Greenwich Social Work Review
2020, Vol 1, No 2, 141-149
https://doi.org/10.21100/gswr.v1i2.1172 ISSN: 2633-4313

Delivering the Strengthening Families Program to Native American Families during COVID-19: Lessons and next Steps

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Received 30 October 2020
Accepted for publication 12 December 2020
Published 18 December 2020

Abstract

The COVID-19 pandemic of 2020 led to change and adaptation for all Americans. Programs that serve Native American children and families are particularly critical during this time due to the disproportionate risks and disparities faced by this population. The objective of this qualitative utilization focused evaluation was to gather adult participant feedback on a telehealth adaptation of the Strengthening Families Program (SFP). This evaluation builds on previous knowledge of SFP group leadership which suggests that supportive helping relationships paired with dynamic flexibility are facilitators of effective family engagement. Participant feedback suggests that caregivers felt comfort, care, and genuine concern related to their involvement in telehealth SFP groups. In addition, all participants noticed a difference in their families' communication and relationships. The COVID-19 pandemic, both tragic and challenging, forced a spotlight on barriers (limited Internet access, social services, and food resources) that required solutions to sustain participation of Native American families in a family skills intervention in one Midwestern state. What started as "how do we replicate this service" became about building resiliency and learning from the experiences of Native American families in this critical time in history.

Keywords: COVID-19, telehealth, Native American, Utilization Focused Evaluation, caregiver perspectives

1. Introduction

The COVID-19 pandemic (COVID) of 2020 has necessitated that programs for children and families adapt their operations to ensure the continued safe and secure provision of services. Programs that serve Native American children and families are particularly critical during this time due to the disproportionate risks and disparities faced by this population (Jones, 2006). Adaptations and resilience building strategies by a program that serves Native American families are highlighted with a focus on service recipient feedback and experiences. Findings indicate that a participatory, responsive approach is key to maintaining connections to strengthen Native American families during COVID-19.

The Kansas Serves Native American Families (KSNAF) initiative was established to improve the wellbeing of Native American children affected by parent and community substance abuse through culturally-integrated implementation and evaluation of the Strengthening Families Program (SFP) (Kumpfer and Magalhaes, 2018). In a typical SFP, eight to ten families participate in a two-hour in-person group session once a week for 14 weeks. Each session begins with a family meal after which adults meet together for a lesson on a particular parenting skill while similarly aged children meet together in a group focused on a related life skill. Afterward, family members reunite for informal family practice time that includes coaching by group leaders. Sessions address managing stress, communication, problem-solving, setting limits and other skills to strengthen relationships and support wellbeing. The goal of KSNAF SFP is to positively impact family bonding, communication, and caregiver supervision in a way that reflects community cultural values. KSNAF recruits and trains Native American individuals to lead SFP groups within tribal communities and for tribal populations in urban settings supported by university-based researchers. To facilitate participation, the program provides families with transportation, childcare, and referrals to other services on an as needed basis.

The KSNAF program serves a uniquely vulnerable and uniquely resilient population (Ore, Teufel-Shone and Chico-Jarillo, 2016). Colonization, including forced relocation,

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boarding schools, deliberate introduction of infectious disease, and associated historical trauma, has resulted in persistent socioeconomic and health disparities for Native American communities such as high rates of poverty, unemployment, and chronic illness (Ore, Teufel-Shone and Chico-Jarillo, 2016; Sarche and Spicer, 2008). Native American and Alaska Native children and families currently experience repeated traumatic loss from disproportional rates of deaths due to injuries, accidents, suicide, and homicide (Sarche and Spicer, 2008). Adding to these vulnerabilities, over half of Native Americans live in rural areas, often in small, geographically isolated communities with inadequate services, limited Internet access, few transportation options, and other barriers (First Nations Development Institute, 2017). Extended family, cultural identity and traditions, spiritual practices, and child-rearing beliefs are strengths that facilitate survival and resilience among Native American people (Burnette et al., 2020; Sarche and Spicer, 2008).

