ASSESSING CONSUMER INTENT TO ENGAGE IN EVIDENCE-BASED SERVICES IN PARENTS OF YOUTH WITH MENTAL HEALTH DISORDERS

A THESIS SUBMITTED TO THE GRADUATE DIVISION OF THE UNIVERSITY OF HAWAI‘I AT MĀNOA IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF ARTS
IN
PSYCHOLOGY

DECEMBER 2012

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Keywords: evidence-based services, consumer engagement, dissemination
ABSTRACT
Although major gains have been made in identifying evidence-based services (EBS), there continues to be low levels of implementation by clinicians. Therefore some researchers have stressed the importance of a strong collaboration with consumers in the development, evaluation and implementation of services. Within the area of youth mental health, parents as consumers offer valuable perspectives on factors that influence their treatment-related decision-making for their children. The Theory of Planned Behavior (TPB) may also have utility in explaining and predicting parents’ intent to engage in EBS. The current study begins development of a reliable and valid measure of consumer intent to engage in EBS, guided by principles of the TPB, following a multimethod approach to instrument development focused on content validity, while using a sample of parents from the target population along with experts in varying fields related to childrens’ mental health. Implications and recommendations for future research are discussed.
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LIST OF ABBREVIATIONS

CAMHD…….Child and Adolescent Mental Health Division
CAEBS…….Consumer Attitudes towards Evidence-Based Services scale
DOE………...Department of Education
EBS………..Evidence-based Services
ED………...Education
HFAA………Hawai‘i Families As Allies
MH…………Mental Health
PEEBS…….Parent Engagement in Evidence-Based Services
PO………….Parent Organization
SPIN…….Special Parent Information Network
TGI……….Theme Generation Interview
TPB……...Theory of Planned Behavior
UB…………University-based
CHAPTER 1. INTRODUCTION

Major gains have been made over the past two decades in identifying evidence-based psychosocial interventions for adult and youth populations (Chambless & Hollon, 1998; Lonigan, Elbert, & Johnson, 1998; Ollendick & King, 2000; Silverman & Hinshaw, 2008; Substance Abuse and Mental Health Services Administration, 2008). Many of these efforts stem from the work of the American Psychological Association Task Force on Psychological Intervention Guidelines, originally formed in 1992 to develop the first template for judging the efficacy and effectiveness of psychosocial interventions (APA, 1995). Since then, work from that task force, the APA Division 12 Task Force on Promotion and Dissemination of Psychological Procedures (1995) that followed it, and other similar efforts have laid the foundation for identifying empirically supported treatments (Chorpita & Daleiden, 2009; Chorpita, Daleiden, & Weisz, 2005; Weisz, Hawley, & Doss, 2004).

Despite such progress for evaluating and identifying treatment interventions, evidence-based services (EBS) are not widely used in everyday clinical practice (Riemer, Rosof-Williams, & Bickman, 2005; Stewart & Chambless, 2007). Studies of youth mental health clinicians in community settings have found that interventions employed in actual clinical practice are often not based on empirical evidence (Daleiden, Lee, & Tolman, 2004; Weersing, Weisz, & Donenberg, 2002). Therefore a next step for promoting EBS usage in everyday clinical settings involves moving beyond EBS identification efforts, towards initiatives that stress the dissemination and implementation of these practices (Becker, Nakamura, Young, & Chorpita, 2009; Chorpita & Regan, 2009).

Unlike the frameworks that have emerged over the past 20 years for evaluating a treatment strategy’s efficacy and effectiveness, empirically based dissemination and implementation efforts specific to behavioral health care are still in their infancy and have much yet to be desired. In order to aid in the dissemination and implementation of EBS, significant resources have been allocated to programs developed at the national, state, and individual treatment developer levels that have typically targeted clinical providers and the larger service systems in which they are embedded (McHugh & Barlow, 2010). Despite these efforts, there continues to be low levels of EBS
implementation in both clinical practice settings (e.g., Stewart & Chambless, 2007) and clinical training programs (e.g., Weissman et al., 2006), suggesting that an alternative, complementary approach in aiding these efforts might be warranted.

**Consumer Involvement in the Dissemination and Implementation of EBS**

Since EBS dissemination and implementation efforts to date have focused mainly on practicing mental health clinicians, the exchange of information has traditionally been unidirectional in manner, stressing pathways from treatment developers to therapists and perhaps even program administrators. However, such an approach by itself may not ultimately result in EBS adoption by therapists and subsequent delivery to consumers (Grimshaw et al., 2001). Specifically, some investigators have stressed the importance of an interactive dialogue between not only researchers and therapists (and their administrators and organizations), but also between researchers and consumers for needs, desires, and concerns related to EBS implementation (Rogers, 2003; Sanders, 2008; Boote, Telford & Cooper, 2002). Furthermore, a bidirectional approach involving a reciprocal exchange of info between EBS advocates and consumers or other stakeholders seems needed to inform researchers about the extent to which EBS are working or accepted in local settings (Stirman, Crits-Cristoph, & DeRubeis, 2004). Along these lines, some studies suggest that patients may benefit from information that enables them to participate in the service delivery process; thereby helping to ensure patients’ values (rather than just professionals’) are reflected in the health care they receive and increasing the likelihood of patient adherence to treatment (Buchanan, 1988; Longo et al., 2006; Vick & Scott, 1998). Following this idea, social marketing strategies have also been used to explore consumer needs, ensure that interventions are matched with those needs, and influence the behavior of consumers to improve their welfare (Andreasen, 1995). Targeting consumers in dissemination efforts may help to increase awareness of the existence of effective psychosocial treatments, improve understanding of psychological services resulting in decreased stigma and misperceptions about mental health, and ultimately increase the demand for clinicians that are trained in EBS (Santucci, McHugh & Barlow, 2012).

When attempting to increase the use of evidence-based interventions in community-based settings, better understanding consumer attitudes may help to more
effectively tailor EBS dissemination and implementation efforts and provider responsiveness to consumer preferences. It is important to note that consumers have cited health care providers as their primary source of information when making treatment decisions (Tanenbaum, 2008a); therefore it is possible that they may share some of the negative concerns about EBS found in past studies of provider attitudes towards such practices (Addis & Krasnow, 2000; Baumann, Kolko, Collins, & Herschell, 2006; Nelson & Steele, 2008). However, studies investigating consumer mental health treatment preferences found that they prefer interventions supported by research (Tanenbaum, 2008a; Scheyett, McCarthy, & Rausch, 2006; Flynn, 2005), and in some cases may even support the usefulness of EBS treatment guidelines more than providers (Cleary, Hunt, Freeman, & Walter, 2007). Most recently, Tanenbaum (2008a) conducted focus groups with severely mentally ill consumers in the public mental health system to investigate their perspectives on EBS. Three major themes were found: consumers have positive and negative attitudes towards evidence, consumers seek and receive information from multiple sources, and consumers have competing and complementary principles for decision making. Findings from these focus groups, particularly that consumers want to be better informed about and involved in decisions related to their care, can potentially be used to effectively tailor interventions and dissemination efforts in response to these unique consumer concerns.

A small number of studies have targeted the families of adult consumers with mental health problems in order to investigate their views towards EBS. Scheyett et al. (2006) found that both consumers and families perceive EBS as predominantly helpful interventions, but are not aware of any specific information regarding EBS models. Their work also suggests that families and consumers seem to emphasize the equal importance of evidence-based processes (e.g., therapeutic relationships, attending to the consumer voice, promoting messages of hope and recovery to consumers, services that support autonomy) and evidence-based environments (e.g., communities, systems, and policies that facilitate effective services and maximize recovery) along with the implementation of the actual EBS. Flynn (2005) suggests that families’ EBS attitudes are influenced by perceptions of high cost and not knowing where to obtain them. Focusing on these unique
family perspectives have provided helpful information regarding EBS in the field of adult mental health.

**Consumer Research with Parents of Youth with Mental Health Problems**

Research studies on consumer-centric EBS dissemination and implementation efforts for youth mental health needs tend to be more complicated than investigations only on adult patients. In children’s mental health, the consumer unit not only includes the youth him/herself, but also parents and family and there is an increasing recognition that parents should be involved in identifying, developing, and promulgating youth services (Hoagwood, 2005; Flynn, 2005). At a legal level, there exists a protective demand for parents who provide consent to participate in therapy on behalf of their children, and it is possible that parents’ opinions may differ when considering treatment for themselves versus their youth. In that regard, informed parents are in the best position to advocate for the most effective treatments for their children. Providing information regarding interventions available for their children might create a sense of empowerment in parents that may potentially lead to improved quality of care, increased accountability and better outcomes (Gruttadaro, Burns, Duckworth, & Crudo, 2007). Additionally, mental health professionals reported that providing parents with information about treatment options helps parents feel more comfortable, reduces parental stress, aids them in making better treatment related decisions, and improves outcomes of other treatments (Cunningham et al., 2009). Despite these noted benefits, studies have found that parents generally lack accurate knowledge regarding causes and treatment of children’s mental health problems (Lazaratou, Anagnostopoulos, Alevizos, Haviara, & Ploumpidis, 2007; Sonuga-Barke & Balding, 1993), and are most times not aware of what mental health professionals do (Richardson, 2001). Therefore it is suggested that in order to promote the implementation of EBS, providing parents with specific information regarding treatment can produce the benefits of adding transparency, sharing informed decision-making, containing disagreements, building consensus and promoting realistic expectations for therapy (Hamilton, 2004). Indeed, research in evidence-based parenting interventions has begun to reflect the benefits of direct collaboration with parents in the development, evaluation and implementation of these services, including improved
quality of interventions and enhanced outcomes for consumers (Sanders & Kirby, 2012; Metzler, Sanders, Rusby & Crowley, 2012).

Generally speaking, findings across consumer-centric studies focusing on parent perspectives of youth mental health treatments point to three conclusions. First, parents as consumers strongly prefer programs that are based on extensive research (Spoth & Redmond, 1993), suggesting that parents may generally have favorable attitudes towards EBS. Second, higher parent knowledge of effective treatments for youth is associated with greater acceptability (Bennet, Power, Rostain, & Carr, 1996) and a higher likelihood of enrolling in EBS (Corkum, Rimer, & Schachar, 1999; Johnston, Seipp, Hommersen, Hoza, & Fine, 2005). Third, parent consumers provide researchers and clinicians with unique and valuable information regarding factors that influence their treatment decisions. In a study by Aarons, Wells, Zaqursky, Fettes, and Palinkas (2009), three examples of EBS were described to parents of children receiving mental health services, along with other stakeholder groups. Participants were asked to report on any barriers or facilitators that they perceived as influencing the implementation of EBS. Parents rated consumer values and marketing (e.g., empowered consumers demanding measurable outcomes; communicating and marketing EBS to consumers) as more important than did other stakeholder groups. Parents also reported consumer concerns, such as cultural compatibility and the possible stigma reduction associated with receiving mental health services, as important factors in the implementation of EBS. Overall, these findings suggest that integrating consumer perspectives into the development of youth EBS dissemination and implementation models would be beneficial in addressing concerns specific to consumers, thereby increasing the likelihood of parents considering EBS when making mental health decisions on behalf of their children.

**The Theory of Planned Behavior**

There are a number of well-studied theories that have been used to predict or explain consumer health-related behavior including the social cognitive theory (Bandura, 1986), the health belief model (Janz & Becker, 1984), the transtheoretical model (Prochaska & DiClemente, 1983) and the diffusion of innovations theory (Rogers, 1995). Of the available theories, the Theory of Planned Behavior (TPB; Ajzen, 1988, 1991), developed as an extension of the Theory of Reasoned Action (Ajzen & Fishbein, 1980),
is considered the most widely researched theory in behavior change. Ajzen (2011) estimated that the TPB has served as the model for more than 1,200 empirical studies of behavior prediction and change. The TPB suggests that behavioral intentions capture the motivational factors that influence behavior and can be used as a proximal measure of the behavior itself. Many studies have substantiated the predictive validity of behavioral intentions (e.g., Albarracin, Johnson, Fishbein, & Muellerleile, 2001; Godin & Kok, 1996; Hausenblaus, Carron, & Mack, 1997). For example, Sheeran (2002) reviewed different meta-analyses covering diverse behavioral domains and reported a mean correlation of .53 between intention and behavior. Additionally, Armitage and Conner’s (2001) meta-analytic review of 185 studies based on the TPB found that approximately 27% of the variance in behavior was predicted by behavioral intentions.

