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Is It Easy to Use and Useful? Mental Health Professionals' Perspectives Inform Development of a Novel Treatment Engagement System for Youth Mental Health Services

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User experiences are essential to the adoption of an intervention and can be integral to intervention design. We applied two concepts from the technology acceptance model (i.e., perceived ease of use, perceived utility) to understand how mental health professionals experienced a novel system of resources (i.e., engagement system) designed to improve problem identification, coordination, and treatment planning decisions related to addressing problems of low treatment engagement in school mental health services. We conducted a 1-hour focus group with 10 mental health professionals (provider n = 8, supervisor n = 2) using prompts to elicit their perspectives about the effort involved in using the engagement system and about the usefulness of the system in their work. The focus group was transcribed and segmented into 70 excerpts by trained coders. We analyzed the transcript using a consensual qualitative research approach. Ease of use was coded in 15 (39%) excerpts and utility was coded in 24 (61%) excerpts. The valences of excerpts were neutral (n = 18; 46%), positive (n = 10; 26%), and negative (n = 11; 28%). Thirty-nine (56%) excerpts discussed the engagement system. Excerpts pertained to problem identification (n = 18; 46%), coordination (n = 18; 46%), and treatment planning (n = 3; 8%). Findings revealed that resources and procedures were rated differently on their perceived ease of use and utility. Participants reported that the coordination resource had high utility and positively impacted their clinical practice and supervision, while the problem identification resources had low ease of use and were burdensome or difficult to use. Some lessons learned include the value of designing resources that provide structure to clinical decision processes yet allow for some flexibility, the need for simpler and automated procedures to reduce provider burden, and the importance of clear guidelines on how resources should and should not be used. We used this feedback to inform changes to the engagement system prior to testing in a randomized trial. This brief report highlights how applying the technology acceptance model to evaluate interventions can aid in the successful implementation of novel clinical interventions.

Discussion around intervention design has become a topic of growing importance, especially within mental health services research, due to its potential impact on implementation outcomes. Indeed, scholars have called attention to the importance of intervention characteristics by leveraging user- or human-centered design approaches to maximize the reach and impact of mental health interventions (Lyon & Koerner, 2016; Lyon et al., 2020). However, intervention design has yet to be widely prioritized (Lyon et al., 2020), though some bodies of research have attempted to expand our collective knowledge of how intervention characteristics and design influence its use.

In the youth mental health field, evidence suggests that mental health intervention users are sensitive to factors of intervention design. For example, in one study, community providers rated a modular treatment as more effective and satisfying compared to other standard treatment designs (Chorpita et al., 2015). In another study, providers differentially rated the appeal and limitations of five distinct treatments, further suggesting that providers are sensitive to intervention features (Reding et al., 2014). Moreover, the more appealing providers viewed a treatment, the more they reported using it (Reding et al., 2014). Ideas about

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how intervention developers incorporate user perspectives are becoming more prominent. For example, in youth mental health services, scholars have advocated for models of treatment design allow for the coordination of research and evidence resources in ways that allow providers to design tailored treatments in context for specific cases (e.g., elevating youth and family preferences to guide prioritization of treatment goals and/or treatment selection)—in this way, the user perspective is integral throughout the design and delivery of mental health services (Chorpita & Daleiden, 2014, 2018).

In the digital mental health field, scholars have urged intervention developers to adopt "design thinking" principles to enhance the impact and reach of digital mental health interventions (Scholten & Granic, 2019). Design thinking involves leveraging a human-centered approach to understand user experiences, gaining interdisciplinary perspectives about the intervention, and iterative testing with the end users during the intervention development process (Scholten & Granic, 2019). Employing design thinking in intervention development is likely to yield positive user and implementation outcomes. For example, utilizing these principles in the development of a novel youth e-mental health service was associated with high acceptance of the intervention (Alvarez-Jimenez et al., 2020). Similarly, understanding professionals' perceptions of and experiences with interventions as a means of refining intervention designs can aid in intervention adoption and implementation (Scholten & Granic, 2019). Taken together, the literature underscores the importance of learning from user perceptions of interventions.

