"This person is still here with us today": A qualitative follow-up with Mental Health First Aid First Nations training participants

Andrea Delaney [a,*], Monique Auger [b], Kim van der Woerd [c], Claire V. Crooks [d,e]

[a] *Project Manager, Centre for School Mental Health*
[b] *Reciprocal Consulting*
[c] *Principal, Reciprocal Consulting*
[d] *Director, Centre for School Mental Health*
[e] *Professor, Applied Psychology, Faculty of Education, Western University*

A B S T R A C T

First Nations people in Canada experience high rates of mental health disorders associated with colonial trauma. The international course Mental Health First Aid (MHFA) was redeveloped by the Mental Health Commission of Canada to be more culturally relevant for First Nations communities. This follow-up study is an exploration of participants' experiences in applying first aid following their 2.5 day training in Mental Health First Aid First Nations (MHFAFN).

MHFAFN course participants were invited to complete a follow-up survey at an average of 9 months (SD = 3.3) after training. The online survey included questions about their experiences using MHFAFN skills and asked for a description of the scenario, response, and outcomes. Responses were gathered from 33 participants and qualitative analysis was completed using an inductive approach to develop overarching themes. The majority of respondents personally experienced a situation where a mental health emergency or issue arose (n=25) and all but two reported they were able to respond using MHFAFN skills. For the participants who responded to the situation, they perceived their actions helped. A valuable aspect of the training was inclusion of cultural content and historical context. Respondents indicated feelings of increased confidence in responding to mental illness situations. Respondents perceived reduced mental illness stigma in their communities or work. Most respondents can translate MHFAFN content into everyday use to help a person experiencing a mental health problem. MHFAFN may help mitigate barriers to accessing mental health care in First Nations contexts.

1. Introduction

For many First Nations[1] people in Canada, mental health challenges are prevalent symptoms of traumatic and ongoing colonization, oppression, racism, and discrimination (Allan & Smylie, 2015; Gone et al., 2019; Kirmayer et al., 2000). Compounding the issue of mental health inequities are the many barriers to mental health services faced by First Nations people in Canada. There are insufficient resources in most remote and small First Nations communities (Nguyen et al., 2020; Office of the Auditor General of Canada, 2015). If mental health services are available, there are typically not enough care providers, resulting in staff burnout and high turnover rates (Horrill et al., 2018; Nguyen et al.,

2020). Many mental health services do not reflect the traditions, values, and concepts of wellness of First Nations people, resulting in health care that is inadequate or even detrimental. Fears of stigma and discrimination continue to deter uptake of mental health services when they are available (Kurtz et al., 2008; Nguyen et al., 2020; Place, 2012).

The First Nations Mental Wellness Continuum Framework states that a full spectrum of culturally competent mental health services includes: health promotion, prevention, community development and education, and early identification and intervention (Assembly of First Nations & Health Canada, 2015). To overcome these challenges and barriers, there is a need to consider solutions that increase the community-level mental health knowledge and skills to help people with mental health problems.

Mental Health First Aid (MHFA) is a course created to teach individuals how to recognize signs and symptoms of mental health crises and early states of mental illness, how to respond appropriately, and help connect the individual with professional mental health care (Kitchener & Jorm, 2002). The course also aims to reduce the social distance between an individual and a person with a mental health problem (i.e., reduce stigmatizing views). MHFA is a well-established training for improving participants' knowledge, attitudes, and helping behaviour (Hadlaczky et al., 2014).

Although MHFA has been shown to have positive impacts in many settings, the mainstream version does not recognize the historical context in which mental health challenges among First Nations emerge (Caza, 2010). One of the key strategies to enhance mental health literacy listed in the Mental Health Literacy Framework by the Canadian Alliance on Mental Illness and Mental Health (2008, p. 9) is to "recognize the intergenerational effects of residential schools and colonization". Furthermore, cultural continuity is a known social determinant of health for First Nations people and is associated with health outcomes in First Nations communities (Auger, 2016; Kirmayer et al., 2000). Historical context and cultural continuity strategies were addressed through the adaptation of MHFA for First Nations contexts by the Mental Health Commission of Canada (MHCC) in collaboration with First Nations communities (Crooks et al., 2018; MHCC, 2014).

The first culturally adapted version of MHFA was created in Australia with the goal of providing an appropriate and relevant course for Aboriginal and Torres Strait Islander peoples (Kanowski, et al., 2009). Adaptation reports and evaluations of the Aboriginal MHFA program in Australia highlight the importance of culturally appropriate experience, content, and trainers (Armstrong et al., 2018; Day et al., 2021; Hart et al., 2010). In Canada, the process of creating a First Nations adaptation of the MHFA course began in 2011, when MHCC started relationship building with three First Nations partner sites and convened a guidance group of nationally recognized First Nations leaders. The third author of this paper served as a member of the First Nations guidance group. MHCC hired an Indigenous consulting firm to assist in the early development of the MHFA cultural adapation. Over the next few years of development, the three First Nations sites were expanded to six First Nations partner sites, and many First Nations individuals, community sites, and organizations influenced the development of the Mental Health First Aid First Nations (MHFAFN) course.

