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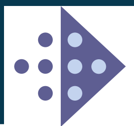

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Community Focus Groups Inform Culturally Sensitive Nursing Telehealth Training Curriculum Development

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Abstract

Introduction: Racial and ethnic minority youth and young adults experience disparities in mental health treatment. This study assessed mental healthcare needs among young adults to align graduate psychiatric mental health nurse practitioner (PMHNP) clinical training to community needs when practicing tele-psychiatry.

Methodology: Youth and young adults (N = 57) completed surveys and participated in focus groups.

Results: Participants noted significant depression, stress, anxiety, and trauma among youth and young adults in their communities. Their most common sources of support for these problems were family members and friends, rather than mental health professionals, potentially indicating unmet needs for mental healthcare.

Discussion: Mental health services for youth and young adults in minority communities should differentiate topics by age, link youth to care within school settings, and establish trust and confidence in telehealth modalities. Educating PMHNPs in tele-psychiatry could increase access to care in underserved communities.

Keywords

Telehealth, Community engaged research, Curriculum development, Latinos, Hispanic, Latinos, Minorities

Intoduction

Overall mental health issues are on the rise for Hispanic/Latino individuals between the ages of 12-49 (SAMHSA, 2018). Serious mental illness rose from 4% to 6.4% in Hispanic/Latino people ages 18-25, and from 2.2% to 3.9% in the 26-49 age range between 2008 and 2018. According to the Pew Research Foundation (2019) [1], as many as 60 million Hispanics/Latinos are living in the United States (U.S.), constituting approximately 18% of the population. This figure is expected to grow to 119 million by 2060 and constitute 28.6% of the population (Mental Health America, 2020) [2]. Hispanic/Latino youth present with higher rates

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of mental health disturbances in schools compared to non-Hispanic/Latino youth, including adjustment, anxiety, and depressive disorders and are less likely to seek mental health services (Center for Health and Health Care in Schools, 2011) [3]. The prevalence of depressive episodes, among Hispanic/Latino youth, increased from 12.6% to 15.1% in youth aged 12-17, 8% to 12% in young adults 18-25, and 4.5% to 6% in the 26-49 age range between 2015 and 2018 (SAMHSA, 2018) [4]. Suicidal thoughts, plans, and attempts are also rising among Hispanic/Latino young adults. While still lower than the overall U.S. population, 8.6% (650,000) of Hispanics/Latinos 18-25-year-olds had serious thoughts of suicide in 2018, compared to 7% (402,000) in 2008. Three percent (224,000) made a suicide plan in 2018, compared to 2% (116,000) in 2008, and 2% (151,000) made a suicide attempt in 2018, compared to 1.6% (90,000) in 2008. Various barriers that prevent Hispanic/Latino youth from access to services include lack of transportation, language-appropriate services, immigration status, affordability, stigma, and health disparities (Mental Health of America, 2020) [2]. Hispanic/Latino children and adolescents under the age of 17 are more likely to reside within disadvantaged circumstances, have insufficient access to adequate mental health care, and have limited understanding of the benefits of seeking mental health supports (Alegria, et al., 2015) [5]. Furthermore, Hispanics/Latinos are more likely to receive psychiatric care in organizations such as community health centers that have limited capacity to provide quality mental health care (Rosales & Calvo, 2019) [6].

Telehealth has been suggested as a novel means of addressing recognized disparities, specifically for Latinos who have been indicated as a population with greater utilization of the Internet and associated technologies than other population groups (Martinez & Perle, 2019) [7]. The integration of technology allows for opportunities for improved education, prompting of recommendation drug usage, monitoring of vitals, and application of other direct treatments in relation to the most common medical and mental health issues faced by Latinos. However, a majority of the available telehealth research focuses on non-Latino individuals. Therefore, although telehealth has been utilized to meet the growing demand for mental health services, more research needs to be done to understand community response to telehealth versus in person service delivery among young adults. It will be important to understand if telehealth mediums and methods that have proven effective with non-Latino populations, can be applied to Latinos or if tailoring needs to occur due to age, cultures, dialects, health literacy, acculturation, and family factors such as level of involvement. These research findings can help to account for differences in motivation for adherence, accessibility for data and internet services, and costs to patient, provider, and organization. Because of the high need for mental health services and lower service utilization among Hispanics/Latinos, it is important to develop a more comprehensive and nuanced understanding of community mental health needs to inform the development and implementation of new training programs and interventions (Martinez &Perle, 2019) [7].

