Adapting a Depression Self-management Intervention Integrating the Method for Program Adaptation through Community Engagement (M-PACE) and 8 Common Steps Frameworks

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BACKGROUND

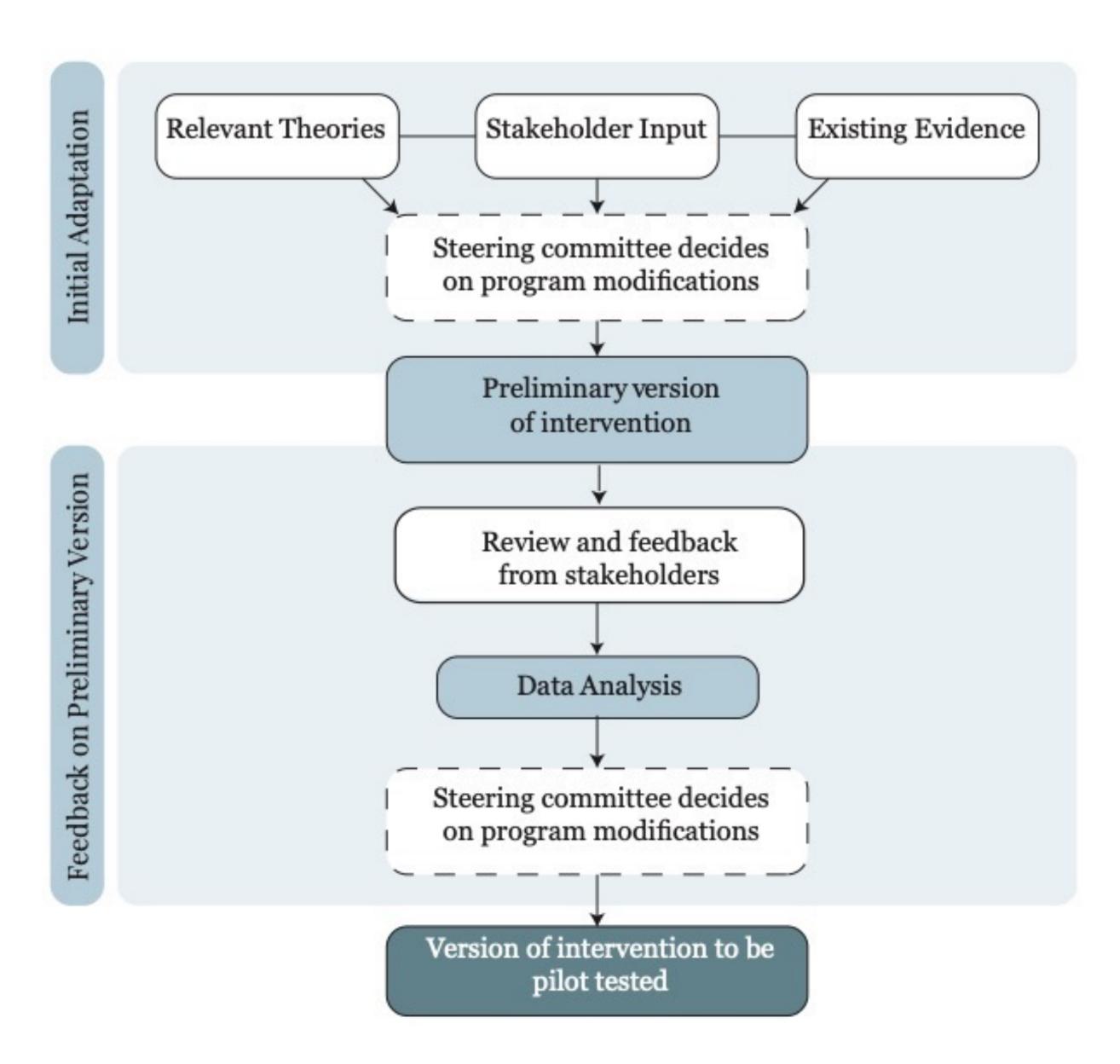
Intervention adaptation is more resource efficient than developing new ones.¹ However, adaptation needs to be **theoretically and empirically driven** to avoid changes to core components or misalignment with a new population that results in failure to reproduce initial effect.²

OBJECTIVE

To adapt an existing depression self-management intervention for adults with chronic conditions,³ called *DIRECT-sc*, to include a caregiver role.

METHODS

- Frameworks selected to guide adaptation: 1) M-PACE⁴ provides detail on operationalization and reflects patient-oriented research, and 2) a scoping review identifying 8 commonly used steps⁵ (henceforth '8 common steps').
- Proposed changes to original intervention were generated from two systematic reviews, theory, and interviews with stakeholders (n = 21).
- A steering committee of 10 experts, including care recipient/caregiver partners used three criteria to adjudicate on proposed changes:
 1) importance the degree to which the change may improve effectiveness or reach, 2) feasibility, and 3) congruence with the core components of the original intervention.



RESULTS

Challenges	Recommendations	Lessons learned
Deciding who will be on the steering committee of experts	Careful deliberate consideration of members	 More than one patient partner for representation and comfort Involving those who developed original intervention Familiarity with other members may facilitate discussion
Availability of committee members	Schedule meetings well in advance (particularly for clinicians)	 Avoid individual meetings as these result in loss of discussion and challenges integrating divergent feedback
What changes require committee approval	Prior to adjudication, discuss input at different decision-making points	 Minor changes (e.g., aesthetic, editorial) may not be worth committee time How many iterations of feedback are needed/feasible throughout the process (can some be via email)?
Balancing time efficiency with space for dialogue	Survey completed prior to meetings identified suggested modifications reaching a high level of (dis)agreement	 Helped facilitator efficiently allocate meeting time Streamlined discussion Terminology of adjudication criteria may not be familiar to everyone
Providing avenues for dissent and facilitating disagreement	Consider using different strategies for meeting facilitation and receiving feedbac	 Prepare strategies to include all committee members' views (e.g., go around of take home messages) Prepare how to facilitate when diverging opinions arise Varied options for feedback: survey, direct messaging or emailing facilitator
Integrating incongruent feedback	Agree on decision-making process and rule (e.g., simple majority, consensus) prior to adjudication	 Will 'voting' be formalized? How will strong dissenting opinions be integrated (e.g., vetoes)? Will certain perspectives/considerations be prioritized (e.g., patient partners, congruence)?

STRENGTHS

- Agreed upon decision-making method (75% supermajority of committee members)
- Specific predetermined adjudication criteria
- Surveys to identify proposed changes reaching a high level of (dis)agreement among members to streamline discussion during meetings

CONCLUSION

To evaluate acceptability, pre-testing is underway with an additional 10 care recipients and caregivers and 5 healthcare professionals.

In detailing this evidence-informed adaptation process, we aim to support the growing work seeking to identify best-practices for intervention adaptation and outline notable lessons learned.

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