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RESEARCH ARTICLE

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I heard it through the grapevine: Where and what parents learn about youth mental health treatments

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Abstract

Objective: This study investigates where parents learn about, and what parents know about child mental health services. Parents who are better informed about mental health services may be more likely to utilize services for their children.

Methods: In a national online survey, 196 parents of children between the ages of 4 and 17 years reported on their information-seeking behaviors and their familiarity and experience with psychosocial approaches.

Results: Parents reported utilizing multiple information sources with mental health providers, pediatricians, and social networks being the most prominent. Parents' trust in different sources varied, with parents generally trusting healthcare professionals the most. Parents exposed to mental health services were more aware of specific therapeutic approaches.

Conclusions: Data on how parents receive and understand mental health-related information contributes to ongoing dissemination and implementation efforts.

KEYWORDS
dissemination, mental health, parents, psychological treatments, service use, survey, youth

1 | INTRODUCTION

Parents are typically the ones to seek mental health services for their children, and research suggests that when parents are better informed about treatment and service options, they are more likely to utilize services for their children (Corkum, Rimer, & Schachar, 1999; Cunningham et al., 2008; Johnston, Seipp, Hommersen, Hoza, & Fine,

2005). Yet despite recognition that increased treatment-related knowledge leads to increased service use, there are limited data on parents' knowledge of mental health treatment approaches, and where they learn (and would like to learn) mental health-related information. Greater parental awareness of evidence-based treatments may help our field, creating a "pull-demand" for such services (Gallo, Comer, & Barlow, 2013). Currently, of the approximately 17% of youth with mental health concerns, many do not receive any form of treatment (Kessler et al., 2005; Weisz et al., 2017) and those who do, often do not receive evidence-based treatment (Garland et al., 2010). One way to improve dissemination efforts may be to identify and increase the general population's knowledge of evidence-based treatments.

Studies in the general population have indicated that individuals use a variety of sources to acquire health information, ranging from professional sources such as medical doctors and mental health providers to informal sources, such as family members and the internet (Clarke et al., 2016; Cutilli, 2010; Rains, 2007). Research suggests that adults increasingly use the internet to procure health-related information but trust healthcare professionals more (Cutilli, 2010). Treatments for autism spectrum disorder (ASD) provide an illustrative example of how parents seek and use information on youth mental health services. A prominent concern among mental health professionals is that many parents prefer treatments with limited empirical support (Pickard & Ingersoll, 2015; Smith, 2005). In a survey of parents of youth with an ASD, parents identified books on autism, professionals other than medical doctors (e.g., psychologists, behavioral analysts, and occupational therapists), and recommendations made by other parents as the most commonly used sources of information for treatment-related decisions (Miller, Schreck, Mulick & Butter, 2012). Another study also found that parents of youth with ASD used a combination of "formal" connections such as healthcare providers and teachers, and "informal" connections such as family members and friends, to acquire information on treatment (Pickard & Ingersoll, 2015). Approximately 67% of parents indicated having used formal connections compared to 33% of parents utilizing informal connections to get recommendations for their child's treatment, yet parents expressed similar levels of trust in informal and formal connections. Parents having similar levels of trust in informal and formal sources has important implications for dissemination of evidence-based treatments as the source of the information tended to be associated with the utilization of evidence-based treatment approaches; formal connections tended to recommend evidence-based treatments whereas informal connections tended to recommend nonevidence-based treatments.

Beyond identifying the information sources parents use, want to use, and trust, it is important to assess parents' familiarity with different treatment approaches and how recognition of treatment differences and familiarity with treatment approaches relates to where parents seek information. When seeking out high-quality information on youth mental health treatments, the distinctions between psychosocial treatment approaches that are readily apparent to clinicians and researchers may be less clear to parents who do not have familiarity with different types of therapy. This may, in part, be reflected in the fact that there are few studies assessing parental preferences for youth mental health treatments, and those that exist tend to focus only on medication versus therapy (e.g., Bradley, McGrath, Brannen, & Bagnell, 2010; Chavira, Stein, Bailey, & Stein, 2003; Jaycox et al., 2006).

Using "therapy" as an all-encompassing label is problematic, given that a substantial body of evidence supports differential effectiveness of psychosocial treatment approaches (Weisz, Jensen-Doss, & Hawley, 2006). Among the many psychosocial treatment approaches tested in youth populations, cognitive and behavioral therapies have been among the most evidence-based treatments for a range of youth emotional and behavioral problems (Southam-Gerow, & Prinstein, 2014).

We conducted a national survey of parents of youth aged 4–17 years old using the MTurk platform to assess perspectives from a broad range of participants. The goals of the current study include examining: (a) parents' information-seeking behaviors and preferences, (b) their perceptions of different information sources, (c) their familiarity with psychosocial treatment approaches, and (d) their experience with youth mental health services.

