) likely varies despite system-wide policies, procedures, and standards of care. Although, within the current study, we demonstrated consistent statements around how the UP fits within the overall VA culture of taking an evidence-based approach. In general, there was a sense that the longstanding focus on EBPs lays a solid foundation for fit of the UP within the VA; however, at a local level, some may not share the prioritization of EBPs. Clinicians who do not fully believe in the larger mission around EBP implementation in the VA may have a hard time with the UP as a result of a lack of appreciation for EBPs more broadly:

> "I think the colleagues of mine that are… likeminded in terms of evidence-based practice and who have experience in training in foundational CBT and EBPs are all really taking to the Unified Protocol and really like the model. There are also providers in VA who have less experience with EBPs, and with exposure therapy in general, … [they might] need some warmup time or additional assistance learning foundational CBT and exposure therapy and getting comfortable themselves with providing that type of treatment" [provider].

Another participant echoed this stating, "there are people who have been trained in different eras of psychotherapy, so maybe people whose training predated the advent of manualized treatment would be less inclined to use it" [provider]. These data highlight the potential implementation barriers to using the UP in the VA that may be largely non-specific to the UP and would still impact potential implementation efforts.

## Perceived Alignment with VA Priorities

The importance of matching treatment with the VA system's policies and incentives was a common theme across mental health staff interviews. It was broadly noted in the majority of interviews that the UP aligned well with the VA patient-centered care approach, or "treating the whole veteran." As one stakeholder expressed, "I think that there is a big push for…patient-centered approaches and patient-driven treatment plans, and …a lot of time veterans really want the full range of their symptoms to be addressed, so I think this is really in the spirit of that" [provider]. Overall, stakeholders endorsed a sense that the UP could be used to provide one course of treatment to address multiple needs of veterans and internal policies. This theme was illustrated across many provider interviews highlighting the match between the UP and the VA's I-CARE core values, which stands for Integrity, Commitment, Advocacy, Respect, and Excellence, and guides the culture and values of the VA when serving those who have served the country. Many reported a consistency between the UP and I-CARE: "it's this whole 'I CARE' this patient-centered thing. You know, if you're treating a patient holistically, I think that's a major goal of the VA, so I think [the UP] meets that call" [provider].

Readiness for implementation technically focuses on tangible and immediate indicators of a commitment to implementation of an intervention at an organization level. This theme overlaps with climate and may also speak to organizational readiness. All clinicians and administrative participants indicated that their leadership was on board with the use of the UP within their clinics, likely due to the nature of our sampling at two VAs that had participated in the study. However, it is important to note that despite existing infrastructure that would make training in a treatment like the UP easier within a setting where EBPs are common, there were important barriers that would significantly limit implementation if they were not addressed on a larger scale. The lack of space and trained personnel were commonly cited across interviews, and captured by one participant: "Space!…it's a big VA problem…I'm sure there could be a training in the basement. I guess it's really just the personnel: who's knowledgeable in it [the UP], who can do the training, I'm not sure" [provider]. The other common concern was the amount of time it takes to get trained and the competing

demands that would be seen in any VA with any new treatment, unrelated to the UP. One participant stated, "I guess a more pressing need that would get in the way, it's not specific to the UP, it's just specific to trying to roll out anything new, which is it's just hard for providers and clinicians to prioritize time for one of our trainings when they have such a load of patients to get through. I think that is really the only thing I can imagine being a barrier, but it's not specific to the UP. It's just for any kind of roll out" [provider].

However, most participants directly noted that due to the climate being friendly to learning EBPs, there is existing infrastructure for training in new protocols, consultation, didactics, and implementing measurement-based care. However, about a third of participants noted the limited number of people already training in the UP and how that might limit opportunities to extend training in the protocol and/or provide necessary supervision for trainees that come in with experience with the UP but need a knowledgeable supervisor. Yet, there is also a limitation in the implementation climate around having few, if any, clinicians trained in the UP to provide supervision, "…it might even be that grad students are trained in it [the UP] in grad school now, but people here providing supervision are not, and so those trainees can't do it because their supervisors don't know enough about it" [provider].