The COVID-19 pandemic has disproportionately affected Native American communities due to differences in rates of underlying chronic health conditions, access to health care, poverty, housing and household size, and other inequities that increase risk and facilitate community transmission (Tai et al., 2020; Hatcher et al., 2020). Historically underfunded U.S. governmental obligations for tribal health are further magnified by the impact of the pandemic. A number of tribes depend on income from casino operations to support health care, social services, and other community infrastructure (Meister Economic Consulting, 2020). Closing or limiting casino operations during the pandemic helps to keep tribal members safe yet can result in increased stress of job loss and economic uncertainty for individuals as well as cuts in funding for tribal community services (Meister Economic Consulting, 2020). Tribal ceremonies and gatherings that support cultural identity, spiritual practices, and healing have been cancelled or moved online. While not unique to tribes, the resulting isolation and increased stressors combine to contribute to increased risk of abuse, neglect, domestic violence, mental health difficulties, and substance use.

2. Connecting via telehealth

Telehealth interventions provide a way to maintain connection and possibly prevent increased impacts of the aforementioned stressors during COVID. For the purpose of this study, telehealth interventions are defined as telephone or internet-based strategies (zoom, email or instant messaging) to engage participants in an intervention without physical contact (Chi and Demiris, 2015). Though not delivered through a health care setting, we define our internet-based delivery of SFP as telehealth because it is an intervention designed to impact individual and family well-being. A brief review of literature on best practices in telehealth interventions with the keywords searched telehealth, parent, and interventions rendered over 200,000 hits. Pairing the search down to best practices, telehealth, and parent support revealed six key articles which were closely reviewed to identify strategies for immediate use as the KSNAF team worked to quickly adapt SFP to a telehealth intervention. The selected studies suggest that transitioning to telehealth provides some opportunities to maintain connection and engagement and possibly overcome barriers created by distance, lack of transportation, and opportunity to access (Banbury et al., 2018).

For instance, one study, found that "*online technologies to deliver parenting support*" are a "*promising avenue"* for improving treatment engagement and producing positive outcomes (Dittman et al., 2014, p. 243). Furthermore, this study found that the traditional risk factors named and studied such as lower parent education, lower income, high levels of child behaviors, and parent depressive symptoms were not predictors of child behavior or parenting outcomes rather number of sessions attended was a predictor of improved outcomes (Dittman et al., 2014). Other research validates the finding that enhanced engagement strategies that can only be provided by human support assist with completion of online parenting programs (Mohr, Cuijpers and Lehman, 2011; Zbikowski et al., 2010). Specific strategies noted in the articles reviewed included preparing for the intervention and developing relationships by gaging interest, technical needs, and scheduling preferences. In addition, assessing motivation to participate was highlighted as helpful information to know in order to know how much to engage participants throughout the course of intervention (Mohr, Cuijpers and Lehman, 2011; Zbikowski et al., 2010).

Coaches or group leaders with the necessary expertise (technology and curriculum content) were also found to enhance engagement and participation in online interventions (Georgeson et al., 2020). Group leaders can create a culture of trust online by conveying that mistakes are part of the learning process (Mohr, Cuijpers and Lehman, 2011). Coaches who model how to use curriculum skills through examples helped participants know how to engage and what to share (Mohr, Cuijpers and Lehman, 2011).

Telehealth engagement strategies derived from the summary of key studies were used to pave a path to maintain social connection during a time of forced isolation or quarantine. These strategies were shared with the research team and group leaders as the KSNAF program worked to adapt the SFP intervention to a telehealth format.

3. Challenges

Many communities have utilized shelter-in-place and physical distancing policies as essential strategies to help limit the spread of COVID-19. Yet, along with addressing the stated epidemiological purpose, these approaches have also further highlighted challenges faced by people living in rural areas and tribal lands.

As a way to keep connected to services and goods during the coronavirus outbreak, Americans throughout the country

have utilized their computers, tablets and smartphones. Online ordering has allowed supplies to be delivered directly to their homes, and telehealth services have provided continued healthcare. However, rural and tribal communities face a myriad of barriers in the online world. A 2018 US Federal Communications Commission report on the deployment of high-speed broadband Internet access confirmed the continuation of telecommunication gaps for rural and tribal areas. Specifically, it noted that roughly one in three people (35.4%) on tribal lands lacked high speed Internet compared to 2.1% in urban areas (US Federal Communications Commission, 2018, p. 22). The gaps extend to cell coverage and are the result, in part, of a lack of cell towers and fiber optic cables (Lo Wang, 2018). There have been calls to address these barriers. In May 2020, a group of Native American/Alaska Native organizations submitted a letter to the U.S. House of Representatives leadership that laid out their tribal priorities. It contained a specific call for a Tribal Broadband Fund to address critical technology infrastructure needs (National Congress of Native Americans et al., 2020, p. 3).