2 | METHODS

2.1 | Participants

The participants were 196 adults between the ages of 21 and 57 years ($M = 34.52$, $SD = 7.72$). Gender information was available for a subsample ($n = 106$) of the participants; 59% ($n = 62$) identified as female. Approximately half of participants were married (57%), with 19% identifying as single, 15% unmarried but living with a partner, and 9% divorced. The majority of participants identified as White (83.2%), with 12.2% identifying as Hispanic or Latino, 8.2% as Black or African American, 3.6% as Asian American, 0.5% as Native American, and 0.5% as Native Hawaiian or Pacific Islander (respondents could indicate more than one race). In terms of education level, 6.6% reported having a professional degree, 40.8% of respondents reported having a degree from a 4-year college, 25.5% reported completing some college, but not receiving a degree, 15.8% reported having an associate's degree from a 2-year college program, and 11.2% reported having a high school degree or general education development (GED).

Participants provided information on any children between the ages of 4 and 17 years. A majority of participants ($n = 134$) reported having one child between the ages of 4 and 17 years; 55% male, mean age of 8.05 ($SD = 4.01$). Sixty-two participants reported having more than one child between the ages of 4 and 17 years. Of those identified as oldest children, 63% were male with a mean age of 11.74 ($SD = 3.55$). Of those identified as youngest children, 50% were male with a mean age of 7.85 ($SD = 3.10$).

2.2 | Procedure

Parents of youth between the ages of 4 and 17 years were recruited to take an online survey using Amazon's Mechanical Turk (MTurk; mturk.com), an internet-based platform from which participants seeking monetary compensation are able to complete surveys. MTurk draws from a large, diverse participant pool and has been found to produce valid results, similar to noninternet-based platforms (Paolacci, Chandler, & Ipeirotis, 2010; Schleider & Weisz, 2015). In this study, participants were restricted to US citizens. Participants were allowed to take the survey only if they had previously demonstrated a 97% or above task approval for completing previous MTurk tasks. This approval rate has been recommended to ensure high-quality work (Peer, Vosgerau, & Acquisti, 2014). Participants were excluded if they were under the age of 18 years, did not live in the United States, did not have a child between the ages of 4 and 17 years or if they incorrectly responded to attention checks (for additional quality assurance).

Interested participants were provided a description of the study and a link to an external online survey. Participants who failed attention checks or provided responses inconsistent with the study inclusion criteria were automatically taken to the end of the survey and thanked for their participation. Participants who were excluded at this point were told why they were excluded and that they would not receive payment. Participants who successfully completed the survey were provided with a unique code to receive compensation. Participants were paid $2.25 for 20 minutes (rate of $6.75 per hour), more than the median hourly wage of many MTurk tasks (Horton & Chilton, 2010)

To obtain a balanced sample of parents who had a child who received mental health services and parents who had no experience with youth mental health services, a subsample of parents were recruited only if they had a child in the specified age range who had received mental health services. This recruitment strategy provided a larger sample size to estimate statistics based on parents with exposure to the youth mental health service system. As such, the data for parents of youth who had received services ($n = 95$) is reported separately from parents of youth who have not received services.

2.3 | Measures

2.3.1 | Sources of information

Participants indicated which sources of information they *have used* for information about youth mental health and treatment, whether they would *like to use* a source for information, and how much they *trust* the information from the source. This measure was based off of a similar measure utilized by Lewin, McGuire, Murphy, and Storch (2014). The current study based the sources of information off of those used by Lewin et al. (2014), and also included questions about whether parents would like to use a source and how much they trust it. Specifically, for whether they have used or would like to use a source, participants answered "yes" or "no" and for how much they trust a source of information, participants rated the trustworthiness of the source on a scale from 1 ("*not trust at all*") to 6 ("*completely trust*"). Separately, participants chose which source of information they would trust the most out of all the sources of information provided. The sources of information presented to participants were: pediatrician, psychologist or other mental health provider, psychiatrist, friend, ask child about his or her preference, support group, family member(s), research treatment options or recommendations from internet, research treatment options or recommendations in books or academic journals, and church or religious leader.

2.3.2 | Familiarity with different treatment modalities

Participants answered two true or false questions to determine whether parents are aware that there are different types of talk therapies for youth mental health difficulties and whether different talk therapies are equally effective. We defined "talk therapy" as "a type of mental health treatment [referring] to therapy or counseling from a therapist, psychologist, counselor, school psychologist, social worker, or psychiatrist for any social, emotional, or behavioral problems. Talk therapy does not include medication."

To assess a parent's familiarity with the names of different forms of youth mental health treatment, participants were presented with the following list of treatment modalities and asked if they had "heard of" each of the treatments: Cognitive Behavioral Therapy, Dialectical Behavior Therapy, Psychoanalysis, Interpersonal Psychotherapy, Mindfulness-Based Therapy, Family Therapy, and Play Therapy.[1]

To determine the list of included treatments, we reviewed the evidence-based treatment lists from the PracticeWise PWEBS database (www.practicewise.com), choosing treatments targeting a broad range of symptoms or disorders and supplemented this list with several well-known treatments with less empirical support (e.g., psychoanalysis and play therapy). If participants endorsed having heard of a treatment modality, they were asked to rate how favorable they found each treatment on a scale from 1 ("*not favorable at all*") to 5 ("*very favorable*"). Participants were also given the option of saying they did not know enough about a treatment to make a favorability rating and these ratings were counted as missing data.

