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ADAPTATION OF INTERPERSONAL COUNSELLING FOR ADOLESCENTS (IPC-A) FOR FINNISH STUDENT WELFARE SERVICES – RETROSPECTIVE EVALUATION BY USING AN EXPANDED FRAMEWORK FOR REPORTING ADAPTATIONS AND MODIFICATIONS (FRAME)

ABSTRACT

Background: *Interpersonal counselling for adolescents (IPC-A) is a brief, individual-based psychosocial intervention focusing on interpersonal relations as a factor of resilience in depressive symptoms. It has been adapted from IPC for adults in the United Kingdom (UK) in 2015. IPC-A was first adapted to Finnish student welfare services in a pilot study, conducted in 2016-2018. Further modifications were made during national implementation between 2020 and 2023. However, the description of the adaptation process is lacking. To support both implementation and research, we wanted to describe adaptation of the IPC-A retrospectively. We chose an expanded framework for reporting adaptations and modifications to evidence-based interventions (FRAME) for structured description of the adaptation.* ***Objectives:*** *1) To retrospectively describe the adaptation of the Finnish IPC-A by using FRAME 2) To evaluate the utility of the FRAME in retrospective description of an IPC-A adaptation in a real-life context.* ***Materials and methods****:Information about the IPC-A adaptation was collected iteratively: 1) from the published reports and articles, 2) by comparing UK and Finnish IPC-A manuals, and 3) by interviewing key stakeholders involved. Snowball method was used to identify interviewees. Identified IPC-A modifications were classified by using the FRAME framework supplemented with the FRAME coding manual. The coding was made by the first two authors and reviewed by the last author. The six domains of FRAME used were: 1) what was modified, 2) who made the decision to modify, 3) what was the goal, 4) when did the modification occur, 5) were the modifications fidelity-consistent, and 6) were adaptations planned.* ***Results:*** *The adaptation process of the IPC-A was conducted by several actors in research and healthcare, and it seemed uncoordinated. More than 30 modifications were made to IPC-A during the pilot and national implementation. Most adaptations occurred in the pilot phase, were proactive and were executed to improve feasibility and outcome. No fidelity-inconsistent modifications were recognized. FRAME framework showed clear added value in recognizing and categorizing modifications, even retrospectively, and provided a useful, structured framework for a retrospective description.* ***Conclusions:*** *National implementation and adaptation of interventions requires systematic processes, resources and clear responsibilities which were only partly evident in the case of IPC-A, but can be improved in the future. We recommend the use of FRAME for guiding and reporting future adaptations of psychosocial interventions in Finland.*

KEYWORDS: INTERPERSONAL COUNSELLING, ADAPTATION, FRAME, ADOLESCENT, STUDENT WELFARE

BACKGROUND

After an increase over several years, more than a third of adolescent girls and a tenth of boys reported having depressive symptoms at least for two weeks during the past year in the national Finnish School Health Survey [1]. However, the ability of primary care to respond to mild to moderate symptoms of depression has been considered to be insufficient. As a response, a strategic aim in Finland was to identify a suitable intervention and train professionals in student welfare services [2]. Finnish student welfare services include school and student healthcare and services of school social workers and psychologists.

Interpersonal counselling for adolescents (IPC-A) was identified as a suitable intervention for prevention and treatment of adolescent (12-19 years) depression [3]. IPC-A is an adaptation of the adult interpersonal counselling (IPC) [4]. IPC as well as IPC-A is a brief, individual-based psychosocial intervention (3 to 6 sessions) focusing on interpersonal relations as a factor of resilience in depressive symptoms. IPC was developed by Professor Myrna Weissman and team from interpersonal therapy (IPT) that has shown strong evidence in treating depression [5]. IPC and IPC-A have three main differences compared to IPT: 1) shorter duration, 2) designed for clients with mild depression, and 3) can be delivered by non-mental health professionals after short IPC (-A) training [6].

IPC-A was piloted in Finland in 2016-2018 in a randomized controlled trial assessing feasibility and effectiveness [3,7]. After encouraging results, IPC-A was nationally implemented in a government-funded project in 2020-2023 as a part of initiatives in the Finnish Mental Health Strategy 2020-2030 (8). More than 1500 IPC-A counsellors have been trained since. The process of implementation is described elsewhere [2].