The digital divide is exacerbated by the fact that individuals without consistent or efficient Internet access often do not have opportunities to learn skills that online formats such as video conferencing and telehealth require. Before the pandemic, a mere 8.7% of patients in rural communities were accessing care through telehealth (Heath, 2019). A systemic review of literature on Home Online Health Consultation conducted by Almathami, Win and Vlahu-Gjorgievska (2020) found in several studies that people accepted and utilized the technology being used when they were familiar with it. Additionally, they found that the absence of training on how to use the technology was deemed a barrier. Thus, the lack of familiarity with and easy access to internet communications in rural and tribal areas can present a formidable barrier.

The KSNAF Team found other challenges emerge when in-person programs are moved to an online format with adaptations needed to ensure the material works in a virtual setting. For example, content that requires a physical exchange of information or that is more dependent on body language and detailed visual cues may need modification. However, alterations must be balanced with the need to maintain fidelity, particularly if the intervention being offered is evidence informed. Additionally, participants may need more frequent breaks with online delivery and may desire variations in the delivery to maintain a feeling of engagement. Other information used to establish and reinforce concepts like group guidelines or overarching principles that once hung on the walls of meeting rooms now must be provided in another way.

4. Adaptations

With these challenges in mind, the KSNAF Team began working on adaptations to provide the intervention via telehealth, staying true to the aforementioned goal which is to positively impact family bonding, communication, and caregiver supervision in a way that reflects community cultural values. As summarized above, there are three main supportive components to SFP (meal, transportation, and childcare). In addition, gas cards or transportation is provided to each family to ensure their presence at each in person session. Supplies and handouts necessary to carry out the assigned activity for each session were also provided prior to COVID.

In March 2020, in-person group sessions were halted at two active SFP sites due to health safety concerns and restrictions on in-person gatherings. The KSNAF team paused to determine how to continue serving families and replicate the features of SFP in an online format. For example, could the weekly meal be provided through a food delivery service? During this time, food delivery services were limited or non-existent in these areas, and SFP families were affected by a lack of food and basic household supplies. The enrolled SFP families lived in rural areas that could be up to 15 miles away from the closest city, which may have only one to two stores. Most local grocery stores in the rural areas had limits on food purchases, if food was even available. Some of the families would have to travel even farther to a larger city for more options including food assistance programs. After receiving special approval from the university to provide "humanitarian aid", the KSNAF team was able to deliver food and supplies to SFP families following no contact delivery protocols. With the high demand for food and household items, it was a challenge to find a vendor to partner with to purchase quantities beyond the local restrictions (i.e. 1 pound of meat per customer). During the food service deliveries, the KSNAF team would provide the families with games and activities that would assist with the new telehealth adaptation of SFP. Throughout this time, the KSNAF team communicated with families so that supports could be adapted to fit current needs (e.g. as local resources opened up, needs shifted).

Offering the SFP sessions in an online format introduced new challenges. Standard SFP is led by a site coordinator whose job is to coordinate services at the physical location (site). This role was adapted to a moderator role for zoom, which is the person who navigates the zoom services. To provide SFP online, buy-in from the implementation staff (children's group leaders and adult group leaders) was key. It was decided to re-start one site at a time, with the first site restarting in May 2020 and the second site restarting in July 2020. We began the process by holding a meeting with project leadership and implementation staff to solicit all stakeholders' thoughts about how to proceed. The site coordinator also gathered families' preferences for meeting times and needs for technology. Adaptations were also made to support staff and empower them to problem solve and make family directed decisions.

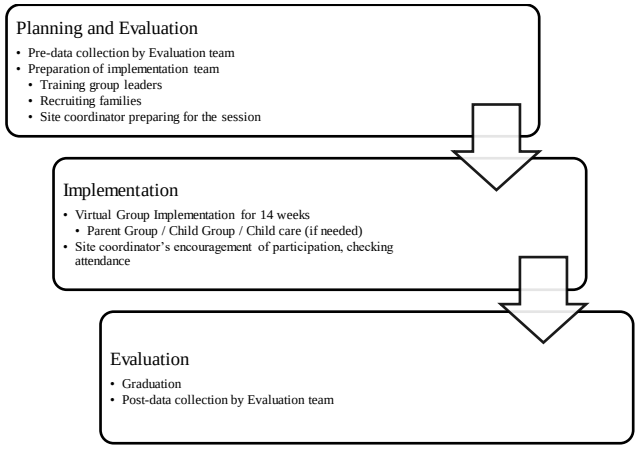
First, two Zoom Pro accounts were purchased to support SFP the group leaders' decision to deliver back to back separate sessions; with the parent or adult group held at 6 PM and the child group to follow at 7 PM. Technology and data