Value of Focus Groups for Mental Health Training and Services

Focus groups qualitative data collection with moderated small-group discussions are valuable for both exploration and evaluation within nursing and health research (Davidson, et al., 2013) [8]. Focus groups allow for a semi-structured discussion which includes diverse members of a specific community who serve as valuable contributors (Amico, et al., 2011) [9]. Community participation in the research provides an opportunity to create a refined understanding of the characteristics and needs of the population (Allen, et al., 2019; Habeger, et al., 2018; Hackett, et al., 2018) [10-12]. Focus groups help researchers understand the specific audience that they plan to serve. Such knowledge helps healthcare providers develop more customized treatment and training programs to serve the needs of the chosen audience (Baral, et al., 2016) [13]. The Telehealth Education and Learning in Psychiatry (T-HELP) study used focus groups to explore the mental health needs of underserved populations in Los Angeles and Orange County, California, as an initial step toward development of a tele-psychiatry health training program to enhance the skills of psychiatric mental health nurse practitioner (PMHNP) students, while providing valuable health education and primary prevention services to Hispanics/Latinos and other underserved populations.

Purpose of the Study

This qualitative study seeks to better understand the barriers of Hispanic/Latino youth and young adults seeking mental health services and perceptions of telehealth as a promoter to meet community needs in order to inform curriculum development of a culturally sensitive pilot training program for PMHNP students.

Methods

Study design

This study employed a qualitative approach with a cross-sectional demographic survey. Data were obtained via the demographic survey and focus groups. The survey assessed demographic characteristics and mental healthcare utilization. Additionally, mental health screening for depression, anxiety, and trauma was completed to inform the curriculum development and to provide supplemental referrals as needed. The focus groups explored the mental health service needs of young Hispanics/Latinos and other underserved groups. The study was approved by the Institutional Review Board for the Protection of Human Subjects (IRB) at California State University, Long Beach.

Participants

Purposive sampling methods were used to recruit participants. Recruitment was conducted by project staff at four collaborating organizations: a large, urban university, an urban high school, and two community-based organizations. Recruitment was facilitated through flyers, announcements at community events, outreach by partner staff, emails, and social media posts. Interested participants were referred to

contact the project staff, who screened them for eligibility in person or by phone. Eligibility criteria included: 1) Hispanic/Latino or other underserved population member as identified by partner organizations; 2) Between 13 and 24 years old; and 3) Resident of Los Angeles or Orange County. Participants aged 18 or older provided written informed consent, and participants under age 18 provided written parental consent and youth assent. Parental consent and assent forms were available in English and Spanish to accommodate participation from youth with monolingual parents.

Data Collection

Participants completed the survey before the focus group. The survey was collected via Qualtrics on project-owned and password-protected iPads. The survey assessed age, sex, race/ethnicity, education, household characteristics, and mental healthcare utilization, as well as validated measures of depression, anxiety, and trauma: the Patient Depression Questionnaire-9 (PHQ-9; Kroenke, et al., 2001) [14]; the Generalized Anxiety Disorder-7 (GAD-7; Spitzer, et al., 2006) [15]; and the Trauma History Screen (THS; Carlson, et al., 2011) [16]. The validity and reliability of the PHQ-9 as a diagnostic tool for depression was originally established with adults 18 years and older (Kroenke, et al., 2001) [14]. It has since been validated among Latinos (Huang, et al., 2006) [17] and adolescents aged 13-17 (Richardson, et al., 2010) [18]. Similarly, the GAD-7 has been validated with adults aged 18-95 (Spitzer, et al., 2006) [15], as well as with Hispanic/Latino Americans (Mills, et al., 2014) [19] and adolescents aged 12-17 (Mossman, et al., 2017) [20]. Finally, the THS has been validated with a community sample of young adults aged 18-22 years and adults 23 years and older, including Hispanic/Latinos, (Carlson, et al., 2011) [16]. Assessment of the THS, however, has not been completed with youth and is noted as a limitation in this study.

A semi structured focus group guide was designed to understand the mental health needs of Hispanics/Latinos and other underserved youth and young adults. The core questions inquired about the main mental health issues impacting this population, areas of stress and struggle, help seeking behaviors, and barriers to seeking help. Additionally, questions assessed the participants' comfort in seeking professional help and using technology (i.e. phone or computer) to talk with a therapist. To ensure comprehension by the participants, the focus group guide was written at a 5th grade reading level. The focus group questions are included in the Supplemental Materials.