The resulting course, MHFAFN, situates mental health and wellbeing within First Nations culture and traditions, with particular importance placed on balancing western and holistic models of mental health. MHFAFN stages the current disparities and challenges faced by many First Nations within the historical context, while also recognizing the strengths and resiliency of First Nations peoples. For MHFAFN, the five foundational strategies originally from MHFA were adapted and reorganized as "EAGLE." EAGLE is a conversation for carrying out culturally safe Mental Health First Aid. EAGLE stands for: "*Engage and evaluate the risk of suicide or harm*," "*Assist the person to seek professional help*," "*Give reassurance and information*," "*Listen without judgment*," and "*Encourage self-help strategies and gather community supports*" (MHCC, 2014). MHFAFN is a cultural adaption in that the intervention incorporates First Nations cultural activities and content, but remains embedded in the Western framework of MHFA (Allen & Mohatt, 2014).

Community-based mental health promotion strategies have been identified as best practice for First Nations because many communities have strong social bonds, supportive networks, and members willing to act to create benefit for their communities (Smye & Mussell, 2001). MHFAFN training has a community-specific exercise that situates the participants within their own "*Circles of Support*," and helps them identify both personal and community-level health resources. MHFAFN has the flexibility to include teachings, customs, and protocols of the local community where the intervention is being implemented. Aspects of the course that may help strengthen First Nations engagement with mental health care services include Circles of Support, cultural context

of mental health, and teaching participants to assist the person to seek professional help.

Our research team conducted a national evaluation of MHFAFN that began in 2012 when the fourth author of this paper was contracted by MHCC for an external evaluation of the pilot (Crooks et al., 2018). In 2013, in partnership with community sites and MHCC, our research team was granted funding from the Canadian Institutes of Health Research to conduct a more thorough evaluation of MHFAFN. Between 2013 and 2015, our team engaged with and followed the process of piloting and refining the course. In 2016, MHCC began to offer the current version of MHFAFN more broadly and our team visited 11 community sites across Canada for data collection. Our national evaluation demonstrated MHFAFN is an acceptable training where participants felt culturally safe (Auger et al., 2019). We discovered gains in participants' mental health knowledge, awareness, and first aid self-efficacy, and reductions in mental illness stigma beliefs (Crooks et al., 2018). In response to a vignette scenario of a friend in mental health crisis, participants were able to come up with a sample response using on average three EAGLE strategies (M = 2.96, SD = 1.31). In 2017 we followed up with participants to find out if they were able to use the skills and knowledge gained in the training to help someone. The qualitative approach allowed us to capture participants' experiences applying MHFAFN skills as the respondents described the situations in their own words.

2. Methods

2.1. Procedure

Participants attended a MHFAFN course in one of 11 sites in British Columbia, Manitoba, Ontario, or Nova Scotia as part of the initial national study (Crooks et al., 2018). The course was typically delivered over 2.5 days for a total of 20 hours. As a follow-up, participants were contacted through email twice (invitation and reminder) approximately 9 months after training (M= 9.2 SD = 3.3; range 1 to 14 months post course completion). The MHFAFN course was conducted at different times between June 2016 and February 2017, the follow-up survey invitations were first distributed in February 2017 and survey responses were accepted until the end of the funding period in fall of 2017, resulting in the follow-up range of 1 to 14 months. Participants were sent an invitation with an anonymous link to the follow-up survey hosted on Qualtrics, a secure online survey tool. Participants received a $10 gift certificate for participating in the follow-up survey. All research protocols were approved by Western University's Non-Medical Research Ethics Board and site partners.

2.2. Relationship

Our research team is made up of Indigenous women from diverse First Nation and Métis communities and treaty territories across Canada, and one settler / ally woman. Our research was designed and conducted in partnership with the First Nations communities and organizations and adheres to the OCAP Principles of Ownership, Control, Access, and Possession. Our original proposed research design for this follow-up involved returning to each community for a feast and sharing circle several months post-course completion to collect follow-up data in a culturally relevant and safe way. This in-person data collection was attempted with very limited success in that although numerous participants indicated a desire and intention to attend, they were unable to due to last minute circumstances. Out of respect for our partners' and participants' limited time and resources, we opted for a more convenient, albeit less indepth, online survey that was created based on the the in-person focus group protocol we had intended to use.