2.3.3 | Child psychological functioning

Parents reported on each of their children's anxiety using the 5-item version of the Screen for Child Anxiety Related Emotional Disorders (SCARED-5; Birmaher et al., 1999). The items are scored on a scale from 0 to 2: 0 = *not true or hardly ever true*, 1 = *sometimes true*, and 2 = *true or often true*. The SCARED-5 has shown good internal consistency and reliability (Birmaher et al., 1999). Parents reported their impressions of each of their children's psychosocial functioning using the 17-item version of the Pediatric Symptom Checklist (PSC-17; Gardner et al.,

[1]We included in the survey mutlisystemic and psychodynamic therapy, as well as a nonexistent therapy ("psychotranslational") as a validity check. However, we did not report on multisystemic or psychodynamic therapy as these categories were not endorsed to a greater degree than the nonexistent therapy, suggesting parents' familiarity with these interventions were no greater than chance.

1999). The PSC-17 consists of 17 items that are rated as "*Never*," "*Sometimes*," or "*Often*" present and scored 0, 1, and 2, respectively. A clinical cut-off score of 15 is used to discriminate youth with clinical levels of dysfunction from youth with nonclinical levels. The PSC-17 has shown good test–retest reliability, internal consistency, and validity (Gardner et al., 1999, Gardner, Lucas, Kolko, & Campo, 2007).

2.4 | Data analytic plan

Reflecting the exploratory focus of this study and the limitations of null hypothesis significance testing (Cumming, 2014), data analyses were largely based on descriptive statistics (i.e., describing the perspectives of the sample) and effect sizes (i.e., measures of the degree of relationship between variables in standardized terms). In some cases, inferential statistics (i.e., null hypothesis significance testing) were used to facilitate comparisons to the existing literature. When reporting on constructs that may relate to familiarity with mental health services, analyses were conducted separately on the two subsamples: parents who had a child who had used services and those who had not used services. Differences between the subsamples are reported.

2.5 | Ethical approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards.

3 | RESULTS

3.1 | Preliminary analyses

Although in-depth analyses regarding individual child psychological functioning is beyond the scope of this study, parent-reported scores of emotional and behavioral problems are summarized. To provide the upper-end estimate of child symptoms parents observed, the highest score of each parent's children were included in the sample average. Parents who identified having received mental health services reported a mean maximum child SCARED score of 3.91 ($SD = 2.69$) and a mean maximum PSC-17 score of 12.93 ($SD = 6.80$). Forty percent of these youth scored above the clinical cut-off on the PSC-17. Parents of youth who have not received mental health services reported child mean maximum SCARED scores of 1.95 ($SD = 1.69$) and mean maximum PSC-17 scores of 7.17 ($SD = 5.56$). Approximately 13% of these youth scored above the clinical cut-off on the PSC-17.

3.2 | Sources of information parents would like to use and have used

Of the information sources presented (see Figure 1), parents of youth who had received mental health services ($n = 95$) were most likely to want to use healthcare providers to receive information about youth mental health services, with a large proportion of parents reporting wanting to use a pediatrician, a psychologist or other mental health provider and psychiatrist. Parents also reported wanting to use individuals in their own familial social networks such as family members and their own child's preference as sources of information and to a lesser extent their friends. Over half of the parents reported wanting to use the internet, with slightly fewer parents wanting to use academic books or journals to get information. Support groups and church or religious leaders were least likely for parents to report wanting to utilize.

A significant percentage of parents whose children had not received mental health services ($n = 101$; see Figure 2) also reported wanting to receive information about youth mental health services from a pediatrician but mental health providers and psychiatrists to a lesser extent than parents of youth who had received services. These parents placed

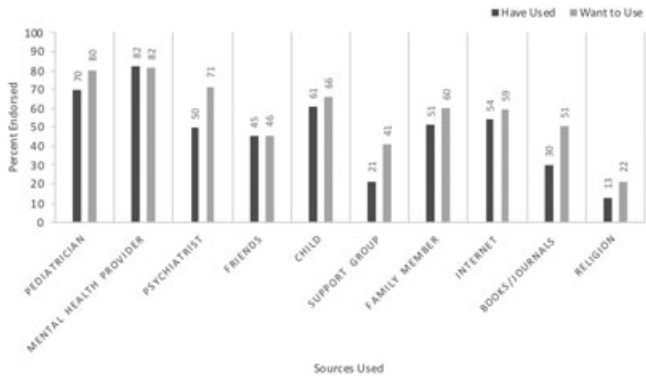

FIGURE 1 Actual and desired information sources for parents with youth mental health service system experience. Religion: church or religious leader

similar emphasis on wanting to use their own social networks compared to mental health providers, with over half of parents wanting to use a family member, their own child's preference, and wishing to utilize a friend for information. Approximately half of these parents reported wanting to use the internet and academic books or journals to get information. Similar to parents of youth who had received services, support groups and church or religious leaders were least likely for parents to report wanting to utilize.