The TPB model (Ajzen, 1988, 1991) describes three predictors that interact to influence behavioral intentions: (a) attitude – a person’s overall evaluation or beliefs about the outcomes associated with a particular behavior; (b) subjective norms – a person’s estimate of the social pressure to perform or not perform the target behavior; and (c) perceived behavioral control – the extent to which a person feels they have the capability and opportunity to perform the behavior. Each of these predictors in turn are influenced by different beliefs relevant to the behavior. Attitudes are assumed to be a function of behavioral beliefs – a person’s subjective probability regarding consequences of the behavior. These behavioral beliefs are theorized to produce a positive or negative attitude toward the behavior. Subjective norms are influenced by normative beliefs – the expectation that a given referent individual or group (e.g., friends, family, coworkers, physicians) would approve or disapprove of performing the behavior under investigation. Perceived behavioral control is assumed to be based on accessible control beliefs – a person’s perception of the ease or difficulty of performing the behavior of interest. These beliefs can facilitate or impede the performance of the behavior and include such factors as required skills and capabilities; availability or lack of time, money, and other resources; and cooperation by other people. Meta-analyses have demonstrated that intentions can be predicted with considerable accuracy from measures of attitudes toward the behavior (mean correlations ranging from .45 to .60), perceived behavioral control
(mean correlations ranging from .35 to .46), and subjective norms (mean correlations ranging from .32 to .42) (Ajzen & Cote, 2008).

The TPB also provides a model for behavior modification. *Elicitation studies* are used to determine the behavioral, normative, and control beliefs of a population and to obtain information about the cognitive foundations of their behavior (Ajzen & Fishbein, 1980). In short, elicitation studies are necessary to develop a meaningful understanding of why people do or do not perform a behavior, and allow for the creation of strategies to alter the predictors affecting intentions and thereby behavior. In this paradigm, a sample from the population of interest is selected to participate in one-to-one interviews or focus groups. Open-ended questions are used to directly assess the three predictors of behavioral intention (i.e., attitudes, perceived behavioral control, and subjective norm) and their associated beliefs. The responses are then content-analyzed into themes and labeled by two separate coders (Francis et al., 2004). For example, when developing an HIV prevention intervention for persons with mental illnesses, Tennille, Solomon, Fishbein, and Blank (2009) first conducted an elicitation study using focus groups to explore HIV risk and safe sex behaviors in this population. They found sexual side effects of psychotropic medications to be a potential cause of both medication non-adherence and HIV risk behaviors, and therefore recommended prevention efforts take these issues into consideration when designing HIV prevention interventions for those with mental illness. A recent meta-analysis of elicitation studies by Webb and Sheeran (2006) suggests that interventions aimed at changing intentions are consistently and moderately associated with behavior changes. Additionally, assessing the beliefs associated with attitudes, subjective norms, and perceived behavioral control and comparing differences in those beliefs between individuals who do and do not engage in the behavior can provide insight into the behavior’s determinants. Elicitation studies have also been shown effective for positively influencing behaviors related to dieting, physical exercise, cancer self-examinations, sunscreen use, condom use, smoking, binge drinking, and automobile speeding (Godin & Kok, 1996; Armitage & Conner, 2001).

Although elicitation studies guided by the TPB have been used predominantly to understand health-related behaviors (Perkins at al., 2007; Limbert & Lamb, 2002), there is growing support for the application of TPB with mental health clinicians (e.g.,
Klaybor, 1998; Meissen, Mason & Gleason, 1991). For example, an elicitation study by Casper (2007) demonstrated that utilizing TPB principles in continuing education classes for mental health clinicians resulted in stronger participant intentions for using a new assessment tool as compared to a standard class format. At three month follow-up, significantly more participants in the TPB theory driven class as compared to participants in the standard class had also implemented the assessment tool (74% versus 24%). A recent study by Kelly, Deane, and Lovett (2012) used the TPB to predict clinician intentions to use EBS in the field of substance abuse. The model accounted for 41% of the variance, with attitudes, subjective norms, and perceived behavioral control all significant predictors of substance abuse workers intentions to use EBS. The TPB has also been supported in studies investigating social workers’ utilization of the Diagnostic Statistical Manual of Mental Disorders, Fourth Edition, in client assessment and treatment planning (Klaybor, 1998), and clinical psychology or social work graduate students’ intentions to refer patients to self-help groups (Meissen et al., 1991). In sum, research suggests that TPB-grounded strategies may provide a method of modifying practice among mental health practitioners and increasing clinicians’ use of EBS.

Given the promising outlook of the application of TPB to clinicians in mental health, and the large body of literature supporting the use of TPB on changing the health-related behaviors of patients and consumers (Perkins et al., 2007), it is possible that the TPB may be a helpful model in promoting youth consumer use of EBS. Somewhat relatedly, findings in the field of men’s mental health suggest that the TPB may have utility in explaining their help-seeking behavior (e.g., Skogstad, Deane, & Spicer, 2006). Additionally, attitudes towards psychological help has consistently been found to be the strongest predictor of intention to seek help in male prison inmates, therefore, interventions designed to target negative attitudes may increase men’s willingness to obtain mental health services (Smith, Tran, & Thompson, 2008). When investigating consumer preferences in the context of the TPB, this author suggests that raising expectations regarding the benefits of EBS (behavioral beliefs/attitudes), reducing obstacles constraining the belief that one could obtain EBS successfully (perceived behavioral control/ control beliefs), and/or mobilizing the normative influences of therapist recommendations (subjective norms/normative beliefs) could enhance
consumers’ behavioral intentions to seek evidence-based services (EBS). Furthermore, measuring consumer intent to seek EBS could be used to predict parents’ actual behavior of obtaining those services for their children.

The Consumer Attitudes Towards Evidence-Based Services Scale

One instrumentation effort for examining consumer attitudes towards EBS has begun fairly recently with the development of the Consumer Attitudes towards Evidence-Based Services scale (CAEBS; Teh & Mueller, 2011). The CAEBS is a 29-item survey that assesses general EBS attitudes for consumers hypothetically seeking mental health services for themselves or a loved one. Participants respond on a five-point Likert-scale the extent to which they agree with statements covering different themes anticipated to be related to consumer attitudes towards EBS, with one indicating “strongly disagree” to five indicating “strongly agree.”

With regard to the development of the CAEBS, Teh & Mueller (2011) employed the following methods to generate the instrument’s items. In the first stage, three overarching strategies were used to develop the original 108 items, including: (a) a search of the extant literature on consumer preferences regarding mental health services, (b) use of clinical experience and rational deduction to choose themes hypothesized to be related to consumer attitudes, and (c) consultation regarding the clarity and objectivity of item wordings with graduate students. Next, a pilot study was conducted to examine the factor structure of the CAEBS. Data was collected from a sample of 294 undergraduate psychology students at the University of Hawai‘i at Mānoa. An exploratory factor analysis revealed a five-factor solution with an oblique rotation to be the most interpretable. Items were removed from the measure based on the factor pattern matrix using the following criteria: (a) items that loaded on multiple factors with a correlation of less than 0.3 apart, (b) items that did not load on any factor with a correlation of greater than 0.4, and (c) items that were thought to be confusing. The top five or six items with the highest factor loadings were chosen. On the basis of these criteria, 29 items out of the original 108 items were retained. The five factors were labeled: Radical Support of EBS Implementation, Barriers to Consumer Empowerment, Trust in the Benefits of EBS, Skepticism about Science, and Cultural Incompatibility Concerns.
Despite efforts to determine the factor structure of consumer attitudes with their measure, Teh & Mueller (2011) were unable to demonstrate a clear model of the construct. This was most likely due to several different factors. First, the sample included undergraduate students (students age 18-48, mean age=21.67) hypothetically seeking services for themselves or a loved one, thus generalizability to consumer populations is limited. Second, the authors did not examine test-retest reliability, which is important for evaluating the stability of the measurement from one administration to another. Third, the measure’s content validity, or the degree to which an assessment is relevant to and representative of a targeted construct, was not explored. Content validity is important to ensure that the assessment measure can satisfactorily demonstrate that the construct of interest explains the variance in obtained scores (Haynes, Richard, & Kubany, 1995). An instrument that is content invalid may run the risk of overrepresenting, underrepresenting, or omitting important facets or domains of the construct, and may also include variables that are outside of the construct domain. Building upon Teh & Mueller’s (2011) investigation, the CAEBS may benefit from further refinement, with an emphasis on the measure’s content validity and overall development processes guided by TPB principles. Specific to this study, the investigator will focus on a target population of parents of youth with mental health concerns in order to aid implementation and dissemination efforts particularly for child and adolescent EBS.

**Present Study**

The present study aims to begin development of a valid and reliable questionnaire measuring parents’ behavioral intent to engage in EBS through requesting or seeking such services. Research investigating parent perceptions of EBS as a potential barrier to implementation is limited due to a lack of psychometrically supported instruments designed to measure intent to use EBS in parent populations. To date, most research involving parent feedback to inform EBS has involved retrospective consumer surveys to evaluate their experience of a program (Turner & Sanders, 2006). To my knowledge, this is the first study to investigate the construct of parent intent to use EBS while selecting or engaging in mental health services for their child. The current study builds upon the work of Teh & Mueller (2011) by creating a new questionnaire assessing factors influencing the adoption of EBS, adapted for use with a parent population, and guided by TPB-
related constructs and processes. An elicitation study methodology investigating parents’ attitudes/behavioral beliefs, along with perceived behavioral control/control beliefs and subjective norms/normative beliefs, will help to develop an understanding of why parents may or may not choose EBS for their children’s mental health needs. The main goal of the current study is to begin developing an initial item pool to be employed in subsequent validity and reliability analyses. The main purpose of this measure will be to predict parents’ behavioral intention to seek EBS, which the TPB suggests can be used to proximally measure the actual behavior of obtaining EBS for their children. The development and subsequent usage of such an instrument could aid community- or population-based implementation efforts by allowing for the creation of strategies to alter factors affecting parents’ intentions for seeking and using EBS, informing interventions aimed at increasing consumer knowledge and empowerment, and tailoring EBS interventions to suit specific consumer needs.
CHAPTER 2. METHODS

Participants

In all, there were five types of participants that aided in the development, modification and evaluation of measure content. These participants, explained in greater detail below, generally included parents, workers from government agencies, employees from educational settings, parent advocates, and university-based researchers. In order to gain parent consumer perspectives on EBS, participants from the target population were recruited for one-to-one interviews through the University of Hawai‘i Center for Cognitive Behavioral Therapy (UH CCBT) and the Honolulu Family Guidance Center (HOFGC) of the Child and Adolescent Mental Health Division (CAMHD). “Parent Participants” were referred to these agencies through the Hawai‘i State Department of Education (DOE), CAMHD or through private referrals for mental health services, and were defined as parents of youth experiencing emotional or behavioral problems that are either in the initial process of obtaining services or currently receiving treatment from various organizations.

The remaining participant types were recruited in order to gain the perspectives of a wide variety of youth mental health stakeholders. The second type of participants were CAMHD employees and employees of mental health agencies contracted for services with CAMHD. CAMHD employees included youth mental health support staff such as Mental Health Care Coordinators while employees from contracted agencies were youth mental health clinicians providing intensive in-home therapy to CAMHD-registered youth. Collectively, these two participant types were referred to as “Mental Health (MH) Experts” and were defined as staff that coordinate or provide youth mental health services. MH Experts were included to gain their unique perspective on common issues and concerns that arise when helping caregivers navigate treatment related decisions within the context of a large public sector youth mental health system.

The third participant group was referred to as “Education (ED) Experts.” These included service providers or support workers (e.g., Behavioral Health Specialists, Student Service Coordinators, School Psychologists) for children receiving mental health services primarily in the school setting. These participants were included to capture the perspective of school-based behavioral health stakeholders. Additionally, it was hoped
that these participants would provide stakeholder perspectives for youth primarily receiving services within an educationally-driven context.

To gain further insight into caregiver concerns regarding youth EBS potentially above and beyond Parent Participants, members from two relevant parenting organizations were asked to participate in the study. First, members of Hawai‘i Families As Allies (HFAA) were approached. HFAA is the Hawai‘i state chapter of the National Federation of Families for Children’s Mental Health, an organization that supports families of children and youth with emotional and/or behavioral challenges through education, technical assistance, and advocacy. Second, staff from the Special Parent Information Network (SPIN) were contacted. SPIN is a parent networking organization sponsored by the Disability and Communication Access Board and the Department of Education, which provides information, support, and referrals to parents of children and adolescents with disabilities and the professionals who serve them. Participants from these two groups were referred to as “Parent Organization (PO) Experts,” and collectively compose the fourth type of participants for the study. Efforts were made to include PO Experts that serve as both workers in family organizations and actual parents of youth with mental health challenges. It was anticipated that participants who serve both functions would be able to provide a broad perspective of parent concerns regarding child and adolescent interventions along with their personal attitudes towards EBS.

