**The target behaviours specified here in terms of who (‘Target’), what (‘Action’), where (‘Context’) and when (‘Time’).**

The application of the Theoretical Framework of Acceptability1,2 (TFA) in the present study has had to take into consideration the following key points:

* TFA, as it was developed, is focused on acceptability of ‘an object’ (i.e. an intervention) not acceptability of ‘behaviour’ i.e. receiving/using/.. that intervention) while the current project is focused on acceptability of both an object (the trial) and behaviour (i.e. sets of target behaviours that therapists and parents would need to do for a trial to be undertaken, see tables 1 and 2 for the sets of behaviours).
* The current project is focused on (i) eliciting people’s views about a hypothetical trial before an opportunity to experience it and (ii) predicting people’s future behaviours related to such a trial (i.e. will people perform the target behaviours listed in tables 1 and 2, below).

Table A1. Target behaviours related to parents specified for who, what, where and when

|  |  |  |  |
| --- | --- | --- | --- |
| **Who (Target)** | **What (Actions)** | **Where (Context)** | **When (Time)** |
|  | reply to opt-in vs opt-out | Initial information stage of the study | Within two weeks |
| Parents of children aged 0 to 13 years receiving healthcare (assessments and/or interventions)  | discuss the study and make a decision about participation | With healthcare professional during routine care vs with an independent research team member  | Within a few weeks from the initial study letter |
|  | share (various degrees of) information with the research team | In a context of the research study | Months to years – during the course of the study |

Grey box = the main aspect of the behaviour on which the vignette is seeking to elicit views

Table A2. Target behaviours related to therapists specified for who, what, where and when

|  |  |  |  |
| --- | --- | --- | --- |
| **Who (Target)** | **What (Actions)** | **Where (Context)** | **When (Time)** |
| Therapists providing healthcare\* to children 0-13 years old | agree for the service to take part in a study | in a study where therapists will be allocated to provide specific, protocolised self-care interventions | in the next three years |
| discuss the study with patients and consent patients | at routine healthcare appointments |
| share information with the research team | In a context of a research study collecting patient and personal information  |

Grey box = the main aspect on which the vignette is seeking to elicit views. \*any type of healthcare, including assessment, intervention, advice, etc.

Table A3. Framework for questionnaire development

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Acceptability construct** | **TFA original definition related to intervention acceptability 1** | **TFA example items2** | **Similar constructs from other theories, their definitions, and examples of measurement items** | **Definition used in the present UKOTRF study in relation to trial designs’ acceptability** | **Draft content for the UKOTRF study, presented in the order matching the sample vignette: Enabling self-care in children with disabilities: Study 2 questionnaire draft and sample vignette v2019.05.14** |
| **PART 0: Welcome note, and introduction to the study and the questionnaire** |
| **PART 1: General acceptability questions Q1-3** |
| Intervention coherence | The extent to which the participant understands the intervention and how it works | It makes sense to me how [intervention] will result in improvements in [clinical condition/ practice]: (professional)It is clear to me how [engaging with the intervention] would help me manage my [clinical condition] (patient) |  | The individual’s understanding of research and trials; and how a cluster randomised trial might work in their healthcare provision context. | **Q1:** It is clear to me how research trials improve children’s therapies and outcomes.A brief explanation of a cluster randomised controlled trial.**Q2:** It makes sense to me how a cluster trial might work in my therapy situation.For both, response option 7-point Likert scale. |
| Perceived effectiveness | The extent to which the intervention is perceived to be likely to achieve its purpose | The [intervention] is likely to improve [behaviour/ condition/ clinical outcome]: | *Behavioural beliefs and outcome evaluations from the Theory of Planned Behaviour:* Indirect measurement:If I [the target behaviour] I will [outcome]Unlikely 1 2 3 4 5 6 7 Likely*Beliefs about consequences from the Theoretical Domains framework 3:* defined as acceptance of the truth, reality, or validity about outcomes of a behaviour in a given situation. Theoretical constructs: beliefs, outcome expectancies, characteristics of outcome expectancies, anticipated regret, consequents.What do you think will happen if you do [target behaviour]? | The extent to which the [target behaviour] is perceived to be likely to achieve its purpose. | **Q3:** A cluster trial is likely to inform the actual treatments children receiveResponse option 7-point Likert scale. |
| **PARTS 2-7: Specific questions to measure beliefs about the behaviours related to trial participation Q4-7**In this, each part presents one target behaviour from Table 1 or 2, above, in a form of a vignette followed by a standard set of question items Q4-7, below. |
| Affective attitude  | How an individual feels about the intervention | Did you like or dislike the [intervention]?The [intervention] is [affect e.g. interesting]:5-point Likert scale | *Attitude from the Theory of Planned Behaviour4:* a person’s overall evaluation of the behaviour, including beliefs about consequences and the corresponding positive or negative judgements.Indirect measurement:* Open-ended questions to elicit participants’ thoughts in response to a structured vignette