Six focus groups were conducted: Three among youth participants ages 13-18 years (conducted at an urban high school and a community-based clinic) and three among young adult participants 18-24 years (conducted at an urban university and a community-based center). Participants from the urban high school that identified being 18 years of age were still allowed to participate in the youth focus group, as that was deemed more appropriate for their developmental stage. Focus groups were moderated by trained research staff. Additionally, a board certified PMHNP attended each focus group to provide referrals and address any mental health needs raised. The focus group discussions were digitally recorded, and handwritten notes were taken by note takers to document non-verbal responses as well as keep a timeline of the discussion. Each focus group session lasted approximately 90 minutes. Each participant received a $20 incentive.

Analysis

To ensure confidentiality, aliases and unique identification numbers were assigned to discussion members and surveys, respectively. Quantitative survey data were analyzed using IBM SPSS Version 26.0 (IBM Corp. Released 2019, Armonk, NY). Descriptive statistics were completed to describe the participants, and scores from the validated scales assessing depression, anxiety, and trauma were computed.

Qualitative transcripts from the digital recordings of each focus group were analyzed by three research team members, who independently read and coded the transcripts to identify key themes. All qualitative analysis was completed using Dedoose Version 8.1.9 (a web application for managing, analyzing, and presenting qualitative and mixed methods research data [2018], Los Angeles, CA: Socio Cultural Research Consultants, LLC, www.dedoose.com). Using the focus group guide and debriefing notes as base documents, the coders met several times to discuss coding, compare findings, and agree on key themes.

Results

Sample characteristics

A total of 57 eligible participants were recruited from Los Angeles and Orange County. The majority of the sample self-identified as Hispanic/Latino (68%). Table 1 shows the participants' demographic characteristics.

From the total sample, 35% of participants had seen or talked to a mental health professional (e.g., psychiatrist, psychologist, psychiatric nurse, or clinical social worker) in the last 12 months. The mean PHQ-9 score was 8.6 (SD = 7.1, range 0 - 25). The majority of participants (63%) had a PHQ-9 score below the clinical depression cut-point of 10, while 25% of participants had PHQ-9 scores greater than 15, which is indicative of major depression. Similarly, the majority of participants (63%) had a GAD-7 score below the threshold score of 10, representing minimal to mild levels of anxiety severity. Ten participants (18%) had scores that were indicative of moderate severity of anxiety symptoms, and eleven participants (19%) had scores that were indicative of severe anxiety. The mean GAD-7 score was 7.7 (SD = 6.3, range 0 - 21). Most (74%) participants reported a history of trauma. The most common traumatic events "sudden death of a close family or friend" (44%); "some other sudden event that made [them] feel very scared, helpless, or horrified" (40%); "seeing someone die suddenly or get badly hurt or killed" (25%); "a really bad car, boat, train, or airplane accident" (18%); and "suddenly abandoned by spouse, partner, parent, or family" (18%). The mean frequency of high magnitude stressors (HMS) reported was 9 (SD = 11.6, range 1 - 47). Participants with moderate to severe levels of depression, anxiety, or trauma, were provided with supplemental referrals.

Table 1: Sample characteristics (N = 57).

Demographic Characteristics	n	%	Range
Gender			
Male	19	33.3	
Female	38	66.7	
Age (years)	17.1 (mean)	3.0 (SD)	13 - 23
Hispanic or Latino[a]	39	68.4	
Race/Ethnicity[b]			
White	18	31.6	
Black	4	7.0	
American Indian/Alaska Native	2	3.5	
Asian/Pacific Islander	4	7.0	
Other	19	33.3	
Education Completed			
Elementary	3	5.3	
Middle school	31	54.4	
High school	22	38.6	
College degree	1	1.8	
Household Characteristics	**n**	**%**	**Range**
Type of Household			
Parent's home	39	68.4	
Extended family's home	1	1.8	
Apartment (shared)	1	1.8	
Residential housing alone	3	5.3	
Residential housing shared	11	19.3	
Trailer/Mobile home	2	3.5	
Total Number of People in Household	4.5 (mean)	2.1 (SD)	1 - 10
Number of Children in Household[c]	1.4 (mean)	1.2 (SD)	0 - 4

Note: [a] Refused to answer n = 1; [b] Refused to answer n = 13; [c] Refused to answer n = 2.

Themes identified

Emerging themes from the qualitative analysis were organized into three subtopics: Main mental health issues, areas of stress and struggle, and help seeking behaviors.