### Relative Priority

The potential fit of the UP with VA policies yielded realistic concerns across a number of interviews with respect to the current infrastructure of the VA mental health services. The VA has engaged in national efforts to roll out specific single disorder evidence-based protocols (EBPs) over the past 10–15 years (Karlin and Cross 2014). Several interviews yielded concern that training is largely focused on these rollout efforts and the UP may be seen as a threat to some of these EBPs if there is overlap between the UP's "consolidated manual" across presenting problems and the SDPs already rolled out in the VA. This concern is captured in the following quote, "…they already have these [EBPs] that they're rolled out. I think that this could be a legitimate threat to those … and if this really does encompass a lot of those [EBP rollouts], then this may be seen as redundant with those things that they've already invested a lot in, or that could unseat some of those treatments that they've invested so strongly in" [provider].

Despite it seeming like a natural fit to address needs and increase efficiency, there was a common theme that for clinicians with limited time for training, the UP could potentially be overshadowed by the priority of the existing EBP rollouts across the VA: "there are a lot of different rollouts for a lot of different treatments, and it's a matter of manpower. If everybody's doing some sort of evidence-based treatment

that requires them to meet a certain number of times with people or to receive consultation…it's going to be hard…there seem to be competing opportunities that limit the number of people that can probably realistically receive training in and implement some of these newer treatments at any given time" [provider]. Similarly, clinician and administrator participants raised the question of whether a protocol that is not part of the larger VA EBP rollout could be widely implemented without a top-down mandate. This was a theme that came up across approximately half of the interviews. One participant captured this concern, "It has to be…a VA rollout, basically, and you know, there's a lot of training activities already for the trainees here, and [clinicians are] spread pretty thin…I think it would be a choice, basically. You couldn't do that [UP training] and CPT in the same training year, you'd have to pick…that's a tough call for a lot of people" [provider].

However, it was also explicitly noted by one participant that "we do have the ability to offer more—not VA rollouts trainings—to interested providers at our site. So that's kind of how the Unified Protocol has really taken root and gotten traction at our site, through some of these more informal grassroots efforts" [provider]. In settings where implementation climate is strong, the UP is used despite no formal or systemic rollout.

### Characteristics of the Individual

Individual characteristics of the individuals implementing or potentially implementing the UP demonstrated consistency in this study. All stakeholders expressed enthusiasm for the UP in the VA and with trauma-exposed individuals with one stakeholder noting "I'm confident that it [UP] will be useful" [provider], and another stating, "I think it's great…it seems it holds a lot of promise; it seems to be cutting edge" [provider]. The majority of the stakeholders also expressed motivation to use the UP as an EBP within the VA setting. However, 60% of stakeholders expressed concern that barriers at the organization level, such as time and current workload, could hamper use of the UP.

## Discussion

Our study intended to examine the potential fit of the UP within the VA through CFIR-based interviews to assess administrator, provider, and veteran perspectives on the UP. To our knowledge, this is the first qualitative study to examine the potential utility of a transdiagnostic treatment for emotional disorders for veterans. Overall, we found the UP to be highly acceptable and feasible within the VA, with some common potential barriers identified that may play a

key role in implementation for any EBP that is not part of a formal VA rollout.

Some of our findings suggest ways in which perspectives of the UP may be related to aspects of the broader VA setting (the CFIR outer context) such as policies and incentives, recommendations and guidelines. The VA is a government institution characterized by external policies and incentives that impact day-to-day processes across a spectrum of services. In the current study, we found that the UP fit with the overarching expectation within the VA system that veterans have access to mental healthcare that addresses their perceived needs. Research on sustainability has highlighted that contextual fit of an intervention is key for sustainment of implementation efforts. Our findings support the importance of considering the perceptions of fit of intervention to the context, within clinics and within organizations, to increase the likelihood of successful implementation and to maximize sustainment (Stirman et al. 2012).

