Made available through Montana State University's ScholarWorks

Training community members to deliver an intervention for substance use disorder: Overcoming implementation barriers in American Indian communities

Monica C. Skewes, Vivian M. Gonzalez, Allen Stix

© This manuscript version is made available under the CC-BY-NC-ND 4.0 license https://creativecommons.org/licenses/by-nc-nd/4.0/

Accessibility Disclaimer:

For a more accessible version of this document, please submit an accessibility request form through the Montana State University Library website.

Training Community Members to Deliver an Intervention for Substance Use Disorder: Overcoming Implementation Barriers in American Indian Communities

Monica C. Skewes,[1] Vivian M. Gonzalez,[2] & Amy Stix[3]

[1]Department of Psychology, Montana State University

[2]Department of Psychology, University of Alaska Anchorage

[3]Center for American Indian and Rural Health Equity, Montana State University

Author Note

This research was supported by the National Institute on Drug Abuse of the National Institutes of Health under Award Number R01DA053791. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health. The authors express heartfelt admiration and gratitude to the community members who committed their time, knowledge, and experience to leading the way to addiction recovery for their people.

Correspondence concerning this article should be addressed to Monica C. Skewes, Department of Psychology, Montana State University, 320 Traphagen Hall, Bozeman, MT 59717. Email: monica.skewes@montana.edu. No authors have conflicts of interest to declare.

Abstract

Introduction: Although American Indian and Alaska Native (AI/AN) people have high rates of abstinence from alcohol and other drugs, there also is evidence of greater rates of substance use disorders (SUDs) in Native communities. Health disparities associated with substance use are compounded by inadequate access to evidence-based treatments (EBTs). Lack of mental health providers is one notable barrier to EBT implementation in rural AI reservation communities. Our *Indigenous Recovery Planning* (IRP) intervention merges cultural lessons and culturally adapted relapse prevention strategies to facilitate SUD recovery in the reservation environment. One key implementation strategy is training non-specialist community-based facilitators to deliver IRP, thereby increasing its acceptability and sustainability. This manuscript reports the facilitator training, supervision, and fidelity monitoring procedures used in our ongoing clinical trial of IRP. **Method:** Four AI non-specialist providers were recruited from the community to serve as IRP facilitators. Initial training involved an introductory motivational interviewing workshop followed by a 2-day workshop in the IRP curriculum. Then we conducted an open trial of the 6-week intervention with weekly supervision meetings as part of the facilitator training process. During the open trial we also assessed participant and facilitator receptivity to the IRP intervention and pilot tested our fidelity monitoring protocol. **Results:** The initial training workshops provided facilitators with information they needed to understand the rationale behind IRP and determine whether the facilitator role was a good fit; however, additional training and supervision during the open trial was needed to ensure proper treatment delivery. Although participant and facilitator feedback ratings were positive, the open trial helped us identify revisions needed to improve our approach to facilitator training, supervision, and fidelity monitoring. We revised these procedures, and also developed a protocol to train new facilitators

who join the study midstream. **Conclusion:** The open trial was an important aspect of the facilitator training process and helped our team identify several areas of improvement. Our approach to training, supervising, and monitoring community member facilitators may serve as an example of how to overcome one barrier to implementing evidence-based SUD treatments in rural reservation communities with few mental health professionals.

Keywords: American Indian; Addiction Treatment; Implementation Supports; Facilitator Training; Community-Based Participatory Research

Highlights

American Indian (AI) community members were trained to deliver addiction treatment.

An open trial was conducted as part of the facilitator training process.

The open trial suggested revisions needed to the training and study protocols.

We revised our procedures for training, supervision, and fidelity monitoring.

Community-based providers can help expand treatment access in AI communities.

Training Community Members to Deliver an Intervention for Substance Use Disorder: Overcoming Implementation Barriers in American Indian Communities

Although American Indian and Alaska Native (AI/AN) people have high rates of abstinence from alcohol and other drugs (e.g., Cunningham et al., 2016), there also is evidence of greater rates of substance use disorders (SUDs) in Native populations (Brave Heart et al., 2016; Grant et al., 2015, 2016). Health problems caused or exacerbated by substance use disproportionately affect AI/AN people (Rieckmann et al., 2012; Whitesell et al., 2012), making SUD treatment a priority for many tribal communities. However, there is a paucity of mental health professionals available to provide culturally responsive treatment in AI/AN communities (O'Keefe et al., 2021). Training paraprofessional, non-specialist providers such as lay community health workers to provide treatment services is one promising implementation strategy that may increase the availability of services and narrow the gap between those who need treatment and those who receive it (Barnett et al., 2018a, 2018b; Mongelli et al., 2020; O'Keefe et al., 2021; Rebello et al., 2014; van Ginneken et al., 2013).

To address substance use-related health disparities in a rural AI reservation community, our team of academic and community co-researchers developed a culturally grounded intervention for SUDs. Our *Indigenous Recovery Planning* (IRP) intervention employs community members to deliver cultural lessons merged with culturally adapted relapse prevention strategies to increase protective factors and mitigate locally relevant risk factors within the reservation context (Skewes et al., 2024). Using a Community-Based Participatory Research (CBPR) framework (Wallerstein & Duran, 2006, 2010), our partnership is in the process of testing the effects of IRP on substance use outcomes using a randomized controlled

trial design. In the present manuscript, we describe our process of training, supervising, and monitoring the community-based facilitators who deliver the IRP intervention.

The study site is a rural AI reservation with high rates of poverty, few healthcare professionals, and inadequate opportunities for SUD treatment. There is one on-reservation outpatient SUD treatment center in the community, but waitlists are long and it can be difficult to access services. The IRP intervention provides an alternative option that circumvents barriers to engagement in effective treatment, including lack of access to evidence-based treatments (EBTs), poor fit of EBTs with AI culture, few mental health professionals, and practical barriers such as lack of transportation and childcare. These barriers also impede participation in evidence-based mental health treatments in other minority, rural, and low-income communities (Handley et al., 2014; Jackson & Shannon, 2012; Kouyoumdjian et al., 2003; Rosen et al., 2004). A key innovation of IRP is its strengths-based focus on planning for recovery (Skewes et al., 2024) and its use of trained community members to deliver the intervention.

Relapse Prevention as Underutilized Evidence-Based Practice in AI Communities

Given the health disparities associated with SUDs among AIs, effective treatments are critically needed (Etz et al., 2012). Most AI individuals needing SUD treatment never receive EBTs, and it is unclear whether the treatments they do receive are effective (Novins et al., 2016). Fewer than 1% of all participants in NIH-funded research studies on substance misuse are AI/AN (National Institutes of Health, 2024) and few studies have focused on examining the efficacy or effectiveness of SUD interventions for AI/AN people. While there are a number of evidence-based SUD interventions tested with the general population (Carroll & Onken, 2005; McGovern & Carroll, 2003) that could be culturally adapted to make them more relevant to AI people, we focused on relapse prevention, as our partner community identified relapse as a key barrier to

recovery on the reservation (Skewes et al., 2019, 2020, 2021). Relapse prevention is a psychoeducational and skills-based cognitive behavioral intervention that has significant empirical support (Bowen et al., 2014; Irvin et al., 1999). While relapse prevention has not been tested for use with AIs and does not account for cultural aspects of SUD recovery, our partnership determined that it could be readily adapted to include components addressing barriers to recovery in the reservation environment, as well as content designed to enhance protective factors such as community and cultural connection. In addition, relapse prevention strategies were deemed pragmatic, accessible, and suitable for delivery by community members.

Overview of Indigenous Recovery Planning (IRP)

The IRP program merges evidence-based relapse prevention strategies with local cultural lessons and activities intended to affirm AI identity and increase social support for change. It consists of six group sessions led by trained community members who have experience with or knowledge of SUD recovery on the reservation. At each group session, facilitators provide psychoeducation and lead activities and practice exercises to help participants develop new skills to support their recovery. With support from the facilitators, participants create personalized recovery plans using skills they learn each week.