The technology acceptance model (TAM; Davis, 1989) is a widely used model from the field of information technology. It posits that two constructs are related to the user experience of an innovation: (a) perceptions that the innovation will require low effort (ease of use) and (b) perceptions that the innovation will enhance productivity (utility or usefulness). Subsequent iterations of the TAM (e.g., TAM2: Venkatesh & Davis, 2000; unified theory of adoption and use of technology: Venkatesh et al., 2003) have included additional constructs (e.g., subjective norms, enjoyment, habit) as determinants of ease of use and utility. Research demonstrates that perceived ease of use and utility mediate the relationship between the features of the innovation and an individual's behavioral intentions to use and their actual use of an innovation (e.g., Al-Qeisi et al., 2014; Davis, 1993; Dohan & Tan, 2013; Venkatesh, 2000).

The TAM might be relevant when considering how mental health professionals perceive interventions, given its application in other disciplines. For example, the TAM has been used to evaluate the implementation of an acute telemedicine program for nurses (Bagot et al., 2020), the acceptability of student assistive technology by special education teachers (Nam et al., 2013), and adolescents' experiences with a digital physical activity intervention (Drehlich et al., 2020). While there are many implementation theories and frameworks, such as the theory of planned behavior (Ajzen, 1985), or the consolidated framework for implementation research (CFIR; Damschroder et al., 2009), the TAM's conceptual model focuses on users' perceptions of the specific innovation. Moreover, the TAM overlaps with some constructs described in the CFIR—namely, the constructs of complexity and relative advantage. However, these constructs may not reflect user perceptions of the intervention, as an intervention may be complex in design but relatively easy to use for users. The TAM thus offers a simple conceptual model to understand how intervention characteristics are perceived by its users.

In this brief report, we describe how the TAM was applied to understand mental health professionals' experiences with a novel set of mental health resources. Specifically, we piloted an engagement system (ES; i.e., a collection of engagement-focused resources that work together) designed to help mental health professionals use evidence when making decisions about cases that were at risk for discontinuing treatment due to engagement concerns (Becker et al., 2019). Our initial pilot study revealed that the ES was generally feasible and acceptable (Becker et al., 2019). However, given that a key function of pilot studies is to identify areas for improvement or modifications before conducting a larger-scale trial (Leon et al., 2011), we needed a more nuanced understanding of users' perspectives on the ES. Additionally, some of the ES resources and procedures were novel from the typical resources that mental health professionals use in routine care. Thus, we conducted a focus group to elicit user perspectives about the ES resources and procedures, and coded responses according to the TAM constructs of ease of use and utility. We hypothesized that participants would perceive high utility of the ES, such that they would report that the ES gave them useful ideas about how to address engagement challenges they encounter in their work with youth and caregivers. However, given the novel and potentially complex design features of the ES, we hypothesized that participants might report initial low ease of use.

Method

Participants

Participants were school mental health providers (n = 8) and their supervisors (n = 2). They ranged in

age from 28 to 47 ($M = 37.8$, $SD = 6.09$). They identified as Spanish/Latino (60%), Asian/Asian American (20%), Black/African American (10%), and White/European American (10%). All participants were female, fluent in English (60% Spanish–English bilingual), and had obtained a master's degree in social work.