cards for SFP staff and families were provided to carry out the remaining SFP sessions via telehealth. Tablets were provided to all children and parents so that they would be able to participate in the Zoom meetings. If no wireless internet service was available, the KSNAF team would provide phone cards with enough data to connect the tablet to the phone's wireless internet service or "hotspot." If the family had wireless internet service, then the KSNAF team would still provide a phone card with data to assure enough wireless internet service was available for weekly meetings. Families and staff received training and technical assistance on using tablets and Zoom that included sessions to practice signing on and testing equipment. The KSNAF leadership team followed the telehealth process very closely, by initially facilitating a pre- and post-meeting for the SFP group leaders to provide feedback, support, and brainstorm together on how to enhance SFP family engagement. After three weeks of pre- and post-meetings, these support sessions were combined into a once weekly meeting attended by the SFP fidelity implementation consultants who offered additional feedback. These consultants also met individually with the group leaders as needed to support fidelity of the SFP intervention during this initial adaptation time.

Individualized check ins with families were one strategy that evolved out of post session meetings to support family engagement. For example, after one post-session brainstorming meeting, the site coordinator reached out by phone to a SFP family whose participation had decreased. During this conversation, the site coordinator became aware of increased needs the family had to stabilize the children in the home. Referrals to appropriate services were made and the family's attendance at subsequent sessions increased.

Upon completion of the remaining sessions and graduation of both groups, the KSNAF evaluation team designed and implemented an evaluation process to gather family feedback on the virtual implementation adaptations and general helpfulness of the SFP intervention (see Figure 1).

Figure 1. *Planning, implementation, and evaluation process for telehealth adaptation*



Previous qualitative study of adult or parent perspectives of completing SFP suggest that group leaders' aptitude to "*build supportive helping relationships*" and address changing group needs were important to parents' perceived helpfulness and engagement in SFP (Akin et al., 2018, p. 735). The SFP has the potential to counter the impact of stressors caused by the pandemic and increase resiliency of families who participate. The objective of this evaluation was to gather adult participant feedback on what is working well and what changes are needed with the telehealth adaptation of the SFP. Until this point, SFP had not been delivered remotely before, and as such feedback on the adaptation from in person to remote delivery during the pandemic, is critical to maintaining the integrity of SFP and exploring strategies to increase access and participation.

5. Methodology

The present research is a qualitative utilization focused brief evaluation (Patton, 2012). The literature summary described above informed the design of a brief semi-structured interview guide (see Appendix A). The purpose of this qualitative evaluation is to gain a better understanding of ways to improve the delivery of the telehealth version of The Strengthening Families Program. Broadly, the research question is how effective the telehealth adaptation of the Strengthening Families Program from caregiver perspectives was. Specifically, the implementation team wanted to understand participants' interest and motivation to participate, perceived helpfulness of the online versus face-to-face delivery, technical needs and adaptations that were made, effectiveness of group leaders' approach, and perceptions of how well youth were engaged. A modification to the original research procedures was submitted, and the University's Human Subjects Committee approved the modification.

5.1 Procedures

One evaluator contacted families who had completed the adapted SFP program. First contact was made by mail to explain the study and provide a copy of the questionnaire as well as the informed consent. The evaluator then contacted all the families by phone and scheduled a phone interview that was recorded, but not transcribed. The recordings were stored on a secure university server and were deleted once the analysis was completed. No participant incentives were provided for this additional research study.

A domain focused method of note taking, and analysis was utilized to summarize key themes from each interview (Patton, 2012). One researcher took detailed notes during the interviews and went back to transcripts to check quotes and notes. A domain focused method of analysis was utilized so that the findings could be immediately shared and incorporated in the quality improvement process of adapting SFP to an online format. Thus, the key themes were

summarized and shared in weekly research team meetings as well as shared at a KSNAF steering committee meeting.