Table 1
Characteristics of follow-up participants (n=33).

	% (n)
Age group (Range: 20-64 years)	
20–29 years	18.2% (6)
30–39 years	21.2% (7)
40–49 years	33.3% (11)
50+ years	15.2% (5)
Not indicated	12.1% (4)
Gender	
Female	75.8% (25)
Male	12.1% (4)
Not indicated	12.1% (4)
Indigenous identification	
Indigenous	69.7% (23)
Non-Indigenous	15.2% (5)
Not indicated	15.2% (5)
Role in the community	
Mental health professional	48.5% (16)
Non-mental health professional	51.5% (17)
Main reason for attending	
Mental health interest	45.5% (15)
Job related	42.4% (14)
Cultural aspect	12.1% (4)
Continued post-course to become a MHFAFN trainer	
Yes, became a certified MHFAFN trainer	63.6% (21)
No, did not become a certified MHFAFN trainer	36.3% (12)

2.3. Participants

Of the 89 participants who completed surveys directly after the course, 41 responded to the follow-up surveys. Eight of the surveys were significantly incomplete or missing data on key variables and excluded from analyses. Of the remaining 33 participants, most were female (86.2%) and identified as First Nations or Métis (82.1%). Participants who did not identify as First Nations or Métis, identified as: Canadian, African, and European; and all were living and/or working in First Nation communities and organizations. More demographics information can be found in Table 1.

2.4. Measures

The participant follow-up survey was a 19-item measure that was developed for this follow-up study. The survey included seven demographics questions. There was one initial dichotomous item asking whether participants had experienced a post-course situation where they encountered someone with a mental health issue. Participants who replied 'yes' to this screening question were asked: "Did you try to use your MHFAFN skills?", "Please briefly describe the situation," "Did your actions help the situation?" and "What was the outcome?". All participants were then asked if they had "situations where you experienced challenges trying to apply your MHFA skills?" and if "yes", were asked to please describe the challenges. Participants were asked to comment on "ongoing supports that you feel are needed to best put your MHFA skills into practice?" There were two open-ended questions asking for reflections: "What were the two most valuable aspects of the training for you?" and "Overall, now that time has passed, are there things you learned in MHFAFN training that you use in everyday life? (If 'yes', please describe)." There were two questions asking for feedback the course. One was general comments and suggestions and the other asked: "Looking back, are there parts of the program you wish the facilitator had spent more time on?" and if 'yes', "Which area of the training do you wish there was more time on?" Finally, there was an open-ended question on the impact of MHFAFN on the level of stigma for mental health issues in the community.

2.5. Data Analysis

Simple quantitative analyses of respondent characteristics and frequency of responses were conducted in SPSS using descriptive statistics. Qualitative data were analyzed using a general inductive approach for evaluation data (Thomas, 2006). The general inductive approach is a set of procedures for analysis of qualitative data where the analysis is guided by focused evaluation questions (Thomas, 2006). The purpose of the approach is the development of 3-8 valid and reliable summary themes from the underlying experiences in the raw data, not from prior expectations or models (Thomas, 2006). The procedures include: multiple close readings and interpretations of the data, coding over multiple iterations to develop categories, memoing to produce category descriptions, and category assessment to identify which categories are the most important given the evaluation objectives. Procedures for trustworthiness and rigour that are applicable to the general inductive approach include peer debriefing, member and stakeholder checks, and conducting a research audit (Lincoln & Guba, 1985; Thomas, 2006). For this study, written responses to the open-ended survey questions were collated in Dedoose web application Version 8.3.17. The compiled qualitative data were closely read by first and fourth authors of the team. The first author open coded the data and annotated through several rounds. A codebook was created using annotations to describe the codes and quotes for illustrative examples from the data. Codes were organized into overarching themes to describe the major elements of the responses, and the fourth author was consulted for interpretation and peer debriefing. The themes were compared for consistency with previous findings and field notes from the larger evaluation study. The first author selected quotes to share that exemplified the findings as a way of honouring the participants' voices and acknowledging the tradition of storytelling as knowledge transfer.

3. Results

In this section, findings from the follow-up survey are shared, including respondent demographics, themes from the respondent reflections, and examples of their experiences with the MHFAFN skills.

3.1. Survey Respondent Demographics and Use of MHFAFN Skills

Table 1 shows the demographics of the survey respondents. The majority of participants identified that in the months between attending a MHFAFN course and taking the follow-up survey, they had an opportunity where they could use the MHFAFN skills (n=25). Of the survey participants who had an opportunity, 88% reported they responded to the situation and tried to use the skills they learned from MHFAFN. All participants who responded to the situation with MHFAFN skills noted that in their opinion, their application of MHFAFN skills helped the person they were trying to support (n=22). Four respondents indicated they faced situations where they experienced challenges trying to apply MHFAFN skills (n=4). One of the challenges was lack of opportunity to apply the skills: "*I have not run into barely any situations like this. Which is a good thing for our community*" (Female). The other three respondents who provided responses, also reported they had used their MHFAFN skills to attempt to help someone, despite the challenges: "*It is sometimes difficult hearing the stories…but we remember to listen without judgement and remind them we are not mental health professionals…*" (Female).