IPC adaptation for adolescents was first made in the United Kingdom (UK) by Dr. Paul Wilkinson and team in cooperation with Professor Myrna Weissman [4]. The IPC-A was piloted in UK where youth health workers treated young people with mild or subthreshold depression [4]. In addition to the pilot, a later study showed that IPC-A is likely to be a feasible, acceptable and useful treatment for young people in primary care [9]. The evidence of effectiveness of the IPC-A is preliminary [4,10–12]. A new Finnish effectiveness study started in March 2024 [13].

As IPC-A was transferred to a new context, i.e. Finnish student welfare services, the need for adaptation was evident. Adaptation enhances context-fit which can lead to improved engagement, acceptability and outcomes [14–17]. The Finnish IPC-A adaptation was made in several phases, and by several stakeholders, but the description of the adaptation process was lacking.

To support further implementation and future research, we wanted to describe adaptation of the IPC-A retrospectively. Several frameworks for structured description that support adapting evidence- based interventions exist, including the expanded Framework for Reporting Adaptations and Modifications-Enhanced (FRAME) [18–20].

FRAME has been described to be a suitable tool for characterizing iterative stakeholder-engaged adaptations [21,22]. Further, FRAME has been reported to enhance deep understanding of the adaptation process [23]. For these reasons, we decided to use FRAME (Figure 1) for reviewing the adaptation of IPC-A during the pilot study [3,10,24], as well as the further process of adaptation towards the IPC-A currently used in the Finnish welfare services.

The objectives of this study were:

1. To retrospectively describe the adaptation of the Finnish IPC-A by using FRAME
2. To evaluate the utility of the FRAME in retrospective description of an IPC-A adaptation in a real-life context

METHODS

Research material regarding IPC-A adaptation was gathered in three phases and the information was collected by the first author. First, possible modifications were identified based on published reports and studies involving descriptions of Finnish and UK IPC-A [2–4,7,9,24,25]. These included three studies, two from Finland and one from UK, one UK protocol and three Finnish reports.

Second, we identified two Finnish manuals, one from 2015 [26] and the revised version from 2023 [27]. The UK IPC-A manual [6,28] was compared to the Finnish 2015 manual and the 2015 manual to the 2023 manual to identify possible modifications. The UK manual was delivered to the first author by the principal investigator (PI) of the Finnish IPC-A study, who had received the manual from Dr. Wilkinson.

Third, three key stakeholders of the Finnish pilot study [3,7,24] and national implementation phase were interviewed. Snowball method was used to identify further interviewees, and in total eight professionals were interviewed. Interviews were executed either in person, via phone or Teams, or by

email. Two interviews were executed only by email, one by telephone and complemented by email, four by Teams of which two were complemented by email. The interview of the UK trainer was transcribed and in others the interviewer made notes. All Teams interviews and the phone interview lasted for an hour. Interviewees included:

1. PI of the research team in the pilot study
2. Senior researcher in the pilot study
3. Clinician who was responsible for translating the UK IPC-A manual to Finnish
4. UK trainer of the IPC-A
5. Finnish trainer of the IPC-A
6. Finnish researcher and trainer of the IPC for adults who was a researcher in the pilot study and involved in translating the IPC-A manual
7. A professional who was involved in the pilot study and also a member of the project team for the process of building the IPC-A online training. Second author of this study
8. Coordinator of the national support team of the Finnish Mental Health Strategy 2020-2030. Last author of this study

The interviews were iterative: an interview of one stakeholder could produce the need to interview another stakeholder again. Interview questions included an open question about how IPC-A was adapted, followed by more specific questions derived from the literature, comparing the manuals and information from other interviews. The PI of the research team provided additional material (power point presentations etc.) to deepen the first author's understanding of the adaptation process.

Identified modifications were classified by using the FRAME framework supplemented with the FRAME coding manual [29]. All modifications were listed in a chart and coded by the first two authors. Coding was made according to the six FRAME domains. The domains "Nature of the content of the modification" and "Level of delivery" were not used as it was thought that the coding would not bring added value. The chart was reviewed by the last author. The final chart represents identified modifications and characterizes the nature of the adaptations (*Table 1*).