Analyses were conducted to determine the magnitude of the relation between wanting to use an information source and actual service use. We used Cohen's (1992) guidelines for estimating effect sizes (ϕ), with small effect sizes considered to be values of 0.10 or less, medium 0.30 or more, and large 0.50 or more. ϕ represents the square root of the χ^2 value divided by the number of observations. χ^2 tests for independence (with Yates Continuity Correction) indicated small effects for the association between youth service use and wanting to use a mental health provider, χ^2 (1, n = 183) = 13.72, $p < 0.001$, $\phi = 0.27$; and a psychiatrist, χ^2 (1, n = 185) = 11.52, $p = 0.001$, $\phi = 0.25$. Small effects were found for youth service use and wanting to use a support group, χ^2 (1, n = 186) = 2.37, $p = 0.12$, $\phi = 0.11$; and church or religious leaders, χ^2 (1, n = 185) = 2.38, $p = 0.12$, $\phi = 0.11$, for information, although these results were not statistically significant. Parents of youth who had service use were more likely to endorse wanting to use these sources of information compared to parents of youth who had not received mental health services. Wanting to use pediatricians, friends, their own child's preference, family members, academic books or journals, and the internet was not related to having a child who had received mental health services.

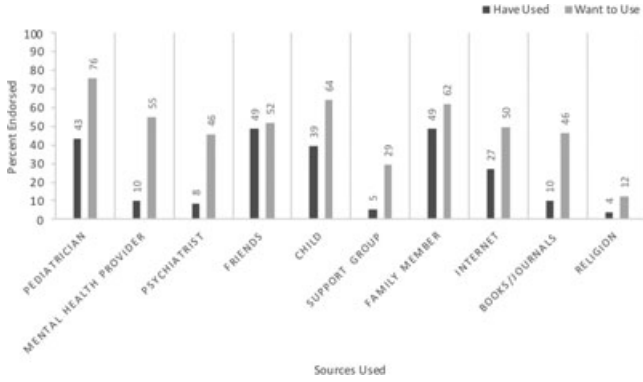

FIGURE 2 Actual and desired information sources for parents without youth mental health service system experience. Religion: church or religious leader

In addition to reporting from which sources they would want to receive information on youth mental health care, parents also noted which sources they had actually used. Almost all parents ($n = 94$, 99%) of youth who had received services reported having used at least one source, whereas 65% of parents of youth who had not received services reported having used at least one source. A large proportion of parents of youth who had received services (see Figure 1) reported having used mental health providers the most, closely followed by pediatricians. A smaller majority of parents endorsed having used their own children, the internet, family members, psychiatrists, friends, academic books or journals, support groups, and church or religious leaders as sources. Parents of youth who had not received services (see Figure 2) reported having used fewer sources overall, endorsing having used family members and friends the most, followed by pediatricians, their own children, the internet, mental health providers, academic books or journals, psychiatrists, support groups, and church or religious leaders.

Medium to large effect sizes (ϕ) were found for having received youth services and being more likely to have used mental health providers, χ^2 (1, $n = 195$) = 99.40, $p < 0.001$, $\phi = 0.71$; and psychiatrists, χ^2 (1, $n = 194$) = 40.89, $p < 0.001$, $\phi = 0.46$, for information. Small effect sizes (ϕ) were found for associations between having received youth services and being more likely to have used the internet, χ^2 (1, $n = 193$) = 14.58, $p < 0.001$, $\phi = 0.28$; pediatricians, χ^2 (1, $n = 195$) = 13.85, $p < 0.001$, $\phi = 0.27$; academic books or journals, χ^2 (1, $n = 190$) = 11.58, $p = 0.001$, $\phi = 0.25$; support groups, χ^2 (1, $n = 194$) = 11.44, $p = 0.001$, $\phi = 0.24$ (0.24); their own children, χ^2 (1, $n = 193$) = 8.71, $p = 0.003$, $\phi = 0.21$; and church or religious leaders, χ^2 (1, $n = 194$) = 4.92, $p = 0.03$, $\phi = 0.16$. Having used family members and friends for information was not related to having a child who had received mental health services.

