Stakeholder-Informed Adaptations of a Behavioral Health Intervention in a VA Setting

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INTRODUCTION

A systematic adaptation process including documentation is necessary to ensure balance between local customization and fidelity.

Collaborative Decision Skills Training (CDST) is an eight-session intervention intended to empower people with serious mental illness (SMI) during treatment decision-making. It was originally developed for adult civilians with SMI. In this study, CDST was systematically adapted for Veterans with psychosis.

Core functions of CDST

Core Functions (Standardized)	Forms (Tailored)
Empowerment-focused therapeutic approach, especially related to participation in one's own mental health care and recovery	Examples: • Psychoeducation about patient rights
Evidence-based skills training strategies to improve ability to initiate and engage in collaborative decision-making and related skills when desired	Examples: • Role-plays • Worksheets
Training in specific skills as they specifically apply to collaborative decision-making and related skills	Examples: • Resolving disagreements with clinicians diagram
Psychoeducation on relevant topics	Examples: • Treatment team worksheet
Increase comfort and confidence related to participating in treatment decision-making	Examples: • Coping skills
Consider, validate, and support patients in identifying possible solutions for patient level, patient/clinician level, and patient/system level barriers	Examples: • Conflict and disagreement section and exercises

METHOD

Veteran and clinician stakeholders provided input on CDST adaptation needs during qualitative interviews. A multi-step iterative process including Adaptation Resource Team (ART) group meetings, surveys, and consultant meetings developed and integrated agreed-upon adaptations.

A modified version of the expanded framework for reporting adaptations and modifications to evidence-based treatments (FRAME) was used to specify adaptations (Wiltsey-Stirman et al., 2019).

Modified version of FRAME

FRAME +

- **Size of the change (i.e., % of intervention impacted in time)**
- **Scope of the change (i.e., % of sessions impacted)**
- **Targeted population (e.g., Veterans)**

RESULTS

Stakeholders responded positively to CDST. There were 164 unique adaptations. 64 adaptations did not impact delivery of CDST and were excluded from documentation of size and scope. **83 adaptations were relatively small and were estimated to impact less than ten minutes.** Some changes were small in size yet large in scope.

17 adaptations tailored CDST for the Veteran population or setting. Another 17 adaptations improved fit for people with SMI.

Size of the change	Number of changes
0%	30
0.21%	3
0.42%	10
1.04%	29
2.08%	11
3.13%	6
4.17%	3
6.30%	3
8.33%	2
10.40%	1
16.67%	2
Total	**100**

Scope of the change	Number of changes
0 sessions/0%	8
1 session/12.5%	62
2 sessions/25%	11
3 sessions/37.5%	4
4 sessions/50%	0
5 sessions/62.5%	1
6 sessions/75%	0
7 sessions/87.5%	3
8 sessions/100%	11
Total	**100**

Example Adaptation Description	Size of the change?	Scope of the change?	Population-specific?
Customize language to fit VA & Veterans and remove language that was customized for other service setting (e.g., “client” to “Veteran).	0%	100%	Veteran/military
Discuss the rationale for at home practice, why it is important, and what you get out of it in the beginning of CDST.	1.04%	12.50%	No
Embed coping skill training and practice into the sessions. Discuss how to use these skills to help you engage in CDM when you are struggling, are nervous/intimidated, but still want to pursue CDM.	16.70%	100%	Serious mental illness
Provide a practice group for Veterans to join after group sessions. These practice groups will run for 30 mins to help Veterans on the assignments that they are given.	N/A	N/A	No

DISCUSSION

Our systematic adaptation process led to a more contextually appropriate version of CDST. The use of a multi-stakeholder ART greatly facilitated this process. The multi-step, iterative adaptation process allowed for input from diverse stakeholders at multiple timepoints.

Documenting adaptations made to interventions is essential for implementation and understanding impact. In this study, the addition of documenting size and scope of the adaptation demonstrated variability between and within these categories. The addition of documenting target population of the adaptation demonstrated that many of these adaptations could benefit other populations as well.

It is important to systematically track these adaptations to monitor the modifications’ impact on outcomes and to increase implementation success.