Furthermore, our interviews revealed that in addition to aligning with VA policies and incentives, the UP was viewed as efficient in treating multiple problems that veterans might present for treatment with. Although the current study did not include a cost analysis of using a transdiagnostic treatment like the UP, the potential financial impact of using a single protocol within a system to treat complex presentations is important and requires further research. The potential efficiency in training and cost has previously been discussed (e.g., McHugh et al. 2009), but costs to the system remain unstudied. However, regardless of the potential cost or time savings that may accompany a transdiagnostic treatment, our findings indicated some concerns over navigating the implementation of the UP in the VA if it was not implemented through a formal rollout by VA Central Office. This is an understandable limitation and one that some of the participating stakeholders in our study overcame at their local sites.

A major theme was the natural translation of the UP into VA mental healthcare given that clinics are already set up to deliver EBPs and have a structure to support delivery and assessment of such effort, suggesting that the UP may be more easily implemented in settings with higher readiness and stronger implementation climates. Additionally, it was noted that many administrators are open to finding more efficient ways to deliver effective treatment, so if the UP could serve that role, decision makers within the clinical context would be even more open to its implementation. However, this positive finding should not discount the concern for obstacles supporting training efforts in the UP with a limited number of trained UP providers and trainers at the current time. Research on implementation leadership has demonstrated that without a leader's involvement (e.g., support, knowledge of the intervention, proactive problem solving) providing some

centralized support, the implementation success is limited (Aarons et al. 2014). Implementation leadership is likely to be important to implementation and sustainment despite favorable perceptions of the UP (Aarons 2006; Aarons and Sommerfeld 2012; Moullin et al. 2017).

Fit with individual therapist and patient needs, as well as the broader context, also emerged as an important theme. Research has demonstrated that even in healthcare systems with substantial support for implementing interventions, a significant number of providers modified manuals through tailoring or lengthening (Cook et al. 2014). While there is a debate around the role of treatment fidelity and adaptations in promoting optimal patient level outcomes, (e.g., Dearing 2009; Palinkas et al. 2008; Schoenwald et al. 2004) approaches that allow greater flexibility, which is inherent in the UP, and increased compatibility with diverse patient needs have been proposed and investigated with success (Borntrager et al. 2009). Our study support for the potential benefit of flexible treatment approaches to increase compatibility for both providers and patients in a veteran population.

Patient needs and satisfaction are often not directly assessed in implementation research despite being central to successful implementation (Rosen et al. 2016). In the current study, patient participants in the open trial were asked about their own needs and resources in relationship to the UP. Support for the UP was expressed across interviews, with participants noting that the UP allowed them to address multiple symptoms without being forced to focus on a single problem or diagnosis. As a result, participants acknowledged that the UP could broadly be useful for other veterans. This endorsement is important to note in light of previous literature on SDPs suggesting that some patients may "vote with their feet" (Cook et al. 2018; Hamblen et al. 2015). Implementation success and sustainment may require sufficient consumer demand and satisfaction, which this study offers preliminary support for with the UP. This demand may be complementary to leadership support and is an important area to consider in future research.

This study had several strengths, including its novelty in exploring perspectives on a transdiagnostic treatment within the VA and examining multiple stakeholder perspectives, including that of the veteran. However, there are also several limitations to note. First, the sampling for this study was purposive. While this allowed us to achieve conceptual depth that we needed to answer our questions, this may limit generalizability. In particular, providers at both settings were interested enough in the UP to participate in interviews and/or UP treatment delivery, and all endorsed administrator support of the UP. The VA system is quite diverse and these sites are likely not representative of programs across the VA Healthcare System and the therapists and administrators who work there. It is also important to note that the purposive sampling in the current study likely yielded a sample where

there was a high degree of implementation leadership, ultimately influencing the findings.

Additionally, reliance on answers that were from specific interview questions grounded in the CFIR may have limited identification of other constructs that may be important for the potential of the UP within the VA system, although our coding system did allow for identification of emergent codes and themes. However, the use of the CFIR allowed us to assess potential determinants of implementation more systematically, and may have allowed us to capture perspectives about specific factors that stakeholders may not have identified or articulated through a less structured interview. Our approach revealed a perceived need for a transdiagnostic approach such as the UP, and a perceived fit with some VA priorities. While local support was strong in the two VA settings that were sampled, an acknowledgement that other priorities may negatively impact implementation at the system level reflects the reality that in large healthcare system, alignment of leadership and policy support at multiple levels are necessary for broad and sustained implementation. Additionally, we did not directly assess cos-effectiveness in the study and are therefore unable to directly speak to whether the perceptions of benefits of the UP being more efficient are backed by quantitative data.