3.3 | Trustworthiness of sources

For each source of information listed, parents were asked to report on the level of trustworthiness, regardless of whether they had used a particular source of information (see Table 1). We used Cohen's (1992) guidelines for estimating effect sizes (d), with small effect sizes considered to be values of 0.20 or less, medium 0.50 or more, and large 0.80 or more. Cohen's d represents the difference between means divided by the pooled standard deviation. Overall, parents tended to rate healthcare providers as the most trustworthy with mean trust ratings for these sources ranging from 5.02 to 5.22 (on a 1–6 scale) for parents of youth who had received services and 4.54–5.04

TABLE 1 The degree to which parents trust different sources of information and percent of parents who would trust a source the most

	Service use		No service use	
Sources of information	Mean trust rating (*SD*)	% That would trust the most	Mean trust rating (*SD*)	% That would trust the most
Pediatrician	5.22 (0.94)	26.3	5.04 (1.12)	39.6
Mental health provider	5.2 (1.04)	51.6	4.74 (1.30)	28.7
Psychiatrist	5.02 (1.37)	15.8	4.54 (1.42)	7.9
Child	4.16 (1.73)	3.2	4.07 (1.67)	9.9
Family member	4.01 (1.71)	2.1	3.9 (1.51)	8.9
Academic books or journals	3.86 (1.58)	0	3.81 (1.28)	1
Support group	3.57 (1.68)	0	3.46 (1.39)	1
Friends	3.55 (1.61)	0	3.47 (1.43)	2
Internet	3.35 (1.61)	0	3.26 (1.43)	0
Church or religious leader	2.65 (2.09)	0	2.2 (1.49)	1

Note. SD: standard deviation.

for parents of youth who had not received services. Other sources presented were rated as less trustworthy, with means ranging from 2.65 to 4.16 for parents of youth who had received services and 2.2–4.07 for parents of youth who had not received services. Overall, trust ratings did not tend to differ greater than a small effect size based on youth service use, although *t* tests revealed that parents of youth who received services tended to rate mental health providers, $t(176) = -2.57$, $p = 0.01$, $d = 0.39$ (two-tailed), 95% CI [0.10–0.69]; and psychiatrists, $t(166) = -2.27$, $p = 0.03$, $d = 0.34$ (two-tailed), 95% CI [−0.10–0.78], as more trustworthy compared to parents of youth who had not received services.

Out of the sources provided, parents were also asked to indicate the source they would trust the most (see Table 1). Parents of youth who received mental health services ($n = 95$) were most likely to choose mental health providers as the source they would trust the most, followed by pediatricians and psychiatrists. Parents of youth who had not received services were most likely to choose pediatricians as the source they would trust most, followed by mental health providers. Of the sources listed, very few parents in either service group were likely to most trust friends, academic books or journals, support groups, and church religious leaders (see Table 1). No parents reported trusting the internet the most.

3.4 | Familiarity with and favorability of therapy modalities

Parents also reported on their impressions of different psychosocial treatment approaches. The majority of parents ($n = 193$, 99%) agreed with the statement that there are different types of "talk therapies," with 41% ($n = 80$) endorsing the statement that all talk therapies are equally helpful.

As displayed in Figure 3, for parents of youth who had received mental health services ($n = 95$), the treatment approaches with which most parents were familiar were family therapy and cognitive-behavioral therapy. A majority of these parents also reported hearing of play therapy and psychoanalysis, with no other treatment approach receiving more than 28% of parents having said they were familiar with the approach. Parents of youth who had not received mental health services followed a similar pattern, with slightly fewer parents having heard of each treatment modality compared to parents of youth who had received services (see Figure 3). A χ^2 test for independence (with Yates Continuity Correction) indicated a small effect for the association between youth service use experience and having heard of cognitive-behavioral therapy, χ^2 (1, $n = 196$) = 5.03, $p = 0.02$, $\phi = 0.17$; and play therapy, χ^2 (1, $n = 196$) = 10.18, $p = 0.001$, $\phi = 0.24$.

Of the parents who endorsed familiarity with the most commonly known approaches (familiar to >25% of the sample), favorability ratings were generally high. For parents of youth who had received services, means

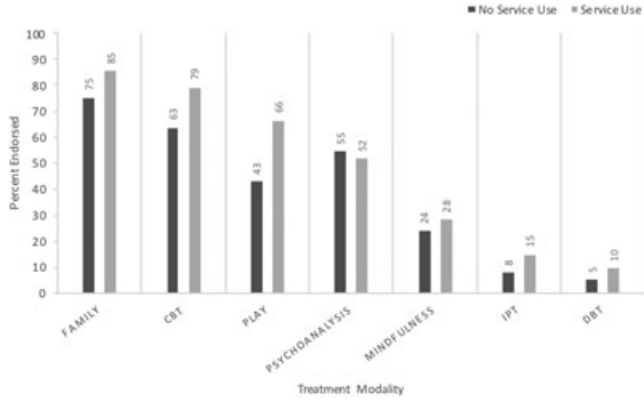

FIGURE 3 Familiarity with treatment modalities among parents with and without youth mental health service system experience. CBT: cognitive-behavioral therapy; DBT: dialectical behavior therapy; Family: family therapy; IPT: interpersonal psychotherapy; Play: play therapy

TABLE 2 Favorability of different therapy modalities

Therapy modalities	Service use		No service use	
	n	Mean (*SD*)	*n*	Mean (*SD*)
Family therapy	79	4.29 (0.88)	66	4.29 (0.87)
Cognitive-behavioral therapy	62	4.48 (0.62)	45	4.27 (0.78)
Psychoanalysis	35	3.4 (1.09)	42	3.12 (1.13)
Play therapy	59	4.53 (0.80)	39	4.15 (0.84)
Mindfulness	25	4.4 (0.82)	21	4.14 (0.85)
Interpersonal psychotherapy	11	3.91 (0.83)	5	4 (1.23)
Dialectical behavior therapy	4	4.75 (0.5)	5	4 (0.78)