Main mental health issues: Participants were asked to share their perceptions of the main mental health issues facing youth and young adults. The most frequently mentioned health issues were depression, stress/anxiety, suicide, and trauma.

Depression was consistently mentioned as the primary mental health issue experienced by youth and young adults across all of the focus group discussions. It was also often referred to as one of the primary things that came to mind when asked to share what they thought mental health or mental illness meant. Multiple respondents depicted depression as very common among their peers and within society, in general. For some participants, depression was referred to negatively as a way of seeking attention or as a trendy thing to say.

"Depression is something big that like, affects almost like, half the teenagers in school. 'Cause us teenagers, we go through a lot. Like, our minds are still developing so like, it's a lot to take in, when like so much can happen to us during that time. So, I feel like depression is something we experience commonly because if it weren't so common, there wouldn't be like resource people coming to our school talking about it. And like the symptoms and treatments we should get." (Youth Participant, Community-based Clinic).

"I think of people who are like depressed, and or like, who's seeking attention, but also I think of people go through major, you know, test anxiety." (Young Adult Participant, Urban University).

Stress and anxiety were often referenced together and were noted as a key mental health issue for youth and young adults. The most common sources of stress and anxiety were school, family, and work-life balance.

"I think a mental problem within our generation is anxiety. And maybe social anxiety sometimes because we get or at least for me, sometimes I feel like I get so caught up in my academics that I can't focus in, like the actual person I'm becoming throughout my college years." (Young Adult Participant, Urban University)

Suicide was most commonly mentioned in focus group discussions with the youth participants, wherein they identified it as a major mental health issue for people their age. Youth were aware of the increasing rates of suicide among adolescents and noted the difficulties in identifying teens at risk for suicide. Youth participants also expressed an increased interest and comfort in talking about suicide in group settings, whereas the issue was less prominent in the discussion groups with the young adult participants.

"I think teenage suicide are actually in the high…this population of teenagers that committing suicide are growing. Because I think the reason why people are not noticing is because they mask it. They mask their emotions, and they don't show it, to anyone, like they isolate themselves from social media, they start unfollowing people, they start not hanging out with friends or doing their normal activities, the, the appetite goes away.

People are not noticing that." (Youth Participant, Community-based Clinic)

Young adult participants were more often than youth participants to mention trauma as a primary mental health issue. Trauma was referred to as self-experienced trauma (e.g., abuse) as well as witnessing or listening to traumatic events (e.g., mass shootings). Traumatic events such as being a part of or hearing about mass shootings was specifically mentioned in multiple focus group discussions with young adult participants. Additionally, young adults made reference to traumas passed down by generations. Some youth participants made reference to childhood traumas, however, little to no information was added and it was most often referred to as a recommended group topic for future discussions.

"[…] or like school shootings, things like that things that like, you know, mentally like mess you up in the head, kind

of [...]. And like so far there hasn't been like school shootings or any like schools like warnings, but I'm always scared that there's something that's going to happen to my school. Because I don't want to die before I graduate." (Young Adult Participant, Community-based Center)

Areas of stress and struggle: Most participants identified school as the main area of stress and struggle among youth and young adults. Participants expressed concern about school performance, such as getting good grades and maintaining a good grade point average (GPA).

"So like, it's sorta like, there's so much competition nowadays so like you have to be, like get straight A's and be like one of the best so you can get into college and it's so stressful." (Youth Participant, Community-based Clinic)

"I think definitely like school is the main stressor that all college students face. Because we have to worry about passing our classes and making sure that we are able to like have a good GPA." (Young Adult Participant, Urban University)

Balancing the demands of school, and/or work, and/or family, and maintaining a social life was also identified as an area of stress and struggle. Most participants expressed concern about balancing their schoolwork and social life (e.g., spending time with family and friends). One participant worried about not being mindfully present at their job because of all of their obligations; whereas another participant mentioned being overwhelmed with family obligations, which added to their stress of balancing multiple jobs.

"My cause of daily stress would be work, I have two jobs. And I am the eldest of the family. So, on top of that work, I feel like I get anxious and stressed over the fact that I have to help out, pick up the younger siblings, take them to school and take over work. And just on top of that, like, it's just added stress that I don't need (exhales)". (Young Adult Participant, Community-based Center)

Family and social interactions were also highlighted as areas of stress and struggle, wherein some participants mentioned not being able to be themselves with their families or struggling to "fit in".

