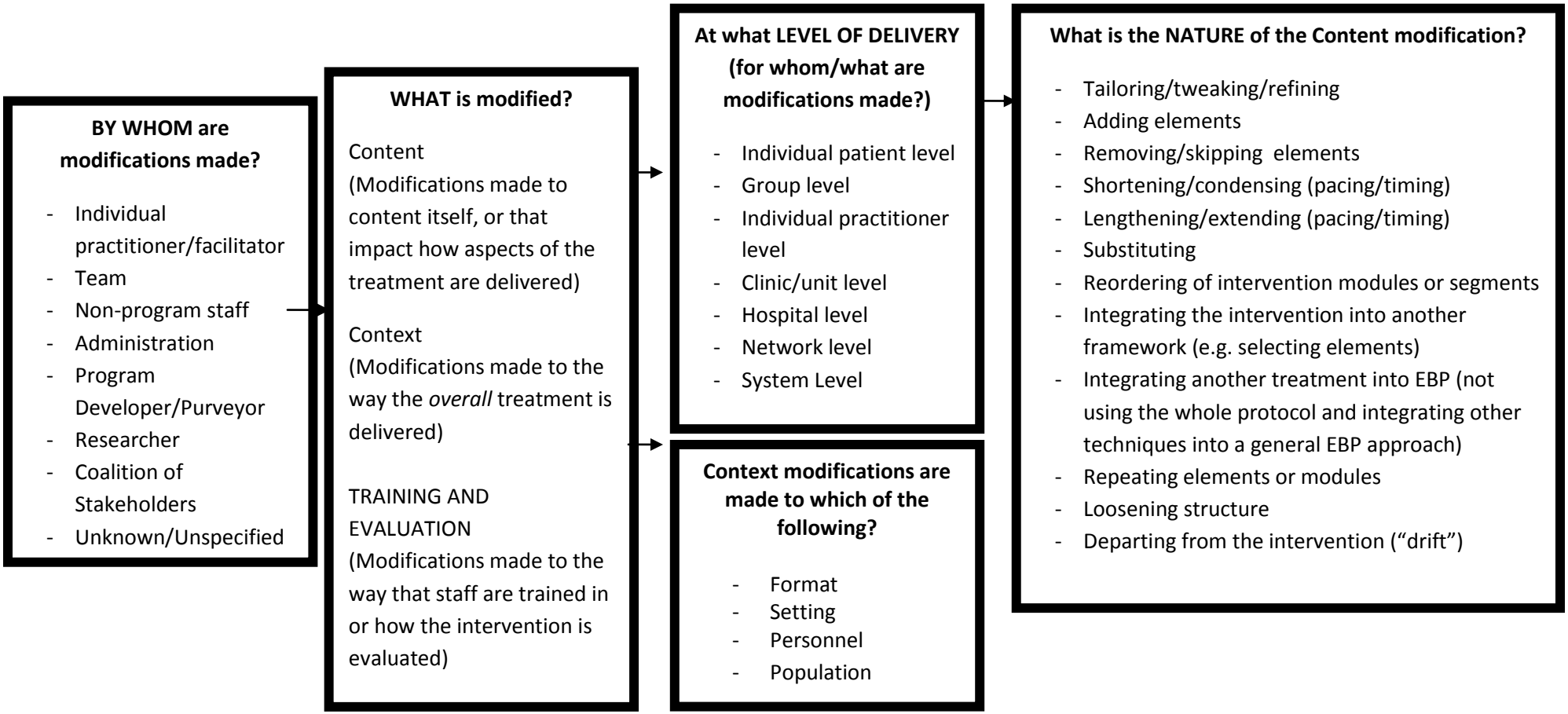
Appendix D

Framework and coding system for classifying adaptations to EBPs

Appendix E-System of Classifying Modifications and Adaptations to Evidence-Based Programs or Interventions



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Recommended procedure for coding modifications. Please note that a self-report can be found on the last page as well.

Interviews:
First, break the interview down into distinct segments that describe unique modifications. Sometimes more than one modification will be included in an interview response. If so, annotate the transcript.

For example, if a transcript says, "Sometimes instead of giving the worksheets for homework—I don't actually call it homework, I usually call it something like practice—I just write down a couple of questions on a notecard":
Modification 1a "gives a notecard instead of a worksheet"
Modification 1b "call it practice instead of homework"

We used a spreadsheet with columns for the source/subject as well as for each part of the framework (codes were numbered).

Observation:
During observation—if recorded, note the timestamp where you see evidence of the modification if possible (unless it's something like lengthening or shortening)

Familiarity with the intervention is important for getting good rater agreement as well as in making appropriate distinctions. If interview data have not been collected, it is helpful for the interviewer to be familiar with the coding system so that they can make appropriate codes and determine if they have enough information to decide the most appropriate code.