Lastly, a panel of “University-based (UB) Experts” were recruited from the University of Hawai‘i at Mānoa based on their area of research, experience with children with mental health problems, and knowledge of child and adolescent EBS. Experts who were trained in EBS and have experience delivering these treatments were sought out in order to gain insight into the implementation of empirically supported treatments with youth and their families. These experts have also conducted research in the area of dissemination and implementation science. Educational background levels for these UB Experts were graduate and doctoral level degrees in Clinical Psychology. See Table 1 for examples of specific types of participants as described above. Participant characteristics are also described below in greater detail, divided into each stage of the study in which they participated.
Table 1. Examples of Participants Across All Stages of Item Development and Review

<table>
<thead>
<tr>
<th>Parent Participants</th>
<th>MH Experts</th>
<th>ED Experts</th>
<th>PO Experts</th>
<th>UB Experts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Service Providers</td>
<td>Recruited from UH CCBT and Honolulu Family Guidance Center</td>
<td>Intensive in-home therapists, Multisystemic therapists</td>
<td>School Based Behavioral Health Specialists, School Psychologists</td>
<td>Recruited from UH CCBT Staff</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support Workers</td>
<td>Mental Health Care Coordinators, Mental Health Supervisors</td>
<td>Student Services Coordinators, Administrative Staff</td>
<td>UH CCBT Clinic Directors</td>
<td></td>
</tr>
</tbody>
</table>

*Note. MH = Mental Health; ED = Education; PO = Parent Organization; UB = University-based; UH CCBT = University of Hawai’i Center for Cognitive Behavioral Therapy*

**Measures**

*Consumer Attitudes towards Evidence-Based Services* (CAEBS; Teh & Mueller, 2011). The CAEBS is a 29-item questionnaire that measures consumer attitudes towards EBS based on five areas of concern: Radical Support of EBS Implementation, Barriers to Consumer Empowerment, Trust in the Benefits of EBS, Skepticism about Science, and Cultural Incompatibility Concerns (see Appendix A). The CAEBS was built for use with consumers providing answers for themselves or a loved one when seeking mental health services. Respondents indicate their answers on a scale from 1-5 (with 1 corresponding to “strongly disagree,” 2 corresponding to “disagree,” 3 corresponding to “neither agree nor disagree,” 4 corresponding to “agree,” and 5 corresponding to “strongly agree”). Total scores range from 0-145, with higher scores indicating more favorable attitudes toward EBS.

*Theme Generation Interview (TGI).* The TGI was developed for the purpose of this study and guided by a manual developed by Francis et al. (2004) for constructing questionnaires based on the TPB. This manual has been employed by a large number of research investigations and has resulted in the development of multiple measures showing good psychometric support (e.g., Fogg, Mawn, & Porrell, 2011; Knowlden,
The TGI is a semi-structured interview (see Appendix B) consisting of open-ended questions that elicit responses related to attitudes, perceived behavioral control, and subjective norms (i.e., along with their associated beliefs, which collectively are thought to be predictors of behavioral intention within the TPB). The interview questions were generated in accordance to the guidelines developed by Francis et al. (2004), and tailored to elicit the underlying beliefs of the TPB predictors in relation to EBS. In order to explore whether other themes unrelated to the TPB were influential in parents’ treatment decision-making, these questions were preceded with open-ended queries regarding parents’ perception of their role in obtaining mental health services, history of obtaining services, and general factors that influence which supports they would choose for their child. Additionally, parents’ knowledge of EBS was assessed to gather data on the number of parents being interviewed that were aware of these types of interventions prior to discussing their specific views on EBS. Subsequently, parents were presented with a definition of the construct (see Procedure discussed below) to facilitate the interview process and provide participants a basis on which to form their responses to TPB questions. The TGI was reviewed by a panel of UB Experts before administration in an effort to minimize the chance of interviewer bias. Additionally, in order to explore the suitability of language for parents, the questions were subjected to the Flesch-Kincaid Grade Level Test to assess readability (score = 4.7 grade level).

**Procedure**

Prior to data collection, all procedures were approved through the University of Hawai‘i’s Committee on Human Subjects (CHS). Participants provided CHS-approved written consent before engaging in any stage of the study. Once individuals agreed to participate, they were contacted over the phone, by e-mail, or in person for an interview or administered rating forms through email depending on the stage of the study to which they were assigned. Interviews were audio recorded and archived on computers housed in a laboratory at the University of Hawai‘i at Mānoa.

**Study Design**

The present study is divided into five stages: EBS Definition Generation, Item Generation, Item & Definition Modification, Item & Definition Evaluation, and Content
Validation (see Figure 1). This study utilized a multimethod, quantitative and qualitative process for all elements of measure development. Content validity is “the degree to which elements of an assessment instrument are relevant to and representative of the targeted construct for a particular assessment purpose” (Haynes et al., 1995, p. 238). Given the preliminary data on the usefulness of the CAEBS in measuring consumer attitudes, the original CAEBS questions were retained in order to subject them to the content validity analysis. The initial item pool also included items generated from the literature on consumer research and semi-structured interviews with parent consumers. Following the generation of items, panels of experts as described above made modifications and evaluated the content validity and language appropriateness of these items along with a definition of EBS. Experts were selected based on availability and interest in the current study.
CHAPTER 3. ANALYTIC STRATEGY AND RESULTS

Stage 1: EBS Definition Generation

Prior to any data collection, a panel of UB Experts consisting of three clinical psychology graduate students and one Ph.D. level expert in child and adolescent EBS dissemination and implementation science, met with the primary investigator to define the construct of EBS. The first step towards defining this construct involved systematically reviewing existing definitions from the literature. In all, four definitions were considered for direct adoption prior to any panel modifications. These four reviewed definitions included works from: (a) the American Psychological Association’s Presidential Task Force on Evidence-based Practice (APA, 2006), (b) formal criteria for “Defining Empirically Supported Therapies” (Chambless & Hollon, 1998), (c) descriptions of the multiple evidence bases used to support clinical decision making (Daleiden & Chorpita, 2005), and (d) Teh & Mueller (2011) CAEBS measure. For both broad-based and specific reasons, none of these definitions were adopted in their entirety. At a general level, given recent findings that only a small percentage of parents receive EBS (Sanders, Markie-Dadds, Rinaldis, Firman & Baig, 2007) or are aware of the existence of such services (Tanenbaum, 2008a), combined with the academic or research-based nature of the first three definitions, definitions proposed by the APA (2006), Chambless and Hollon (1998), and Chorpita and Daleiden (2005) were rejected for full adoption. At a more specific level, the CAEBS’ (Teh & Mueller, 2011) definition was not adopted in its entirety because the primary author judged it to be too vague and narrow for a parent consumer population. After this review, the principle investigator generated a preliminary definition of EBS based on a synthesis of the existing descriptions above and presented it to the UB Expert panel for review (see Table 2: “Initial EBS Definition proposed by the primary investigator”).
<table>
<thead>
<tr>
<th>CAEBS definition</th>
<th>Evidence-based services are methods that have been scientifically shown to help people with specific mental health problems get better.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial EBS Definition proposed by the principal investigator</strong></td>
<td>The term “evidence-based services” is commonly used in children’s mental health to describe treatments that have been shown to ‘work’ based on the best available and most up to date scientific research. Additionally, treatments are thought to be evidence-based if the clinician (1) draws upon knowledge gained from their experience working with youth with mental health challenges, (2) takes into account treatments that have been helpful for other children with similar issues in Hawaii, and (3) tailors the treatment program to fit the client and their family’s preferences, history, values, cultural views, and other factors unique to the child.</td>
</tr>
<tr>
<td><strong>Definition revised by the UB panel for use in initial TGI</strong></td>
<td>Evidence-based practice refers to therapies that are supported by some form of evidence. Evidence can come in all sorts of forms, but for our interview, I want us to think of only two types of evidence. The first type of evidence comes in the form of big research studies that are a lot of the time done on the mainland. For example, in medicine, Prozac is one type of medicine that has been shown to be effective, because a lot of research has shown it works for depression. The second type of evidence for evidence-based therapies is if progress can be seen over and over again either for a specific child or children with similar problems. For example, if a child responds positively to rewards and structure, those would be considered evidence-based.</td>
</tr>
<tr>
<td><strong>Definition revised by the UB panel for use in final TGI</strong></td>
<td>Evidence-based services refer to therapies that have been scientifically proven to have a positive effect in the treatment of a particular disorder or problem area. When a treatment is called EBS, it means the treatment has been studied, usually in an academic or community setting, and has been shown to work through repeated research studies looking at the same topic and conducted by several different research teams. For example, in medicine, Prozac is one type of medicine that has been shown to be effective, because a lot of research has shown it works for depression. In EBS research, studies typically use uniform training and a treatment manual to guide therapists in the treatment. For example, (describe manual), which therapists have to follow step by step when treating a child. In children’s mental health, these are the problem areas that are studied to find EBS: (Blue Menu example specific to child’s presenting problem)</td>
</tr>
</tbody>
</table>
Next, the panel collaboratively rewrote the definition proposed by the primary author until a consensus was reached on the appropriateness of the construct for use with Parent Participants in Stage 2: Item Generation using the TGI (see Table 2: “Definition revised by the UB panel for use in initial TGI”). Based upon feedback from the initial administrations of the TGI indicating that parents were having difficulty understanding the construct of EBS, the definition was revised once more resulting in the “Definition revised by the UB panel for use in final TGI” presented in Table 2. Numerous parameters were considered when defining the EBS construct, including the American Psychological Association’s (2006) formal definition along with other commonly accepted forms of evidence such as case-specific historical information and local aggregate evidence (Daleiden & Chorpita, 2005). Balancing the need to acknowledge multiple forms of evidence, while keeping to a strict definition to facilitate measure development, the panel ultimately decided to adhere to a fairly circumscribed definition of EBS as it was originally developed in the interest of simplifying the construct as much as possible.

Stage 2: Item Generation

The initial version of this new consumer measure began with all 29 items of the CAEBS in order to evaluate their content validity; a process not performed in the creation of the original measure. In order to increase the likelihood of obtaining themes representative and relevant to the construct of parents’ intent to engage in EBS, semi-structured interviews were conducted with participants from the targeted population (Haynes et al., 1995). The TGI was administered to a sample ($n = 12$) of parents of youth with emotional or behavioral problems (92% female). Initially parents were recruited while attempting to balance sample representativeness with youth primary problem area (e.g., disruptive behavior, anxiety, depressive, inattention/hyperactivity diagnoses). However, over time recruitment pace proved more difficult than originally anticipated and parents were selected based on availability and interest in the study. Children represented by this sample were half male ($n = 6$); age ranged from 7 to 17 years ($M = 12.2$); had primary diagnoses related to internalizing ($n = 4$), externalizing ($n = 6$), or both internalizing and externalizing ($n = 2$) problems; and were either receiving treatment through the DOE ($n = 4$), through CAMHD ($n = 6$), or not receiving services ($n = 3$). Parent Participants were contacted by email or phone and met in person with the primary
investigator for one-to-one administration of the TGI; interviews lasted approximately 30 minutes. All interviews were audiotaped and transcribed with the consent of participants. Interviews were continued until the point of data saturation, when three respondents in a row failed to produce novel themes (Francis, Johnston, Robertson, Glidewell, Entwistle, Eccles, & Grimshaw, 2010).

Parent Participant responses were explored using template analysis (King, 1998) in order to identify shared themes among participants. Template analysis is considered a flexible approach to coding qualitative data employing methodology that falls between content analysis (Weber, 1985), where codes are predetermined and statistically analyzed, and grounded theory (Glaser & Strauss, 1967) where codes are not defined a priori. In template analysis, (a) some themes are determined a priori based on previous literature and hypotheses in order to guide analysis, (b) themes are modified and added to by the researcher as text is read and interpreted, and (c) themes are organized into a coding template (King, 1998). Themes are organized into higher-order codes (e.g., the overview of topics covered by the interview) and lower-order codes (e.g., subsidiary probes that allow for distinctions to be made within and between cases) that can be revised through insertion, deletion, changing the scope, or changing higher-order classification (King, 1998). This approach was chosen given that, while the TPB may guide consumer behavioral intentions, other factors may be involved in parents’ decision-making regarding intent to seek EBS.