The current study provides strong preliminary support for the UP for veterans from clinicians, administrators, and patients. The aim is to use this information to yield successful implementation of the UP in VA. Ensuring consumer demand and satisfaction is high is important for implementation success, yet full implementation in the VA would require other factors including centralized support and alignment of policies. However, these data could represent an opportunity for VA to apply lessons learned and advances in implementation science to increase the likelihood of success. Following some of the Expert Recommendations for Implementing Change (ERIC; Powell et al. 2015) would facilitate better uptake of the UP. Specifically, altering incentives to adapt and implement the UP system-wide, documenting educational meetings central to core CBT principals in the form of on going trainings, and leveraging facilitation to problem solve and support clinicians trying to use the UP in clinic would further support successful implementation. The findings suggest that despite the use of an intervention intended to be more compatible with general mental health contexts, which could be applied to a greater variety of primary and comorbid presenting problems, perceptions of additional barriers, similar to those found for other EBPs, remain salient. Even with a flexible and more broadly applicable protocol, efforts will need to be made to address barriers at the system and organization level. Furthermore, this study is among the first to examine the UP for trauma exposures in a general mental health treatment settings, rather than PTSD treatment settings, in the VA. Identification of potential determinants in these settings is important to establish in specialty care settings outside PTSD clinical teams. Further consideration and examination of the UP for veterans is necessary to understand the full impact of the UP on cost, efficiency of treatment, and symptoms reduction in veterans seeking treatment in the VA.

## Compliance with Ethical Standards

**Conflict of interest** The authors declare that they have no conflict of interest.

**Ethical Approval** All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

**Informed Consent** Informed consent was obtained from all individual participants included in the study.

## References

Aarons, G. A. (2006). Transformational and transactional leadership: Association with attitudes toward evidence-based practice. *Psychiatric Services, 57*(8), 1162–1169. https://doi.org/10.1176/appi.ps.57.8.1162.

Aarons, G. A., Ehrhart, M. G., & Farahnak, L. R. (2014). The implementation leadership scale (ILS): Development of a brief measure of unit level implementation leadership. *Implementation Science, 9,* 45. https://doi.org/10.1186/1748-5908-9-45.

Aarons, G. A., & Sommerfeld, D. H. (2012). Leadership, innovation climate, and attitudes toward evidence-based practice during a statewide implementation. *Journal of the American Academy of Child and Adolescent Psychiatry, 51*(4), 423–431. https://doi.org/10.1016/j.jaac.2012.01.018.

Barlow, D. H., Farchione, T. J., Bullis, J. R., Gallagher, M. W., Murray-Latin, H., Sauer-Zavala, S., et al. (2017). The unified protocol for transdiagnostic treatment of emotional disorders compared with diagnosis-specific protocols for anxiety disorders: A randomized clinical trial. *JAMA Psychiatry, 74*(9), 875–884. https://doi.org/10.1001/jamapsychiatry.2017.2164.

Barlow, D. H., Farchione, T. J., Fairholme, C. P., Ellard, K. K., Boisseau, C. L., Allen, L. B., et al. (2011). *The unified protocol for transdiagnostic treatment of emotional disorders: Therapist guide.* New York: Oxford University Press.

Barlow, D. H., Sauer-Zavala, S., Carl, J. R., Bullis, J. R., & Ellard, K. K. (2014). The nature, diagnosis, and treatment of neuroticism: Back to the future. *Clinical Psychological Science, 2*(3), 344–365. https://doi.org/10.1177/2167702613505532.

Bolton, P., Bass, J. K., Zangana, G. A. S., Kamal, T., Murray, S. M., Kaysen, D., … Van Wyk, S. S. (2014). A randomized controlled trial of mental health interventions for survivors of systematic violence in Kurdistan, Northern Iraq. *BMC Psychiatry.* https://doi.org/10.1186/s12888-014-0360-2.