For coding procedure
1) read the entire codebook before you start coding—each time you sit down to code.

2) be sure to read the question or prompt before each clinician segment as it sometimes includes context that will help with determining which code to assign.

3) read the description for each code each time you assign it to make sure it fits. Also read others that you think it could possibly be to help you make sure you're made the right distinction.

3) make notes about anything that's uncertain for you in the spreadsheet

4) contact the team if you see a segment that you believe is not actually a description of what the therapist does/would do (e.g., an abstract future hypothetical situation in an interview)

5) read the codebook again after you finish coding—if you realize that something may not fit after you've assigned it, go back and check

6) For consensus meetings—recommend that the coders get a spreadsheet with discrepancies highlighted before the meeting so they can look back over the items and codebook prior to the meeting. Additional decision rules or examples that are unique to the EBP may need to be added to the codebook.

By whom was the decision to modify made?

This code indicates the individual or group of individuals who made the decision regarding whether or how to modify the intervention.

1. Provider, practitioner, or facilitator: The individual who delivers the intervention made the modification.
2. Team/multiple providers: A group of providers modified the treatment (e.g., either an intervention that requires multiple providers is modified by those providers, or a unit of providers decide together to deliver a program or intervention in a different way).
3. Administrator or supervisor: The individual responsible for oversight of an individual provider, team, unit, organization, or system decided how to modify the intervention or program
4. Researcher: A researcher determined how to modify a program or intervention *for the purposes of research* (e.g., to study the impact of a particular adaptation or set of adaptations).
5. Purveyor or Intervention Developer: The individual who developed the intervention or an (often external) individual with expertise in the intervention who was tasked with supporting the implementation determined how to adapt or modify the treatment.

- ****If the purveyor and researcher are the same individual, the coding decision is made based on whether the modification is made for research or implementation purposes.

6. Coalition of Stakeholders: A group of stakeholders actively participated in the decision-making regarding the types of modifications that are made to an intervention. If the purveyor or researchers used focus groups, interviews, or other means of gathering input to guide their decisions regarding modifications, this code was NOT used, unless stakeholders also directly participated in the process of using that information to adapt the intervention.

WHAT is modified?

1. Content: modifications made to content itself, or to how components of the treatment are delivered
2. Context: modifications made to the way the overall treatment is delivered. This can be better understood by noting the subcategories (Format, Setting, and Personnel) below (sometimes
3. Training and Evaluation: Modifications made to the way that staff are trained in or evaluated on the EBP. Note that this category, unlike those above, does not result in additional ratings from other categories

Context Modifications are made to which of the following?

(As the name implies, these are only applied to Context modifications)

1. Format: use this rating if changes are made to the format of treatment delivery (e.g. a treatment originally designed to be used one-on-one that is now delivered in a group format)
2. Setting: use this rating if the treatment is being delivered in a different setting (e.g. a treatment originally designed to be used in a mental health setting that is now delivered in primary care)
3. Personnel: use this rating if the treatment is being delivered by different personnel (e.g. a treatment originally designed to be administered by a psychologist that is now delivered by a psychiatric nurse or clergy)
4. Population: use this rating if the treatment that was SPECIFICALLY DEVELOPED to target a particular population is being delivered to a different population than originally intended (e.g., if an intervention developed for adults is now being delivered to older adults or teens; or if an intervention for borderline personality disorder is being delivered to individuals with PTSD). Note that this should not be used for delivering a treatment to individuals in different countries or with different cultural backgrounds unless the intervention was specifically developed for a particular ethnic group or country (e.g., CBT applied to a Latino population would not receive this code because CBT wasn't developed to specifically target non-Latino populations). However, a change in the actual delivery of the intervention based on the target population would still be content, at the group level.
   Note the following examples for clarification:

   - Delivering a treatment to a Hispanic/Latino individual that wasn't originally designed with a particular ethnic group in mind: not a modification.

   - Delivering a treatment to a Hispanic/Latino population that was originally specifically designed for African Americans: context, population.

   - Delivering a treatment that wasn't originally designed with a particular ethnic group in mind, but modifying it to accommodate cultural or language differences: content, at the group level (tailoring, see below).

   - Delivering a treatment to a Hispanic/Latino population that was originally designed for African Americans, and ALSO modifying the treatment itself to accommodate cultural or language differences: context, population AND content, group (tailoring, see below).