In order to code the content from the 12 parent interviews mentioned above, coding templates were produced based on the TPB predictors of behavior intention (attitudes, perceived behavioral control, and subjective norms). Initially, the primary investigator and a Ph.D. doctoral candidate in clinical psychology with expertise in EBS- and TPB-related research examined a subset of the transcript data and collaboratively defined codes based on the intent of the study. Simultaneously, a provisional template was created to include four higher-order and six lower-order codes. The four higher-order codes included the three TPB predictors (i.e., attitudes, perceived behavioral control, and subjective norms) along with an “other” category to encompass themes unrelated to the TPB. Lower-order codes included themes that were elicited by the follow up questions targeting underlying beliefs (see Table 3 for the initial thematic template). Following the
completion of interviews, the primary investigator and additional coder then independently reviewed the full set of transcripts, coding all sections of the text to (a) index them as relating the one of the template themes, (b) establish whether any additional themes could be identified, and (c) generate a preliminary item to facilitate the process of actual item generation. The primary investigator separated segments of text into discrete units ranging from sentences to paragraphs, depending on the amount of content provided by the participant in response to the interviewer’s prompt. Coders then provided each unit of text with a code from the initial thematic template, while also creating a preliminary item by condensing the unit into a single representative statement. Regular meetings were held between the coders throughout the review process in order to minimize drift and identify and reconcile discrepancies of code assignment. In the event that a consensus could not be reached between the coders, the items were brought before the panel of UB Experts from Stage 1 for discussion.

Upon completion of coding by the individual raters, the primary investigator worked towards developing a clear and comprehensive final template by consolidating all preliminary items within each higher-order code and revising the coding template to include a wider range of lower-order codes. Similar preliminary items derived from the same section of text by each coder were unified into one representative item, while unique items by each rater were retained in order to ensure that all possible thematic items were represented in the item pool. This process resulted in 254 items. Items

<table>
<thead>
<tr>
<th>Table 3. Initial Thematic Template</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Attitudes</td>
</tr>
<tr>
<td>1 Advantages of EBS</td>
</tr>
<tr>
<td>2 Disadvantages of EBS</td>
</tr>
<tr>
<td>2 Perceived behavioral control</td>
</tr>
<tr>
<td>1 Parent facilitators</td>
</tr>
<tr>
<td>2 Parent barriers</td>
</tr>
<tr>
<td>3 Subjective norms</td>
</tr>
<tr>
<td>1 Groups/people who would approve</td>
</tr>
<tr>
<td>2 Groups/people who would disapprove</td>
</tr>
<tr>
<td>4 Other</td>
</tr>
<tr>
<td>1 Parent role</td>
</tr>
<tr>
<td>2 Sources of information</td>
</tr>
</tbody>
</table>
measuring behavioral intention do not require interview-based content generation (Francis et al., 2004), therefore one behavioral intention item was generated by the primary investigator and included in this pool to undergo all other stages of measure development. Next, the 29 original CAEBS items were added to the initial item pool for a grand total of 283 items to be included in the following preliminary content validation process.

The preliminary content validation process entailed revision of the working thematic template through several meetings with the primary investigator and panel of UB Experts. Multiple discussions ensued in order to clarify and revise higher-order and lower-order codes based on the items listed within each category (See Table 4 for the final thematic template). For the next stages of modification, evaluation, and final content validation, the higher-order codes are referred to as “domains” and the lower-order codes are referred to as “subdomains.” The UB panel then worked to generate well-formed items, combine items with similar concepts to reduce redundancy, delete irrelevant or low base-rate items (e.g., case specific issues that would likely not generalize to other parents), create construct definitions for each domain, and ensure all domains were adequately covered. At the end of Stage 2, 76 items generated through interviews with Parent Participants were added to the original list of 29 CAEBS items, for a combined 105 items brought forward to the next stage.
Table 4. *Final Thematic Template*

<table>
<thead>
<tr>
<th>Section</th>
<th>Subsections</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Attitudes</td>
<td>1 Advantages/Disadvantages of EBS</td>
</tr>
<tr>
<td></td>
<td>2 Trust in Research</td>
</tr>
<tr>
<td></td>
<td>3 Fit/Compatibility</td>
</tr>
<tr>
<td>2 Perceived behavioral control</td>
<td>1 Barriers</td>
</tr>
<tr>
<td></td>
<td>1 Lack of knowledge/skill/experience</td>
</tr>
<tr>
<td></td>
<td>2 Lack of confidence/control</td>
</tr>
<tr>
<td></td>
<td>3 Perceptions of cost</td>
</tr>
<tr>
<td></td>
<td>2 Facilitators</td>
</tr>
<tr>
<td></td>
<td>1 Therapist adoption</td>
</tr>
<tr>
<td></td>
<td>2 Consumer empowerment</td>
</tr>
<tr>
<td></td>
<td>3 School role</td>
</tr>
<tr>
<td>3 Subjective norms</td>
<td></td>
</tr>
<tr>
<td>4 General treatment factors</td>
<td>1 Advantages/Disadvantages</td>
</tr>
<tr>
<td></td>
<td>2 Fit</td>
</tr>
<tr>
<td></td>
<td>3 Epistemology</td>
</tr>
<tr>
<td></td>
<td>4 Knowledge</td>
</tr>
<tr>
<td></td>
<td>5 Confidence</td>
</tr>
<tr>
<td></td>
<td>6 Perceptions of Cost</td>
</tr>
<tr>
<td></td>
<td>7 Consumer empowerment</td>
</tr>
<tr>
<td></td>
<td>8 School role</td>
</tr>
<tr>
<td></td>
<td>9 Consumer marketing</td>
</tr>
<tr>
<td>5 Behavioral intention</td>
<td></td>
</tr>
</tbody>
</table>
Stage 3: Item & Definition Modification

Following Stage 2 described above, a total of eight various types of participants were recruited by phone, email, or in person to adapt and modify all 105 items to be appropriate for use with a parent population. Haynes et al. (1995) posit that the optimal number of judges for this type of work varies as a function of the element under review and practical considerations, but the confidence in the robustness of ratings will generally increase with more judges. Along these lines, various types of participants for this stage included: two MH Experts (one Mental Health Care Coordinator and one Ph.D. level intensive in-home therapist), two ED Experts (one Student Services Coordinator and one Behavioral Health Specialist), two PO Experts (one each from SPIN and HFAA), and two UB Experts (one graduate student and one Ph.D. level clinical psychologist). In addition to reviewing the 105 items created in Stage 2, participants also reviewed how EBS was defined for the current study. Prior to sending out the definition for review, however, the EBS definition created in Stage 1 was rewritten by the primary investigator to be more suitable for use in a written measure as opposed to the verbal definition contained in the TGI that allowed for further elaboration by the interviewer.

Each participant was emailed an electronic document containing items to modify directly on the form and resend to the primary investigator upon completion (see Appendix C for an example). In order to reduce the effects of fatigue in modifying 105 items, each item was randomly assigned to three of the eight experts. This resulted in each expert receiving an average of 36 items derived from all four domains along with the definition of EBS for modification. Participants were asked to reword each item for parent appropriateness while maintaining the same meaning of the original item. In order to address the representativeness of the item pool, participants were also given the opportunity to suggest additional items if they felt there were topics not included in their item set that may influence parents’ intent to seek EBS based on their attitudes, perceived behavioral control, subjective norm, general treatment factors, or any other facet not mentioned. Each of these constructs were briefly defined on the rating form and also discussed with participants over the phone or in person to ensure the domains were clear.

Each item was modified by three experts resulting in up to three modified versions of each item (for an example of modified items, see Table 5). Some participants
chose not to modify every item indicating that the item was already appropriately worded for parents. One additional item related to perceived behavioral control that was not already included in the measure was suggested by a PO expert and added to the pool. Therefore a total of 243 items and seven definitions of EBS were generated in this stage.
### Table 5. Examples of Modified Items

<table>
<thead>
<tr>
<th>Original Item</th>
<th>Modified Item (Participant 1)</th>
<th>Modified Item (Participant 2)</th>
<th>Modified Item (Participant 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>If I were presented with multiple treatment options, I would be more inclined to choose the intervention with the most research support.</td>
<td>If I was shown various treatment choices, I would be more likely to choose the one with the most positive results.</td>
<td>If I was given several/ various treatment options, I would be more likely to select the intervention that has the most research support.</td>
<td>If I could choose between different treatment options, I would be more likely to choose the treatment that had the most research support.</td>
</tr>
<tr>
<td>I don’t know enough about available treatments to choose an EBS for my child's diagnosis.</td>
<td>I don’t know enough about the different treatments out there to choose an EBS for my child’s problem.</td>
<td>I have limited knowledge of the available treatments to choose an EBS for my child’s diagnosis.</td>
<td>I don’t know enough about available treatments to choose an EBS for my child's problem area.</td>
</tr>
<tr>
<td>The most important factor above all other treatment components is that the therapist has rapport with my child and my family.</td>
<td>The most important factor above all other treatment components is that the therapist have a good relationship/ connection with my child and my family.</td>
<td>The most important factor in treatment is that the therapist has rapport with my child and my family.</td>
<td>The most important factor above all other treatment components is that the therapist has rapport (i.e., a warm, open, and trusting relationship) with my child and my family.</td>
</tr>
</tbody>
</table>
Stage 4: Item & Definition Evaluation

Next, various types of participants were recruited by phone, email, or in person to “judge” all 243 items and seven EBS definitions on two dimensions: content validity (i.e., degree to which the item measures or is relevant to parents’ intent to engage in EBS) and language appropriateness (i.e., appropriate for a parent population, wording, clarity). Participants for this stage included: two MH Experts (one Mental Health Care Coordinator and one post-doctorate intensive in-home therapist), two ED Experts (one Student Services Coordinator and one School Psychologist), two PO Experts (one each from SPIN and HFAA), and two UB Experts (one graduate student and one Ph.D. level clinical psychologist).

In order to minimize the chance of rater fatigue in evaluating all 243 items and seven EBS definitions, two forms of item evaluation were created by dividing the four domains (attitudes, perceived behavioral control, subjective norms, general treatment factors) and definitions amongst participants in each category of experts (see Appendix D for an example). One evaluation form included the domains of Attitudes (81 items) and General Treatment Factors (35 items) along with four sets of definitions, while the second evaluation form included the domains of Subjective Norms (27 items) and Perceived Behavioral Control (100 items) along with three sets of definitions. Participants were asked to rate language appropriateness on a scale from 1-4 (1 = inappropriate, 2 = slightly inappropriate, 3 = appropriate, 4 = very appropriate) based on how appropriately worded the item was for a parent population. A definition of each domain assigned to participants for evaluation was provided (i.e., see Appendix D) in order for them to rate the content validity of statements on a scale from 1-5 (1 = poor, 2 = fair, 3 = average, 4 = good, 5 = excellent). Content validity was assessed by asking each participant to rate the degree to which they felt the item was relevant to parents’ intent to engage in EBS based on one of the four domains: (a) Attitudes or parents’ overall evaluation of EBS, which could include their perceived advantages or disadvantages of EBS, trust in research, and fit or compatibility concerns; (b) Perceived Behavioral Control or the extent to which parents feel able to obtain EBS, including facilitators (e.g., therapist adoption of EBS, consumer empowerment, school role) and barriers (e.g., lack of knowledge or control, perceptions of cost) to receiving these services; (c) Subjective
Norms or the felt influence of people or groups on parents’ treatment related decisions, and (d) the influence of General Treatment Factors or issues not specific to EBS that parents consider when making mental health treatment related decisions. In order to address the representativeness of items, participants were allowed the opportunity to add items to the pool if they felt there were other issues not mentioned within each domain that measured parents’ intent to engage in EBS. Three additional items related to subjective norm were suggested by UB experts and added to the item pool following this stage. Similarly, participants were asked to provide a content validity rating for each EBS definition, or the degree to which the rater felt the statement measured the construct of evidence-based services, along with a language appropriateness rating.

Each item received four content validity scores and four language appropriateness scores by four different experts. Items were distilled implementing these ratings and using the following methods. First, within each subset of modified items, including the original item and up to three modified versions provided by experts, the item with the highest language appropriateness score was retained for further evaluation (see Table 6 for an example). On occasions when there were ties in language appropriateness ratings, the item with the highest content validity rating was retained. This resulted in the reduction of items from 243 to 109. Second, the remaining 109 items were rank ordered by their content validity scores within their subdomains and the bottom quartile was eliminated to further reduce the items from 109 to 82. The primary investigator chose this cutoff to best utilize experts’ rating of item content and reduce overall measure length. Some items within the bottom quartile were retained based on the primary investigator and UB panel’s judgment of their relative importance in relation to the construct of interest and literature in this area.

Additionally, each of the seven EBS definitions received four content validity scores and four language appropriateness scores by four different experts. The definition with the highest mean content validity score and language appropriateness rating was retained to be included in the instructions of the final instrument.
Table 6. *Examples of Average Language Appropriateness Ratings*

Example of how average language appropriateness scores (i.e., scores in bold) were obtained by four separate raters based on the degree to which the item is written in a language appropriate for parents. The item with the highest average LA rating was retained (in this case, Modified Item 1 was retained).