5.1 Participants

The population of interest in this study was primary caregivers who had completed the adapted SFP at the two project sites. Seven of eight primary caregivers responded to the researcher's efforts to be interviewed. Out of seven participants, five were female (71%). Average age of the participants was 43.4, and of them, three of the grandmothers who participated in the interview were the primary caregiver. All but one of the participants identified as Native American, with the one exception identifying as white. Five participants were an enrolled member of a federally recognized tribe, and one was a descendant of an enrolled member of a tribe.

Participating families included a "focal child" between the ages of 5 to 12 who was the primary target of the intervention. A total of 15 children participated with their families in these groups. All children were Native Americans including six who were enrolled member of the tribes, and nine who were descendants of an enrolled member. For two other children, we do not have information about whether they are enrolled or the descendant of the tribe even though they consider themselves as Native Americans. All the children were living in a private residence (e.g. not treatment facility). The family composition was diverse including single-mother headed households to multi-generational families. All children were recipients of Medicaid.

6. Findings

Findings are reported based on six themes that emerged within the underlying structure of the questionnaire, with a summary of overall key themes at the end of this section.

6.1 Theme 1: Technical needs

As previously described, participating family groups received two tablets prior to the transition of SFP to telehealth. All participants agreed that the tablets were helpful to support participation. Having a larger, dedicated device proved to be key, as participants explained that for one session, a group leader participated by smart phone, and it was difficult to communicate.

Internet connection and speed had an impact on all participants. There were challenges in the rural areas finding connection and securing enough data to participate. Project staff provided data plans, but participants explained that these would run out sometimes before the scheduled group session. Two participants responded that more data would be helpful to assure participation.

Zoom, the teleconferencing platform that was used, was new to every participant. All participants had to learn how to use Zoom, and this took time. Participants said that group leaders were patient and helped to trouble shoot how to "*get on*" zoom. The majority of participants suggested that in the future the team "*give a good overview of Zoom, how it works"* and ensure that future participants understand how to use it.

6.2 Theme 2: Interest and motivation to participate

Participants' motivation for participating in SFP reflected the traditional goals for these groups as well as the unique aspects and needs of the public health crisis that the groups unintentionally addressed. Participants were asked to respond to the question, "On a scale from 1-10, with ten being very interested/motivated and one not interested/motivated, please rate your interest in SFP." Participants' ratings ranged from 5 to 10. Higher motivation was influenced by the desire to gain new knowledge and connect with others on how to use new skills and learn together, which are key goals of SFP. Reasons cited for being motivated to participate were: 1) a way to stay connected during physical distancing, 2) the intervention gets the whole family involved and gives a reason for family to come together, 3) easy to do from the comfort of your own home, 4) hearing other input and opinions was helpful, and 5) participants felt supported and not judged. The lowest score given was a 5, with the participant commenting, "*Wasn't sure how it was gonna work."*

6.3 Theme 3: Accessibility of sessions and content

Participants indicated that the telehealth version of SFP provided accessibility and convenience. For example, families could participate with audio while driving or they did not have to worry about travel time. Some said they could participate in the comfort of their own homes and that they "*looked forward to the day and time*."

Packets with written materials and supplies for the group sessions were mailed to families before sessions, which one participant said was helpful. However, there was indication that having to navigate the materials alone without in person support could be difficult. One participant commented that written materials were difficult for them to understand, due to a disability. Thus, they suggested it might be helpful to gather information from participants about learning disabilities or other challenges participants may have interpreting written materials. Another participant said that hands on activities were easier to understand and learn during in person SFP.

6.4 Theme 4: Logistics of adapting family sessions for online delivery

Traditional SFP begins with a family dinner, followed by separate, simultaneous adult and child groups. The transition to telehealth required group leaders find a way to hold both parent and child groups via televideo when it was most convenient for all involved. For the transition to telehealth, group leaders sought input about the time of day to provide SFP, and the majority of participants said the selected time of day worked for them, one group agreed upon Sundays at 5 PM and another group agreed upon Wednesdays at 6 PM.

However, according to two participants, it was difficult to remember the scheduled time. Group leaders used Facebook messenger and the SFP Facebook page to remind participants. One participant said that the scheduled time was challenging at times because it was dinnertime.

Three of the participants said they were satisfied with the order of sessions, having parent session, following by the children's session. One participant felt having the children go first might be helpful or having one adult session one day and the children's session the next day might be helpful. Having both sessions all at once seemed like too much.

