How do Veterans with SMI and VA clinicians vary in their perceptions of needed adaptations of recovery-oriented interventions for VA settings? An investigation of a systematic adaptation.

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BACKGROUND

- A systematic adaptation of a group-based recovery-oriented intervention for individuals with serious mental illness (SMI), Collaborative Decision Skills Training (CDST), was conducted to ensure its fit for the VA setting and the Veteran population.
- Understanding the differential contributions of a mixed stakeholder team can help inform researchers about:
  - What is most important to different stakeholders.
  - How to design adaptation studies so that stakeholders' voices and needs are maximally included, especially Veterans'.

AIMS

1. Examine similarities and differences in suggested adaptations and their underlying rationale between Veterans and Clinicians.
2. To investigate whether a gap exists between clinician perception and Veteran reports of Veteran adaptation needs and preferences, and if so, to characterize that gap.

METHODS

Qualitative interviews of **five** Veterans and **two** Clinicians to identify potential adaptations.

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293 suggestions assigned a code.

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193 suggestions are intended to impact Veterans.

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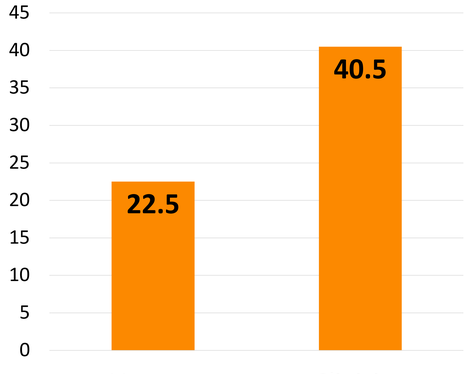
Rationales are coded.

Description of rationale codes

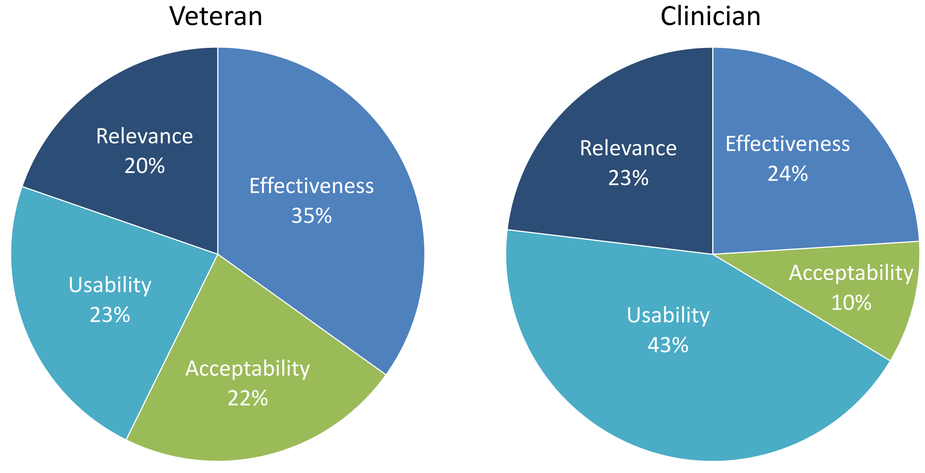
Effectiveness - The impact of an intervention on important individual outcomes.
Acceptability - How much the population likes the intervention and are willing to participate in it.
Usability - Ease of use of the intervention.
Relevance - Whether the intervention is meaningful to the needs, desires, values, and preferences of the population.

RESULTS

Average number of suggestions by stakeholder



Percentage of rationale codes by stakeholder



Quotes from Veterans & Clinicians to illustrate each rationale code

	Veteran	Clinician
Effectiveness	"Now that I have a tool like [the CDST overview card], I'm probably going to have more effective communication with all of my treatment team, specifically my psychiatrist about medication decisions."	"[Veterans] don't know how to address [dissatisfaction with medication] with the provider so I think practicing speaking with a medication provider is a good idea."
Acceptability	"The [vignette] about missing appointments, I would have loved to have that about ten years ago."	"I thought the [treatment team discussions] were great, I think it would make a lot of sense to [the Veterans]."
Usability	"[The NOW model] is really self-explanatory and it's broken down a whole lot."	"'Shared decision making is a balanced decision-making model' - I think the statement is very jargony."
Relevance	"Just the going over about the difference between being assertive, passive aggressive, and aggressive - I thought that was really spot on for [Veterans with SMI]."	"I really like the example on page 23, medication causing [Veterans with SMI] to sleep twelve hours a day, I thought that was very relevant, I hear that all the time."

CONCLUSION

On average, Clinicians provided nearly twice as many suggestions than Veterans did. However, since there were five Veterans and two clinicians, the total number of suggestions between these two groups were roughly equal. Veterans based suggestions on effectiveness and acceptability more often than Clinicians did, while Clinicians based suggestions about usability more often.

Future Directions & Limitations: Veterans and Clinicians base adaptation suggestions on different underlying rationales. Multi-stakeholder adaptation teams with proportionally more Veterans improves representation of all perceptions and needs. Next steps include understanding why needs differ, how well Veteran-identified adaptations are implemented, and whether results generalize to different populations and different interventions.