Borntrager, C. F., Chorpita, B. F., Higa-McMillan, C., & Weisz, J. R. (2009). Provider attitudes toward evidence-based practices:

Are the concerns with the evidence or with the manuals? *Psychiatric Services, 60*(5), 677–681. https://doi.org/10.1176/ps.2009.60.5.677.

Brown, T. A., Campbell, L. A., Lehman, C. L., Grisham, J. R., & Mancill, R. B. (2001). Current and lifetime comorbidity of the DSM-IV anxiety and mood disorders in a large clinical sample. *Journal of Abnormal Psychology, 110*(4), 585–599. https://doi.org/10.1037//0021-843x.110.4.585.

Chorpita, B. F., Daleiden, E. L., & Weisz, J. R. (2005). Modularity in the design and application of therapeutic interventions. *Applied and Preventive Psychology, 11*(3), 141–156. https://doi.org/10.1016/j.appsy.2005.05.002.

Chorpita, B. F., Taylor, A. A., Francis, S. E., Moffitt, C., & Austin, A. A. (2004). Efficacy of modular cognitive behavior therapy for childhood anxiety disorders. *Behavior Therapy, 35*(2), 263–287.

Chorpita, B. F., & Weisz, J. R. (2005). *Modular approach to therapy for children with anxiety, depression, or conduct problems.* Honolulu, HI, and Boston, MA: University of Hawaii at Manoa and Judge Baker Children's Center, Harvard Medical School.

Cook, J. M., Dinnen, S., Thompson, R., Simiola, V., & Schnurr, P. P. (2014). Changes in implementation of two evidence-based psychotherapies for PTSD in VA residential treatment programs: A National Investigation. *Journal of Traumatic Stress, 27*(2), 137–143. https://doi.org/10.1002/jts.21902.

Cook, J. M., Simiola, V., McCarthy, E., Ellis, A., & Stirman, S. W. (2018). Use of reflective journaling to understand decision making regarding two evidence-based psychotherapies for PTSD: Practice implications. *Practice Innovations, 3*(3), 153–167. https://doi.org/10.1037/pri0000070.

Creed, T. A., Frankel, S. A., German, R. E., Green, K. L., Jager-Hyman, S., Taylor, K. P., et al. (2016). Implementation of transdiagnostic cognitive therapy in community behavioral health: The Beck community initiative. *Journal of Consulting and Clinical Psychology, 84*(12), 1116–1126. https://doi.org/10.1037/ccp0000105.

Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009). Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science. *Implementation Science, 4,* 50. https://doi.org/10.1186/1748-5908-4-50.

Dearing, J. W. (2009). Applying diffusion of innovation theory to intervention development. *Research on social work practice, 19*(5), 503–518. https://doi.org/10.1177/1049731509335569.

Eftekhari, A., Ruzek, J. I., Crowley, J. J., Rosen, C. S., Greenbaum, M. A., & Karlin, B. E. (2013). Effectiveness of national implementation of prolonged exposure therapy in veterans affairs care. *Journal of American Medical Association Psychiatry, 70*(9), 949–955. https://doi.org/10.1001/jamapsychiatry.2013.36.

Ellard, K. K., Fairholme, C. P., Boisseau, C. L., Farchione, T. J., & Barlow, D. H. (2010). Unified protocol for the transdiagnostic treatment of emotional disorders: Protocol development and initial outcome data. *Cognitive and Behavioral Practice, 17*(1), 88–101. https://doi.org/10.1016/j.cbpra.2009.06.002.

Fairburn, C. G. (2008). *Cognitive behavioral therapy and eating disorders.* New York: Guilford Press.

Farchione, T. J., Fairholme, C. P., Ellard, K. K., Boisseau, C. L., Thompson-Hollands, J., Carl, J. R., et al. (2012). Unified protocol for transdiagnostic treatment of emotional disorders: A randomized controlled trial. *Behavior Therapy, 43*(3), 666–678. https://doi.org/10.1016/j.beth.2012.01.001.