3.2. Respondents' Reflections on MHFAFN Training

Table 2 identifies the themes that arose from coding the responses to the open-ended questions asked in the survey. Here we provide an introduction to the themes, with more information on the findings presented under each theme's sub-heading. One major theme is the importance of the First Nations Specific Content (n=15), even though participants were not asked any direct questions about their opinions of including First Nations content in the course. Mental Health Literacy was mentioned in many responses to various open-ended questions including the most valuable aspects of the training and how MHFAFN

Table 2
Themes Identified in Participants' Accounts of Using MHFAFN to Help Others

Theme	Description	Example
First Nations Specific	Participant references learning about First Nations culture, the importance of Elder participation, First Nations historical context and mental health, or indicate recognizing and responding to mental illness is unique and specific to First Nations people.	*"Tying in our historical traumas to today,"* *"the language is simple and applies to Native people"*
Mental Health Literacy	Participant demonstrates knowledge of the EAGLE steps, or provides an example of a personal experience of using the EAGLE skills, or mentions increased mental health knowledge in a specific area.	*"People were thankful to have someone who* listened without judgement *and knew of other resources to refer* them to," *"learning how some of the mental health challenges described in the material and how they manifest differently in people."*
Stigma reduction	Participant indicates their opinion that MHFAFN has had an impact on the stigma surrounding mental illness in their community.	*"Reassures that people with mental illness are not weak,"* *"…when the training was provided to many people, I feel it created a ripple effect on breaking stigma and negative attitudes as these people were going to their own families and telling them what they had learned and starting many conversations about mental health."*
Self-Efficacy	Participant describes feelings of new or increased ability to respond appropriately to a mental health emergency.	*"I will be able to not panic,"* *"I wouldn't have known really what to do, prior to learning the skills."*

has influenced their every day lives (n=31). In response to the question about the perceived effects of MHFAFN on stigma in the community, 17 participants indicated they observed the benefit of reduced stigma in the community or place of work. The majority of reflections were positive and appreciative, and six respondents indicating feelings of increased self efficacy despite not being asked directly. There was one negative comment on the training: "*I was disappointed with the overall quality of the program as well as the delivery of the material by the trainers*" (Female).

3.2.1. Cultural Content

For the theme of First Nations specificity in the training, there were two sub-themes identified in the data. The first was the relevance of cultural content when learning about mental wellness and responding to mental illness (n=5). One female respondent referenced the intersection between First Nations culture and providing first aid when she said she used her MHFAFN skills in her "*daily work with clients. Helped to come from a perspective that is culturally relevant.*" Another female respondent said the inclusion of First Nations traditions made the mental health information more relevant for her: "*Traditional relevance with each topic. The teachings that root the information is very relevant for me.*"

The second sub-theme identified was First Nations historical context and how it relates to current mental illness (n=10). As one respondent noted:

> Knowing that the residential schools still has an effect on our people, that's something I always wondered about and never knew why it was so important and why we can't move on from that and why it was taught to us, but understanding that the mental effects it still plays on our people today was a great aspect to the training. I took a lot of CPR training and have ASIST under my belt, but to understand how mental thoughts and illness can affect a person, it greatly helped me understand how to help people in more ways of just helping injuries and people who want to end their lives. (Female)

Similarly, another participant noted how understanding the context

of health inequities can help people view challenges in a different way:

> The historical context of the training is the most valuable to me. When I hear people talking about 'why does it have to be this way or why are the people this way,' these history lessons explain so much and spark an interest in people wanting to learn more. (Male)

In addition to the two sub-themes, some of the respondents referenced cultural content by mentioning Elders being present and participating in traditions during the training. Not all MHFAFN trainings of this study had these enriching traditional aspects.

3.2.2. Mental Health Literacy

The overarching theme Mental Health Literacy came from combining the following codes: Mental health knowledge, where participants indicated that they learned about specific mental illnesses in the course (n=8); EAGLE, where EAGLE was specifically mentioned or one of the EAGLE skills was provided (n=14); and Skills, where broader reference to learning first aid skills or tools was noted (n=9).

3.2.3. Stigma

While 17 participants indicated they observed the benefit of reduced stigma in the community or place of work, including a "*rippling effect on breaking stigma and negative attitudes*"(Table 2), not all stigmatizing views can be changed through participating in the course. For example, one individual responded to a few open-ended questions with what could be considered stigmatizing remarks or even lateral racism about the struggles of fellow community members with mental illness. Others indicated no response or no perceived changes in the stigma surrounding mental illness.