Note. SD: standard deviation.

ranged from 4.29 to 4.53 (on a 1–5 scale) and for parents of youth who had not received services, means ranged from 4.15 to 4.29. For both parent groups, psychoanalysis was rated less favorably (see Table 2). Overall, parents of youth who received services tended to rate treatments more favorably (see Table 2) compared to parents who had not received services. *t* Tests indicated a medium effect for the association between youth service use and favorability of play therapy, $t(96) = -2.21$, $p = 0.03$, $d = 0.46$ (two-tailed), 95% CI [0.06–0.88]; and cognitive-behavioral therapy, $t(105) = -1.60$, $p = 0.11$, $d = 0.30$ (two-tailed), 95% CI [−0.08–0.69].

Of parents whose youth had received services, 40 (42%) endorsed their child having received the generically termed "talk therapy," with 29 of those parents endorsing another modality as well. Forty-two parents (44%) endorsed their child having received cognitive-behavioral therapy, behavior therapy, or both, making this family of approaches one of the most popular, next to family therapy, which 44 parents (46%) reported having used.

4 | DISCUSSION

The current study examined parents of youth aged 4–17 years old about their information-seeking behaviors and preferences, perceptions of various information sources, familiarity with psychosocial treatment approaches, and experience with youth mental health services. To account for the effect of parental experience with youth mental health services on parent information-seeking behavior, preferences, and familiarity with psychosocial treatment approaches, the results are discussed separately for parents with and without such service experience.

In terms of sources from which parents would like to receive information about youth mental health and treatment, parents report wanting to use professionals to the greatest extent, regardless of whether or not their child had received mental health services. Specifically, a significant portion of parents across the entire sample reported wanting to use pediatricians as a source of information. This finding is in line with research showing patient deference to professionals, and primary care being a key point of entry into the mental health service system (Frosch, May, Rendle, Tietbohl, & Elwyn, 2012; Kelleher & Stevens, 2009; Kolko & Perrin, 2014). If the youth had received mental health services, their parents were significantly more likely to want to use mental health providers and psychiatrists compared to parents of youth who had not received services. Although parents of youth who had not received services also reported wanting to use mental health professionals for information, they placed a similar emphasis on wanting to use their own social networks.

More research is needed to understand patterns of information-seeking following contact with a mental health provider, as, to the best of our knowledge, no research currently exists on changes in parental use of information

following child mental health service use. Future research would do well to explore this in more detail and several hypothesized explanations are outlined below. The fact that parents with mental health service experience want information from mental health professionals to a greater degree than parents who do not have service experience may mean that parents in the mental health service system may need more specialized information due to the fact that their child is more likely to have dealt with social, emotional, or behavioral issues. Moreover, mental illness and treatment-related stigma can be a deterrent to help-seeking behavior (Clement et al., 2015; Heflinger & Hinshaw, 2010). Once in the mental health service system, parents may also feel more comfortable utilizing psychological service providers as information sources, as the sense of stigma relating to youth mental illness may decrease.

Overall, even though many parents indicated that they would seek information about their child's mental health from a variety of sources, pediatricians remained one of the most desirable. This finding aligns with others that the provision of youth mental health care by physicians has increased over the past several decades (Olfson, Blanco, Wang, Laje, & Correll, 2014); pediatricians are often the first professional with whom parents share mental health concerns. However, many pediatricians believe that their role is not to provide mental health treatment but to identify the need for and refer for such treatment, highlighting the importance of interdisciplinary collaboration (Asarnow, Rozenman, Wiblin, & Zeltzer, 2015; Heneghan et al., 2008; Olfson et al., 2014). Recent findings suggest that integrated medical-behavioral primary care is advantageous for youth (Asarnow et al., 2015; Asarnow, Kolko, Miranda, & Kazak, 2017) and the results of this study underscore the utility in using primary care settings to bridge the gap between mental health and pediatric services. Given the degree to which parents trust pediatricians, it follows that mental health services may be better received and adhered to within an integrated care setting. Indeed, many efforts are underway promoting such collaborations, such as Mental Health Awareness Day, sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), which focuses on the importance of addressing youth physical, emotional and behavioral health needs in concert, highlighting the importance of cross-discipline communication (samsha.gov). The National Institute of Mental Health (NIMH) has also noted the importance of delivering mental health services across healthcare settings, as outlined in their Strategic Plan for Research (Strategic Objective Number 4: Strengthen the Public Health Impact of NIMH-Supported Research; nimh.nih.gov).