Engagement System

The ES, which we formally referred to as a coordinated knowledge system (CKS; Becker et al., 2019), included multiple resources to support a process of decisions and activities related to (a) problem identification; (b) coordination, which refers to the selection of a well-suited clinical procedure for the identified problem; and (c) planning for the implementation of the chosen clinical procedure. Problem identification was facilitated by a 35-item engagement survey completed by youth and caregivers about their experiences receiving school mental health services. Additionally, mental health professionals reflected on a separate series of questions about their perspectives of youth and caregiver engagement problems. Coordination was supported by a two-page worksheet that guides clinical reasoning about how to prioritize problems and select well-fitting solutions from a menu of options appropriate for the identified problem. Planning for the implementation of the chosen clinical procedure was supported by a library of 12 two-page guides that each outlined steps for delivering an engagement procedure. Providers and their supervisors were instructed to use the ES together within the context of clinical supervision by reviewing data relevant to problem identification, completing the coordination worksheet to select a relevant engagement procedure, and preparing for treatment by reviewing the relevant clinical materials from the library of guides.

Providers and supervisors participated in a 6-hour training during which they learned how to carry out study procedures (e.g., consent for youth and caregivers, recording of supervision) and how to use the ES resources and procedures. Training included extensive discussion, modeling, and rehearsal (e.g., role play of how to record a supervision conversation while using the coordination worksheet). A full description of the ES, training, and pilot trial can be found in Becker et al., 2019.

Procedure

A 1-hour focus group was held at a local school after the completion of the pilot study. Providers and supervisors from the pilot study were invited via e-mail and all attended. Informed consent was obtained from participants. The focus group was facilitated in person by M.M.B., A.L.P., and B.F.C. K.D.B. joined the focus group via phone. The facilitators included three females and one male. The facilitators used a rationally derived set of 14 prompts organized by the TAM constructs to guide the focus group. The prompts were designed to elicit perspectives around the ease of use and utility of the ES resources and procedures pertaining to problem identification (e.g., "What was it like to use the engagement survey scoring system?"), coordination (e.g., "What was your experience filling out the worksheet in supervision?"), and treatment planning (e.g., "What other aspects would you like from the guides?"). Specifically, for ease of use, participants were asked to describe challenges and successes with learning and using each of the ES resources and procedures. For utility, participants were asked to reflect on the helpfulness of the ES in supervision and with planning for treatment. Additional prompts elicited suggestions to improve the ES resource and procedures. Notes were taken and an audio recording of the focus group was later transcribed by research assistants. The pilot trial and focus group were approved by the Institutional Review Boards at the University of California, Los Angeles and the Los Angeles Unified School District.

Coding

A consensual qualitative research methodology (Hill et al., 1997) was used to code the focus group transcript. Coders were one postbaccalaureate student, one doctoral student, and one postdoctoral scholar. Prior to coding, two coders separately identified excerpts (i.e., a collection of quotes on a single topic) and met to finalize the set of excerpts for the transcript. The purpose of excerpting was to create meaningful units of analysis within the transcript, allowing coders to easily navigate the transcript and assign descriptive codes to sections of text (Saldaña, 2015). Seventy excerpts were identified and coded. Excerpts included discussion of the ES resources and procedures, as well as general study procedures (e.g., how to use a recording device) that were not focal to this current study. Conversations unrelated to the focus group (e.g., comments about catering) were not excerpted. After excerpting the transcript, two coders met to identify codes for the qualitative codebook. Codes were categorized into a theme, subtheme, or valence. Theme codes pertained to the ES procedures and resources (problem identification–engagement survey, coordination–worksheet, treatment planning–guides) and subtheme codes pertained to a TAM construct (ease of use and utility). Valence codes included positive, negative, and neutral. Two coders independently coded the transcript (i.e., assigning a theme,

subtheme, and valence to excerpts) and then met to establish consensus. A third coder was trained to code the transcript. All coding was recorded using Microsoft Excel. Interrater reliability was calculated using Cohen's kappa by comparing the consensus coding with the third coder's responses. Reliability ranged from substantial agreement to almost perfect agreement (Landis & Koch, 1977). Valence had the highest interrater agreement ($\kappa = .86$), followed by theme ($\kappa = .81$) and subtheme ($\kappa = .75$).