Intervention topics include setting goals, understanding relapse and recovery, adopting a growth mindset, planning for triggers and coping with cravings, addressing trauma and stress, enlisting social support for recovery, and lifestyle rebalancing (see Skewes et al., 2024 for a detailed description). Locally relevant relapse risks (e.g., historical trauma) and protective factors (e.g., spirituality, AI identity) are addressed throughout the sessions. Community and cultural connections are fostered by opening sessions with a prayer and smudging, a ceremonial energy cleansing practice involving the burning of sage; presenting a cultural story or lesson relevant to

recovery; teaching new words and phrases in the Native language; and extending invitations to participate in sober community and cultural events. Before each session, participants and their family members are invited to share dinner with the facilitators. Transportation and childcare are also provided to decrease barriers to engagement.

The Promise of Non-Specialist Providers

There is a nationwide shortage of mental health professionals in the U.S., particularly in rural areas and ethnic minority communities (Butryn et al., 2017; Kuehn, 2022; Thomas et al., 2009). At the same time, the need for mental health treatment services is high, with many more people needing than receiving treatment (Evans-Lacko, 2018; Mongelli et al., 2020; Sahker et al., 2024). People from ethnic and racial minority groups are less likely to receive mental health care relative to White patients, and when they do receive treatment, they are less likely to receive quality, evidence-based services (Barnett et al., 2018a; Mongelli et al., 2000). Providing interventions that are cost-effective, situated within underserved communities, and that use non-professional providers is a goal of initiatives led by the World Health Organization and National Institute of Mental Health aimed at addressing the mental health treatment gap (Escobar, 2015; World Health Organization [WHO], 2008).

Non-specialist providers such as community health workers play an important role in implementing EBTs in low-resource settings (Barnett et al., 2018a, 2018b). Training community health workers to conduct outreach, support professional providers, or serve as primary treatment providers can help expand access to EBTs in populations that need them most (Barnett et al., 2018b). Such task-sharing approaches are key to broadening EBT access and narrowing the treatment gap in low-resource and ethnic minority communities (Barnett et al., 2018b; O'Keefe et al., 2021; van Ginneken et al., 2013; WHO, 2008). Research shows that non-specialist mental

health treatment providers are capable of delivering EBTs (Barnett et al., 2023; Singla et al., 2017), and that interventions delivered by non-specialist providers have been effective at reducing mental health symptoms (Barnett et al., 2018a; Singla et al., 2017) and reducing alcohol consumption among problem drinkers (van Ginneken et al., 2013). In addition, non-specialist providers who are members of the target community have the advantage of understanding the community's history, culture, and views of healing and recovery, which may increase trust in providers and facilitate engagement in treatment (Barnett et al., 2018a; O'Keefe et al., 2021).

Despite the evidence that non-specialist providers can be trained to deliver EBTs that effectively improve mental health outcomes (e.g., Barnett et al., 2018a, 2023; Singla et al., 2017; van Ginneken et al., 2013), there is a gap in the literature regarding the implementation supports (i.e., training, supervision, and fidelity monitoring) needed to ensure effective delivery of EBTs by community health workers (Barnett et al., 2023; Bunn et al., 2021; Singla et al., 2017). There is significant variability in training and supervision of non-specialist providers, and limited information is available in the literature about how to train community members to deliver EBTs with fidelity (Barnett et al., 2018a, 2018b, 2023; Bunn et al., 2021; Caulfield et al., 2019; Singla et al., 2017). Thus, information on training, supervision, and fidelity monitoring of non-specialist providers is critically needed for efforts aimed at expanding access to EBTs in communities that need them (Barnett et al., 2023; Bunn et al., 2021; Singla et al., 2017). In this manuscript we describe our procedures for training and supervising the community members who deliver IRP, and for monitoring treatment fidelity. We also describe the open trial conducted as part of our facilitator training process and changes we made to our training and fidelity protocols in response to the lessons we learned.

Method

Facilitator Recruitment and Initial Training Workshops

Facilitator recruitment began through nomination by the project's Community Advisory Board (CAB) and local project manager. Through a series of discussions, we identified several community members with the qualities needed to deliver the intervention, such as not currently having a SUD, being a good listener, being well-known and respected in the community, and being motivated to serve the community. We then approached four potential facilitators and invited them to join our team. While only two facilitators are needed to conduct each session, with one serving as lead facilitator and the other serving as co-facilitator, we aimed to train four people to ensure adequate staffing for the later clinical trial. All four agreed to undergo IRP training to learn whether the role of facilitator would be a good fit.

Training began with a two-day introductory workshop in motivational interviewing (MI), as IRP uses the spirit of MI in intervention content delivery (e.g., collaboration, nonjudgmental acceptance; Miller & Rollnick, 2013). The research team including the four facilitator candidates, reservation-based project manager, university-based research coordinator, Principal Investigator (PI), Co-Investigator (Co-I), consultants, and research assistants gathered for the MI training, which was led by an experienced trainer from the Motivational Interviewing Network of Trainers (MINT, n.d.). This in-person gathering was helpful for building team cohesion and for conveying the nonconfrontational, nonjudgmental, collaborative style needed to deliver IRP with fidelity. Throughout the training, the facilitators expressed their enthusiasm for the MI approach and desire to learn more about the IRP intervention.

Following the MI workshop, facilitators completed a two-day workshop to learn the IRP content and rationale. This training took place on the reservation and was led by the PI and Co-I.

The trainers presented an overview of the research study, offered background information on addiction and SUD treatment research, and reviewed the IRP intervention. This introduction to IRP included information on relapse prevention and motivational interviewing, the group therapy format, best practices for facilitating groups, and potential ethical considerations and participant safety issues that could arise during the intervention. Facilitators were trained to recognize when participants need referral to a licensed mental health provider (e.g., signs of extreme distress or suicide ideation) and how to make such a referral, if necessary.

Next, the group reviewed each of the six IRP sessions, using the treatment manual as a guide. We discussed the rationale for the content and intended aims of each session, presented the IRP worksheets and handouts, and practiced the intervention activities. Opening IPR sessions, reviewing the practice exercises, and wrapping up sessions also were discussed. At the end of the IRP training, facilitators understood the history, philosophy, rationale, ethical considerations, safety concerns, and practical aspects of leading IRP groups. The four facilitators expressed enthusiasm for the intervention and agreed to remain involved in the project.

Open Trial

As part of the facilitator training process, we conducted an open trial of the intervention to understand barriers to and facilitators of IRP implementation. The open trial was an underpowered pilot trial of the IRP curriculum that aimed to increase facilitators' competence and confidence in delivering the intervention content, and to ensure that they were interested in and appropriate to serve as facilitators in the clinical trial. The open trial also allowed us to pilot test our facilitator supervision and fidelity monitoring procedures, gather information from participants and facilitators about their receptivity to the intervention content and its delivery, and to evaluate and refine our study protocols. All information gathered during the open trial was

strictly for the purpose of training facilitators and evaluating our protocols; open trial data were not used to evaluate IRP. Explaining the purpose of the open trial and emphasizing its use as a trial run of the intervention helped ease facilitators' anxiety and increase their comfort with leading the groups.

Participants and Facilitators

Open trial participants were tribal members who met the inclusion criteria for the IRP clinical trial (i.e., treatment-seeking AI adults with a SUD). Participants were recruited by the local project manager, who conducted the eligibility screening, obtained informed consent, and administered assessments with supervision from the PI. Participants included five AI women (M_{age} = 42) who reported methamphetamine as their primary drug. All had less than a high school education and the median monthly income reported was $762. All met criteria for a severe SUD (six or more of the 11 criteria; American Psychiatric Association, 2013) and reported using methamphetamine on 36 days of the previous 90. Other than gender, these characteristics were representative of the target population for whom IRP was developed.