Table 1. Types of IPC-A modifications and actors during the three phases of IPC-A implementation in Finland

Modifications	**Actors**					
	Phase I: pilot 2016-2018	**Phase II: national implementation 2020-2023**			**Phase III: maintenance 2023 ->**	
	Research team	IPC-A trainer	Implementation teams	Project team	Project team	Implementation teams
Manual	x				x*	x*
Measures	x	x		x**		
Training		x		x	x	
Supervision	x		x	x		
Executing IPC-A	x			x		

*cooperation
**in cooperation with the Finnish Institute for Health and Welfare

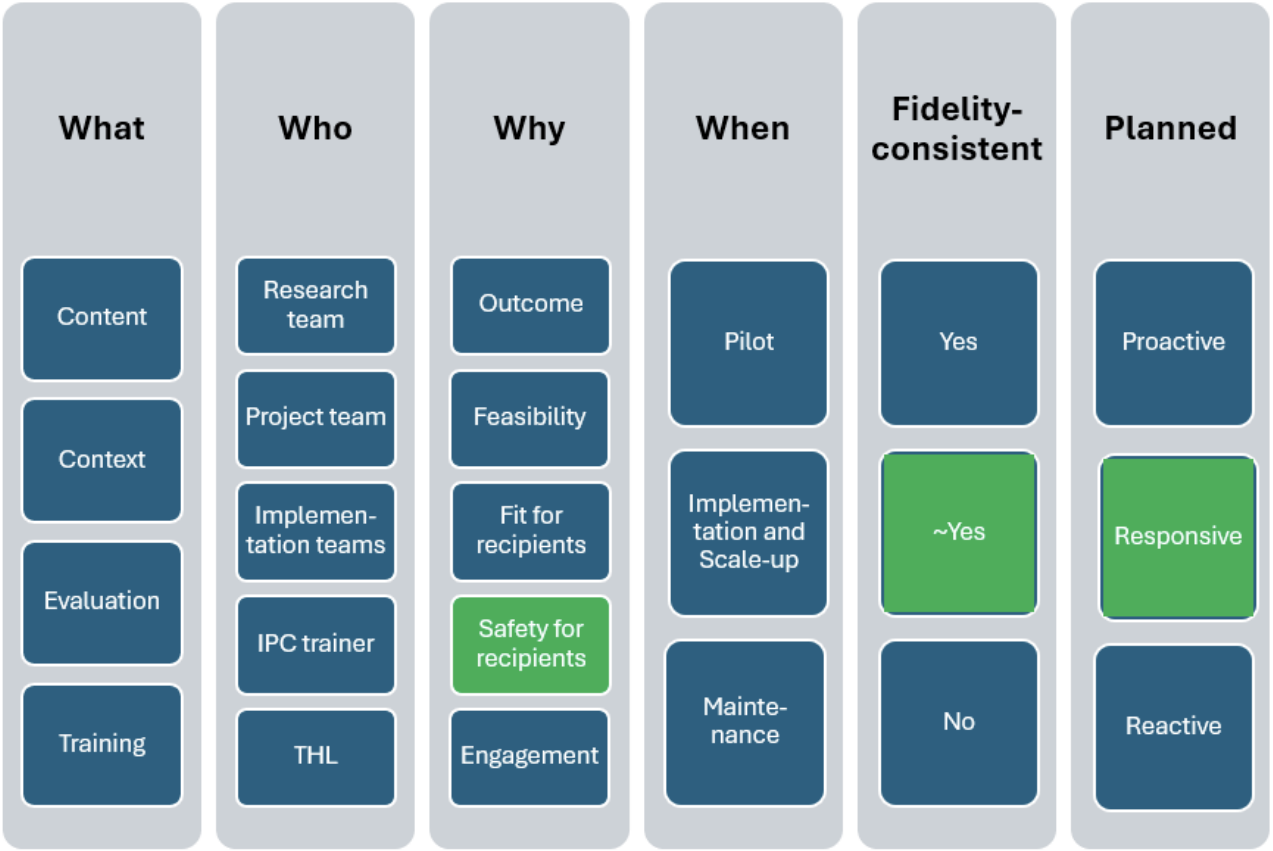
The FRAME domain "Who" was categorized as follows:

1. research team: responsible for the adaptation during the pilot
2. IPC trainer: adapted face-to-face training in Finland
3. implementation teams: government-funded teams responsible for national implementation project and located in all five collaborative areas for healthcare and social welfare in Finland
4. project team: one of the implementation teams, responsible for building the online training as well as updating the Finnish manual
5. Finnish Institute for Health and Welfare (THL): support team for implementation of the National Mental Health Strategy

The FRAME domain "Fidelity-consistent" examines the relationship of the modifications to fidelity. Fidelity-consistent modifications preserve core elements of the intervention that are needed for the intervention to be effective. Fidelity-inconsistent modifications alter the intervention in a manner that fails to preserve its core elements [29].