Forman-Hoffman, V. L., Carney, C. P., Sampson, T. R., Peloso, P. M., Woolson, R. F., Black, D. W., et al. (2005). Mental health comorbidity patterns and impact on quality of life among veterans serving during the first Gulf War. *Quality of Life Research, 14*(10), 2303–2314. https://doi.org/10.1007/s11136-005-6540-2.

Grubbs, K. M., Fortney, J. C., Kimbrell, T., Pyne, J. M., Hudson, T., Robinson, D., et al. (2017). Usual care for rural veterans with posttraumatic stress disorder. *Journal of Rural Health, 33*(3), 290–296. https://doi.org/10.1111/jrh.12230.

Hamblen, J. L., Bernardy, N. C., Sherrieb, K., Norris, F. H., Cook, J. M., Louis, C. A., et al. (2015). VA PTSD clinic director perspectives: How perceptions of readiness influence delivery of evidence-based PTSD treatment. *Professional Psychology: Research and Practice, 46*(2), 90–96. https://doi.org/10.1037/a0038535.

Hersh, J., Metz, K. L., & Weisz, J. R. (2016). New frontiers in transdiagnostic treatment: Youth psychotherapy for internalizing and externalizing problems and disorders. *International Journal of Cognitive Therapy, 9*(2), 140–155. https://doi.org/10.1521/ijct.2016.9.2.140.

Hofmann, S. G. (2014). Toward a cognitive-behavioral classification system for mental disorders. *Behavior Therapy, 45*(4), 576–587. https://doi.org/10.1016/j.beth.2014.03.001.

Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*(9), 1277–1288. https://doi.org/10.1177/1049732305276687.

Karlin, B. E., Brown, G. K., Trockel, M., Cunning, D., Zeiss, A. M., & Taylor, C. B. (2012). National dissemination of cognitive behavioral therapy for depression in the Department of Veterans Affairs health care system: therapist and patient-level outcomes. *Journal of Consulting and Clinical Psychology, 80*(5), 707–718. https://doi.org/10.1037/a0029328.

Karlin, B. E., & Cross, G. (2014). From the laboratory to the therapy room: National dissemination and implementation of evidence-based psychotherapies in the U.S. Department of Veterans Affairs Health Care System. *American Psychologist, 69*(1), 19–33. https://doi.org/10.1037/a0033888.

Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the national comorbidity survey replication. *Archives of General Psychiatry, 62*(2), 617–627. https://doi.org/10.1001/archpsyc.62.6.617.

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry, 52,* 1048–1060. https://doi.org/10.1001/archpsyc.1995.03950240066012.

Knapp, M., Funk, M., Curran, C., Prince, M., Grigg, M., & McDaid, D. (2006). Economic barriers to better mental health practice and policy. *Health Policy Plan, 21*(3), 157–170. https://doi.org/10.1093/heapol/czl003.

Lang, A. J., Schnurr, P. P., Jain, S., He, F., Walser, R. D., Bolton, E., et al. (2017). Randomized controlled trial of acceptance and commitment therapy for distress and impairment in OEF/OIF/OND veterans. *Psychological Trauma: Theory, Research, Practice, and Policy, 9*(Suppl 1), 74–84. https://doi.org/10.1037/tra0000127.

Lang, A. J., Schnurr, P. P., Jain, S., Raman, R., Walser, R., Bolton, E., et al. (2012). Evaluating transdiagnostic treatment for distress and impairment in veterans: A multi-site randomized controlled trial of Acceptance and Commitment Therapy. *Contemporary clinical trials, 33*(1), 116–123.

Maguen, S., Madden, E., Patterson, O. V., DuVall, S. L., Goldstein, L. A., Burkman, K., et al. (2018). Measuring use of evidence based psychotherapy for posttraumatic stress disorder in a Large National Healthcare System. *Administration and Policy in Mental Health and Mental Health Services Research, 45*(4), 519–529. https://doi.org/10.1007/s10488-018-0850-5.

Martin, P., Murray, L. K., Darnell, D., & Dorsey, S. (2018). Transdiagnostic treatment approaches for greater public health impact: Implementing principles of evidence-based mental health interventions. *Clinical Psychology: Science and Practice, 25*(4), e12270.