3.2.4. Self efficacy

For this study, participants were not directly asked about their feelings of increased confidence in applying first aid skills to a mental health scenario; however, six participants mentioned feelings of increased self-efficacy for responding to mental health crises after the MHFAFN course. One person responded to the question of challenges they faced in applying MHFAFN skills by reporting a lack of self efficacy: "*I don't feel adequately equipped to deal with tough situations*" (Female).

3.3. Applying Skills Learned in MHFAFN to Mental Health Crises

We present accounts from MHFAFN participants who applied their MHFAFN skills to situations involving mental health crises. We chose to share the following stories because they are representative of the themes found throughout the responses, and they depict the utility of the actions taken. Although the stories are brief, they depict real-world experiences of MHFAFN course participants. Participants described being able to provide immediate and short-term help for the individuals facing a mental health issue, and help connect them to professional supports and resources. Participants spoke about the ways in which they have applied their MHFAFN knowledge and skills to help people who were considering dying by suicide:

> "I have had someone close to me come to me with suicidal thoughts and urges… with my knowledge from the training about dealing with mental health emergencies, I was able to listen and direct this person to the resources I knew available in our community. Person is currently receiving help at the professional level." – Female Participant, First Nation Community in Nova Scotia

One respondent indicated that her use of non-verbal communication was helpful in supporting a person in a culturally specific way:

> I knew how to respond to someone contemplating suicide, and I knew how to use my body language with our First Nations people. It is different than the regular population, as well, the eye contact. I hope my actions helped the individual. This person is still here with us today. As well, they confide

in me completely. Thankful for MHFAFN. – Female Participant, remote First Nations Community in Northern Manitoba

Participants also reported using MHFAFN skills in intimate familial relationships. As indicated in the stories below, two respondents described their feelings of increased abilities to understand, recognize, and empathize with their loved ones who are struggling with a mental disorder and the stress of a sudden trauma:

After the training, I felt more confident in being able to recognize signs and symptoms that people struggle with in regards to mental health. I have a daughter who has anxiety and having taken this training, I was able to pick up on different things in her and get her the help she needs. She is now in counselling. We never minimize her worries and allow her the time to tell us how she's feeling. I do several check-ins with her and keep in regular contact with her teacher... Also, instead of telling her, she was going to start counselling, we asked her if it was okay if I call someone to come and talk to her and thankfully, she agreed. – Female Participant, Winnipeg, Manitoba training for surrounding First Nations communities

Used MHFA skills mostly within my family, in my job I don't see clients per se. There were situations in my family where I was able to remember the "steps" of Mental Health First Aid. There was a suicide in my family last year, two days after I took this training... I believe just my natural caring/helping nature came out, with the awareness of how trauma effects people. I was able recognize in my family who needed more support. – Female Participant, Ottawa, Ontario training for Northern First Nations health board-level stakeholders

A participant who had not had an opportunity to use his MHFAFN skills to help a person in mental health crisis, described a different way of applying what he learned in MHFAFN:

"I may not use it in a one-on-one sense, but I have certainly had the opportunity to give advice over the phone or in passing to others that may be dealing with persons with disorders...The stigmatizing terms exercise brought forth a lot of feelings about how our language or even slang is and was stigmatizing. A lot of people I have talked to have expressed their feelings about the shame they have for using terms without even knowing that the person is going through. It changes opinions and perspective!" - Male Participant, Winninpeg, Manitoba training for surrounding First Nations communities.

While not an example of mental health first aid skills, this quote is describing one of the other aims of MHFAFN, which is reducing the stigma of mental illness.

4. Discussion

The preliminary national study indicated that participants experienced self-rated increases in mental health knowledge, mental health first aid skill application, and self-efficacy, and reductions in stigma beliefs after participating in MHFAFN (Crooks et al., 2018). Although the follow-up study contains only a subset of the participants in the initial study, the emergence of improved mental health literacy as a theme in their responses supports the larger study's findings. While mental health literacy does not necessarily translate to effective recognition of mental illness and appropriate intervention in mental health emergencies, follow-up study responses provided real world context to the preliminary study's positive findings. Furthermore, the stories provided some compelling examples of participants' experiences in translating their Mental Health First Aid skills into practice. The challenges shared provide credibility to the positive findings of skills application, because despite feeling they faced challenges, three of four respondents were still able to try to apply the skills they learned to provide aid.