In the FRAME domain "Planned", proactive refers to a process of planned adaptation ideally as early as possible in the implementation process. Reactive refers to less systematic adaptation which occurs during the course of implementation, often due to unanticipated obstacles. Reactive adaptation often occurs in an impromptu manner, in reaction to constraints or challenges that are encountered, and may or may not be aligned with the elements of the intervention that make it effective [19,29].

Figure 1. FRAME (an expanded framework for reporting adaptations and modifications to evidence-based interventions) [19] domains and categorizations used in this study. Additional categories added by the authors marked with green colour



THL=Finnish Institute for Health and Welfare
IPC=interpersonal counselling
~Yes=describes cases where the modification itself was not fidelity-inconsistent but could potentially lead to reduced fidelity

RESULTS

IPC-A ADAPTATION

Several IPC-A modifications were made in several phases. IPC-A manual, training and supervision were adapted to Finnish context. Modifications were made to measures used within IPC-A and to the way IPC-A is executed (*Table 1*).

The adaptation process of the IPC-A was conducted by several actors and generally seemed uncoordinated. According to the interviews, the decision-making responsibilities, including adaptation decisions, were not totally clear during the national implementation.

Three key phases of adaptation and implementation can be identified (*Table 1*):

1. Phase I: Original adaptation and an IPC-A pilot study conducted between 2016 and 2018. Modifications made by the research team
2. Phase II: National implementation and scale-up between 2020-2023. Modifications made by several actors
3. Phase III: Maintenance phase of the IPC-A started from 2023 and is still ongoing. Modifications made by several actors

More than 30 modifications, which can be seen as part of the adaptation process of the IPC-A, were identified and classified. *Table 2* describes the adaptations and how they were categorized by using the FRAME. Individual changes in the wording are collected in *Table 3* and modifications of the measures used can be found in *Table 4*. Most adaptations occurred in the pilot phase, were proactive and executed to improve feasibility and outcome (*Table 2*). No fidelity-inconsistent modifications were recognized.

Table 2. IPC-A adaptations by FRAME domains

Adaptations made	What	Who	When	Planned	Fidelity-consistent	Fidelity-consistent
Modifications of the manual						
Manual translation	Content	Research team	Pilot	Proactive	yes	Feasibility
Nine word changes or additions, see Table 3	Context	See Table 3	See Table 3	See Table 3	yes	Feasibility
Instructions for evaluating the risk of suicidality added to the session zero (=evaluation session)	Content	Research team	Pilot	Proactive	yes	Safety, outcome
Detailed one-page examples of the four focus areas added to session 1	Content	Research team	Pilot	Proactive	yes	Feasibility
Interpersonal inventory added as a possibility to session 1. In practice, using interpersonal inventory is trained to be important and is routinely performed	Content	Research team	Pilot	Proactive	yes	Feasibility, engagement, outcome
In the first translated manual at the end of first session there is a short guidance for summarizing which in the updated manual was replaced by a separate section called case formulation.	Content	Project team	Scale-up	Proactive	yes	Feasibility
Example of the monthly treatment maintenance after IPC termination changed from once a month for three months to 1-2 times during next three months	Content	Project team	Scale-up	Proactive	yes	Feasibility, engagement
Measures						
Evaluation measures changed three times during the pilot and national implementation, see Table 4	Evaluation	See Table 4	See Table 4	Proactive	yes	Outcome

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Adaptations made	What	Who	When	Planned	Fidelity-consistent	Fidelity-consistent
Training						
Training modified. See the text for details	Training	See the text	Pilot, implementation, scale-up	Proactive (pilot), reactive (implementation) and responsive (scale-up)	yes	Feasibility, outcome
Basic training and experience qualifications of IPC-A counsellors defined and specified as national implementation progressed	Training	Implementation teams	Scale-up, maintenance	Proactive and responsive	yes	Outcome
Accreditation criteria defined and modified as national implementation progressed	Training	Research team together with international experts	Pilot, project team	Proactive and reactive	~yes	Feasibility
A part about adolescent development has been first added to face-to face training and then later moved as preparation material of the face-to-face training and also included in the online training	Training	IPC trainer, project team	Implementation, scale-up	Proactive, responsive	yes	Outcome, fit
Information and training about different evaluation measures used in IPC-A added	Training	IPC trainer	Scale-up	Responsive	yes	Outcome, feasibility
Online training						
Additional information related to IPC-A added as links to deepen know-how	Training	Project team	Scale-up	Proactive	yes	Outcome
Videos and examples added to make training livelier	Training	Project team	Scale-up	Proactive	yes	Engagement, outcome
Small exercises and final test added to support learning	Training	Project team	Scale-up	Proactive	yes	Outcome
IPC-A audio recording scale was modified	Training	Project team	Scale-up	Proactive	~yes	Outcome, feasibility
Supervision						
The extent of the supervision modified. See the text for details	Training	Research team, implementation teams, project team	Pilot, scale-up, maintenance	Proactive and responsive	yes	Outcome