The open trial facilitators were the four AI tribal members who had completed the MI and IRP trainings. Two facilitators were men aged 40 and 49 and two were women aged 35 and 51. Both men and one of the women were in long-term recovery from alcohol use disorder; one of the women had never had a substance use problem herself but had supported relatives through recovery and was knowledgeable about addiction. One facilitator had completed some college, two had bachelor's degrees, and one had a master's degree. All had work experience in social service-related fields and were employed by local agencies. Although two facilitators had previous experience as support staff in a SUD treatment setting, they were not involved in client

care. Notably, none had advanced training in SUD treatment. All facilitators were well-known and respected in the community and were deeply connected with traditional cultural practices.

Procedure

The open trial participants met with the reservation-based project manager for a private one-on-one meeting at the research office. After obtaining informed consent, the project manager informed them about the start date and format of the 6-week group intervention. In accordance with the IRP study design, sessions were held once per week in the evenings and took place at the local tribal college. Dinner was served prior to each session, and transportation and childcare were provided to facilitate attendance. The facilitators rotated between leading and co-leading IRP sessions. For sessions where a facilitator was assigned as neither lead nor co-facilitator, they were invited to observe the session to increase their familiarity with the week's content and exercises. All sessions were audio recorded with participant consent, and facilitators completed an IRP content checklist to help ensure that the session's content was covered. Facilitators and participants also completed feedback forms at the end of each session. Following each session, all feedback forms and checklists were gathered by the project manager and shared with the investigators, along with the audio recording of the session.

Participant Rating Forms

Our team created separate rating/feedback forms for the participants and facilitators in the open trial. Participant forms were completed after each session and included both quantitative and qualitative items. The three quantitative items on the participant forms were: 1) the lessons presented in the session were easy to understand, 2) the lessons and activities were helpful for my recovery, and 3) I felt comfortable participating in group discussions and activities. These items were rated on a four-point scale from 1 (*strongly disagree*) to 4 (*strongly agree*).

Participants also were asked the following open-ended questions: 1) “What was your favorite part of the group today?”, 2) “What is something you learned today?”, 3) What did you dislike about the group today?”, and 4) “Any other comments about this week’s group?”.

Facilitator Rating Forms and Content Checklists

Facilitators present at each session completed rating forms that included the following qualitative items: 1) “Did the group seem engaged?”, 2) “How did the check-in/homework discussion go?”, 3) “Were you able to get through all the material?”, 4) “What activity or exercise worked out the best? What did people seem to respond to?”, 5) “What activity or exercise was the hardest to get through? Why?”, 6) “What is your general impression of this session? Did you feel good about it?”, 7) “What problems or concerns came up?”, 8) “What do you think we should change?”, and 9) “Any other observations about this group or session?”. In addition, facilitators completed self-report IRP content checklists at each session. Separate session-specific checklists were developed by the investigators, with bullet points outlining each content area, exercise, and activity to be covered in that week’s session. Facilitators were asked to indicate whether the material in each bullet point was covered during the group (Yes/No) and, if no, the reason it was not covered.

Fidelity Rating Forms

In the open trial, we selected items from previously developed fidelity measures, the Motivational Interviewing Treatment Integrity Code (MITI; Moyers et al., 2016) and the Yale Adherence and Competence Scale (YACS; Carroll et al., 2020), to assess fidelity. Items selected from the MITI (Moyers et al., 2016) included one item to assess *partnership* (e.g., how well the clinician fosters collaboration with the client), one item to assess *empathy* (e.g., how well the clinician understands and attends to the client’s point of view), one item to assess *softening*

sustain talk (e.g., how well the clinician responds to the client's language favoring the status quo), and one item to assess *cultivating change talk* (e.g., how well the clinician responds to the client's language favoring change). Scores on each item ranged from 1 (*low*) to 5 (*high*).

Additional items were selected from the YACS (Carroll et al., 2020) for inclusion in the fidelity rating form used in the open trial. For example, items were selected to rate *self-disclosure* (e.g., the extent to which the clinician refers to their own life experiences), *spirituality* (e.g., the extent to which the clinician discusses a higher power as a source of strength), *coping skills training* (e.g., the extent to which the clinician teaches/models/reviews specific coping skills), *past high risk situations* (e.g., the extent to which the clinician explores specific actions taken to avoid or cope with risky situations), *future high risk situations* (e.g., the extent to which the clinician encourages the client to anticipate future risky situations and develop strategies to cope with them), *slip vs. relapse* (e.g., the extent to which the clinician explains that a slip does not necessarily mean that the client will experience a relapse), and *cravings/triggers/urges* (e.g., the extent to which the clinician explores cravings, triggers, or urges to use the client's drug of choice for the purpose of labeling triggers and planning to cope with them). Each item was rated for frequency and extentiveness of delivery on a scale from 1 (*not at all*) to 7 (*extensively*) and also was rated on skill of delivery on a scale from 1 (*very poor*) to 7 (*excellent*).

Facilitator Supervision and Monitoring

Each week following the IRP session, the PI and Co-I, a licensed clinical psychologist with training in relapse prevention for SUDs, reviewed the participant and facilitator rating forms and content checklists, and listened to the session audio recordings. While listening to the session recordings the investigators completed the fidelity rating forms discussed previously. They took detailed notes on facilitators' adherence to the treatment manual, their effectiveness in delivering

the IRP content, and any areas of improvement identified while listening to the recordings (e.g., missed content, issues with pacing, group management). A weekly meeting was held via videoconference to provide positive feedback on the use of MI style (e.g., use of affirmations) and IRP content that was presented well, to review content that was not presented, to review issues that may have contributed to missed content (e.g., issues with pacing and session focus) and to suggest solutions to facilitator concerns and questions (e.g., group management). These meetings lasted approximately 1 hour and allowed the facilitators to receive personalized feedback, ask questions about the intervention, and to share suggestions with the investigators. Facilitators received $250 for each session and corresponding feedback meeting they completed.

Results

Intervention Acceptability

Participant Feedback

Participant ratings on the quantitative items were very positive, ranging from 3.50 to 4.00 (on a scale from 1 to 4) for all items. These ratings indicate that the IRP content was easy to understand, the lessons were seen as helpful for recovery, and the participants were comfortable participating in the groups. Participant responses to the open-ended questions also were very positive. Regarding their favorite part of the group, participants shared that they enjoyed being around other group members and listening to them share, learning new tools for recovery, and expanding their social networks. Participants were especially enthusiastic about the cultural elements of the intervention. Regarding new things learned in the group, participants discussed learning new coping skills, developing greater self-compassion, developing a hopeful outlook on their journey, and gaining a greater understanding of their cultural identity and how it is linked to

their substance use. Regarding things they disliked about the group, participants shared that they were disappointed that the group was ending; no other concerns were reported.

Facilitator Feedback

Facilitator feedback on the intervention also was very positive, but the facilitator rating sheets did help us identify areas of improvement. All facilitators indicated that participants were engaged at each session and that they were able to get through the intervention content. They identified activities and exercises that went smoothly at each session, which helped us understand which lessons were well-articulated in the treatment manual and likely to be well-received by participants. Regarding the item about the group check-in and homework review, facilitators indicated that some participants did not complete the practice exercises and they were not sure what to do in this situation. They also shared that they needed direction regarding how to help participants catch up if they missed a session and then attended the next one.

In response to the question about activities and exercises that were most difficult to get through, facilitators reported that nothing was too challenging, but did share some important observations. For example, they noted that discussions of cultural identity were difficult for some participants, as some viewed their Native identity in a negative light. They also noted that some participants had difficulty completing the IRP worksheets and requested more guidance about how to present them to the group. In addition, although no participants became inordinantly distressed during the open trial, facilitators expressed concerns about potential participant distress during discussions about trauma and healing in future groups.