When considering a public health approach in First Nations contexts in Canada, it is imperative to consider the historical legacy and continued trauma of colonialization, which damaged and continues to erode First Nations' health and wellbeing at the individual, familial, and community levels (Adelson, 2005). First Nations cultural continuity is widely acknowledged as a potential mitigation to the many barriers to health care faced by First Nations people (Nguyen et al., 2020; Smye & Mussel, 2001). First Nations specificity arose as a theme throughout the qualitative responses despite not being a direct topic of any survey questions, which indicates that the respondents felt the First Nations components were a valuable aspect of their experiences in this training and had a lasting impact. More broadly, this theme supports the notion that responding to mental illness may require specific cultural approaches (AFN & Health Canada, 2015; Smye & Mussell, 2001). Moving forward, MHCC could ensure the inclusion of community-specific historical context in MHFAFN, considering more than one participant mentioned learning about the history of their people improved their understanding of current struggles with mental illness. While it has been stated that there is room in MHFAFN for community- or Nation-specific adaptation, the inclusion of any cultural traditions and community-specific history is up to the individual trainers and Elders to provide that level of cultural richness. Furthermore, including First Nations historical and cultural content in the training is important, but is only one step in dismantling the entire colonial trauma framework, through which the current health disparities of First Nations people needs to be viewed (Mitchell et al., 2019).

In Canada, First Nations communities are very often geographically remote, small, and highly socially interconnected (Richmond & Ross, 2008). In many First Nations cultures, the notion of individual wellbeing is situated in the collective community (Adelson, 2005). Due to this social embeddedness, social supports have a complex influence on health behaviours in First Nations communities (Richmond & Ross, 2008). Because of these cultural and community characteristics, population health-based approaches such as MHFAFN are especially relevant for First Nations communities. MHFAFN is based on improving mental health through individual and collective relationships, spanning from familial to community level. There were also participant examples of MHFAFN impacts on the community level: speaking openly about mental illness, making the links to historical traumas, and the resulting observed reduction in social stigma surrounding mental illness rippling through the community. In Canada, trained participants living in a First Nations community will still face great barriers to proper mental health care including physical accessibility, availability of services, racism, and the retention of healthcare professionals (Allan & Smylie, 2015; Horrill et al., 2018; Kurtz et al., 2008; Nyugen et al., 2020). Health behaviours can be improved on the individual and community levels; however, as long as First Nations communities continue to have inadequate mental health resources, these population health efforts will remain necessary but not sufficient.

The reality of such inadequacies in mental health services in many First Nations communities means that even though MHFAFN is not intended to be a mental health professional training, it is possibly being utilized in a professional capacity. Our follow-up demographics show that almost half of respondents are mental health professionals and 42% of respondents took the training course for their jobs (Table 1). Fear of stigma for mental illness, exposure to racism and discrimination in health services, and lack of culturally relevant care, are major barriers for First Nations mental health service utilization (Allen & Smylie, 2015; Nguyen et al., 2020). Implications for MHFAFN as a culturally relevant training for mental health professionals working with First Nations people could be a future area of inquiry.

The following limitations of our study should be considered. Only approximately one-third of participants in the original study completed the follow-up questionnaire. As a result, our sample was small and likely non-randomly skewed toward those who received the most benefit from the training. Our methodology purposefully did not include a pre-post design and comparison group for many reasons including our research team's desire to avoid the appearance of *testing* the participants and a

decisive effort to conduct research with respect to First Nations cultural storytelling traditions (Auger et al., 2019; Crooks et al., 2018)). However, because of the entire reliance on participants' self-report, we must be careful when interpreting the results. We cannot assume that the individuals who responded to the follow-up survey, would not have been able to recognize mental distress and help those individuals without the course. However, our confidence is bolstered by the fact that in most cases participants linked their responses to their experience of the training. There was also an entire subset of the original participant group that did not respond to the follow-up survey, which could be because they did not find the course beneficial. The participants who responded to the survey had a large range in follow-up period from only one month to over a year (although most were in the 6-12 month range). This could create both not enough time for post-course experiences with MHFAFN skills and too long of a span for collecting meaningful reflections on the course. Finally, the effectiveness of the actions taken were shared from the perspective of the person providing first aid, and not from the lived experience of the individual who received the care. An area of future inquiry is the impact of the training on the individual receiving Mental Health First Aid, whether the recipient felt supported, and if they accessed mental health services.