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Adaptations made	What	Who	When	Planned	Fidelity-consistent	Fidelity-consistent
Supervisors defined to have either IPT training or be an experienced IPC counsellor with supervisor training	Training	Research team	Pilot	Proactive	yes	Outcome
Initially there was a guidance for those in training to have a specific question for the supervisor in each supervising session. Later this was specified for later sessions	Training	Not known, variable practices since the pilot	Scale-up	Reactive	~yes	Feasibility
Video/audio monitoring of the fidelity as a part of supervision left out	Training	Research team	Pilot	Proactive	~yes	Feasibility
Fidelity was decided to be assessed by using translated adapted IPC audio recording rating scale by Dr. Wilkinson	Training	Research team	Pilot	Proactive	~yes	Outcome
Executing IPC						
Manuals do not describe the use of the timeline which however is common practice and emphasized in the training	Content	Research team	Pilot	Proactive	yes	Outcome, feasibility
In Wilkinson's audio recording scale used to assess fidelity, the questions were re-grouped by IPC-A phases, some questions were left out and others slightly modified	Content	Implementation teams, project team	Scale-up	Reactive	yes	Outcome, feasibility
Instructions for evaluating adolescent's suitability for the intervention were added	Context	Finnish Institute for Health and Welfare	Scale-up	Proactive	yes	Outcome, safety

Abbreviations:
IPC-A=interpersonal counselling for adolescents
IPC=interpersonal counselling
FRAME=an expanded framework for reporting adaptations and modifications to evidence-based interventions
~yes=describes cases where the modification itself was not fidelity-inconsistent but could potentially lead to reduced fidelity
IPT=interpersonal therapy

Table 3. Linguistic modifications of the IPC-A manual and reasoning. Finnish terms in parenthesis

Original word	Modified word	Reason for the change	Who	When	Planned
IPC therapy (IPC terapia)	IPC counselling (IPC ohjaus)	In Finland, word therapy is strongly related to psychotherapy and was therefore found to be unacceptable in preventive services	Research team	Pilot	Proactive
IPC therapist (IPC terapeutti)	1. IPC counsellor (IPC-ohjaaja) 2. IPC worker (IPC työntekijä)	In Finnish terms counsellor (ohjaaja) and supervisor (menetelmäohjaaja) are similar which caused misunderstandings. Therefore, the term counsellor was changed to worker	1.Research team 2. Project team	1. Pilot 2. Scale-up	1. Proactive 2. Responsive
Problem area (ongelma-alue)	Focus area (fokusalue)	Anna Freud centre from UK educated Finnish IPC trainers and supervisors, and the new term derived from them	Research team	Pilot	Proactive
Problem area “loneliness and isolation” (yksinäisyys ja eristyneisyys)	1.Focus area “loneliness and timidity” (yksinäisyys ja arkuus). 2. Focus area “Loneliness and timidity”, i.e. social timidity and isolation (yksinäisyys ja arkuus eli sosiaalinen arkuus ja eristyneisyys)	Instead of term isolation (eristyneisyys), word sensitiveness (derived from interpersonal therapy (31) was decided to be used in Finland. This was translated as timidity (arkuus) because it was thought to describe especially well Finnish patients who had difficulties in forming social relationships. In phase IIb, loneliness was found to rule out other socially isolated adolescents and was therefore changed to social timidity. Also, previous definitions were included in the new manual and therefore the name of the focus area is loneliness and timidity, i.e. social timidity and isolation	1.Research team 2. Project team	1. Pilot 2. Scale-up	1. Proactive 2. Responsive
Problem area “relationship disputes ” (ihmissuhderistiriita)	1. Focus area relationship disputes (ihmissuhderistiriita) 2. Focus area relationship, i.e. role disputes (ristiriidat eli rooliristiriidat)	Anna Freud centre from UK educated Finnish IPC-A trainers and supervisors, and the new term derived from them	1. Research team 2. Project team	1. Pilot 2. Scale-up	1. Proactive 2. Proactive