Regarding recommendations for improvement, facilitators suggested adding a review of group guidelines to each session because some participants interrupted others and dominated the conversation, and some began to share “war stories,” or potentially triggering anecdotes about

previous drug experiences. They also suggested adding reminders about confidentiality at each session to ensure privacy in this small rural community. Facilitators provided suggestions for modest revisions to the IRP manual as well—for example, to reorganize the content in one session and reduce the length of one of the in-session activities. In response to questions about their general impressions of the sessions, problems or concerns that arose, or other observations, facilitators reported feeling enthusiastic about the intervention and excited about its potential to benefit the community.

Fidelity of Intervention Delivery

In the open trial, fidelity was assessed using fidelity rating forms completed by the investigators while listening to the session audio recordings, and by comparing the content delivered during the session with the IRP facilitator manual. The content checklists completed by the IRP facilitators proved not to be helpful for assessing fidelity, as all facilitators indicated "yes" to every item, even when the investigators rated the content area as inadequately covered to warrant a "yes" response. The open trial illustrated that our selected rating items from the MITI (Moyers et al., 2016) and YACS (Carroll et al., 2020) also were poorly suited for assessing fidelity of IRP delivery. While the detailed notes taken by the investigators as they listened to the session recordings suggested that the facilitators were largely delivering the intervention as designed, a mismatch between the treatment manual and rating items resulted in poor fidelity scores for many sessions. For example, the MITI was designed to assess fidelity to motivational interviewing (MI). While IRP uses the spirit of MI, facilitators were not providing MI treatment. High ratings on the partnership item would require that faciltators actively encourage power sharing and allow the client's perspective to influence the nature of the session (Moyers et al., 2016). This was not often possible in this manualized intervention delivered in a group setting.

The items selected from the YACS also were inadequate for assessing fidelity to IRP, as they asked about content that was not covered in every session. For example, facilitators received high scores on the items regarding past and future high-risk situations in the sessions in which these topics were covered, but poor scores (by necessity) in sessions that did not include these topics. Therefore, although the investigators agreed that the facilitators were delivering most of the IRP content with fidelity, the fidelity ratings did not reflect this, and a revised procedure was deemed necessary.

Revisions Made in Response to the Open Trial

Changes to Facilitator Training and Supervision

Upon review of the session audio recordings and the feedback received during the open trial, we determined that revisions to the facilitator training and supervision protocols were needed. Per their own report, facilitators often did not adequately prepare for the session ahead of time. Rather than reviewing the manual in detail prior to the session, they presented some topics by relying on their memory of the content from the IRP training or by reading directly from the manual. Also, facilitators did not spend enough time explaining and emphasizing the importance of the in-session worksheets and take-home practice exercises. In response, we modified our protocol to devote time in the weekly supervision meetings to preparing for the next session. In these meetings, we emphasized the importance of the worksheets and practice exercises and provided a rationale for how each one would aid group members in their recovery, explaining that these activities constitute the "active ingredients" of the intervention. We began reviewing the session activities and exercises in detail each week, explaining that participants will only take them seriously if facilitators thoroughly explain their rationale and importance, and devote time during sessions to beginning the exercises and reviewing the content. We

modified our protocol to provide additional training on how to present the worksheets/activities and how to explain their purpose to the group, how to review the home practice exercises completed since the previous session, and how to respond in cases where participants did not complete them or when a participant returns to the group after missing a session. We also added strategies to improve group facilitation, such as reviewing the group ground rules at the beginning of each session and adding rules as needed for a particular group. In addition, we modified our protocol to continue ongoing weekly supervision meetings until facilitators consistently deliver IRP with fidelity, with subsequent supervision meetings and refresher trainings offered as needed. Finally, we offered additional guidance on recognizing signs of distress in participants that warrant referral to a licensed mental health provider, how to make such a referral, and how to redirect in-depth discussions about trauma should they arise. While the intervention does touch upon the link between trauma and substance use, IRP is not intended to provide treatment for trauma and therefore referrals to licensed providers may be needed.

Addition of Facilitator Guides

At times during the open trial, preparation for delivery of sessions was inadequate and facilitators relied heavily on the IRP facilitator manual (e.g., reading it aloud, flipping pages in search of content). To aid facilitators in their delivery of the intervention, we created facilitator guides for each session, which are two-page quick reference guides to the essential content and messages to be conveyed to group members in each topic area. These guides outline the sessions and provide prompts for opening sessions (e.g., smudging, prayer, and presenting the cultural and language lessons) and for reviewing the previous week's session and homework. They also provide essential information on the content to be covered (e.g., primary points to emphasize when explaining a topic), worksheets or activities that will be used in the current session, and

prompts for closing the session (e.g., review homework to be completed during the week). These guides were used during facilitator prep sessions to guide review of the next session's content and to provide feedback on delivery of the previous session.

Changes to Fidelity Monitoring

The open trial also led us to completely revise our fidelity monitoring procedures to better match the IRP intervention and our expectations for facilitators. The items selected from existing fidelity measures proved to be a poor fit and we instead focused on how we would conceptualize competent delivery of the IRP intervention. Following the open trial, we developed a fidelity rating manual and individual session rating forms (i.e., specific to each session's content), similar to the Twelve Step Facilitation Adherence Competence Empathy Scale (TSF-ACES; Campbell & Guydish, 2012). Like the TSF-ACES, each session is rated for the extent of delivery of major content areas in a manner consistent with the intervention (adherence) and how well the content is delivered (skill), with an emphasis on rating how understandably the content was delivered assuming an average group member. Fidelity rating forms list the components of each session in the IRP facilitator manual along with a quantitative rating of 1) *extensiveness* (i.e., how extensively the content was covered), and 2) *skillfulness* (i.e., how skillfully the content was covered) for each intervention component. Skillfulness was defined as conveyed expertise, competence, and commitment to IRP; clarity of communication; attunement to the group members; and appropriate timing of the intervention content. Response options for extensiveness range from 1 (*not at all*) to 6 (*extensively*) and response options for skillfulness items range from 1 (*unsatisfactory*) to 6 (*excellent*).

In addition to rating how extensively and skillfully the IRP content was presented, the revised fidelity rating sheets also include quantitative assessments of general proscribed and

prescribed facilitator behaviors that are not session-specific. These ratings are similar to items in the TSF-ACES, but instead focus on factors important to the delivery of IRP. *Proscribed behaviors* are facilitator behaviors that would be inconsistent with skillful delivery of IRP and include the extent to which facilitators: 1) present didactic material in an overly structured, non-interactive manner; 2) use excessive, inappropriate, or irrelevant self-disclosure; 3) allow the prescribed focus of the session to drift to irrelevant and/or IRP-inconsistent topics; and 4) use confrontation (e.g., denial, blaming, castigating, being critical, arguing, fixing). These behaviors were generally absent during the open trial, except for allowing group discussions to drift, which resulted in IRP content not being presented as designed or sessions becoming rushed to make up for time. *Prescribed behaviors* are facilitator behaviors consistent with IRP philosophy (e.g., reinforcing efforts to change, nurturing self-compassion, fostering self-efficacy). These behaviors include the extent to which facilitators: 1) redirect or soften sustain talk; 2) use affirmation (appreciation, encouragement); 3) display the spirit of MI (accepting, non-judgmental, respectful, empathic, warm, friendly, courteous, compassionate, honoring autonomy; Miller & Rollnick, 2013); and 4) encourage growth mindset and hopefulness, emphasize the positive, and/or foster self-efficacy (e.g., reframe occasional slips as learning opportunities, emphasize that change is possible, focus on positive changes made). Response options for proscribed and prescribed behaviors range from 1 (*not at all*) to 5 (*extensively*). We continue to use session audio recordings to rate fidelity as the clinical trial progresses and provide retraining as needed.