Results

The ES resources and procedures were mentioned in 39 of 70 (56%) excerpts. Of these excerpts, the valences were neutral ($n = 18$; 46%), negative ($n = 11$; 28%), and positive ($n = 10$; 26%). Excerpts pertained to problem identification ($n = 18$; 46%), coordination ($n = 18$; 46%), and treatment planning ($n = 3$; 8%). Ease of use was coded in 15 (39%) excerpts and utility was coded in 24 (61%) excerpts.

Problem Identification

Ease of Use

Comments about ease of use of the engagement survey were predominantly negative. Participants stated that clients "felt uncomfortable" responding to the survey in front of providers. Participants also had challenges in learning how to score the survey and administer the survey alongside other demands related to their clinical practice.

> It is difficult when we are trying to engage with them, with throwing them . . . a lot of documentation and a lot of paperwork already—so throwing in another questionnaire was . . . an added burden . . . challenge for the families.

Utility

Participants had some concerns about the survey's utility, mostly speaking to the validity of survey responses. For example, there were concerns about whether client responses were influenced by external factors, such as whether the case was transferred from another provider, the timing in which the survey was delivered, or cultural factors.

> I had a couple [clients] that were transferred to me so they had a previous clinician, so I was kind of beginning with them again, but they had had . . . some experience in therapy, so that's going to affect how they answer.

> Just thinking culturally too, a lot of the parents are Spanish speaking. They're not going to say anything about the therapist. . . . They are just going to say, "Oh yeah, that's great."

Coordination

Ease of Use

Comments about ease of use of the coordination worksheet that supported clinical decision making were mostly neutral or positive. Providers and supervisors said the worksheet helped with expectations during clinical supervision and described how it became easier to use when completing the resource together.

> I found it helpful doing it together because [supervisors] knew what we were going to talk about with the client. . . . A lot of the times in supervision, you go off on different things [and] this really helped us focus.

> It seemed very scripted to me, helpful because it was kind of scripted because [supervisors] would give me the sheet and I would prep for the supervision. So, I already kind of knew in my mind what we were going to be touching on and discussing.

Some providers and supervisors experienced challenges understanding how to use the worksheet for their clients—for example, participants described how the worksheet was "confusing" due to uncertainty about whether the youth or caregiver was the target of the ES.

> Some of the questions were confusing because . . . we couldn't tell [what clients] were talking about, was it themselves or the parent. . . . It was just a family questionnaire, about the family, but the way the clinicians were filling it out, sometimes they were responding to those questions based on their relationship with the client or with the parent.

Utility

With regard to the worksheet's utility, there were comments that the structured aspect of the worksheet may not work for all providers or supervisors and seemed to be "very rehearsed." Other participants reported liking the additional structure that the worksheet provided to supervision and reported that it contributed to their clinical practice by helping them consider different domains of engagement, and by facilitating problem selection and treatment planning.

> It increased my awareness of how maybe I need to work more on clarity and roles and expectations, and really emphasizing that at the beginning so that in 6 weeks we're not kind of lost and often on different tangents.

> Going through [the worksheet] together really helped us to pick an area to emphasize. I found myself asking the clinicians, "When you filled this out, who did you have in mind, the parent or the client?" and then to decide on the practice.

> I really appreciated the format and structure. . . . We don't always go back and do so much reflection and comprehensive assessment on each piece. Especially for the more difficult families, I think this is a really useful tool because you address so many different pieces.

Treatment Planning

Ease of Use and Utility

Ease of use of the library of the two-page guides was discussed briefly by participants.One participant shared how they might select a guide to plan a specific clinical engagement procedure. To improve the utility of the treatment planning resources, providers and supervisors suggested supplementing the guides with additional resources.

> I think making it clear that there are some practice guides or practice elements that weren't listed. . . . We were adding stuff that wasn't on the list, so make it clear that these are not the only things that could be used. . . . We found ourselves adding to what was in place, so not necessarily finding what was in place appropriate.