Beyond where parents would like to get information about youth mental health, it is also important to know where parents have actually received information. Parents who had exposure to youth mental health services sought mental health-related information from more sources than parents who had not had such exposure, as could be expected. These parents reported using pediatricians and mental health providers more than other sources. Only a small portion of parents whose children had not received services reported seeking information about child mental health concerns from multiple sources, with many of these parents utilizing pediatricians and their own social networks for information. Approximately half of the parents with no exposure to youth mental health services reported having received information about youth mental health from a friend or family member, and to a slightly lesser extent (43%), pediatricians. These results suggest that parents of youth who may not necessarily require mental health services are still seeking information about youth mental health to some extent. This may reflect the relative accessibility of these sources or the type of information sought, such that parents of youth who are not in critical need of services may gather sufficient information from more informal sources. Jorm (2012) proposed the "overlapping waves of action" model to better understand such findings, noting that help-seeking or action behaviors by individuals with mental health concerns tend to increase with level of distress (Jorm, 2012). He highlights that for mild levels of distress, individuals are more likely to utilize family members and friends, but as distress increases, the use of health professionals increases and the use of social networks decreases (Jorm, 2012). Although these general trends are well-established, questions remain about the quality of the information gathered from nonprofessional sources and how this translates to any future decisions made regarding youth mental health service use.

Parents may report having used and wanting to use a wide variety of sources of information, but the extent to which they trust the information provided varied as well. For the most part, parents with exposure to youth mental

health services and parents without exposure to services tended to report similar levels of trustworthiness for the listed sources, with parents rating health professionals as the most trustworthy. These findings align with other studies that found health professionals are generally trusted more than health information found on the internet (Hesse et al., 2005; Khoo, Bolt, Babl, Jury, & Goldman, 2008). However, parents with exposure to youth mental health services rated mental health providers and psychiatrists as significantly more trustworthy compared to parents of youth who had not received services. Although parents who have not had experience with youth mental health services assign high trust ratings to mental health professionals, having potentially had direct experience with mental health professionals makes it even more likely that a parent trusts the information provided. This may reflect a general tendency to mistrust the unknown or it may suggest that the public perception of mental health professionals, as influenced by media and/or stigma, tends to be less favorable than the modal experience of interacting with a mental health professional. It is encouraging that on average, mental health service use increases the trustworthiness of mental health professionals. However, as mentioned earlier, stigma continues to be a significant barrier to receiving mental health services and thus future work will need to continue to identify the ways in which such barriers impact information seeking and service use.

The trust ratings parents assigned to the different sources highlights the fact that parents reported having used and wanting to use a number of sources that they do not trust as much as professionals. This pattern was even more striking when parents were asked to choose the source of information they would trust the most. No parents reported trusting the internet the most, yet 40% of the entire sample of parents had used it to get mental health-related information and 52% of all parents in the sample reported wanting to use it for mental health-related information. This suggests that parents recognize that certain sources, such as the internet, may not provide the most accurate information, yet the ease of using the internet may make it a common information source.

How individuals access health information online has received more attention in recent years as the internet is an increasingly prominent source of health information (Amante, Hogan, Pagoto, English, & Lapane, 2015). Norman and Skinner (2006) coined the term eHealth Literacy, defined as the ability to "seek, find, understand, and appraise health information from electronic sources and apply the knowledge gained to addressing or solving a health problem." In eHealth Literacy, a consumer's ability to determine the credibility of a source is key. Parents report that they often have difficulty determining the credibility of sources related to their children's health (Knapp, Madden, Wang, Sloyer, & Shenkman, 2011), posing a challenge for parents seeking health information online. Examination of different internet sources was beyond the scope of this study (the term "internet" was used in a general sense); future research needs to examine the way in which information is presented online and the extent to which the information is perceived as credible by parents. We know that consumers deem web-based information as more credible when it is easy to access and understand (Ye, 2011), and tailored to specific demographics, such as age and race, as sociodemographic differences can play a role in the sources used and the degree of credibleness assigned (Paige, Krieger, & Stellefson, 2017).

It is also likely that parents who use the internet may not be using it as the sole source of information (no one in the current sample reported using only the internet for information). These results align with other studies that have found that parents generally receive information from medical professionals and tend to supplement this information with findings from the internet and other nonprofessional sources (Pickard & Ingersoll, 2015). Regardless, dissemination efforts may need to target more informal networks so that the information parents are receiving from nonprofessional sources is not competing with information about best practices and supported treatment approaches. Utilizing parents who have had experience with evidence-based approaches may be helpful in spreading information, but to our knowledge, no studies have examined how best to capitalize on both formal and informal social networks in regard to mental health information. However, models exist in the developmental disabilities and early childhood literature that point to the success of utilizing parents as educators of other parents and professionals (Gallagher, Rhodes, & Darling, 2004), suggesting that parent education around child mental health may have impacts beyond their own child.