Protocol for Onboarding New Facilitators

As IRP groups that are led by facilitators who have been trained to competence are ongoing, we developed a protocol for training new facilitators who join the study that utilizes

existing groups as a method of training. Specifically, in place of the 2-day intensive IRP workshop, our current training protocol uses trained facilitators as models for the delivery of the intervention and spreads out training from a 2-day intensive to six incremental 1.5-hour training sessions. These training sessions take place on a weekly basis as new facilitators observe an existing IRP group. We believe this training protocol is more effective and easier for facilitators based on our observations and facilitator reports that it was difficult to retain all of the information presented during the initial IRP intensive workshop that amounted, in some respects, to "drinking from a fire hose."

Because the spirit of MI is crucial for successful delivery of IRP content, an introduction to MI training remains important for new facilitators. Thus, the first step in facilitator training remains an introductory 2-day MI workshop, although online training has proven more practical for training individual facilitators. This workshop helps prospective facilitators grasp the spirit of the IRP intervention and determine whether this approach is congruent with their worldview (e.g., emphasis on personal choice and non-confrontation). After MI training, we ask new facilitators to sit in on all six IRP sessions to observe the existing facilitators as they deliver the intervention, reviewing the material in the manual as it is presented by the trained facilitators. These observations are accompanied by weekly 1.5-hour training sessions on the week's content delivered by the Co-I, a clinical psychologist with training in SUD relapse prevention, who also monitors fidelity. In these weekly meetings, the trainer provides the background and rationale for the week's session; reviews the content, worksheets, and activities; provides tips for leading sessions; and answers questions or addresses issues that came up during the observed session.

After 6 weeks of observation and training in IRP, the new facilitator serves as a co-facilitator in the next 6-week round of the intervention. As a co-facilitator, they assist with

discussions and share the duties of delivering the intervention with an experienced facilitator who has been trained to fidelity. During the 6 weeks of co-facilitation, the new facilitator in training participates in weekly videoconference meetings with the IRP trainer/fidelity manager, who reviews the audio recording of the previous week's session and offers tips, strategies, and feedback on their performance, while also preparing the facilitator for the next week's session (e.g., reviewing upcoming content and activities). After 6 weeks of observation and 6 weeks of co-facilitation with weekly observation and feedback, new facilitators who have demonstrated competence as co-facilitators are eligible to lead future IRP groups. If a prospective facilitator does not demonstrate competence after training, they are invited to co-facilitate subsequent rounds of the intervention with weekly feedback and prep sessions until they are delivering IRP with fidelity. If ratings show that IRP is being delivered with fidelity, supervision meetings/prep sessions are held only as needed (i.e., if fidelity ratings drop) or as desired by the facilitator. See Table 1 for a summary of facilitator recruitment strategies, qualifications, responsibilities, training, and compensation.

Discussion

Providing mental health interventions that are delivered by non-specialist providers and situated within underserved communities is an important strategy for expanding access to EBTs and addressing mental health disparities (Barnett et al., 2018a, 2018b, 2023; Escobar, 2015; O'Keefe et al., 2021; WHO, 2008). Non-specialist providers such as community health workers are capable of delivering EBTs, and EBTs delivered by non-specialists are effective for reducing mental health symptoms (e.g., Barnett et al., 2018a, 2023; Singla et al., 2017; van Ginneken et al., 2013). However, there is a gap in the literature regarding the implementation supports (i.e., training, supervision, and fidelity monitoring) needed to support non-specialist providers as they

deliver interventions in their communities (e.g., Barnett et al., 2023, Bunn et al., 2021; Caulfield et al., 2019; Singla et al., 2017).

To expand access to evidence-based relapse prevention strategies in a rural AI reservation community, our academic-community partnership developed a group intervention for SUDs and trained non-specialist providers from the community to deliver it. Our initial training protocol consisted of two 2-day in person training workshops followed by a 6-week open trial of the intervention with weekly supervision meetings. Following completion of the initial workshops, the facilitators had a strong understanding of the IRP intervention and target population, and expressed buy-in for the intervention as a whole. However, additional training throughout the open trial and ongoing supervision were needed to help facilitators feel comfortable and competent leading IRP groups, and to ensure they were able to deliver the intervention with fidelity.

Benefits of the Open Trial and Lessons Learned

Throughout the present study, we learned valuable lessons to inform future SUD treatment research using non-specialist providers. First, we learned that selecting the right facilitators is crucial. The facilitators in our study were deeply invested and concerned about their competence; they asked good questions, offered useful suggestions, and took their roles seriously. Research supports the careful and thoughtful selection of team members tasked with implementing interventions (e.g., Edmonson et al., 2001), and also supports selecting intervention leaders who share cultural backgrounds with the intervention recipients (Greenhalgh et al., 2004). However, even the best facilitators felt anxious about their performance and benefitted from weekly supervision/prep sessions where they had the opportunity to ask questions and receive personalized feedback. Facilitator competence developed more quickly

than their confidence. When training community members to deliver EBTs, it is helpful to provide training incrementally rather than in condensed workshops and to allow ample time for preparation, observation, feedback, and retraining.

Not only was the open trial a crucial component of our facilitator training process, it also helped us identify challenges that needed to be addressed before initiating the clinical trial. For example, we learned that while facilitator buy-in for the intervention as a whole was strong, buy-in for the IRP worksheets and homework assignments was relatively poor. Homework completion during relapse prevention for SUDs is associated with better outcomes (Gonzalez et al., 2006), and many of the skills taught in IRP were emphasized, practiced, and reinforced through completion of the worksheets and homework assignments. Thus it was important to address the inadequate emphasis placed on these crucial intervention activities, which likely contributed to poor participant compliance. Provider knowledge and beliefs about an intervention are important for effective implementation (e.g., Damschroder et al., 2009) and therefore needed to be addressed. We did so by explaining the purpose of and rationale for each exercise during weekly prep meetings, emphasizing the usefulness of each exercise for changing substance use. This has precedence in the literature, as understanding the underlying rationale for intervention components enables providers to tailor interventions to meet local needs and deliver them with fidelity (Barnett et al., 2003). We also provided additional instruction on how to present the exercises during the sessions and how to review them with the group, which proved very effective for bringing facilitators to fidelity. Inadequate facilitator preparation before the IRP sessions also was resolved through the weekly supervision meetings, which were modified to include preparations for the next session in addition to feedback on the previous session, and through the creation of facilitator guides to accompany the intervention manual.

Facilitator feedback and our observations during the open trial indicated that additional supports were needed to help them effectively manage the group dynamics, as some participants strayed off topic, dominated discussions, or engaged in behavior that interfered with content delivery. These issues also greatly impacted fidelity ratings by drawing time away from session content. In response, we made simple modifications to the treatment manual, such as reviewing the group ground rules at the beginning of each IRP session and collaboratively adding to these as needed rather than only discussing ground rules in the first session. We also posted the ground rules on the wall as reminders, per the facilitators' suggestion. Facilitators received additional instruction on strategies for facilitating groups and redirecting off-topic discussions during the weekly supervision meetings, which proved effective at reducing disruptions and helping them deliver the IRP content. In addition, facilitators received further guidance on recognizing and responding to signs of distress in participants, which helped increase their comfort with presenting difficult topics such as trauma.

The open trial provided a valuable opportunity for the perspectives of community-based research team members to shape the intervention delivery, and allowed our team to pilot test and restructure protocols and research materials. For example, the open trial illustrated that our fidelity monitoring procedure was not well suited to IRP, leading us to create a new procedure for use in the clinical trial. Our revised fidelity monitoring procedure allows us to identify and address specific areas in which facilitators need additional training. The open trial also led us to develop a protocol for onboarding new facilitators who may join the study mid-stream. The open trial enabled the investigators and project staff to meet facilitators where they were, identify potential strengths and challenges, and develop new materials and training protocols that would help facilitators successfully deliver the intervention. Without the opportunity for this "practice

run," our team would not have anticipated the issues that arose, necessitating revisions during the clinical trial.