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Original word	Modified word	Reason for the change	Who	When	Planned
Problem area "big changes"	Focus area "big changes", i.e. role transition (suuret muutokset eli roolimuutos)	Anna Freud centre from UK educated Finnish IPC-A trainers and supervisors, and the new term derived from them	Project team	Scale-up	Proactive
Roleplay (roolipeli)	Role training (rooliharjoitus)	In Finnish, the word roleplay is used also in context of LARPing and therefore changed to role training	Project team	Scale-up	Responsive
Session zero (nollakäynti)	Evaluation session (arviointikäynti)	Evaluation session was thought to describe better than session zero the content of the session	Project team	Scale-up	Responsive
None	Support team (tukitiimi)	Anna Freud centre from UK educated Finnish IPC-A trainers and supervisors, and the new term derived from them. Support team supports the recovery of the adolescent	Project team	Scale-up	Proactive

Abbreviations:
IPC-A=interpersonal counselling for adolescents
IPC=interpersonal counselling

Table 4. The changes in measures used in IPC-A and by whom and when the decisions about the measurements were made

	Every session	Other sessions (session number in parenthesis)	Who	When
Measures in the UK manual	10-item RCADS	full 47-item RCADS (1)	NA	NA
Measures in the pilot study in Finland and original manual	YP-CORE	R-BDI (0) BDI-21 (1, 4, 6) ADRSc (1, 4, 6) CGAS (1, 4, 6)	Research team	Pilot
Measures at the beginning of the national implementation*	PHQ-9	BDI (first, last), R-BDI (0)	IPC-Atrainer	Implementation
Measures later during the scale-up and in the revised manual	PHQ-9	YP-CORE (when needed) GAD-7 (when needed)	THL, project team	Scale-up

*There was variation between collaborative areas for healthcare and social welfare
Abbreviations:
IPC-A=interpersonal counselling for adolescents
RCADS= Revised Child Anxiety and Depression Scale
YP-CORE=Young person's Clinical Outcome in Routine Evaluation
BDI-21=The Beck Depression Inventory
R-BDI= Beck Depression Inventory-Short Version
ADRSc= Adolescent Depression Rating Scale clinician version
CGAS= Children's Global Assessment Scale
PHQ-9=The Patient Health Questionnaire
GAD-7= Generalised Anxiety Disorder Assessment
THL=Finnish Institute for Health and Welfare
NA=Not applicable

Modifications of the manual

IPC-A is a clearly manualized intervention and no modifications to the basic structure itself have been made in Finland. IPC manual adapted for adolescents by Dr. Wilkinson and team [6,28] in the United Kingdom was translated into Finnish, adapted and used in the pilot and in the national implementation [26]. In 2023 the manual was revised in cooperation between implementation teams [27]. Manual modifications are presented in *Tables 2* and *3*.

To enhance engagement of the IPC counsellors and feasibility of IPC-A, the language of the manual was adapted to fit better for student welfare professionals (*Table 3*). Especially, references to therapy were found problematic and modified.

Using interpersonal inventory for systematic reviewing of people in adolescents' life and relationships was added as a possibility to first IPC-A session. In IPC-A training, interpersonal inventory is brought up as an important tool and is routinely used as part of IPC-A in Finland.

Instructions concerning treatment maintenance phase after IPC-A termination vary between Finland and UK. In the case that the adolescent's situation has improved but there still are some symptoms after the IPC-A, maintenance treatment is recommended once per month for three months in the original Finnish manual and UK manuals. In the revised Finnish manual, recommendation is 1-2 times during next three months.

Modifications to executing IPC-A

During the national scale-up, a short guidance for executing IPC-A in student welfare services was implemented by Finnish Institute for Health and Welfare (THL) [31]. It included guidance about evaluating adolescent suitability for the intervention and instructions for documenting IPC-A sessions.

Using a timeline in determining the onset of an adolescent's depressive symptoms and factors maintaining the symptoms has been found useful by IPC counsellors and supervisors. The manual does not describe the use of a timeline within IPC-A. However, using the timeline was emphasized by the UK trainer in the initial IPC-A training during the pilot and later in the supervisor trainings, and has now become a common practice in Finland.

Different symptom measures used in IPC-A in Finland have changed since the pilot and vary from the measures defined in the UK manual (*Table 4*). During the scale-up, THL recommended PHQ-9 to be the national instrument for evaluating depressive symptoms, to be used from screening and through the treatment [32]. Before this, Beck depression inventory-short version (R-BDI) was used for screening.