5. Conclusion

The stories shared with us indicate that for at least a subset of the participants, responding to family members, coworkers and/or friends who are comtemplating death by suicide or experiencing other mental distresses is a part of their everyday experiences post-MHFAFN. After completing the training, participants who responded to a mental health crisis were able to use their first aid skills and help direct the person to appropriate supports and services, which fits with our preliminary findings of increased knowledge on mental health and mental health first aid skill application. More rigorous research could examine the extent to which these successful experiences can be attributed to respondents' participation in MHFAFN and whether the recipients of aid did access mental health services in the community or health sector. It is important to recognize that the respondents made a link between receiving training and their experiences applying MHFAFN skills, and we honour their insights in this regard. MHFAFN has the flexibility to include teachings, customs, and protocols of the local community where the intervention is being implemented; however the level of incorporation and content of local history and cultural practices is up to the trainers and could be an interesting area of future exploration. First Nations community-based interventions and research need to be cognizant of the complex integration of social-supports, health care, disparities and colonial trauma. While improvements in health-promoting behaviours of individuals and at the community level are important, it is fundamental to ensure that there are appropriate mental health resources for them to access. Thus, MHFAFN could be an important pillar of a comprehensive approach to promoting wellbeing in communities, but it should not be a standalone initiative.

Declaration of competing Interest

All authors listed have contributed to the research, analysis, and development of the article. All authors grant permission for the final version to be published. The work presented in the manuscript has not been published elsewhere and is not being considered by another journal. Some of the First Nations communities and organizations that participated in this study also helped MHCC to redesign MHFA training for their First Nations contexts. Also involved in the development of MHFAFN were paid First Nations consultants and a First Nations guidance group; a member of which, is an author of this article. This research was funded by a grant from the Canadian Institutes of Health Research (#297664). The funding agent has had no involvement in design, data collection, data analyses and interpretation, writing of articles, nor decision to submit this article for publication.

References

Adelson, N. (2005). The embodiment of inequity: Health disparities in Aboriginal Canada. *Canadian Journal of Public Health, 96*(2), 45–61. https://doi.org/10.1007/BF03403702.

Allen, J., & Mohatt, G. V. (2014). Introduction to ecological description of a community intervention: Building prevention through collaborative field based research. *American Journal of Community Psychology, 54*(1), 83–90. https://doi.org/10.1007/s10464-014-9644-4.

Allen & Smylie. (2015). *First Peoples, second class treatment: The role of racism in the health and well-being of Indigenous peoples in Canada.* Toronto, ON: the Wellesley Institute. https://www.wellesleyinstitute.com/wp-content/uploads/2015/02/Full-Report-FPSCT-Updated.pdf.

Armstrong, G., Ironfield, N., Kelly, C. M., Dart, K., Arabena, K., Bond, K., Reavley, N., & Jorm, A. F. (2018). Re-development of mental health first aid guidelines for supporting Aboriginal and Torres Strait islanders who are experiencing suicidal thoughts and behaviour. *BMC Psychiatry, 18*(1), 228. https://doi.org/10.1186/s12888-018-1809-5.

Assembly of First Nations & Health Canada. (2015). First Nations mental wellness continuum framework. https://thunderbirdpf.org/wp-content/uploads/2015/01/24-14-1273-FN-Mental-Wellness-Framework-EN05_low.pdf.

Auger, M. D. (2016). Cultural continuity as a determinant of Indigenous Peoples' health: A metasynthesis of qualitative research in Canada and the United States. *The International Indigenous Policy Journal, 7*(4). https://doi.org/10.18584/iipj.2016.7.4.3.

Auger, M., Crooks, C. V., Lapp, A., Tsuruda, S., Caron, C., Rogers, B. J., & van der Woerd, K. (2019). The essential role of cultural safety in developing culturally-relevant prevention programming in First Nations communities: Lessons learned from a national evaluation of Mental Health First Aid First Nations. *Evaluation and Program Planning, 72*(2019), 188–196. https://doi.org/10.1016/j.evalprogplan.2018.10.016.

Canadian Alliance on Mental Illness and Mental Health. (2008). National integrated framework for enhancing mental health literacy in Canada: Final report. http://camimh.ca/wp-content/uploads/2012/04/2008-July_-_CAMIMH_-_Mental-Health-Literacy_-_National-Integrated-Framework_-_Full-Final-Report_E.pdf.

Crooks, C. V., Lapp, A., Auger, M., van der Woerd, K., Snowshoe, A., Rogers, B. J., … Caron, C. (2018). A feasibility trial of mental health first aid first nations: Acceptability, cultural adaptation, and preliminary outcomes. *American Journal of Community Psychology, 0*, 1–13. https://doi.org/10.1002/ajcp.12241.

Caza, M. (2010). Final report: Evaluation of the Mental Health First Aid Training in First Nations Communities in Alberta. Ottawa: Health Canada.

Day, A., Casey, S., Baird, M., Geia, L., & Wanganeen, R. (2021). Evaluation of the Aboriginal and Torres Straight Islander Mental Health First Aid Program. *Australian and New Zealand Journal of Public Health.* https://doi.org/10.1111/1753-6405.13064.