Alignment with the Consolidated Framework for Implementation Research

Our approach to training facilitators and preparing for the implementation of the IRP clinical trial was consistent with several constructs from the Consolidated Framework for Implementation Research (CFIR; Damschroder et al., 2009). For example, regarding the *intervention characteristics* domain, we selected an intervention with strong supporting evidence (i.e., relapse prevention; Bowen et al., 2014; Irvin et al., 1999), which we presented during the initial IRP workshop to increase facilitators' perceptions that the intervention will reduce substance use among participants. This aligns with the CFIR construct of *evidence strength and quality* (Damschroder et al., 2009). We also considered the *adaptability* of relapse prevention, making cultural adaptations to ensure that core components could be delivered in a culturally responsive way that meets the needs of tribal members. Furthermore, we demonstrated *trialability* of IRP through the open trial, which allowed us to pilot test our procedures, build facilitators' expertise, and assess the intervention's acceptability among facilitators and participants (Damschroder et al., 2009).

Regarding the *characteristics of individuals* domain (Damschroder et al., 2009), we addressed facilitators' knowledge and beliefs about the intervention through the MI and IRP training workshops conducted before the open trial began. These workshops were helpful for conveying the spirit of the intervention as well as skills needed to deliver it, helped facilitators understand their role in the coming intervention, and generated enthusiasm for the IRP curriculum. Facilitator knowledge and enthusiasm were further strengthened in the supervision meetings that took place throughout the open trial. Another construct in the chararacteristics of

individuals domain, *self-efficacy* (Damschroder et al., 2009), was enhanced through the open trial and weekly supervision/prep meetings. Once facilitators had experienced delivering the intervention content in a low-stakes setting with proper supervision, their confidence in their ability to lead IRP groups increased. This also allowed us to directly target areas in need of additional training, and to provide feedback on areas in which facilitators were performing well.

Our approach also was consistent with constructs related to the *process* domain of the CFIR (Damschroder et al., 2009): planning, executing, and reflecting and evaluating. Regarding *planning*, we aimed to develop a training and supervision protocol that would build local capacity for effective delivery of the intervention. In doing so, we considered the facilitators' skills, motivations, needs, and perspectives; developed standardized monitoring and evaluation procedures; and designed a practice run of the intervention as part of the training process. *Executing* the open trial allowed facilitators to learn the IRP curriculum in a psychologically safe environment and develop their expertise. Psychological safety, or the belief that making mistakes will not be punished, is important for learning and is fostered through early trials and dry runs like our open trial (Damschroder et al., 2009; Edmondson et al., 1996, 2001). Collecting feedback from participants and facilitators after each session, listening to session recordings and completing fidelity rating forms, and meeting with facilitators after each session to debrief and process their experiences were important elements of *reflecting and evaluating* (Damschroder et al., 2009) that helped promote shared learning and collaboration among our team. These important outcomes will support the successful implementation of IRP in the clinical trial.

Considering Sustainability

While continued supervision and fidelity monitoring will help ensure that IRP is delivered with fidelity during the clinical trial, our team is currently considering strategies for

sustaining the intervention in this tribal community as well as disseminating it to other communities after the clinical trial is complete. The need for ongoing facilitator supervision and monitoring beyond the clinical trial is one potential barrier to sustainability. In our current research project, grant funding allows for more intensive training and supervision than may be possible after the project ends. The IRP trainer/fidelity manager is a licensed clinical psychologist with protected research time devoted to this role. As ongoing training and supervision are critical to the successful implementation of EBTs (Barnett et al., 2018a, 2018b, 2023; Bunn et al., 2021; Singla et al., 2017), developing methods to implement continued training and supervision is an important part of our sustainability plan.

One potential solution to the need for ongoing training and supervision is to teach experienced IRP facilitators to train and supervise other facilitators. An apprenticeship model in which community members are trained to supervise community health workers has been used successfully in low-income countries (Murray et al., 2011), and this model may be helpful for increasing sustainability of mental health interventions in other low-resource settings (Barnett et al., 2018b; Singla et al., 2017). However, professional supervision will still be needed to help facilitators intervene in situations warranting care beyond the scope of the facilitators' training—for example, to address traumatic stress or suicide risk—and to address secondary trauma in facilitators (Barnett et al., 2018b).

Another option for implementing ongoing training and supervision would be to enlist local mental health providers such as those employed by the community's Indian Health Service behavioral health clinic to learn the IRP curriculum and assume training and supervision duties as part of their work responsibilities. This would require buy-in from the providers and their employers, and they would need training in IRP. Digital technology can be leveraged to provide

training and supervision from a distance (Naslund et al., 2019) and may help address barriers to scaling up delivery of mental health interventions in low-resource settings (Singla et al., 2017). However, community health workers are not always well-received by professional treatment providers in the community, which may serve as a barrier to their effectiveness as supervisors (Padmanathan & De Silva, 2013). It also may prove difficult for local providers to find time for added supervision duties.

Attention to strategies that may help build and sustain local capacity beyond the clinical trial are needed to ensure that interventions using non-specialist providers are effective for scaling up EBTs and reducing health disparities (Barnett et al., 2018b, 2023). One notable barrier to sustainability is lack of incentives (Padmanathan & De Silva, 2013; Singla et al., 2017), and additional funding to support supervisors and facilitators is needed. We are currently working to identify potential funding sources for sustaining and expanding IRP through service-focused grants available through local, state, and federal governments and through private foundations. Depending on the outcomes of the clinical trial and the cost effectiveness of the intervention, tribal governments also may be willing to fund IRP on an ongoing basis. The sustainability of IRP in the long term will depend on collaborative efforts between the investigators, facilitators, and other community partners as we explore various options for supporting IRP in the community or incorporating it into existing health care structures.

Conclusion

Non-specialist providers such as community health workers are capable of delivering evidence-based mental health interventions, and have great potential to expand treatment access and narrow the treatment gap in low-resource communities. Although research supports the effectiveness of interventions delivered by non-specialist providers, few studies describe the

implementation supports (i.e., training, supervision, and fidelity monitoring) needed to ensure effective delivery of mental health interventions by community members. In the present manuscript, we aimed to fill this gap by reporting our approach to training, supervising, and monitoring community-based facilitators who are delivering the Indigenous Recovery Planning intervention in a rural AI community. We also describe changes to these supports made following an open trial of the intervention, a valuable component of the facilitator training process. We are hopeful that ongoing fidelity monitoring and clinical trial outcome data will demonstrate that this approach was effective for expanding access to evidence-based SUD treatment and reducing substance use among tribal members.

References

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Barnett, M. L., Gonzalez, A., Miranda, J., Chavira, D. A., & Lau, A. L. (2018a). Mobilizing community health workers to address mental health disparities for underserved populations: A systematic review. *Administration and Policy in Mental Health and Mental Health Services Research, 45,* 195-211.

Barnett, M. L., Lau, A. S., & Miranda, J. (2018b). Lay health worker involvement in evidence-based treatment delivery: A conceptual model to address disparities in care. *Annual Review of Clinical Psychology, 14,* 185-208.

Barnett, M. L., Puffer, E. S., Ng, L. C., & Jaguga, F. (2023). Effective training practices for non-specialist providers to promote high-quality mental health intervention delivery: A narrative review with four case studies from Kenya, Ethiopia, and the United States. *Cambridge Prisms: Global Mental Health, 10,* 1-9.

Bowen, S., Witkiewitz, K., Clifasefi, S. L., Grow, J., Chawla, N., Hsu, S. H., Carroll, H. A., Harrop, E., Collins, S. E., Lustyk, M. K., & Larimer, M. E. (2014). Relative efficacy of mindfulness-based relapse prevention, standard relapse prevention, and treatment as usual for substance use disorders. *JAMA Psychiatry, 71,* 547-556.