*Beliefs about consequences from the Theoretical Domains Framework3*“How about advantages or disadvantages of [the target behaviour] – do you think there might be some, and if so what might these be?”5 | How an individual feels about the [target behaviour from Table 1, above], and beliefs about any positive/negative consequences to them. | **Q4:** An open question: Therapists: “What do you like and dislike about the scenario?”Parents: What are your initial thoughts and feelings about this situation?Response options: open boxes. |
| Ethicality  | The extent to which the intervention has good fit with an individual’s value system | There are moral or ethical consequences to [engage with the intervention] (professional)How fair (to all patients) is a system where patients [engage with the intervention]? (patient) | *Goal hierarchy:* a model of hierarchical structuring among the goals involved in creating action. Abstract goals concern being a particular kind of person, concrete goals concern completing a particular kind of action6Goals from the Theoretical Domains Framework3:“Could you tell me your thoughts on how important [the target behaviour] is to you and how does [the target behaviour] fit with (your) other priorities and aims?” 5 | The fit between the individual’s value system, goals and benefits and the [target behaviour]; and including any aspects where adopting the [target behaviour] might result in a perceived opportunity cost elsewhere. | **Q5:**Removed from the questionnaire. Piloting identified responses align to Q4: likes/dislikes, thoughts and feelings. Concept will be explored in analysis. |
| Opportunity costs | The extent to which benefits, profits, or values must be given up to engage in the | [intervention] would interfere with my other priorities: |
| Burden  | The perceived amount of effort that is required to participate in the intervention | How much effort did it take to [engage with intervention]?No effort at all: 1A little effort: 2No Opinion: 3 A lot of effort: 4 Huge effort: 5 | *Environmental context and resources from the Theoretical Domains Framework 3:* defined as any circumstances of a person’s situation or environment that discourages or encourages [target behaviour]. Theoretical constructs: environmental stressors; resources/materials resources; organisational culture/climate; salient events/critical incidents; person x environment interaction; barriers and facilitators.* To what extent do physical or resource factors facilitate or hinder [the target behaviour]?
 | The effort that the individual perceives is required for [the target behaviours from Table 1, above]. | **Q6**: How much effort and resource do you think [target behaviour] will take from you?Response options: 5-point Likert scale |
| Self-efficacy  | The participant’s confidence that they can perform the behaviour(s) required to participate in the intervention | How confident would you feel about [engaging with the intervention]? | Self-efficacy from Albert Bandura’s Social Cognitive Theory7. Self-efficacy is concerned with perceived capability. The items should be phrased in terms of can do rather than will do. Can is a judgment of capability; will is a statement of intention. Please rate how certain you are that you can [target behaviour]0 10 20 30 40 50 60 70 80 90 100 Cannot Moderately Highly  Do can do certain  Can do  | The participant’s confidence that they can perform [the target behaviours from Table 1, above] | **Q7**: How confident are you that you can [the target behaviour from Table 1, above]?10 point Likert scale from “cannot do at all” to “can definitely do” |

1. Sekhon M, Cartwright M, Francis JJ. Acceptability of healthcare interventions: an overview of reviews and development of a theoretical framework. *BMC health services research.* 2017;17(1):88.

2. Sekhon M, Cartwright M, Francis J. Development of a theory-informed questionnaire to assess the acceptability of healthcare interventions: application of prevalidation methods. UK Society for Behavioural Medicine; 12/12/18, 2018; Birmingham, UK.

3. Michie S, Atkins L, West R. The behaviour change wheel: a guide to designing interventions. *Needed: physician leaders.* 2014:26.

4. Francis J, Eccles MP, Johnston M, et al. Constructing questionnaires based on the theory of planned behaviour: A manual for health services researchers. In: Centre for Health Services Research, University of Newcastle upon Tyne; 2004.

5. Kolehmainen N, MacLennan G, Ternent L, et al. Using shared goal setting to improve access and equity: a mixed methods study of the Good Goals intervention in children’s occupational therapy. *Implementation Science.* 2012;7(1):1.

6. Carver CS, Scheier MF. Chapter 3 - On the Structure of Behavioral Self-Regulation. In: Boekaerts M, Pintrich PR, Zeidner M, eds. *Handbook of Self-Regulation.* San Diego: Academic Press; 2000:41-84.

7. Bandura A. Guide for constructing self-efficacy scales. *Self-efficacy beliefs of adolescents.* 2006;5(1):307-337.