<table>
<thead>
<tr>
<th></th>
<th>Original Item</th>
<th>Modified Item 1</th>
<th>Modified Item 2</th>
<th>Modified Item 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MH Expert</strong></td>
<td>If I was presented with multiple treatment options, I would be more inclined to choose the intervention with the most research support.</td>
<td>If I was shown various treatment choices, I would be more likely to choose the one with the most positive results</td>
<td>If I was given several/various treatment options, I would be more likely to select the intervention that has the most research support.</td>
<td>If I could choose between different treatment options, I would be more likely to choose the treatment that had the most research support.</td>
</tr>
<tr>
<td><strong>LA rating</strong></td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td><strong>ED Expert</strong></td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td><strong>LA rating</strong></td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td><strong>PO Expert</strong></td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td><strong>LA rating</strong></td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td><strong>3</strong></td>
<td><strong>3.75</strong></td>
<td><strong>3</strong></td>
<td><strong>3.5</strong></td>
</tr>
<tr>
<td><strong>LA rating</strong></td>
<td><strong>3</strong></td>
<td><strong>3.75</strong></td>
<td><strong>3</strong></td>
<td><strong>3.5</strong></td>
</tr>
</tbody>
</table>

Note. MH = Mental Health; ED = Education; PO = Parent Organization; UB = University-based; LA = Language Appropriateness
Stage 5: Content Validation

In the final stage, the primary investigator met with the panel of UB Experts consulted in previous stages to ensure that all domains and subdomains contained items best matched to their represented constructs. To increase the reliability of the behavioral intention domain, the panel additionally generated two more items measuring behavioral intention in order to demonstrate adequate internal consistency between the items. After a consensus was reached on the appropriateness of the items and domain fit, a final measure was produced containing 84 items: 23 attitude, 36 perceived behavioral control, 11 subjective norm, 11 general treatment factors, and three behavioral intention (see Appendix E). Because the number of items included in a domain does not reflect its importance, it was decided differential item weighting would be used when calculating total scores in the final measure. For example, scores for the perceived behavioral control and subjective norm domains could be weighted more heavily than attitudes and perceived behavioral control, to correct for the relative lack of items in these domains. The five-point Likert-scale (i.e., with one indicating “strongly disagree” to five indicating “strongly agree”) response format of the CAEBS was retained, and the sequencing of the 84 items was randomized to control for order effects. The panel also revised the CAEBS instructions to be pertinent to a parent population and to include the new definition of EBS developed by the current study. This preliminary measure of parents’ intent to engage in EBS was renamed the Parent Engagement in Evidence-Based Services questionnaire (PEEBS) (see Appendix F).
CHAPTER 4. DISCUSSION

The purpose of this study was to develop a new measure that assesses consumer intent to engage in EBS in a population of parents of youth with emotional or behavioral problems. The resulting instrument, the PEEBS, consists of 82 items and is based on a review of the literature, an existing consumer attitudes measure, interviews with parents, and input from experts across several disciplines working in the field of child and adolescent mental health. Haynes et al. (1995) suggest that such a multimethod approach for generating (e.g., examining the literature, interviewing a sample from the target population, receiving input from experts in the field, utilizing other assessment measures) and reviewing items (e.g., having experts provide both quantitative ratings and qualitative feedback) is essential for establishing an instrument’s content validity. The creation of the PEEBS involved all of these methodological suggestions, resulting in a thoroughly developed measure of parent intent to engage in EBS.

This instrument development study fits within and builds upon the larger EBS literature in several ways. First, unlike the majority of most EBS dissemination and implementation efforts that focused on clinical providers as the relevant target group, this study is the first of its kind as its centers on developing a youth EBS measure targeting the needs of a parent consumer population. Such an approach is in line with increasing calls from the literature for building consumer collaborations regarding the development, implementation, and evaluation of services in order to improve the quality, ecological fit, and reach of interventions (Sanders & Kirby, 2012; Santucci et al. 2012). Second, drawing from the psychometric and instrumentation literature, this study incorporates multiple methods recommended by Haynes et al. (1995) for conducting a thorough content validity analysis en route to producing a measure. Teh & Mueller (2011) creation of the CAEBS took a step towards capturing consumer attitudes based on an undergraduate population. However, a limitation of this instrument is that its items were generated based primarily upon a review of the literature and clinical experience, without incorporating other recommended methods (e.g., interviews with the target population, input from experts). The development of the PEEBS included reviewing the available literature, conducting semi-structured interviews with parents of youth with emotional or behavioral disorders, modifying and adapting an existing consumer measure, and having
multiple experts review items for language appropriateness and content validity throughout various stages of the study. These procedures increase the likelihood that items are related to the construct of interest. Third, the creation of the PEEBS was influenced by the TPB, a robust behavior change model designed to predict and explain human health related behavior (Ajzen, 1988, 1991). Given the lack of theories available to explain help-seeking behavior by consumers of youth mental health services, along with the TPB’s growing utilization in the field of mental health (e.g., Casper, 2007; Kelly et al. 2012), it was theorized that this model might be applicable to parent consumers’ intent to engage in EBS. However, in following Francis et al.’s (2004) suggested procedure for creating a TPB measure, difficulties emerged with regard to absolute model adoption. Although the TGI was created by including questions aimed at eliciting beliefs associated with behavioral intention predictors (attitudes, perceived behavioral control, and subjective norms), parent interviews also produced content that did not clearly align with one of the three predictors. It is possible that parents’ lack of knowledge and a thorough understanding of EBS may have affected their ability to comment on their perceived advantages or disadvantages of EBS, the amount of control they felt over performing the behavior, and whether social factors would influence their decision to engage in EBS. Due to this realization, a method of strictly adhering to the TPB predictors was abandoned and a general treatment factors domain was included to increase the chance that the items are representative of the construct of interest; namely intent to engage in EBS behaviors. It is premature at this point to conclude that the TPB does not hold for consumer intent to engage in EBS without further exploration of the psychometrics of the PEEBS.

The complexities of explicating an adequate model for describing consumer mental health decision-making have also been reflected in the literature to date (Tanenbaum, 2008b). Some research suggests that consumer decision-making values both scientific evidence and recovery principles (Tanenbaum, 2006), and that although information is an important factor, a range of other factors (e.g., personal meaning given to treatment) influence consumers’ treatment choices (Tanenbaum, 2008b). On the contrary, however, Richardson’s (2001) work suggests that outcome expectations related to social and cultural factors, provider/client relationship, accessibility and treatment are
most influential in parents’ mental health decisions. Similar to the TPB, Jackson, Cheater, and Reid (2008) maintain that having a sense of control over the treatment-seeking and experience process, talking to others, and information (rather than attitudes) are the main issues related to the support needs of parents attempting to make informed decisions on behalf of their children. Although there is overlap in the factors that are thought to influence parents’ mental health decision-making, there remains a lack of consensus as to one overarching model. Taking these considerations into account, it is possible that the TPB may still be extended and refined to attempt to account for the multiple aspects of decision-making in child and adolescent mental health.

**Limitations**

Several study limitations are noteworthy of discussion. First, the extent to which Parent Participants and their responses are representative of larger consumer populations remain unknown. Parents were selected based on interest in the current study and availability, and results might be confounded by variables such as sample characteristics of those who volunteered. For example, parents who engaged in the interviews were seeking or already engaged in services, and may have been more motivated to obtain treatment in general. Some parents and their children were actually receiving an EBS at the time of the interview, which may have influenced their view of these interventions. However, in a system with a long history of EBS implementation (Nakamura et al., 2011), parents were still not aware of the existence of EBS; 10 of the 12 parents reported not knowing or ever hearing the term “EBS” prior to the interview. To also help mitigate the effects of confound variables, parents from the public sector were recruited in order to maximize generalizability of results to diverse family backgrounds. Additionally, the expert participants chosen to aid in the modification and evaluation processes were specifically recruited from varying backgrounds of child mental health professions in hopes of eliciting feedback based on an aggregate of their client history. Therefore, it is hoped that the information directly obtained from the parent population along with input provided by experts with extensive histories of working with these consumers over numerous years, will minimize the effects of potential sampling bias and nonrepresentativeness of the parent group.
Second, as mentioned above, parents’ lack of knowledge regarding EBS made the construct of intent to engage in EBS difficult to measure. It is therefore possible that the PEEBS measures parent views towards treatment in general, rather than opinions specific to EBS. In order to address this potential problem, however, the EBS definition was elaborated upon during interviews until parents reported having a clear understanding of the construct. Additionally, the interviews were carefully structured in that parents were frequently prompted to respond to questions in relation to EBS specifically, rather than psychological treatments in general. Based on these discussions, the definition also underwent several revisions to maintain a description of EBS that was most easily comprehended by parents. Further, rather than disregarding non-EBS responses, the general treatment factors domain was included to encompass topics that were not specific to engaging in EBS and retained to undergo further evaluation in future psychometric studies. It is hoped that the content derived from the target population, supplemented with quantitative ratings and qualitative feedback from experts, will increase the chance that the items included in the measure are representative of consumer intent to engage in EBS and move towards construct refinement.

Third, experts in the modification and evaluation stages were designated only a subset of items to minimize the chance of rater fatigue and dropout; therefore, no one expert evaluated the complete pool of measure items. However, at least three to four experts reviewed each item, which reduces the possible bias of having only one rater evaluate all the items. Participants across both stages were also given the opportunity to suggest additional items to be included in the measure if they felt the overall construct or specific domains were not adequately represented by the available items.

**Future Implications**

In order to build empirical psychometric support for the PEEBS, future studies should aim to explore the reliability and validity of this measure. A factor analysis would be beneficial for examining the instrument’s validity while also refining its existing items. Based on Hatcher’s (1994) recommendation that the number of subjects equal approximately five times the number of items being analyzed, it is estimated that at least 410 participants will be needed to conduct a factor analysis on the PEEBS. During this process, items can also be added or deleted based on their factor loadings until the final
measure contains a concise number of items that form the appropriate factors representing the construct of parent intent to engage in EBS. Using a random subset of participants from the same sample, test-retest reliability could also be explored by administering the PEEBS to participants approximately four to six weeks from the initial measure completion. Test-retest reliability is important in evaluating the stability of the measure from one administration to the other and is demonstrated by significant correlations between the scores obtained during both administrations.

Pending psychometric support of the PEEBS, the measure could be utilized in a number of ways in order to aid in EBS dissemination efforts and increase awareness of effective psychosocial interventions in parent populations. For example, data collected from the measure could be used to investigate how scores relate to actual help seeking behaviors, explore potential behavior moderators (i.e., child diagnosis, age, or service sector), and examine the relationship between behavioral intentions and treatment outcomes. The PEEBS could also be used to identify areas to target for dissemination efforts and determine how to tailor interventions for specific populations. For example, Cleary et al. (2007) demonstrated how workshops with consumers could be beneficial in increasing knowledge about the role of research and EBS along with intent to participate in such programs. In a similar fashion, the PEEBS could be administered to parents prior to and after attending a workshop designed to boost parents’ EBS seeking behaviors. Scores on separate subscales could be used to determine the strongest predictors of intent to engage in EBS, and efforts could be made within the workshop to increase focus on that area. For example, if subjective norms are found to be the strongest predictor of intent to engage in EBS, parent implementation of EBS might be increased for that sample if there is focus on greater levels of social support. Alternately, responses on the PEEBS could be reviewed to determine whether issues such as misconceptions of low perceived behavioral control or negative attitudes about EBS could be addressed in parent interventions. Further studies employing the PEEBS will contribute to the consumer literature by exploring whether a collaborative approach with parents of youth with emotional or behavioral problems will aid in implementation and dissemination efforts of general child and adolescent EBS; similar to the positive effects demonstrated in specific evidence-based parenting programs.
In conclusion, the present study built upon previous initiatives to facilitate the implementation and dissemination of EBS by enhancing the role of parent consumers. The development of the PEEBS entailed a thorough content analysis procedure; a crucial component not yet performed in this area of the literature. It was theorized that the TPB would provide a model of consumer decision-making processes, and although content derived from parents did not adhere absolutely to this theory, the TPB served to provide a helpful foundation for exploring parent beliefs about EBS, and has yet to be substantiated within this area. Improved understanding of consumer perspectives of EBS may provide insight into the facilitators and barriers caregivers may experience in the area of youth mental health EBS, which may in turn aid in tailoring dissemination and implementation efforts.
Figure 1. Study procedures and participant involvement throughout the measure development and evaluation processes.
APPENDIX A. CONSUMER ATTITUDES TOWARDS EVIDENCE-BASED SERVICES SCALE ITEMS BY FACTOR

CAEBS

Radical Support of EBS Implementation
1. States should not license therapists who will do other treatments when an EBS for the problem has been identified
2. Insurance companies should only reimburse therapists who use EBS.
3. If a therapist failed to provide an available EBS to me, I would consider filing a suit against them.
4. When choosing a mental health treatment, the evidence base is more important than my therapist’s opinion.
5. Mental health therapists who engage in other treatments when an EBS is available should be held responsible for any negative outcomes.
6. Only therapist using EBS should be allowed to treat mental health problems.