Brave Heart, M. Y. H., Lewis-Fernández, R., Beals, J., Hasin, D. S., Sugaya, L., Wang, S., Grant, B. F., & Blanco, C. (2016). Psychiatric disorders and mental health treatment in American Indians and Alaska Natives: Results of the National Epidemiologic Survey on Alcohol and Related Conditions. *Social Psychiatry and Psychiatric Epidemiology, 51*, 1033-1046.

Bunn, M., Gonzalez, N., Falek, I., Weine, S., & Acri, M. (2021). Supporting and sustaining nonspecialists to deliver mental health interventions in low- and middle-income countries: An umbrella review. *Intervention, 19*, 155-179.

Butryn, T., Bryant, L., Marchionni, C., & Sholevar, F. (2017). The shortage of psychiatrists and other mental health providers: Causes, current state, and potential solutions. *International Journal of Academic Medicine, 3*, 5-9.

Campbell, B.K., & Guydish J. (2012). TSF Adherence Competence Empathy Scales (TSF ACES) Fidelity Ratings Manual. Manual developed for NIDA's National Drug Abuse Treatment Clinical Trials Network (CTN) Protocol CTN-0031c.

Carroll, K. M., Nich, C., Sifry, R. L., Nuro, K. F., Frankforter, T. L., Ball, S. A., Fenton, L., & Rounsaville, B. R. (2000). A general system for evaluating therapist adherence and competence in psychotherapy research in the addictions. *Drug and Alcohol Dependence, 57,* 225-238.

Carroll, K. M., & Onken, L. S. (2005). Behavioral therapies for drug abuse. *The American Journal of Psychiatry, 162,* 1452-1460.

Caulfield, A., Vatansever, D., Lambert, G., Van Bortel, T. (2019). WHO guidance on mental health training: A systematic review of the progress for non-specialist health workers. *BMJ Open, 9,* 1-16.

Cunningham, J. K., Solomon, T. A., & Muramoto, M. L. (2016). Alcohol use among Native Americans compared to Whites: Examining the veracity of the 'Native American elevated alcohol consumption' belief. *Drug and Alcohol Dependence, 160*, 65-75.

Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009). Fostering implementation of health services research findings into practice: A

consolidated framework for advancing implementation science. *Implementation Science*, *4*, 1-15.

Edmondson, A. C. (1996). Learning from mistakes is easier said than done: Group and organizational influences on the detection and correction of human error. *The Journal of Applied Behavioral Science*, *32*, 5-28.

Edmondson, A. C., Bohmer, R. M., & Pisano, G. P. (2001). Disrupted routines: Team learning and new technology implementation in hospitals. *Administrative Science Quarterly*, *46*, 685-716.

Escobar, J. I. (2015). From the Guest Editor: Global mental health. *Focus, 13*, 401-402.

Etz K. E., Arroyo, J. A., Crump, A. D., Rosa, C. L., & Scott, M. S. (2012). Advancing American Indian and Alaska Native substance abuse research: Current science and future directions. *The American Journal of Drug and Alcohol Abuse*, *38*, 372–375.

Evans-Lacko, S. A. G. S., Aguilar-Gaxiola, S., Al-Hamzawi, A., Alonso, J., Benjet, C., Bruffaerts, R., Chiu, W. T., Florescu, S., de Girolamo, G., Gureje, O., Haro, J. M., He, Y., Hu, C., Karam, E. G., Kawakami, N., Lee, S., Lund, C., Kovess-Masfety, V., Levinson, D., Navarro-Mateu, F., Pennell, B. E., Sampson, N. A., Scott, K. M., Tachimori, H., ten Have, M., Viana, M. C., Williams, D. R., Wojtyniak, B. J., Zarkov, Z., Kessler, R. C., Chatterji, S., & Thornicroft, G. (2018). Socio-economic variations in the mental health treatment gap for people with anxiety, mood, and substance use disorders: results from the WHO World Mental Health (WMH) surveys. *Psychological Medicine*, *48*, 1560-1571.

Gonzalez, V. M., Schmitz, J. M., & DeLaune, K. A. (2006). The role of homework in cognitive-behavioral therapy for cocaine dependence. *Journal of Consulting and Clinical Psychology*, *74*, 633.

Grant, B. F., Goldstein, R. B., Smith, S. M., Jung, J., Zhang, H., Chou, S. P., Pickering, R. P., Ruan, W. J., Huang, B., Saha, T. D., Aivadyan, C., & Hasin, D. S. (2015). The Alcohol Use Disorder and Associated Disabilities Interview Schedule-5 (AUDADIS-5): Reliability of substance use and psychiatric disorder modules in a general population sample. *Drug and Alcohol Dependence*, *148*, 27-33.

Grant, B. F., Saha, T. D., Ruan, W. J., Goldstein, R. B., Chou, S. P., Jung, J., Zhan, H., Smieth, S. M., Pickering, R. P., Huang, B., & Hasin, D. S. (2016). Epidemiology of DSM-5 drug use disorder: Results from the National Epidemiologic Survey on Alcohol and Related Conditions–III. *JAMA Psychiatry*, *73*, 39-47.

Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., & Kyriakidou, O. (2004). Diffusion of innovations in service organizations: Systematic review and recommendations. *The Milbank Quarterly*, *82*, 581-629.

Handley, T. E., Kay-Lambkin, F. J., Inder, K. J., Lewin, T. J., Attia, J. R., Fuller, J., Perkins, D., Coleman, C., Weaver, N., & Kelly, B. J. (2014). Self-reported contacts for mental health problems by rural residents: Predicted service needs, facilitators and barriers. *BMC Psychiatry, 14,* 249.

Irvin, J. E., Bowers, C. A., Dunn, M. E., & Wang, M. C. (1999). Efficacy of relapse prevention: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 74,* 88-100.

Jackson, A., & Shannon, L. (2012). Barriers to receiving substance abuse treatment among rural pregnant women in Kentucky. *Maternal Child Health Journal, 16,* 1762-1770.

Kouyoumdjian, H., Zamboanga, B. L., & Hansen, D. J. (2003). Barriers to community mental health services for Latinos: Treatment considerations. *Clinical Psychology: Science and Practice, 10,* 394-422.

Kuehn, B. M. (2022). Clinician shortage exacerbates pandemic-fueled "mental health crisis." *Journal of the American Medical Association*, 327, 2179-2181.

McGovern, M. P., & Carroll, K. M. (2003). Evidence-based practices for substance use disorders. *Psychiatric Clinics of North America, 26,* 991-1010.

Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change* (3rd edition). Guilford Press.

Mongelli, F., Georgakopoulos, P., & Pato, M. T. (2020). Challenges and opportunities to meet the mental health needs of underserved and disenfranchised populations in the United States. *Focus, 18*, 16-24.

Motivational Interviewing Network of Trainers. (n.d.). Motivational Interviewing Network of Trainers. https://motivationalinterviewing.org/

Moyers, T. B., Rowell, L. N., Manuel, J. K., Ernst, D., & Houck, J. M. (2016). The Motivational Interviewing Treatment Integrity Code (MITI 4): Rationale, preliminary reliability and validity. *Journal of Substance Abuse Treatment, 65,* 36-42.

Murray, L. K., Dorsey, S., Bolton, P., Jordans, M. J., Rahman, A., Bass, J., & Verdeli, H. (2011). Building capacity in mental health interventions in low resource countries: An apprenticeship model for training local providers. *International Journal of Mental Health Systems*, *5*, 1-12.

Naslund, J. A., Shidhaye, R., & Patel, V. (2019). Digital technology for building capacity of nonspecialist health workers for task sharing and scaling up mental health care globally. *Harvard Review of Psychiatry*, *27*, 181-192.