One common challenge for proponents of evidence-based practice in psychology is helping consumers distinguish between different approaches that may all fall under the umbrella of "talk therapy." Virtually all (i.e., 99%) parents agreed that there are different types of "talk therapy," with many (59%) believing that some psychosocial treatment approaches work better than others. Regardless of whether or not parents had children who had received mental health services, parents were most commonly aware of "family therapy" and "cognitive-behavioral therapy," though parents were more likely to have heard of cognitive-behavioral therapy if they had mental health service use experience. It is possible that efforts to disseminate cognitive-behavioral therapy as an evidence-based practice (Higa-McMillan, Francis, Rith-Najarian, & Chorpita, 2016) have been effective, whether through increasing the use of cognitive-behavioral therapy in service settings (e.g., Nakamura et al., 2011; Southam-Gerow et al., 2014) or making information about it more accessible online (e.g., www.abct.org), such that parents seeking information about treatments learn about cognitive-behavioral therapy more regularly. "Family therapy," being a more generic term, makes it harder to determine the degree to which parents have heard about a specific therapeutic modality (e.g., structural family therapy) versus the concept of including families in treatment for youth mental health. Parents also reported highly favorable attitudes towards these (and other) approaches, with average ratings of above 4 (out of a 5-point scale) for all commonly heard of approaches with the exception of psychoanalysis. On the whole, it seems parents are favorable towards any psychosocial treatment approach with which they are familiar. It should be noted that familiarity and favorability of treatments may have been influenced by actually having had used such treatment modalities, as parents with exposure to youth services tended to rate treatment modalities as more favorable compared to parents with no exposure to youth services. Future research would do well to further distinguish between favorability as stemming from service use and favorability stemming from familiarity only.

4.1 | Limitations

The current study has many strengths, including a national sample comprising parents who have had a range of experiences with the youth mental health service system, providing information that our field needs to understand how families interact with youth mental health services. However, the study also has several limitations. The parents in the study reported on basic demographic characteristics, but additional information on family background, culture, family structure, and details regarding the type of service used would provide a fuller understanding of the relationship between family characteristics and information seeking. Relatedly, although parents completed broad measures of child psychological functioning, specific diagnostic information is unknown. It will be important for future research to examine ways in which parents of youth with diverse clinical presentations seek information. Furthermore, conducting an online survey precluded information about parents who chose not to complete the survey and limited parents' ability to ask questions about the survey. It is possible that parents interpreted questions differently than intended, however, this concern is mitigated by recent findings suggesting participants completing online surveys respond similarly to participants completing surveys in a laboratory setting (Schleider & Weisz, 2015). Moreover, the use of MTurk as a survey platform raises the possibility that the participating parents are not representative of the general population, as internet users may differ from noninternet users (Paolacci & Chandler, 2014). Additionally, as mentioned above, we did not distinguish between formal and informal internet sources, such that the degree to which parents utilize either source is unclear. Finally, larger samples may provide opportunities to examine parental knowledge of mental health services in more depth across more diverse populations.

4.2 | Future directions

This study focused on parent preferences given that parents are often the help-seeking agents in regard to youth mental health treatment. However, parents may not be the only individuals engaging in help-seeking behavior; adolescents and young adults are important consumers of treatment-related information. Studies have generally found that adolescents and young adults may rate informal sources of information more positively than mental health professionals (Burns &

Rapee, 2006; Jorm & Wright, 2007), whereas adults, including parents, tend to trust information from professionals to a greater degree than from informal sources (Cutilli, 2010; Khoo et al., 2008). Understanding the preferences and help-seeking behavior of young people is an important area in dissemination research.

In this particular study, parents were not asked to report which websites or online resources they have utilized, but as dissemination efforts continue, it will be important to know how parents identify which online resources to use (e.g., ones that promote evidence-based treatments or ones which show up first in online search results). Moreover, parental information seeking may not always stem from questions or concerns that would require professional input, such as typical parenting practices to promote healthy emotion regulation or helping a child navigate a particular developmental stage. As such, efforts targeting the dissemination of evidence-based mental health services for youth will need to not only address families specifically seeking information about services but also families that may be seeking more general information about child development. There are a number of online resources geared towards such dissemination efforts, such as effectivechildtherapy.org and infoaboutkids.org, yet to our knowledge, little research exists on whether parents are generally aware of such resources and whether they are able to distinguish them from less credible sources. Future research will need to continue to explore the most effective ways to disseminate information about youth mental health to parents, whether it be continuing to evaluate the effectiveness of integrated care models or devoting resources to web-based marketing of evidence-based treatments.

5 | CONCLUSIONS

Examining the ways in which parents seek out information regarding child mental health services contributes to ongoing dissemination and implementation efforts. This study highlights the fact that parents utilize multiple information sources, both formal and informal, to access information about child mental health. Although parents generally trusted healthcare professionals the most, they often utilized other sources that they rated as less trustworthy. This speaks to the importance of understanding the role that different information sources play in how parents consume information about youth mental health and the way in which it affects help-seeking behavior. Identification of parents as consumers of youth mental health services may be an important avenue through which dissemination efforts are improved, as parents with experience with mental health services were generally more aware of a range of therapeutic approaches. Increasing awareness of evidence-based interventions, through both formal and informal sources, may increase the general population's knowledge of evidence-based treatments.

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CONFLICTS OF INTEREST

The authors declare that there are no conflicts of interest.

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