"Having your family tells you what to do and then when you do it, judging you for everything, basically not being able to do anything you want to do." (Youth Participant, Urban High School)

"I think kids our age they struggle with trying to fit in, like, they'll do anything to just, Like they'll go with the flow, like if they want to hang out with the "cool kids," they'll try vaping, they'll try drugs, they just want to fit in and they're willing to do anything to fit in. And that shouldn't be, they shouldn't do that because if people aren't accepting them for whom they are, then why they are with those kinds of people?" (Youth Participant, Community-based Clinic)

Another related area of stress and struggle included academic transitions, such as transitioning from middle school to high school to college, and then graduating from college. Most young adult participants identified graduation as a major life transition that caused them stress and worry. Not knowing what to expect after school and whether they would be financially stable were closely linked to the stress caused by graduation.

"I'll be a senior next year. So that's kind of been weighing on me a lot recently, because I have no idea what I want to do this. I mean, I know what I'm majoring in, I'm really happy with my major, but I have pretty much no financial stability. And that scares me. And then also my parents enforcing that, like you need to get a job out of college, you need to figure out where you're going to live, because you can't come back and live with us is like, it's very stressful to think about it, but it kind of comes back and creeps up on me at times." (Young Adult Participant, Urban University)

Furthermore, self-identity including generational identity was an area of stress and struggle among young adult participants. Some expressed concern with the person they will or have become due to their personal growth. Furthermore, some participants stressed about how their identity would change in the future once they graduate from college.

"I feel like it also can be a lot of like, discovering who you are, like struggling with finding your identity and is kind of like a turning point in your life, so actually figuring out who you are what you want to do. You can create issues. Throw off your balance". (Young Adult Participant, Urban University)

Other areas of stress and struggle that were mentioned less frequently included bullying and romantic relationships.

Help seeking behaviors: Both youth and young adults identified their parents (especially mothers) as sources of support when they need help.

"I share most of my worries to my mom, just because I'm kind of more comfortable with her." (Youth Participant, Community-based Clinic)

"I don't have brothers unfortunately, but I would turn to my mother, being as my best friend. And so, she's been there for me. And if I were to go to a stressful situation, she would be the first person I will contact or go to not just because she would tell me what I'm doing wrong, or how can I fix it, [but] for a friend." (Young Adult Participant, Community-based Center)

Participants also mentioned siblings as a source of support. For youth participants who identified their sibling as a useful resource, siblings were often older and portrayed as being more relatable than their parents. One participant reported turning to family rather than friends for support because a family member's advice is more genuine.

"I would turn straight to my brothers and my mom because that's how I've always been. Friends, I have close friends but really, I don't feel like, they would, I mean, they would care for me. But they're, they might just care like in a superficial way, and family would actually tell you the truth. Even if it hurts or if it doesn't. I just feel like it's more of the sincere help, that that's why I would turn to my family or my brothers specifically." (Young Adult Participant, Community-based Center)

Contrary to youth participants, young adults were more likely to report seeking help from friends. Friends included best friends, co-workers, roommates or a significant other. Young adult participants who lived on campus typically mentioned roommates or a significant other as sources of support, mostly because of their accessibility.

"I would talk to my roommates because they're always there. And my friends.....I'm gonna have to text them and I wouldn't get an instant reply. But I know my roommate's always there, they would give me an instant reply." (Young Adult Participant, Urban University)

Youth participants who sought help from friends noted that they would only do so if they trusted the friend. Others noted that they would not seek help from anyone and would keep the issue to themselves including journaling.

"I write them for myself." (Youth Participant, Urban High School)

Both youth and young adult participants mentioned having access to professionals on- and off-campus. Youth participants identified resources such as the wellness center and counselors or psychologists at their school or the community-based clinic. Young adult participants, especially those attending university, identified on-campus resources such as the Counseling and Psychological Services (CAPS) office. However, professionals on campus were often mentioned in broad terms, as a known resource or an additional option to other sources of support in their communities. Additionally, both youth and young adult participants expressed a lack of comfort in seeking professional help as well as a distrust in professionals.

"Scared […] Because you don't know that person and you don't know what that person could do with that information." (Youth Participant, Urban High School)

"[I think] that going to a professional, sometimes I find it intimidating because you're opening up to a stranger knowing, and sometimes it's scary to think that we even have errors or stuff like that, so it's like you don't even think about it, you don't even want to […], so it's intimidating." (Young Adult Participant, Community-based Center)

Finally, participants had mixed feelings about their level of comfort in using telehealth services. Some participants expressed support in using telehealth because it made it easily accessible to talk to someone. However, both youth and young adult participants expressed many concerns with the use of telehealth. A subsequent article will aim to further describe participant reactions to the use of telehealth as well as identified barriers and suggested solutions.