National Institutes of Health. (n.d.). *RCDC Inclusion Statistics Report*. Retrieved March 25, 2024, from https://report.nih.gov/risr/

Novins, D. K., Croy, C. D., Moore, L. A., & Rieckmann, T. (2016). Use of evidence-based treatments in substance abuse treatment programs serving American Indian and Alaska Native communities. *Drug and Alcohol Dependence, 161,* 214-221.

O'Keefe, V. M., Cwik, M. F., Haroz, E. E., & Barlow, A. (2021). Increasing culturally responsive care and mental health equity with Indigenous community mental health workers. *Psychological Services, 18,* 84-92.

Padmanathan, P., & De Silva, M. J. (2013). The acceptability and feasibility of task-sharing for mental healthcare in low and middle income countries: A systematic review. *Social Science & Medicine*, *97*, 82-86.

Rebello, T. J., Marques, A., Gureje, O., & Pike, K. M. (2014). Innovative strategies for closing the mental health treatment gap globally. *Current Opinion in Psychiatry*, *27*, 308-314.

Rieckmann, T., McCarty, D., Kovas, A., Spicer, P., Bray, J., Gilbert, S., & Mercer, J. (2012). American Indians with substance use disorders: Treatment needs and comorbid conditions. *The American Journal of Drug and Alcohol Abuse, 38,* 498-504.

Rosen, D., Tolman, R. M., & Warner, L. A. (2004). Low-income women's use of substance abuse and mental health services. *Journal of Health Care for the Poor and Underserved, 15,* 206-219.

Sahker, E., Pro, G., Poudyal, H., & Furukawa, T. A. (2024). Evaluating the substance use disorder treatment gap in the United States, 2016− 2019: A population health observational study. *The American Journal on Addictions*, *33*, 36-47.

Singla, D. R., Kohrt, B. A., Murray, L. K., Anand, A., Chorpita, B. F., & Patel, V. (2017). Psychological treatments for the world: Lessons from low- and middle-income countries. *Annual Review of Clinical Psychology, 13,* 149-181.

Skewes, M. C., Gameon, J. A., Hallum-Montes, R., & Ricker, A. (2021). Determinants of relapse and opportunities for growth: Perspectives on substance use among American Indian community members. *Journal of Psychoactive Drugs, 53,* 474-482.

Skewes, M. C., Gonzalez, V. M., Gameon, J. A., FireMoon, P., Salois, E. M., Rasmus, S. M., Lewis, J. P., Gardner, S. A., Ricker, A., & Reum, M. (2020). Health disparities research with American Indian Communities: The importance of trust and transparency. *American Journal of Community Psychology, 66,* 302-313.

Skewes, M. C., Gonzalez, V. M., Gameon, J. A., Ricker, A., Martell, S., Reum, M., & Holder, S. (2024). Development and feasibility pilot study of Indigenous Recovery Planning: A community-engaged approach to addressing substance use in a Native community. *Clinical Psychological Science, 12,* 253-269.

Skewes, M. C., Hallum-Montes, R., Gardner, S. A., Blume, A. W., Ricker, A., & FireMoon, P. (2019). Partnering with Native communities to develop a culturally grounded intervention for substance use disorder. *American Journal of Community Psychology*, *64*, 72–82.

Thomas, K. C., Ellis, A. R., Konrad, T. R., Holzer, C. E., & Morrissey, J. P. (2009). County-level estimates of mental health professional shortage in the United States. *Psychiatric Services, 60*, 1323-1328.

Van Ginneken, N., Tharyan, P., Lewin, S., Rao, G. N., Meera, S. M., Pian, J., Chandrashekar, S., & Patel, V. (2013). Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low-and middle-income countries. *Cochrane Database of Systematic Reviews, 11*.

Wallerstein, N. B., & Duran, B. (2006). Using community-based participatory research to address health disparities. *Health Promotion Practice*, *7*, 312–323.

Wallerstein, N., & Duran, B. (2010). Community-based participatory research contributions to intervention research: The intersection of science and practice to improve health equity. *American Journal of Public Health*, *100*, S40–S46.

Whitesell, N. R., Beals, J., Big Crow, C., Mitchell, C. M., & Novins, D. K. (2012). Epidemiology and etiology of substance use among American Indians and Alaska Natives: Risk, protection, and implications for prevention. *The American Journal of Drug and Alcohol Abuse, 38,* 376-382.

World Health Organization. (2008). *mhGAP: Mental Health Gap Action Programme: Scaling up care for mental, neurological and substance use disorders*. Geneva: WHO Press.

Table 1.

IRP Facilitator Recruitment, Qualifications, Responsibilities, Training, Compensation

Sources of Recruitment:	Indian Health Services Tribal college faculty/staff in social work, counseling, addiction recovery academic programs/departments Local teachers	Local high school counseling offices and staff Other community-based counseling/addiction recovery organizations	Recovered graduates of IRP program People in SUD recovery w/ counseling and/or mentoring experience
Qualifications:	Belief in IRP therapeutic philosophy Passion for helping adults w/ SUD Experience leading and/or participating in cultural and community events	Listening and verbal communication skills Ability to provide support and feedback in compassionate, non-judgmental manner Attention to detail, ability to follow instructions, and ability to work collaboratively	Ability to receive constructive feedback [a]Associate's degree or higher in social work or related field is helpful; professional background in social work, counseling, or mentoring is helpful Experience teaching or leading groups is helpful
Responsibilities:	Complete facilitator trainings, prep meetings, and post-session debrief meetings prior to leading each of the six group sessions	Lead and support up to 10 tribal member volunteers through 6-week IRP group intervention Lead minimum of two 6-week groups after completion of required trainings	Facilitate completion of participant evaluations after each session Submit session notes and observations to IRP project manager after each session Maintain consistent communication with all IRP team members
Training:	Online training in Social and Behavioral Health Research by the Collaborative Institutional Training Initiative (CITI) (2-3 hrs. total)	Observe facilitation of all six sessions Co-facilitate six sessions under supervision of lead facilitator	[c] Attend weekly supervision/prep meetings as co-facilitator trainee (6 meetings total) Attend weekly supervision/prep meetings for first six sessions trainee leads on their own

	[b]Two-day online Motivational Interviewing workshop (12 hrs. total)		(6 meetings total) Additional supervision/prep meetings as needed or desired
Compensation:	Motivational Interviewing workshop expenses are covered for all trainees	[d] $250 for session prep, co-facilitation of 6 sessions, and weekly attendance in supervision/prep meetings	[e] $350 provided for facilitation of each group session after completion of initial 12 sessions (2 groups) with adequate fidelity

Note. This table demonstrates the specific criteria and key elements used in the facilitator onboarding process for the Indigenous Recovery Planning (IRP) project.

[a] An excellent IRP facilitator candidate may not possess formal educational training/degrees or professional experience in counseling and substance use recovery. A strong candidate may instead possess significant experience as a community volunteer and/or cultural leader. When recruiting facilitators, the hiring team should equally weigh qualifications that include non-formal, experiential backgrounds, which may be just as (or more) impactful as a specific educational degree or job experience.

[b] MI training is provided by professionals certified in MI facilitation through the national *Motivational Interviewing Network of Trainers*: https://motivationalinterviewing.org/about_mint

[c] After completing 6 supervision/prep meetings as a co-facilitator and 6 meetings as lead facilitator, and demonstrating adequate fidelity ratings, participation in additional supervision meetings is optional.

[d] New facilitators receive $250/session (including prep work and supervision meetings) during training and for the first 12 sessions (2 groups) they facilitate.

[e] After completing 12 sessions as a trained facilitator, facilitators who commit to leading an additional 12 sessions earn $350/session, contingent upon continued adequate fidelity ratings. This pay increase helps to retain trained facilitators in the study.