Gone, J. P., Hartmann, W. E., Pomerville, A., Wendt, D. C., Klem, S. H., & Burrage, R. L. (2019). The impact of historical trauma on health outcomes for Indigenous populations in the USA and Canada: A systematic review. *American Psychologist, 74*(1), 20–35. https://doi.org/10.1037/amp0000338.

Hadlaczky, G., Hökby, S., Mkrtchian, A., Carli, V., & Wasserman, D. (2014). Mental health first aid is an effective public health intervention for improving knowledge, attitudes, and behaviour: A meta-analysis. *International Review of Psychiatry, 26*(4), 467–475. https://doi.org/10.3109/09540261.2014.924910.

Hart, L. M., Bourchier, S. J., Jorm, A. F., Kanowski, L. G., Kingston, A. H., Stanley, D., & Lubman, D. I. (2010). Development of mental health first aide guidelines for Aboriginal and Torres Strait Islander people experiencing problems with substance use: A Delphi study. *BMC Psychiatry, 10*, 78. https://doi.org/10.1186/1471-244X-10-78.

Horrill, T., McMillan, D. E., Schultz, A. S. H., & Thompson, G (2018). Understanding access to healthcare among Indigenous peoples: A comparative analysis of biomedical and postcolonial perspectives. *Nursing Inquiry, 25*(3). https://doi.org/10.1111/nin.12237.

Kanowski, L. G., Jorm, A. F., & Hart, L. M. (2009). A Mental Health First Aid training program for Australian Aboriginal and Torres Strait Islander peoples: Description and initial evaluation. *International Journal of Mental Health Systems, 3*(1), 10. https://doi.org/10.1186/1752-4458-3-10.

Kitchener, B. A., & Jorm, A. F. (2002). Mental health first aid training for the public: Evaluation of effects on knowledge, attitudes and helping behavior. *BMC Psychiatry, 2*(1), 10. https://doi.org/10.1186/1471-244X-2-10.

Kirmayer, L. J., Brass, G. M., & Tait, C. L. (2000). The mental health of Aboriginal peoples: Transformations of identify and community. *The Canadian Journal of Psychiatry, 45*(7), 607–616. https://doi.org/10.1177/070674370004500702.

Kurtz, D. L. M., Nyberg, J. C., Van Den Tillaart, S., Mills, B., & Okanagan Urban Aboriginal Health Research Collective. (2008). Silencing of voice: An act of structural violence: Urban Aboriginal women speak out about their experiences with health care. *Journal of Aboriginal Health, 4*(1), 53–63. https://doi.org/10.18357/ijih41200812315.

Lincoln, Y., & Guba, E. (1985). *Naturalistic Inquiry*. Sage Publications.

Mental Health Commission of Canada (Comp.). (2014). Mental health first aid first nations participant's manual [participant's manual]. Ottawa, ON: Mental Health Commission of Canada.

Mitchell, T., Arseneau, C., & Thomas, D. (2019). Colonial Trauma: Complex, continuous, collective, cumulative and compounding effects on the health of Indigenous peoples in Canada and beyond. *International Journal of Indigenous Health, 14*(2), 74–94. https://doi.org/10.32799/ijih.v14i2.32251.

Nguyen, N. H., Subhan, F. B., Williams, K., & Chan, C. B. (2020). Barriers and Mitigating Strategies to Healthcare Access in Indigenous Communities of Canada: A Narrative Review. *Healthcare, 8*(2), 112. https://doi.org/10.3390/healthcare8020112.

Office of the Auditor General of Canada. (2015). Access to health services for remote First Nations communities.(Report No. 4). 2015 Spring Reports of the Auditor General of Canada, Reports to Parliament. https://www.oag-bvg.gc.ca/internet/English/parl_oag_201504_04_e_40350.html#hd2d.

Place, J. (2012). *The health of Aboriginal people residing in urban areas*. National Collaboration Centre for Indigenous Health. https://www.nccih.ca/docs/emerging/RPT-HealthUrbanAboriginal-Place-EN.pdf.

Richmond, C., & Ross, N. (2008). Social support, material circumstance and health behaviour: Influences on health in First Nation and Inuit communities of Canada. *Social Science & Medicine, 67*(9), 1423–1433. https://doi.org/10.1016/j.socscimed.2008.06.028.

Smye, V., & Mussell, B. (2001). *Aboriginal Mental Health: 'What Works Best' A discussion paper. Mental Health Evaluation and Community Consultation Unit.* Department of Psychiatry, UBC. https://www.sfu.ca/carmha/publications/aboriginal-mental-health-what-works-best.html.

Thomas, D., R. (2006). A general inductive approach for analyzing qualitative evaluation data. *The American Journal of Evaluation, 27*(2), 237–246. https://doi.org/10.1177/1098214005283748.