McHugh, R. K., Murray, H. W., & Barlow, D. H. (2009). Balancing fidelity and adaptation in the dissemination of empirically-supported treatments: The promise of transdiagnostic interventions.

*Behaviour Research and Therapy, 47*(11), 946–953. https://doi.org/10.1016/j.brat.2009.07.005.

Moullin, J. C., Ehrhart, M. G., & Aarons, G. A. (2017). The role of leadership in organizational implementation and sustainment in service agencies. *Research on social work practice, 28*(5), 558–567. https://doi.org/10.1177/1049731517718361.

Murray, L. K., Dorsey, S., Haroz, E., Lee, C., Alsiary, M. M., Haydary, A., et al. (2014a). A common elements treatment approach for adult mental health problems in low- and middle-income countries. *Cognitive and Behavioral Practice, 21*(2), 111–123. https://doi.org/10.1016/j.cbpra.2013.06.005.

Murray, L. K., Tol, W., Jordans, M., Zangana, G. S., Amin, A. M., Bolton, P., et al. (2014b). Dissemination and implementation of evidence based, mental health interventions in post conflict, low resource settings. *Intervention, 12*(Suppl 1), 94–112. https://doi.org/10.1097/wtf.0000000000000070.

National Institute of Health, Department of Health and Human Services. (2017, November 3). Dissemination and Implementation Research in Health (R01). Retrieved from https://grants.nih.gov/grants/guide/pa-files/par-16-238.html.

Nelson, J. (2017). Using conceptual depth criteria: Addressing the challenge of reaching saturation in qualitative research. *Qualitative Research, 17*(5), 554–570. https://doi.org/10.1177/1468794116679873.

Norton, P. J. (2012). A randomized clinical trial of transdiagnostic CBT for anxiety disorder by comparison to relaxation training. *Behavior Therapy, 43*(3), 506–517. https://doi.org/10.1016/j.beth.2010.08.011.

Osei-Bonsu, P. E., Bolton, R. E., Wiltsey Stirman, S., Eisen, S. V., Herz, L., & Pellowe, M. E. (2017). Mental health providers' decision-making around the implementation of evidence-based treatment for PTSD. *Journal of Beahvioral Health Services & Research, 44*(2), 213–223. https://doi.org/10.1007/s11414-015-9489-0.

Palinkas, L. A., Schoenwald, S. K., Hoagwood, K., Landsverk, J., Chorpita, B. F., & Weisz, J. R. (2008). An ethnographic study of implementation of evidence-based treatments in child mental health: First steps. *Psychiatric Services, 59*(7), 738–746. https://doi.org/10.1176/ps.2008.59.7.738.

Patel, V., Flisher, A. J., Hetrick, S., & McGorry, P. (2007). Mental health of young people: A global public-health challenge. *Lancet, 369*(9569), 1302–1313. https://doi.org/10.1016/s0140-6736(07)60368-7.

Pettigrew, A. M., Woodman, R. W., & Cameron, K. S. (2001). Studying organizational change and development: Challenges for future research. *Academy of Management Journal, 44*(4), 697–713. https://doi.org/10.5465/3069411.

Powell, B. J., Waltz, T. J., Chinman, M. J., Damschroder, L. J., Smith, J. L., Matthieu, M. M., et al. (2015). A refined compilation of implementation strategies: Results from the Expert Recommendations for Implementing Change (ERIC) project. *Implementation Science, 10*(1), 21–37. https://doi.org/10.1186/s13012-015-0209-1.

Rosen, C. S., Matthieu, M. M., Wiltsey Stirman, S., Cook, J. M., Landes, S., Bernardy, N. C., et al. (2016). A review of studies on the system-wide implementation of evidence-based psychotherapies for posttraumatic stress disorder in the veterans health administration. *Administration and Policy in Mental Health and Mental Health Services Research, 43*(6), 957–977. https://doi.org/10.1007/s10488-016-0755-0.

Ruzek, J. I., & Rosen, R. C. (2009). Disseminating evidence-based treatments for PTSD in organizational settings: A high priority focus area. *Behaviour Research and Therapy, 47*(11), 980–989. https://doi.org/10.1016/j.brat.2009.07.008.