6.5 Theme 5: Creating SFP community in telehealth

There was a strong sense of community among the participants and group leaders. All participants thought group leaders were clear and helpful. They felt like they could approach group leaders and each other if they needed to. Most participants felt comfortable sharing during the groups.

> *Yes, I felt comfortable. At first everything went fine, but then I started having some problems so I stopped sharing. Group leaders noticed the change. When they asked us if we were using the parenting tools, both of us were quiet. They kept asking us to talk. It made me relieved and a little more stressed. They noticed and they care. They wanted to make sure we knew they noticed and cared.*

Though families were able to recreate community in the telehealth format, participants said of the in-person format that they missed the "*closeness, sitting down, and getting to know each other",* and that "*it was hard to pay attention on zoom or understand what is being said."*

6.6 Theme 6: Child engagement and outcomes

Though children were not included in this study, all adult participants reported their children liked participating in SFP. According to the participant caregivers, motivation for the children varied more than adults, with ratings from 2 to 7 on the 10 point scale. Reasons cited for less child motivation included: being pulled away from more desirable activities like video games, swimming in the lake, and "*that it depended on the mood that day."* In contrast, reasons cited that were motivating to children were having a tablet to use, being able to connect with friends, having a reward system for younger children, and having a graduation ceremony. There was a preference for face to face by most of the children, but they still participated online well.

All participants said they noticed positive differences in their families related to communication, patience, and spending time together, which they attributed to participating in SFP. Multiple participants said their children learned a lot, "*I see the improvement in our kids. If they keep coming to classes, people can learn a lot."*

7. Discussion

This study makes a contribution to what is known about families' experiences and perspectives about engagement in a virtual parenting program. Delivering a group parenting intervention virtually is possible, but it takes will, planning, flexibility, and most importantly, commitment to prioritizing families and staff concerns and needs. Even with the switch to virtual SFP implementation, participants noticed a positive difference in their families which they attributed to SFP. This is preliminary evidence that we can connect with families virtually and deliver a service that they find meaningful and useful.

7.1 Summary of lessons learned in adapting SFP for telehealth delivery

The online format is convenient and accessible. Although all participants said they miss seeing each other face to face, all report the program has helped them and their children learn better ways to relate. Adult participants noticed differences in themselves and their children after participating in the program. The telehealth platform utilized, Zoom, was new and everyone had to learn how to use it. Group leaders were helpful in this learning process, but it took some time for everyone to learn. More individualized instruction and planning before starting telehealth sessions might be helpful.

The tablets were helpful to increase participation and were appreciated. Sufficient data or internet to stay on the telehealth platform Zoom is a need. Planning around having sufficient connection is important. Having everyone participate on a tablet is helpful. Smart phones limit the ability to see all participants.

There was a strong sense of community and motivation to participate. The relationships with both group leaders and other participants emerged as key to the participants' experience of SFP. The familiarity seems to be what has helped maintain connection and increased everyone's capacity to adjust to this new format of providing SFP.

7.2 Reflections on adapting and providing services during the COVID-19 pandemic

During the pandemic, the transition to virtual services addresses traditional barriers to service access and engagement (e.g. transportation and childcare needs), while introducing unique challenges such as, what is the best technological set up to achieve optimal engagement and what support is needed to learn the technology.

Support for families and staff is key to creating a caring environment and approach during these stressful times. Empowering staff to make decisions about how to adapt the program and engage families in a localized and family-directed way was one way to facilitate a caring approach. The adaptations were made in the context of support from KSNAF program staff and the SFP implementation consultants.

Adapting the program to use a caring approach is supported in the literature review described via the importance of "human support" and "coaching" in the literature (Georgeson et al., 2020).

In the course of adaptation and implementation of SFP during the COVID-19 Pandemic, it was important to acknowledge that staff were also living through the Pandemic and needed technology and human kindness and support too. In clinical social work practice, this is called a "parallel process"-if staff feel care and concern for their well-being, they will pass this sentiment on to families (Williams, 1997).

What started as "how do we replicate this service" (e.g. do a shared meal virtually) became how do we stay connected to families and communities at this time and what do families need to be strong and survive during this time. Findings suggest families felt "noticed and cared about" in the virtual implementation of SFP, this demonstrates that the parallel process of care and concern described above achieved the desired outcome.