Barriers to Consumer Empowerment
7. EBS might be too expensive for me.
8. My insurance might not pay for EBS.
9. I don’t know how to tell if a treatment is evidence-based.
10. Treatment options overwhelm me.
11. Information about my problem is too hard for me to understand.
12. I don’t feel comfortable making treatment decisions.

Trust in the Benefits of EBS
13. EBS help to show that mental health problems are real.
14. EBS provide hope for people suffering from mental health problems.
15. The use of EBS will improve mental health services.
16. I would be sure to try an EBS before a non-EBS.
17. People will benefit when therapists carefully track their treatment progress.
18. A good therapist will use treatments that have been supported by evidence.

Skepticism about Science
19. EBS do not address the reason why I have problems.
20. Scientific studies get in the way of freedom of choice.
21. Scientific studies often have other agendas besides helping people.
22. I am unsure whether EBS can address my individual needs.
23. Regardless of what the evidence says, I know what works best for me.
24. Scientific studies cannot show that treatment works for the long term.

Cultural Incompatibility Concerns
25. Some EBS might conflict with certain cultural values.
26. All cultures might not believe in EBS.
27. EBS might not be accepted by all cultures.
28. It would be difficult to make sure that all therapists use EBS.
29. EBS are not applicable to all cultures.
APPENDIX B. THEME GENERATION INTERVIEW

Theme Generation Interview

1. What do you feel your role is in choosing mental health supports for your child?
   a. Hx of obtaining services?

2. What kind of things affect what supports you would choose for your child? (e.g., people’s opinions who are close to them, believed outcomes, perceived behavioral control, cultural compatibility)

Now I’m going to ask you questions about mental health supports called “evidence-based services.” Tell me what you know about this type of service.

Evidence-based services refer to therapies that have been scientifically proven to have a positive effect in the treatment of a particular disorder or problem area. When a treatment is called EBS, it means the treatment has been studied, usually in an academic or community setting, and has been shown to work through repeated research studies looking at the same topic and conducted by several different research teams. For example, in medicine, Prozac is one type of medicine that has been shown to be effective, because a lot of research has shown it works for depression.

In EBS research, studies typically use uniform training and a treatment manual to guide therapists in the treatment. For example, (INCREDIBLE YEARS), which therapists have to follow step by step when treating a child.

In children’s mental health, these are the problem areas that are studied to find EBS:
+ Blue Menu example specific to child’s presenting problem

1. What do you believe is good about EBS?
2. What do you believe is bad about EBS?
3. Do you have any other views/opinions about EBS?
4. Are there any people or groups who would approve of your decision to seek EBS?
5. Are there any people/groups who would disapprove of your decision to seek EBS?
6. Is there anything else you associate with other people’s views about EBS?
7. What kinds of things would help you to seek EBS for your child?
8. What kind of things would make it difficult for you to seek EBS for your child?
9. Are there any other issues that come to mind when you think about seeking EBS for your child?
APPENDIX C. EXAMPLE OF ITEM MODIFICATION FORM

Please look at the items below and reword them so that they maintain the same meaning, but are appropriately worded for parents of youth with emotional and behavioral problems.

You also have the opportunity to add items in the blank boxes at the bottom of the list if you think there are additional topics that may influence parents’ intention to seek EBS based on their:

1) **Attitudes**: overall evaluation of EBS (e.g., perceived advantages/disadvantages of EBS, trust in research, fit/compatibility concerns)
2) **Perceived Behavioral Control**: the extent to which parents feel able to obtain EBS [facilitators (e.g., therapist adoption of EBS, consumer empowerment, school role) / barriers (e.g., lack of knowledge or control, perceptions of cost) to receiving these services]
3) **Subjective Norms**: the felt influence of people/groups on their treatment related decisions
4) **General Treatment Factors**: issues not specific to EBS that they consider when making treatment related decisions
5) **Or any other facet not mentioned**

Similarly, please review the definition of EBS presented in the first box below and reword it to maintain it’s meaning, while being presented in “parent-friendly” language.

**Evidence-based services (EBS)** refer to therapies that have been scientifically proven to have a positive effect in the treatment of a particular disorder or problem area. When an intervention is called EBS, it means the treatment has been studied, usually in an academic or community setting, and has been shown to work through repeated research studies looking at the same topic and conducted by several different research teams. In EBS research, studies typically use uniform training with a treatment manual to guide therapists step by step when treating a patient with a particular problem. In children’s mental health, a report called the “Blue Menu” groups evidence-based psychosocial interventions for the major problem areas in youth mental health into categories from Level 1 (Best Support) to Level 5 (No Support).

<table>
<thead>
<tr>
<th>Evidence-based services (EBS) refer to therapies that have been scientifically proven to have a positive effect in the treatment of a particular disorder or problem area. When an intervention is called EBS, it means the treatment has been studied, usually in an academic or community setting, and has been shown to work through repeated research studies looking at the same topic and conducted by several different research teams. In EBS research, studies typically use uniform training with a treatment manual to guide therapists step by step when treating a patient with a particular problem. In children’s mental health, a report called the “Blue Menu” groups evidence-based psychosocial interventions for the major problem areas in youth mental health into categories from Level 1 (Best Support) to Level 5 (No Support).</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A7) EBS is time intensive and can take long time to be effective.</td>
</tr>
<tr>
<td>(A14) Research provides helpful guidelines for therapy through the development of standardized manuals.</td>
</tr>
<tr>
<td>(A20) Regardless of what the evidence says, I know what works best for my child.</td>
</tr>
<tr>
<td>(A27) EBS might not be accepted by all cultures.</td>
</tr>
<tr>
<td>(A33) Treatments that work for the majority of children might not be effective for my child.</td>
</tr>
<tr>
<td>(B4) Mental health therapists who engage in other treatments when an EBS is available should be held responsible for any negative outcomes.</td>
</tr>
<tr>
<td>(B10) Therapists should help me decide the most effective treatments to use.</td>
</tr>
<tr>
<td>(B17) I would evaluate how treatment is working and demand measurable outcomes so I can ensure I am seeing changes in my child during the treatment process.</td>
</tr>
<tr>
<td>(B25) Information about my child’s problem is too hard for me to understand.</td>
</tr>
</tbody>
</table>
(B31) I do not have a clear understanding of my child's problem behaviors to make the best treatment decisions.

(B38) I don’t feel comfortable making treatment decisions for my child.

(B44) I will utilize whatever treatment services are offered to me.

(B51) I would pay for EBS even if it was not covered by my insurance.

(C7) My family's approval of services is important to me.

(C13) What my friends think I should do matters to me when choosing services.

(D7) The stigma surrounding mental health makes me hesitant to seek services of any kind for my child.

(D13) Parents and children would benefit from classes/support groups providing education on mental health issues and treatment options.

(A4) I know what to expect with EBS because it provides structure.

(A10) EBS is uncomfortable because it addresses specific symptoms.

(A17) I would prefer knowing that the intervention the therapist is using has been put through scientific rigor, and would like the therapist to show me the research they base their techniques on.

(A23) Doing what works is more important than following the evidence in every situation.

(A30) Research interventions can be affected by gender, culture, and family differences.

(A36) The steps of a standardized treatment manual should be flexibly organized and modified for my child.

(B7) There should be a regulatory body monitoring the service provision of EBS.

(B14) I have the right to decide what type of treatment techniques my child receives in sessions.

(B21) Schools should only endorse and implement EBS.

(B28) I don't know enough about EBS to form an opinion about it.

(B34) It is too difficult to recognize specific mental health problems.

(B41) I need more assistance when trying to choose a treatment or EBS for my child.

(B48) My insurance might not pay for EBS.

(C4) Choosing mental health services my pediatrician recommends is important to me.

(C10) Online resources affect the services I choose for my child.

(D4) I don't have to know what goes on in session or what therapy is being used, as long as I see progress.

(D10) Therapists should provide information on the type of treatment they provide and orient me to the treatment process (e.g., duration, expected outcomes) in language that I can understand.

(E2) I intend to seek out and obtain EBS for the treatment of my child’s problems.
APPENDIX D. EXAMPLE OF ITEM EVALUATION FORM

<table>
<thead>
<tr>
<th>Language</th>
<th>Content Validity</th>
</tr>
</thead>
<tbody>
<tr>
<td>(B16b) Before I started treatment with a particular provider, I would make sure to learn about their specialty area, credibility, and knowledge of EBS research.</td>
<td></td>
</tr>
<tr>
<td>(B28a) I don't know enough about EBS to have an opinion about it.</td>
<td></td>
</tr>
<tr>
<td>(B2a) States should not allow therapists who use other treatments when an EBS for the problem is known.</td>
<td></td>
</tr>
<tr>
<td>(B37b) The number of treatment options available is overwhelming to me.</td>
<td></td>
</tr>
<tr>
<td>(B7) There should be a regulatory body monitoring the service provision of EBS.</td>
<td></td>
</tr>
<tr>
<td>(B32) I don’t know enough about available treatments to choose an EBS for my child’s diagnosis.</td>
<td></td>
</tr>
<tr>
<td>(B21b) Schools should endorse and implement strategies that work best based upon the individual needs of each child, which may or may not include EBS.</td>
<td></td>
</tr>
<tr>
<td>(B14) I have the right to decide what type of treatment techniques my child receives in sessions.</td>
<td></td>
</tr>
<tr>
<td>(B15a) I am sure I am able to understand the research on child mental health treatment and feel it is my job to learn about successful treatments for my child’s problems.</td>
<td></td>
</tr>
<tr>
<td>(B32b) I have limited knowledge of the available treatments to choose an EBS for my child’s diagnosis.</td>
<td></td>
</tr>
<tr>
<td>(B41a) I would like more help to choose a treatment or EBS for my child.</td>
<td></td>
</tr>
<tr>
<td>(B51a) Based on a positive experience, I would pay for EBS even if it was not covered by my insurance.</td>
<td></td>
</tr>
<tr>
<td>(B49b) Since EBS involves research it is probably expensive.</td>
<td></td>
</tr>
<tr>
<td>(B35a) Not too many people know about EBS.</td>
<td></td>
</tr>
<tr>
<td>(B2) States should not license therapists who will do other treatments when an EBS for a problem has been identified.</td>
<td></td>
</tr>
<tr>
<td>(B26a) I don’t know the kind of treatment therapists are using and if it is EBS.</td>
<td></td>
</tr>
<tr>
<td>(B31a) I do not have enough of a clear understanding of my child’s problem behaviors to make the best treatment decisions.</td>
<td></td>
</tr>
<tr>
<td>(B21) Schools should only endorse and implement EBS.</td>
<td></td>
</tr>
<tr>
<td>(B48) My insurance might not pay for EBS.</td>
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<tr>
<td>(B10a) Therapists should both inform and allow me to decide the most effective treatments for my child to use.</td>
<td></td>
</tr>
<tr>
<td>(B5b) Therapists should be required to explain to their clients the EBS therapeutic interventions they are using along with its advantages and disadvantages.</td>
<td></td>
</tr>
</tbody>
</table>
(B31) I do not have a clear understanding of my child’s problem behaviors to make the best treatment decisions.

(B21a) Schools should only recommend and provide EBS.

(B10) Therapists should help me decide the most effective treatments to use.

(B44) I will utilize whatever treatment services are offered to me.

(B16) Before starting treatment with a particular provider, I would make sure to learn about their specialty, credibility and research involvement.

(B37) Treatment options overwhelm me.

(B39) I am willing to try any type of therapy, unless they harm my child physically or psychologically.

(B8b) Therapist need to be clear about what they are doing in treatment and explain the techniques they are using, so I am aware it is EBS.

(B30) EBS are not easily accessible or available to everyone.

(B25) Information about my child’s problem is too hard for me to understand.

(B42) I feel inferior and intimidated to therapists and don’t know how to challenge what they think is right.

(B20a) Schools should know about EBS and help parents access them.

(B8a) Therapists need to be clear about what they are doing in treatment and what procedure/method they are using so I know they are using EBS.

(B20) School should be knowledgeable about available EBS and help parents access them.

(B34a) It is difficult to understand how mental health problem areas (or diagnoses) are actually different from one another.

(B41) I need more assistance when trying to choose a treatment or EBS for my child.

(B15) I am confident in my ability to understand the research on child mental health treatment, and feel it is my responsibility to learn about effective treatments for my child's problems.

(B26) I don’t know what type of treatment therapists are using and if it is EBS.