[note—if a context-level modification is made, it is also possible that a content-level modification was also made, but that's not always the case. So sometimes 2 modifications would be made—such as: Delivering a treatment to a Hispanic/Latino population (in Spanish) that was originally specifically designed for African Americans: 1) context, population 2) Content, tailoring (language)]

At what LEVEL OF DELIVERY are CONTENT modifications made?

1. Individual patient level: use this code if the clinician states that they modify the EBP for a particular patient (e.g. simplifying language if a patient has cognitive issues or if language barriers exist; cultural modifications for an individual patient)
2. Group level: this code is subdivided.
    G. use code "G" if the clinician modifies the EBP for applying the EBP to a particular cultural, ethnic, clinical, or social group (e.g. simplifying language for all patients with cognitive issues). If a clinician notes that they modified treatment for a particular patient based on a particular patient characteristic, and also indicates they would make the same modification for any other patient with those same characteristics, it would be coded here rather than under "Individual patient level" above. However, if they state they made it for a particular individual due to a particular characteristic *without* indicating that they would do it for <u>all</u> individual with those characteristics, it would be coded at the "individual patient level" above.
    C. Use code "C" (cohort) if the modification is applied for a particular cohort such as a classroom, a particular treatment group (e.g., the 9am DBT skills group), or another grouping of individuals.

3. Individual clinician level: use this code if the clinician states that they modify the EBP for all of their patients (e.g. "I never set an agenda")
4. Clinic/unit level: use this code if the clinician states that all of the clinicians in their sub-clinic or unit within a larger organization have modified the EBP in a particular way (e.g. "We can only do 60 minute PE sessions instead of 90 minute sessions here"). This code should only be applied when a modification is clearly a clinic or unit-wide policy or practice.

5. Hospital/Organization level: See "Clinic/unit level" above, but applied to an entire organization
6. Network level: See "Clinic/unit level" above, but applied to an entire network or system of hospitals or clinics (e.g. a Veterans Affairs VISN)

What is the NATURE of the Content modification?

(As the name implies, these are only applied to Content modifications)

1-Tailoring/tweaking/refining: use this code if the clinician describes a change to the EBP that leaves all of the major EBP principles and techniques intact (e.g. modifying language, creating somewhat different versions of handouts or homework assignments, cultural adaptations)
If you would like to specify that the tailoring was a cultural adaptation, a separate "1C" code can be used to differentiate it from other forms of tailoring.

2-Integrating EBP into another framework: Use this code if the clinician indicates, or if it is apparent, that another treatment approach is the starting point, but elements of the EBP are brought into the treatment (e.g. selecting particular EBP elements or modules to use in the context of another treatment).

3-Integrating another treatment into EBP: Use this code if the clinician indicates, or if it is apparent, that the EBP is the starting point, but that they are also using aspects of different therapeutic approaches or EBP's in their treatment (e.g. integrating an empty chair exercise into a standard "CBT for Depression" treatment protocol). To use this code for interview data, the strategy or treatment should be specifically named, and should not be the use of general therapeutic skills (e.g., validation, listening would not be used, but if someone says, "I integrate a more client-centered approach into the EBP", this code could be assigned). Integration of Motivational Interviewing (MI) into a protocol that does not specify MI principles is another common example.

4-Removing/skipping core modules or components: Use this code if the clinician indicates that their baseline or standard treatment is based on the EBP, but notes that they are dropping particular elements of the EBP. Note that this code may be used if interventions (e.g., agenda setting) or modules (e.g., the Cognitive Processing Therapy safety module) are intentionally left out

5-Lengthening/extending (pacing/timing): use this code if the clinician reports spending a longer amount of time than prescribed by the manual to complete the EBP or EBP sessions (whether due to changed spacing between sessions, or longer sessions, more sessions, or spending more time on one or more modules or concepts)

6-Shortening/condensing (pacing/timing): use this code if the clinician reports spending a shorter amount of time than normal to complete the EBP or EBP sessions (whether due to changed spacing between sessions, or shortening sessions, offering fewer sessions, or going through particular modules or concepts more quickly *without skipping material*.)

* If material is skipped in the context of shortened or abbreviated sessions, then this would qualify as two modifications (both "Removing/skipping" and "Shortening/condensing," e.g. shortening a protocol from 12 to 8 sessions by both condensing material and skipping some materials/interventions entirely).

7-Adjusting the order of EBP modules or segments: use this code if the clinician indicates that they have presented EBP modules or concepts in a different order than originally described in the manual, regardless of the reason (e.g. if the clinician deemed the patient not ready for a particular module, or if the clinician wanted to cover other material that seemed especially relevant to the patient at that time). If the EBP provides flexibility around the order of modules, then this code would <u>not</u> apply.