Discussion

We examined a focus group transcript to understand mental health professionals' perceptions about a novel ES using codes derived from the TAM (Davis, 1989). Specifically, we asked mental health providers and supervisors about their experiences using the ES resources and procedures, and what suggestions they had for improving the ES; we coded their responses according to perceptions of ease of use and utility. We found that while some resources were difficult to use at first, the ES generally had adequate to high utility or usefulness to clinical practice. We briefly describe below what we learned, how participant feedback shaped the next iteration of resources to be tested in a larger trial, and what steps intervention developers might consider in the future.

One of our aims was to understand the ease of use regarding the ES resources and procedures, because perceptions that an intervention will require low effort is associated with an individual's initial use of that intervention (Davis, 1989). Participants initially had difficulty delivering and scoring the engagement survey alongside their existing administrative duties and had difficulty differentiating whether the coordination worksheet was to be completed with the youth or caregiver in mind. This alerted the research team that the higher effort associated with these resources might reduce the likelihood of their future use. We made changes based on this feedback. For example, we offered multiple options for survey administration, including the original paper-and-pencil format, as well as a web-based format. For both formats, front office staff assumed responsibility for survey administration, thereby reducing burden and increasing response confidentiality. Curated feedback by the research team to participants that yielded overall survey scores, rather than responses to individual survey items, also addressed concerns about confidentiality and reduced the burden of manually scoring the survey. We also added instructions on the worksheet to specify that the tool can be used for either youth or caregiver, allowing professionals to use their clinical judgment on which target might benefit most from an engagement intervention. To increase the ease of use of novel interventions, intervention developers might consider designing resources that fit into professionals' current practices or that can be automated to reduce burden, and to provide clear guidelines on how the intervention is intended or not intended to be used.

Another aim was to understand the perceived utility of the intervention because usefulness is a key indicator of sustained use (Venkatesh, 2000; Venkatesh & Davis, 2000). Overall, there was generally positive perceived utility, which meant that if we could increase the ease of use, there might be a chance for sustained use. Still, we gathered feedback that informed adjustments for improving the utility of the ES. For example, in response to concerns about the timing of the survey, we adopted participant recommendations to administer the survey approximately 4 weeks into treatment, when youth and caregivers have a better understanding of what treatment involves. While some participants highlighted that the worksheet was too structured or not useful in cases without engagement problems, others mentioned how the resource provided desired structure to supervision sessions, which supported providers in creating and implementing a clear plan to address the specific engagement problem. To increase the utility of intervention resources, intervention developers might consider how flexibility can be integrated into the resources and procedures while at the same time providing guided prompts and structured points to facilitate decision-making processes.

Limitations

There are several limitations to our study. The sample size was small, though all participants who piloted the ES agreed to participate in the focus group. The focus group transcript did not denote the speakers—thus, we were unable to associate the speaker's role, provider or supervisor, with each excerpt. Distinguishing speaker roles may provide more detailed information about whether user perceptions of the ES vary accord-

ing to role. The focus group was conducted with both providers and supervisors, which may have contributed to a power imbalance and compromised the candidness of participant responses during the focus group. However, participants were informed of this composition beforehand to set clear expectations and were oriented to the purpose of the focus group, which was to provide their perspectives on the ES resources and procedures, rather than the dynamics of supervision.

Conclusions

The TAM provided a framework for understanding mental health professionals' perspectives on the ES, which mapped on to the recommendation on how to improve this ES in anticipation for a larger trial. The implications of this work highlight the need to attend to mental health professionals' perceptions and experiences throughout clinical intervention development and implementation. Moreover, the emphasis on ease of use and utility helped us structure our thinking and make specific changes to improve the intervention. Traditionally, interventions are treated as fixed entities whose implementation outcome is focused on the extent to which the intervention is used as intended (Real & Poole, 2005). Rather, intervention developers might consider a modification approach, whereby a promising intervention can be enhanced through additional fine-tuning that is informed by the perspectives of mental health professionals about their implementation (Real & Poole, 2005).

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