(B16a) Before starting treatment with a particular provider, I would make sure to learn about their degree of experience with children like mine, reputation, and their use of EBS.

(B34) It is too difficult to recognize specific mental health problems.

(B42c) I don’t know how to challenge what therapists think is right.

(B38) I don’t feel comfortable making treatment decisions for my child.

(B18) I feel comfortable declining interventions school suggests if I feel it will not benefit my child.

(B22b) Schools should provide current and available resources (e.g., pamphlets, websites, etc) that parents can easily understand to learn more about EBS.

(B12b) If a therapist failed to provide an available EBS to me, I would consider filing a suit against him or her.

(B22a) Schools should provide helpful information (e.g., pamphlets, websites) that parents can understand to learn about EBS.

(B46) Insurance companies should only reimburse therapists who use EBS.

(B15b) I am confident and capable to understand the research provided on child mental health treatment, and feel it is my responsibility to learn and support effective treatments for my child’s diagnosis.

(B49) Since EBS involves research it is probably costly.
(B50) I would consider EBS if I knew it was covered by my insurance.
(B5) Therapists should explain the EBS they’re using in the beginning of treatment and provide information on what to expect.
(B5a) Therapists should explain the EBS they’re using before starting treatment and what to expect.
(B18a) I am okay with refusing interventions school recommends if I feel it will not help my child.
(B12a) If a therapist did not give an EBS to me that I could use, I would think about suing them/taking them to court.
(B37a) It’s sometimes hard to choose from treatment options offered to me.
(B29b) I am unsure where to find providers that provide EBS.
(B40a) I don’t have the ability to help get the treatment my child wants.
(B27) I don’t know what happens in my child’s therapy sessions.
(B26b) I am unfamiliar with the different types of EBS treatments used by therapists.
(B18b) I would feel comfortable declining a treatment suggested by my child’s school if I thought it would not benefit my child.
(B22) Schools should provide resources (e.g., pamphlets, websites) that parents can understand to learn about EBS.
(B31b) There are times that I do not have a clear understanding of my child's problem behaviors to make the best treatment decisions.
(B2b) If an EBS for the problem has been identified, states should not allow therapists who do not use EBS to be licensed.
(B13) I feel comfortable asking therapists if they are providing EBS/to provide EBS.
(B35b) Information about EBS seems relatively unknown or poorly marketed to consumers.
(B28) I don’t know enough about EBS to form an opinion about it.
(B51) I would pay for EBS even if it was not covered by my insurance.
(B17) I would evaluate how treatment is working and demand measurable outcomes so I can ensure I am seeing changes in my child during the treatment process.
(B39b) I am willing to try any type of therapy as long as it does not cause harm to my child either physically or psychologically.
(B9a) Therapists should get input from parents on all treatment decisions.
(B3) Only therapists using EBS should be allowed to treat mental health problems.
(B43) It takes a lot of persistence to get EBS.
(B35) EBS is poorly marketed to consumers.
(B25a) Information about my child’s problem is too difficult at times for me to understand.
(B49a) Since EBS takes a lot of examining, it is probably expensive.
(B46a) Insurance companies should only pay back therapists who use EBS.
(B12) If a therapist failed to provide an available EBS to me, I would consider filing a suit against them.
(B47) EBS might be too expensive for me.
(B3a) Mental health problems should only be treated by therapists who use EBS.
(B42b) I feel uncomfortable and intimidated with a therapists expertise, and don’t feel competent enough to challenge their thinking or process of what is right.
(B7b) The provision of EBS services for youth should be monitored by a regulatory body.
(B29) I don’t know where to find providers that implement EBS.
(B24) I don’t know how to tell if a treatment is evidence-based.
(B5c) Therapists should explain what the EBS does at the beginning of treatment and provide information to families and children on what they can expect in treatment.

(B29a) I don’t know where to find providers who use EBS.

(B43a) It takes a lot of effort to get EBS.

(B4) Mental health therapists who engage in other treatments when an EBS are available should be held responsible for any negative outcomes.

(B33) Therapists know more about my child’s problems than I do, so I trust them to choose the best treatment for my child.

(B32c) I don’t know enough about available treatments to choose an EBS for my child’s problem area.

(B8) Therapists need to be transparent about what they are doing in treatment and what techniques they are using so I know whether they are using EBS.

(B6) Therapists should be aware of the best practices for my child and always implement those EBS before trying other options.

(B9) Therapists should consult parents on all treatment decisions.

(B40) I don’t have the ability to influence what treatment my child will want.

(B17a) I would evaluate how treatment is working and request measurable outcomes so I can ensure I am seeing changes in my child during the treatment process.

(B39a) I am willing to try any type of therapy, unless it hurts my child physically or mentally.

(B7a) There should be a supervisory team or group monitoring the service provision of EBS.

(B42a) I am afraid of therapists because I don’t know how to question or object to their opinions.

(B24a) I would not know if a treatment is EBS.

(B32a) I don’t know enough about the different treatments out there to choose an EBS for my child’s problem.

If you feel that there are other items measuring parent intent to seek EBS based on their PERCEIVED BEHAVIORAL CONTROL, please enter them in the boxes below.

<table>
<thead>
<tr>
<th>Language</th>
<th>Content Validity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please use the dropdown option in the &quot;Language&quot; column to rate each statement on a scale from 1-4 (1 = inappropriate, 2 = slightly appropriate, 3 = appropriate and 4 = very appropriate), based on how appropriate the wording of the item is for parents.</td>
<td></td>
</tr>
<tr>
<td>In the &quot;Content Validity&quot; column please use the dropdown option to rate each statement on a scale from 1-5 (1 = poor, 2 = fair, 3 = average, 4 = good, 5 = excellent), based on the degree to which the item measures parent intent to seek EBS based on their SUBJECTIVE NORMS, or felt influence of people/groups on their treatment related decisions.</td>
<td></td>
</tr>
<tr>
<td>You also have the opportunity to add items in the blank boxes at the bottom of the list if you think there are additional topics that may influence parents’ intention to seek EBS based on their SUBJECTIVE NORMS.</td>
<td></td>
</tr>
<tr>
<td>(C8d) It is important for me to select mental health services used by other families with similar problems.</td>
<td></td>
</tr>
<tr>
<td>(C5a) Treatments psychiatrists think I should try is very important to me.</td>
<td></td>
</tr>
<tr>
<td>(C8) Choosing mental health services other families with similar experiences have chosen is important to me.</td>
<td></td>
</tr>
<tr>
<td>(C6a) Mental health recommendations from school staff are important to me.</td>
<td></td>
</tr>
<tr>
<td>(C10a) I like to check on-line for possible treatments for my child.</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td></td>
</tr>
<tr>
<td>(C8b) Being able to select a mental health service that others with similar experiences have chosen is important to me.</td>
<td></td>
</tr>
<tr>
<td>(C12a) It is important for me to follow care coordinators’ advice about mental health treatment.</td>
<td></td>
</tr>
<tr>
<td>(C10b) Information from online services influence the services I would choose for my child.</td>
<td></td>
</tr>
<tr>
<td>(C2a) People who mean a lot to me would want me to choose EBS for my child.</td>
<td></td>
</tr>
<tr>
<td>(C11b) Parent advocates' opinions matter and influence the service I would choose for my child.</td>
<td></td>
</tr>
<tr>
<td>(C5) Treatments psychiatrists think I should do matters to me.</td>
<td></td>
</tr>
<tr>
<td>(C5b) A treatment recommended by a psychiatrist is important to me.</td>
<td></td>
</tr>
<tr>
<td>(C8c) I like to check with other parent groups to ask what they think about treatments for children with symptoms similar to mine.</td>
<td></td>
</tr>
<tr>
<td>(C5c) Psychiatrists’ opinions of what treatments I should do matters to me.</td>
<td></td>
</tr>
<tr>
<td>(C4) Choosing mental health services my pediatrician recommends is important to me.</td>
<td></td>
</tr>
<tr>
<td>(C12) Doing what care coordinators think I should do is important to me.</td>
<td></td>
</tr>
<tr>
<td>(C3) I feel under social pressure to obtain EBS for my child.</td>
<td></td>
</tr>
<tr>
<td>(C7) My family's approval of services is important to me.</td>
<td></td>
</tr>
<tr>
<td>(C8a) Choosing mental health services other people with similar situations have chosen is important to me.</td>
<td></td>
</tr>
<tr>
<td>(C6) Mental health services school staff think I should use matters to me.</td>
<td></td>
</tr>
<tr>
<td>(C10c) The availability of online resources affects the services I choose for my child.</td>
<td></td>
</tr>
<tr>
<td>(C2) People who are important to me would want me to choose EBS for my child.</td>
<td></td>
</tr>
<tr>
<td>(C13) What my friends think I should do matters to me when choosing services.</td>
<td></td>
</tr>
<tr>
<td>(C11a) When choosing services, I consider what parent supporters think is best.</td>
<td></td>
</tr>
<tr>
<td>(C10) Online resources affect the services I choose for my child.</td>
<td></td>
</tr>
<tr>
<td>(C11) What parent advocates think I should do matters to me when choosing services.</td>
<td></td>
</tr>
<tr>
<td>(C9) The treatment team's approval of my treatment decision is important to me.</td>
<td></td>
</tr>
</tbody>
</table>

**If you feel that there are other items measuring parent intent to seek EBS based on their SUBJECTIVE NORMS, please enter them in the boxes below.**

Please use the dropdown option in the "Language" column to rate each definition of EBS on a scale from 1-4 (1 = inappropriate, 2 = slightly appropriate, 3 = appropriate and 4 = very appropriate), based on how appropriate the wording of the item is for parents. In the "Content Validity" column please use the dropdown option to rate each definition on a scale from 1-5 (1 = poor, 2 = fair, 3 = average, 4 = good, 5 = excellent), based on the degree to which the item measures the construct of EVIDENCE-BASED SERVICES.
(5) “Evidence-based services” (EBS) is a term you will hear used to describe psychological treatments that have been scientifically proven to help children with a particular problem or diagnosis. When a treatment is classified as an EBS, this means that it has obtained research support at a very high level. In order to be classified as an EBS, a treatment must have been shown to benefit clients with the same diagnosis or problem area in multiple studies using different research teams. EBS research is typically conducted in university or community settings. In these studies, therapists typically use a treatment manual to help them deliver treatment in a step-by-step way. EBS for children are summarized in a report which you will hear referred to as the “Blue Menu.” On the Blue Menu, treatments are grouped both by problem area and by level of research support obtained. There are 5 levels in this system. Level 1 treatments are those treatments that have received the most research support. Level 5 treatments are those that have no research support. There are other levels in between.

(6) Evidence-based services (EBS) refer to therapies that have been scientifically proven to have a positive effect in the treatment of a particular disorder or problem area. When an intervention is called EBS, it means the treatment has been studied, usually in an academic or community setting, and has been shown to work through repeated research studies looking at the same topic and conducted by several different research teams. In EBS research, studies typically use consistent training with a treatment manual to guide therapists step by step when treating a patient with a particular problem. In children’s mental health, a report called the “Blue Menu” separates evidence-based psychosocial interventions for the major problem areas in youth mental health into categories from Level 1 (“Best Support”) to Level 5 (“No Support”).

(7) Evidence-based services (EBS) refer to treatments that have been clinically proven to produce a positive effect in the treatment of a particular problem area. Evidence-based services are treatments that have been shown through clinical research to be effective. In EBS research, studies typically use uniform training with a treatment manual to guide therapists step by step when treating a patient with a particular problem. In children's mental health, a report called the "Blue Menu" groups evidence-based psychosocial interventions for the major problem areas in youth mental health into categories from Level 1 (Best Support) to Level 5 (No Support).
APPENDIX E. FINAL MEASURE ITEMS ORGANIZED BY DOMAIN

ATTITUDES

1. EBS have a history of being effective.
2. A good therapist will use treatments that have been supported by evidence.
3. Treatments with low levels of support may still be effective for my child and should not be disregarded if they appear to be working.
4. Using EBS will improve mental health services.
5. EBS categorizes and then addresses specific symptoms, which may make the information an uncomfortable process for some families.
6. EBS can feel impersonal.
7. EBS requires patience; the process is time consuming and can take a while to show its effectiveness.
8. If I was shown various treatment choices, I would be more likely to choose the one with the most positive results.
9. I would prefer knowing that the intervention the therapist is using has been put through strict scientific tests or studies, and would like the therapist to show me the research they base their techniques on.
10. Research provides a good foundation for therapy since it has been shown to work for a wide range of people.
11. Research based treatments need to be used exactly in the manner they were developed in order to work.
12. Scientific studies cannot show that treatments work for the long term.
13. Research gets in the way of choosing what you want.
14. A therapist does not need to use EBS to be effective.
15. Doing what works is more important than following the evidence in every situation.
16. EBS do not agree with all cultures.
17. Research interventions can be affected by gender, culture, and family differences.
18. The steps of a standardized treatment manual should be flexibly organized and modified for my child.
19. Some EBS might conflict with certain cultural values.
20. Studies done with populations across the mainland are not conducted with samples that adequately represent the population of youth in my area.
21. I do not know whether EBS can help my child’s individual needs.
22. Treatments that work for the majority of children might not be effective for my child.
23. A therapist should not choose a treatment just based on the fact that it was helpful for another similar child.