8-Adding modules: use this code if the clinician indicates that they inserted additional distinct materials or areas of focus consistent with the fundamentals of the EBP (e.g. a therapist doing CBT for depression who adds on a few sessions of CBT for insomnia would be coded here, but adding DBT or mindfulness modules to CBT would be "Integrating another treatment into EBP" above); or modules that are in some way complimentary (e.g., adding psychoed about parenting to an anger management protocol). This differs from integration in that this is adding a distinct/discrete element/focus rather than weaving in other interventions or techniques.

9-Not using/Departing from the EBP ("drift"): Use this code if the clinician indicates either that they would not/did not use the EBP in a particular situation OR that they would stop/stopped using the EBP, whether this stoppage was within a session or a decision to discontinue the treatment altogether (e.g. stopping the EBP for a patient who does not appear receptive to it). Note that this code would not be used if the stoppage/decision not to use an EBP was itself consistent with the EBP (e.g. instituting <u>EBP-consistent</u> emergency procedures in the face of a clinical crisis). Use this code (rather than

"integration with another EBP" above) if the clinician states that they switched to a generic, supportive therapeutic style. Also use this code if the clinician states that they used a different intervention entirely from the EBP in question.

10-Loosening structure: If a clinician indicates that they don't always structure a session as prescribed in the manual but still believe that the EBP is the starting point from which they work, this code is appropriate (e.g., if they say they don't use the formal structure, but still endorse the use of Cognitive Therapy throughout the session; or if they say they allow a brief period of off-topic discussion or processing prior to the start of the CT session/agenda setting). If they also name specific elements that they do not use, a separate code would also be used, namely, "Removing/skipping". This code should not be used if they endorse something more along the lines of weaving CT into another framework (in which case, use Integrating EBP into another framework). Note that saying something like "it's not as formal" is not specific enough (as this could mean they just change the language)—they need to indicate in some way that they emphasize structure less in some way.

11-Repeating. If a module or intervention that is normally prescribed once during a protocol is done more than once, this code should be applied. For example, if one session of breathing re-training is prescribed, but a clinician later repeats this intervention, "repeating" would be coded. If no mention is made regarding implications for the length of the session or protocol, no assumptions should be made about length. However, if it is mentioned that repeating resulted in lengthening of the session/protocol, both codes should be applied as separate modifications.

- 12- Substituting: A module or activity is replaced with something that is different in substance (e.g., replacing a module on condom use with one on abstinence in an HIV prevention program).

0-Not a modification: If activities are consistent with the EBP, even if the clinician does not think they are, it should not be coded as a modification (unless it meets the definition of tailoring/tweaking above). This code can also be used if clinicians endorse making referrals for adjunct services unless this is inconsistent with the EBP.

N=Not enough information to code-use sparingly!

Note on using basic therapy skills: If someone says that they make efforts to listen, build rapport, be empathic, etc. in response to a question about modification, but do not otherwise indicate that they change the treatment in some way, it would not be coded as a modification. However, if they say they do this <u>instead</u> of the EBP, it implies drift.

Note on involving family: Depending on the nature of family involvement, this could be context-format, if the family member is actively participating and it turns the treatment into a dyadic/family treatment rather than an individual treatment. However, if a family member sits in on sessions or comes in at the end to understand what the homework is in order to facilitate it for an individual with impaired memory, it may best be considered content-tailoring (individual or group level, most likely). If a protocol states that family can/should be involved on some level (e.g., an EBP for children), this would not be treated as a modification.

Self-reported Adaptations and Modifications

Please check the box next to any modifications or adaptations that you have made to the treatment or intervention, and describe how and why in the space provided. If the modifications are made of some clients who receive the intervention, check the first box. If they are made for all clients on your caseload or in your unit who receive the intervention, check the second box.

Tailoring/tweaking/refining (e.g., changing terminology or language, modifying worksheets in minor ways) Describe:		
Integrating components of the intervention into another framework (e.g., selecting elements to use but not using the whole protocol) Describe:		
Integrating another treatment into the EBP (e.g., integrating other techniques into the intervention) Describe:		
Removing/skipping core modules or components of the treatment Describe:		
Lengthening/extending session time		
Lengthening/extending number of weeks		
Shortening/condensing session time		
Shortening/condensing number of weeks		
Adjusting other order of intervention modules, topics, or segments Describe:		
Adding modules or topics to the intervention Describe:		
Departing from the protocol starting to use another treatment strategy Describe:		
Loosening the session structure Describe:		
Repeating elements or modules (e.g., repeating a concept or activity covered in a previous session that was not intended for another session) Describe:		
Substituting elements or modules Describe:		
Changing the format (e.g., offering an individual treatment in a group or telephone format). Describe:		
Other:		