Modifications of the IPC-A training

The first IPC-A training and IPC-A trainer training were executed by a UK trainer who also contributed to adapting IPC-A to a school setting in Finland. At the beginning of the national implementation, most of the training was carried out by one trainer. At the moment, there are three official IPC-A trainers in Finland, and since 2022, online training maintained by Helsinki University Hospital.

The content of the Finnish training is based on the training by the UK trainer, however, modified as experience has accumulated. Face-to-face training was reactively modified to Teams training due to Covid-19 pandemic. Responsive adaptations, such as adding videos to the Teams training, were made at the beginning of national implementation.

As most of the professionals in student welfare did not have specific mental health training and therefore no experience of using evaluation measures, the intervention training was complemented with knowledge about recognition and measurement of depressive symptoms. Furthermore, information about adolescent development was first added to the face-to-face training and later changed to be advance material. This was also included in the online training.

In building the online training, further modifications were complementary. Information and material related to depression and IPC-A was added as links to deepen the know-how and to meet the needs of professionals with no previous specific training in mental health. Videos and examples were added in order to make the training livelier. Small exercises and final test were added to support learning.

Duration of IPC-A training has changed during the years (*Table 5*). Online training does not include booster training, instead there is voluntary refresher training offered, however, the frequency and content of the refresher training may vary in different parts of Finland.

Requirement of the number of executed IPC-A cases during the training period has varied between two and four during the years. At the moment the requirement is three cases. Four seemed to be very demanding for the majority of the professionals of student welfare, and two seemed to be inadequate in terms of developing adequate skills.

Table 5. Modifications made to the duration of training and supervision

Phase	Duration of the training	Duration of the supervision
Pilot	3 days + 2 days booster	2.5 hours every other week for six months in groups of 4-5 persons
Face-to-face/Teams training during the national implementation	2 days + 1 day booster	2 hours every three weeks in groups of 4-6 persons for a total of 10-12 times
Online training during national scale-up	2 days of self-study + 2 half-day workshops face-to-face or in Teams	2 hours every three weeks in groups of 4-6 persons for a total of 10-12 times

Modifications to the supervision

Training includes frequent supervision, the content of which, to our knowledge, is not explicitly defined. In an IPC-A effectiveness study protocol by Wilkinson et al., the supervision was defined as follows: "Weekly supervision until adequate competency levels have been demonstrated (two sessions for each of two cases above quality threshold on IPC audio recording rating scale)" [9]. In Finland, the duration and frequency has changed during the years (*Table 5*). Some modifications to the content of the supervision have also been made (*Table 2*).

Adequate skills of the trainee IPC-A counsellors are defined by the supervisors, and in the case of online training, also by an online training provider. Self-assessment of the trainee's competence is evaluated twice during the supervision. Fidelity is assessed by the person to be trained and supervisor by using translated adapted IPC audio recording scale by Dr. Wilkinson. It was a conscious decision to leave out the video/audio monitoring of the fidelity used in UK due to resource and cultural reasons. The research team experienced that Finnish student welfare professionals do not feel comfortable being recorded and therefore it was left out. Later the decision was kept by implementation teams as hundreds of professionals were being trained and no resources were available for executing and evaluating the recordings.

In Finland IPC-A supervisors were defined to have either IPT training or to be experienced IPC-A counsellors with supervisor training. The solution was practical as there were already suitable professionals in the adolescent psychiatric clinics.

EVALUATION OF USING FRAME

FRAME framework showed clear added value in collecting and categorizing modifications, even retrospectively. Using FRAME brought up several adaptations of the intervention that otherwise would not have come up in the interviews. FRAME worked as a reminder of what the different aspects are in adaptation that need to be considered as adaptation.

The description of modifications is necessary while evaluating fidelity and effectiveness as compared to the original intervention. Assessing the domains of FRAME raised further aspects of adaptation and guided interviews. Therefore, our experience was that it was possible to achieve a more thorough view of the adaptation of IPC-A. FRAME was especially helpful as compared to open questions in detecting adaptations outside the manual, i.e. modifications to training and supervision. It also supported describing the reasoning of the modification of the terms.

Responding to the FRAME domains "who", "when" and "planned" supported understanding the timeline and decision processes of the adaptation. Responding to domain "why" created fruitful discussions with the interviewees even when examined retrospectively. Given the complex and unplanned nature of the adaptation processes, it is notable that robustly reconstructing the modifications was still possible.

However, retrospective assessment is laborious and error prone. As especially IPC-A training was extensively modified during the implementation and scale-up, it was difficult to identify all the modifications and their reasoning retrospectively. We recognized that modifications to face-to-face and online training have been made, however, we did not receive detailed enough information to be able to separate all modifications as individual actions that could be categorized by using FRAME. Therefore, we are not able to represent the exact number of modifications made.