PERCEIVED BEHAVIORAL CONTROL

1. Therapists should explain the EBS they're using in the beginning of treatment and provide information on what to expect.
2. Therapists should be aware of the best practices for my child and always implement those EBS before trying other options.
3. Therapist need to be clear about what they are doing in treatment and explain the techniques they are using, so I am aware it is EBS.
4. Therapists should help me decide the most effective treatments to use.
5. Mental health problems should only be treated by therapists who use EBS.
6. Mental health therapists who engage in other treatments when EBS are available should be held responsible for any negative outcomes.
7. I feel comfortable asking therapists if they are providing EBS/to provide EBS.
8. I have the right to decide what type of treatment techniques my child receives in sessions.
9. Before starting treatment with a particular provider, I would make sure to learn about their degree of experience with children like mine, reputation, and their use of EBS.
10. I would evaluate how treatment is working and demand measurable outcomes so I can ensure I am seeing changes in my child during the treatment process.
11. I am confident in my ability to understand the research on child mental health treatment, and feel it is my responsibility to learn about effective treatments for my child's problems.
12. School should be knowledgeable about available EBS and help parents access them.
13. Schools should provide helpful information (e.g., pamphlets, websites) that parents can understand to learn about EBS.
14. Schools should only recommend and provide EBS.
15. I would not know if a treatment is EBS.
16. I don’t know what type of treatment therapists are using and if it is EBS.
17. I don’t know enough about the different treatments out there to choose an EBS for my child’s problem.
18. I don’t know enough about EBS to form an opinion about it.
19. I don’t know where to find providers who use EBS.
20. I do not have a clear understanding of my child’s problem behaviors to make the best treatment decisions.
21. I don’t know enough about available treatments to choose an EBS for my child's problem area.
22. EBS are not easily accessible or available to everyone.
23. Therapists know more about my child’s problems than I do, so I trust them to choose the best treatment for my child.
24. I don’t know what happens in my child’s therapy sessions.
25. I would like more help to choose a treatment or EBS for my child.
26. I don’t feel comfortable making treatment decisions for my child.
27. I will utilize whatever treatment services are offered to me.
28. Treatment options overwhelm me.
29. It takes a lot of effort to get EBS.
30. I am willing to try any type of therapy, unless it hurts my child physically or mentally.
31. I don't know how to challenge what therapists think is right.
32. I would consider EBS if I knew it was covered by my insurance.
33. I would pay for EBS even if it was not covered by my insurance.
34. EBS might be too expensive for me.
35. My insurance might not pay for EBS.
SUBJECTIVE NORM

1. People who mean a lot to me would want me to choose EBS for my child.
2. It is important for me to select mental health services used by other families with similar problems.
3. I like to check online for possible treatments for my child.
4. My family's approval of services is important to me.
5. Choosing mental health services my pediatrician recommends is important to me.
6. Mental health recommendations from school staff are important to me.
7. Parent advocates' opinions influence the service I would choose for my child.
8. A treatment recommended by a psychiatrist is important to me.
9. Choosing mental health services the school counselor recommends is important to me.
10. A treatment recommended by a psychologist is important to me.
11. Mental health recommendations from therapists are important to me.

GENERAL TREATMENT FACTORS

1. Mental health treatments should work quickly and correctly to have an impact.
2. Therapist should provide information on the type of treatment they provide and inform me about the treatment process (e.g., duration, expected outcomes) in language that I can understand.
3. The most important factor above all other treatment components is that the therapist has a good relationship/connection with my child and my family.
4. The location of the services is most important to my treatment decision.
5. I don’t have the time and energy to participate in (my child’s) mental health treatment.
6. Therapists should explain all available options for my child, including different services out there, in an open-minded way.
7. Parents and children would benefit from classes/support groups providing education on mental health issues and treatment options.
8. I don’t understand how the system works or know how to receive services.
9. The stigma surrounding mental health makes me hesitant to seek services of any kind for my child.
10. If services are free, I am not as concerned with what type of treatment they are providing.
11. I don't have to know what goes on in session or what therapy is being used, as long as I see progress.

BEHAVIORAL INTENTION

1. I intend to seek out EBS for the treatment of my child's problems.
2. I expect to obtain EBS for the treatment of my child's problems.
3. I want to use EBS for the treatment of my child's problems.
APPENDIX F: THE PARENT ENGAGEMENT IN EVIDENCE-BASED SERVICES QUESTIONNAIRE

PEEBS
The following questionnaire has been developed to look at parents’ opinions regarding the use of evidence-based services in mental health treatment.

Evidence-based services (EBS) refer to therapies that have been scientifically proven to have a positive effect in the treatment of a particular disorder or problem area. When an intervention is called EBS, it means the treatment has been studied, usually in university or clinical settings, and has been shown to work through repeated research studies looking at the same topic and conducted by several different research teams. In EBS research, studies typically use uniform training with a treatment manual to guide therapists step by step when treating a patient with a particular problem. In children’s mental health, a report called the “Blue Menu” shows evidence-based interventions for the major problem areas in youth mental health and ranks them into categories from Level 1 (Best Support) to Level 5 (No Support).

Please respond to the following items based on how much you agree with each sentence.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. EBS have a history of being effective.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I am confident in my ability to understand the research on child mental health treatment, and feel it is my responsibility to learn about effective treatments for my child’s problems.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I don’t know where to find providers who use EBS.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Some EBS might conflict with certain cultural values.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I like to check online for possible treatments for my child.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. I would consider EBS if I knew it was covered by my insurance.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>7. EBS categorizes and then addresses specific symptoms, which may make the information an uncomfortable process for some families.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. I would evaluate how treatment is working and demand measurable outcomes so I can ensure I am seeing changes in my child during the treatment process.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. People who mean a lot to me would want me to choose EBS for my child.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Treatments that work for the majority of children might not be effective for my child.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Therapists should help me decide the most effective treatments to use.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Using EBS will improve mental health services.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. I am willing to try any type of therapy, unless it hurts my child physically or mentally.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. I feel comfortable asking therapists if they are providing EBS/to provide EBS.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Therapist should provide information on the type of treatment they provide and inform me about the treatment process (e.g., duration, expected outcomes) in language that I can understand.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>16. I am okay with refusing interventions school recommends if I feel it will not help my child.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Neutral</td>
<td>Agree</td>
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<tr>
<td>17.</td>
<td>Therapist need to be clear about what they are doing in treatment and explain the techniques they are using, so I am aware it is EBS.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>I want to use EBS for the treatment of my child's problems.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>I don’t know what happens in my child’s therapy sessions.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>A treatment recommended by a psychiatrist is important to me.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>School should be knowledgeable about available EBS and help parents access them.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>The location of the services is most important to my treatment decision.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>Therapists know more about my child’s problems than I do, so I trust them to choose the best treatment for my child.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>Mental health therapists who engage in other treatments when EBS are available should be held responsible for any negative outcomes.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>I have the right to decide what type of treatment techniques my child receives in sessions.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>Therapists should be aware of the best practices for my child and always implement those EBS before trying other options.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27.</td>
<td>I don’t know enough about EBS to form an opinion about it.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28.</td>
<td>My insurance might not pay for EBS.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29.</td>
<td>Before starting treatment with a particular provider, I would make sure to learn about their degree of experience with children like mine, reputation, and their use of EBS.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30.</td>
<td>It is important for me to select mental health services used by other families with similar problems.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31.</td>
<td>I don’t know what type of treatment therapists are using and if it is EBS.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32.</td>
<td>EBS can feel impersonal.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33.</td>
<td>I do not know whether EBS can help my child’s individual needs.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34.</td>
<td>If services are free, I am not as concerned with what type of treatment they are providing.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35.</td>
<td>EBS requires patience; the process is time consuming and can take a while to show its effectiveness.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36.</td>
<td>Therapists should explain the EBS they're using in the beginning of treatment and provide information on what to expect.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37.</td>
<td>Mental health problems should only be treated by therapists who use EBS.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
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<tr>
<td>38.</td>
<td>Choosing mental health services my pediatrician recommends is important to me.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>39.</td>
<td>My family's approval of services is important to me.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40.</td>
<td>Studies done with populations across the mainland are not conducted with samples that adequately represent the population of youth in my area.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>41.</td>
<td>I don’t understand how the system works or know how to receive services.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>42.</td>
<td>I will utilize whatever treatment services are offered to me.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Neutral</td>
<td>Agree</td>
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</tr>
<tr>
<td>43.</td>
<td>I don’t know enough about available treatments to choose an EBS for my child's problem area.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>44.</td>
<td>The steps of a standardized treatment manual should be flexibly organized and modified for my child.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>45.</td>
<td>I would pay for EBS even if it was not covered by my insurance.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>46.</td>
<td>A therapist should not choose a treatment just based on the fact that it was helpful for another similar child.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>47.</td>
<td>I intend to seek out EBS for the treatment of my child's problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>48.</td>
<td>Research interventions can be affected by gender, culture, and family differences.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>49.</td>
<td>I don’t know enough about the different treatments out there to choose an EBS for my child’s problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>50.</td>
<td>Therapists should explain all available options for my child, including different services out there, in an open-minded way.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>51.</td>
<td>EBS are not easily accessible or available to everyone.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>52.</td>
<td>I would prefer knowing that the intervention the therapist is using has been put through strict scientific tests or studies, and would like the therapist to show me the research they base their techniques on.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>53.</td>
<td>I do not have a clear understanding of my child's problem behaviors to make the best treatment decisions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>54.</td>
<td>A treatment recommended by a psychologist is important to me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>55.</td>
<td>EBS do not agree with all cultures.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>56.</td>
<td>Treatment options overwhelm me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>57.</td>
<td>A therapist does not need to use EBS to be effective.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>58.</td>
<td>Parents and children would benefit from classes/support groups providing education on mental health issues and treatment options.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>59.</td>
<td>Mental health recommendations from school staff are important to me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>60.</td>
<td>It takes a lot of effort to get EBS.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>61.</td>
<td>I would not know if a treatment is EBS.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>62.</td>
<td>Choosing mental health services the school counselor recommends is important to me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>63.</td>
<td>I don't know how to challenge what therapists think is right.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>64.</td>
<td>I would like more help to choose a treatment or EBS for my child.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>65.</td>
<td>Mental health recommendations from therapists are important to me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>66.</td>
<td>Schools should only recommend and provide EBS.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>67.</td>
<td>I don’t have the time and energy to participate in (my child’s) mental health treatment.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>68.</td>
<td>Research gets in the way of choosing what you want.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>69.</td>
<td>Schools should provide helpful information (e.g., pamphlets, websites) that parents can understand to learn about EBS.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>70.</td>
<td>The stigma surrounding mental health makes me hesitant to seek services of any kind for my child.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>71.</td>
<td>EBS might be too expensive for me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Neutral</td>
<td>Agree</td>
</tr>
<tr>
<td>---</td>
<td>------------------</td>
<td>----------</td>
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<td>-------</td>
</tr>
<tr>
<td>72</td>
<td>A good therapist will use treatments that have been supported by evidence.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>73</td>
<td>Research provides a good foundation for therapy since it has been shown to work for a wide range of people.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>74</td>
<td>Research based treatments need to be used exactly in the manner they were developed in order to work.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>75</td>
<td>If I was shown various treatment choices, I would be more likely to choose the one with the most positive results.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>76</td>
<td>I don’t feel comfortable making treatment decisions for my child.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>77</td>
<td>I expect to obtain EBS for the treatment of my child's problems.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>78</td>
<td>Doing what works is more important than following the evidence in every situation.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>79</td>
<td>Treatments with low levels of support may still be effective for my child and should not be disregarded if they appear to be working.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>80</td>
<td>Scientific studies cannot show that treatments work for the long term.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>81</td>
<td>Parent advocates’ opinions influence the service I would choose for my child.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>82</td>
<td>Mental health treatments should work quickly and correctly to have an impact.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>83</td>
<td>The most important factor above all other treatment components is that the therapist has a good relationship/connection with my child and my family.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>84</td>
<td>I don’t have to know what goes on in session or what therapy is being used, as long as I see progress.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
REFERENCES


of research in an integrated mental health service. *Issues in Mental Health Nursing*, 28, 341-358.