Saraceno, B., van Ommeren, M., Batniji, R., Cohen, A., Gureje, O., Mahoney, J., et al. (2007). Barriers to improvement of mental health services in low-income and middle-income countries. *Lancet, 370*(9593), 1164–1174. https://doi.org/10.1016/s0140-6736(07)61263-x.

Sauer-Zavala, S., Bentley, K. H., & Wilner, J. G. (2016). Transdiagnostic treatment of borderline personality disorder and comorbid disorders: A clinical replication series. *Journal of Personality Disorders, 30*(1), 35–51. https://doi.org/10.1521/pedi_2015_29_179.

Sauer-Zavala, S., Gutner, C. A., Farchione, T. J., Boettcher, H. T., Bullis, J. R., & Barlow, D. H. (2017). Current definitions of "transdiagnostic" in treatment development: A search for consensus. *Behavior Therapy, 48*(1), 128–138. https://doi.org/10.1016/j.beth.2016.09.004.

Schmidt, N. B., Buckner, J. D., Pusser, A., Woolaway-Bickel, K., Preston, J. L., & Norr, A. (2012). Randomized controlled trial of false safety behavior elimination therapy: A unified cognitive behavioral treatment for anxiety psychopathology. *Behavior Therapy, 43*(3), 518–532. https://doi.org/10.1016/j.beth.2012.02.004.

Schoenwald, S. K., Sheidow, A. J., & Letourneau, E. J. (2004). Toward effective quality assurance in evidence-based practice: Links between expert consultation, therapist fidelity, and child outcomes. *Journal of Clinical Child & Adolescent Psychology, 33*(1), 94–104. https://doi.org/10.1207/s15374424jccp3301_10.

Seal, K. H., Bertenthal, D., Miner, C. R., Sen, S., & Marmar, C. (2007). Bringing the war back home: Mental health disorders among 103,788 US veterans returning from Iraq and Afghanistan seen at Department of Veterans Affairs facilities. *JAMA Internal Medicine, 167,* 476–482. https://doi.org/10.1001/archinte.167.5.476.

Sripada, R. K., Bohnert, K. M., Ganoczy, D., & Pfeiffer, P. N. (2018a). Documentation of evidence-based psychotherapy and care quality for PTSD in the Department of Veterans Affairs. *Administration and Policy in Mental Health and Mental Health Services Research, 45*(3), 353–361. https://doi.org/10.1007/s10488-017-0828-8.

Sripada, R. K., Pfeiffer, P. N., Rauch, S. A. M., Ganoczy, D., & Bohnert, K. M. (2018b). Factors associated with the receipt of documented evidence-based psychotherapy for PTSD in VA. *General Hospital Psychiatry, 54,* 12–17. https://doi.org/10.1016/j.genhosppsych.2018.07.001.

Stander, V. A., Thomsen, C. J., & Highfill-McRoy, R. M. (2014). Etiology of depression comorbidity in combat-related PTSD: A review of the literature. *Clinical Psychology Review, 34*(2), 87–98. https://doi.org/10.1016/j.cpr.2013.12.002.

Stirman, S. W., Gutierrez-Colina, A., Toder, K., Castro, F., Esposito, G., Barg, F., … Crits-Christoph, P. (2012). Clinicians' perspectives on cognitive therapy in community mental health settings: Implications for training and implementation. *Administration and Policy in Mental Health and Mental Health Services Research.* https://doi.org/10.1007/s10488-012-0418-8.

Vastine, A., Gittelsohn, J., Ethelbah, B., Anliker, J., & Caballero, B. (2005). Formative research and stakeholder participation in intervention development. *American journal of health behavior, 29*(1), 57–69. https://doi.org/10.5993/AJHB.29.1.5.

Zubkoff, L., Carpenter-Song, E., Shiner, B., Ronconi, J. M., & Watts, B. V. (2016). Clinicians' perception of patient readiness for treatment: An emerging theme in implementation science? *Administration and Policy in Mental Health and Mental Health Services Research, 43*(2), 250–258. https://doi.org/10.1007/s10488-015-0635-z.