PROPOSED ADDITIONS TO THE CONTENT OF FRAME DOMAINS

We made three additions to the FRAME domain classifications (*Figure 1*). First, we added "safety" of the recipients to the domain "why". Safety was found to be an important reason for modification and not clearly included in the current options (engagement, feasibility, fit with recipients, outcomes/effectiveness, cost, satisfaction).

Second, we added "responsive" in addition to proactive and reactive as an option to domain "planned". We found responsive, rather than reactive, to describe the situation where the modifications were planned and made intentionally, but in response to emerging contextual issues occurring during implementation [33].

Third, fidelity-inconsistent refers to modifications that have altered the intervention in a manner that fails to preserve its core elements/functions [29]. It has to be noted that in cases where the modification itself was not fidelity-inconsistent but could potentially lead to reduced fidelity, we marked the domain "fidelity-consistent" as ~yes. For example, the decision not to use video/audio monitoring for assessing fidelity was this type of modification (*Table 2*).

DISCUSSION

Retrospective review of adapting IPC-A in Finland showed that coordination was limited, and adaptations were made by several actors without a systematic plan. Circumstances like resources guided some of the adaptation decisions and several repetitive modifications were evidenced possibly due to lack of coordination.

Adaptation is common and necessary in complex contexts like public healthcare in which interventions are implemented [33]. There is evidence that systematic adaptation not just preserves the effectiveness but can improve it [15,34]. A systematic adaptation process requires resources and coordination [16,35]. Ideally, a multiprofessional adaptation team would plan and deliver adaptations [16]. However, in real-life conditions adaptation is often made unsystematically as a part of daily practice [36], which was evident also in this study.

FRAME provided a useful, structured framework for a retrospective description of adaptation of IPC-A. FRAME has primarily been designed for research use [19], however, based on our experience, FRAME could be useful for adapting a psychosocial intervention in real-life context. The use of FRAME has been recognized to improve the efficiency of adaptations, to enable their standardization and to facilitate empirical evaluations of the adapted intervention's outcomes [21,37]. Using FRAME framework for retrospective review brought up the need for coordination and more systematic decision making in terms of context-based adaptation.

It is likely that some of the responsive and reactive IPC-A adaptations could have been executed proactively with fewer changes in practice and resources saved if the needs of adolescents, IPC counsellors, supervisors and student welfare organizations would have been assessed through a systematic coordinated adaptation process [35].

Decision processes regarding adaptation of the IPC-A were mostly undocumented. This might be due to inadequate coordination. A systematic description of the adaptation process can help to ensure a fidelity-consistent delivery of an evidence-based intervention [33], and hence ensure effectiveness [38,39].

We made three adjustments to FRAME. We added "responsive" as an option to domain "planned" to describe adaptations made based on user feedback. Madrigal et al. had the same need, however, they redefined the term reactive adaptation to fit their needs [23].

We added safety for recipients as one of the reasons for adaptation. To our knowledge, no previous study has presented the need for this. Adding instructions for evaluating suicidality of an adolescent to session zero in IPC-A was primarily an adaptation to improve safety. It also provided a sense of security for the professionals with no specific mental training and therefore could have been coded as an adaptation to increase feasibility, however, this would have masked the real reason for adaptation.

All Finnish IPC-A modifications were fidelity-consistent as defined in the FRAME codebook [29]. However, we identified modifications that preserve the core elements of the intervention itself, but in our view, could potentially lead to lower fidelity. The FRAME does not recognize these types of modifications. Of these, the decision not to use video/audio recordings in assessing fidelity in supervision was the most relevant. The use of video or audio recordings in supervision of psychosocial methods is particularly justified as support for the trainee's learning process, alongside the assessment of fidelity [40]. Video/audio recordings were replaced by self-estimation of fidelity by using Wilkinson audio recording scale. Using self-estimation can lead to overestimation of IPC-A trainee's skills [41,42]. High fidelity has been associated with positive outcomes [43,44] and

therefore special attention should be addressed for preserving fidelity while adapting interventions [45,46].

CONCLUSIONS

National implementation and adaptation of interventions requires systematic processes, resources and clear responsibilities which were only partly evident in the case of IPC-A, but can be improved in the future. Based on our findings, we recommend the use of FRAME for guiding and reporting adaptations of psychosocial interventions in Finland.

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