8. Limitations

Despite the unique contributions of the article, the limitations must also be recognized. As with all qualitative research, generalizability was not the focus, but instead, we focused on sharing the experiences of Native American families participating in a specific telehealth family skills group during the COVID-19 pandemic. This study utilized a convenience sample with only a small number of Native American caregivers receiving SFP in one Midwestern state. Therefore, the themes must be viewed as emerging and exploratory in nature and cannot be examined in relation to sample subgroups or characteristics. Another limitation is that our interviews were only with caregivers from the family skills groups that were delivered first in person and then by telehealth, and so we do not know how this translates to children's or group leaders' experiences or groups conducted fully in one modality or the other. Future research with larger numbers of caregivers and with youth and group leaders will benefit from the ability to conduct a deeper comparative analysis of these perspectives.

9. Conclusions

The objective of this qualitative evaluation was to gather caregiver feedback about the initial telehealth adaptation of the culturally integrated Strengthening Families Program for Native American families. This step was critical to maintaining the integrity of SFP and exploring strategies to increase access and participation. These preliminary findings suggest that SFP can be successfully adapted and provided via a telehealth modality, which sets the foundation for future research to investigate the impact on child and family outcomes more closely and in comparison to in person delivery. The core tenants of the SFP program can be delivered; however, unique challenges can and must be addressed through individualized planning and flexibility.

This study builds on previous knowledge of SFP group leadership which suggests that supportive helping relationships paired with flexibility are facilitators of effective family engagement (Akin et al., 2018). The main contribution of this study is that the telehealth adaptations and supportive resource provisions that were made during the COVID-19 Pandemic, decreased disparities and increased access to support and thus the well-being and resilience of the Native American Family participants. Participant feedback suggests that caregiver's felt comfort, care, and genuine concern. In addition, all participants noticed a difference in their families' communication patterns and improved relationships. Although tragic and challenging, the COVID-19 Pandemic highlighted disparities (limited internet access, social service, and food resources) that needed to be addressed to not only sustain SFP participation but also to more generally support well-being and resilience among Native American communities. KSNAF project efforts that initially started out focused on replicating SFP in a remote, virtual way shifted to how can we leverage our knowledge, resources, and connections to meet needs and support resilience for Native American families during this unprecedented public health crisis.

Acknowledgments

This work was supported by the Administration on Children, Youth and Families, Children's Bureau of the U.S. Department of Health and Human Services under grant number 90CU0079, Regional Partnership Grant (RPG) Program. The content and conclusions are those of the authors and should not be construed as the official position, policy or opinions of the Administration on Children, Youth and Families.

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Appendix A

Semi-structured Interview Guide: KSNAF Version of Strengthening Families in Online/Virtual Format – May 13, 2020

Interest & Motivation to Participate

1. First I'd like to understand your interest and motivation to participate in Family Camp. On a scale from 1-10, with ten being very interested/motivated and one not interested/motivated, please rate your interest.
   - Probe: Can you please explain your rating?

2. On that same scale of 1 to 10 how interested/motivated do you think your children were? What about other adults who attend as part of your family unit?
   If more than one child, get rating for each child/other adults.

Helpfulness

3. What was helpful about having this program available online?

4. What was not helpful or something you missed from not being in person?

Technical Needs

5. Were there any technical needs before or during the online sessions?
   Probes:
   - For example, did you have access to a tablet or other device to participate?
   - Did you have an internet connection?
   - What was done or could be done to meet these needs?

Accommodations-Meeting families where they are

6. Tell me your thoughts about the time and day that online sessions were held.
   Probes:
   - Did you provide feedback about times and days that would work best for the adult group? And the children's group?
   - Did the selected day and time work for you?
   - What do you think about the way the sessions were provided (parents first, children second, family group last).

Family Camp Leader Approach (Communication, Clarity, Trust)

7. Did the group leaders provide clear instruction? Did you have the materials you needed to participate? Please explain.
8. Were the group leaders easy to talk to? Approachable? Please explain.
9. If there was an issue with connection or communication, how did the group leader help you?
10. Did you feel comfortable sharing your thoughts and participating? Please explain.

Youth Engagement

11. How do you think it went for your children who participated?
12. Is there anything you think that would have helped it go smoother?

General Feedback

13. Anything else you would like us to know about having the sessions online as we move forward and offer it to more families?

Thank you so much for your thoughts!