Discussion

This study identified some differences between youth and young adults in needs and opinions regarding mental health issues. For example, although depression and stress/anxiety emerged as common mental health issues for both youth and young adults, only youth respondents expressed suicide as another area of concern. Additionally, when identifying topics for discussion, youth participants were more likely to mention suicide and bullying, whereas young adults were more interested in discussing methods for balancing work, school, life, family, etc. Another key difference included the main sources of support. Although both age groups mentioned family as a major source of support, youth were more likely to avoid disclosing their problems at all, whereas young adults were more likely to confide in roommates or significant others.

In contrast, findings related to help seeking behaviors and barriers were more similar among youth and young adult participants. Key barriers to seeking help identified by both youth and young adults included fear of disclosure by professionals, which point to a lack in trust in professionals, as well as fear of judgment or stigmatization from peers and/or family. Additionally, some youth and young adults also mentioned not wanting to burden others or make others feel uncomfortable with their problems as a barrier to seeking help. As for seeking professional help, primarily youth participants did not feel comfortable with this. Some youth participants mentioned a lack of trust in health professionals and expressed their discomfort using words such as confused, nervous, frightened, and scared. These findings will be useful to inform the development of a culturally tailored telehealth intervention to address the identified mental health issues.

Limitations

This study has several limitations. First, participant characteristics varied from the intended target population. For example, the focus groups included a diverse representation of race/ethnicities rather than focusing primarily on Hispanics/Latinos to avoid excluding community participants. The majority of the sample (68%), however, did identify as Hispanic/Latino, and the remainder of participants enrolled were from other underserved populations. Additionally, the study findings are not generalizable to all Hispanics/Latinos due to the small sample size, variability in age among the participants, and inclusion of only English-speaking participants. The reported frequencies of HMS should also be interpreted with caution as the THS has not been validated with youth participants.

The focus group methodology has inherent biases that could affect the validity of the qualitative data. Responses from some of the participants may have conformed to others' opinions to achieve a unified response, to fit in, or to avoid uncomfortable interactions (e.g., judgement or stigma) with other participants. Efforts were made by the trained moderators to address these issues; however, it is uncertain the extent to which these biases are avoided in focus groups. Nevertheless, the findings from the focus groups provide important insights about the mental health needs of Hispanic/Latino youth and young adults and other underserved individuals to aid the development of interventions and tele-psychiatry training programs for PMHNPs to reduce disparities in this area.

Implications for Research and Practice

Findings support the need for age-specific mental healthcare services. Youth could benefit from direct linkage

to school psychologists, as well as a focus on the school environment. Young adults need strategies to achieve work/school/life balance.

The value of focus groups to identify community mental health needs and concerns was essential to the development of a culturally responsive telehealth training program for PMHNP students. Secondarily, the focus groups had value beyond the development of the curriculum, serving as an important strategy to show students the ethical imperative of seeking community input prior to establishing health outreach programs. The variety of community-based responses created a robust example for the PMHNP students regarding the value of culturally sensitive leadership and design of community-based programs. This type of foundation allows for higher public education curriculum to be truly tailored to the needs of the communities these future professionals will serve. The PMHNP telehealth curriculum will include training to recognize and overcome unconscious bias to increase cultural sensitivity, health promotion activities using available technology, and trauma informed care in order to ensure safety, transparency, peer support, and collaboration while also acknowledging cultural issues.

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Supplemental material

Focus Group Questions

Intro/Start-Up

1. Moderator affirmation of instructions: See? The group agrees and disagrees on enjoyable weekend activities

Core Questions

1. When you hear the words mental health or mental illness, what comes to mind? What do you feel are the main mental health issues facing people your age today?

2. What are the areas in your life that are most stressful for you right now? What do you worry about day to day?

3. Where do you struggle the most? At home? At school? With friends or socially? With family? Or something else?

4. If you were going to talk about things that stress you out, what topics would you be open to talking about?

5. If you or a friend needed help, where would you go or who would you turn to? What might stop you? Who do you share your worries with most often?

6. How would you feel about going to a professional for help? How would you feel about using your phone or a computer to talk to someone?

7. Of the topics we heard about [list a few topics mentioned here], which would people your age come to talk about as a group?

Closing

8. [Ask each person] Of everything talked about today, what would you consider the most important?

9. Was there anything we didn't talk about today that you would like to let us know?

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