across our three groups of participants. In particular, adolescents in recovery from substance use disorders, their providers, and members of Tribal communities all were concerned with protecting future trainees' physical and psychological safety.

Planning Recommendations

Planning recommendations focused on striking some delicate balances. First, with regard to timing, participants acknowledged that First Face training will require a meaningful time commitment but recommended that we show respect for trainees' time by offering to hold the training during convenient times, factoring in trainees' existing commitments to work and family. Evening and/or weekend sessions were suggested, ideally with multiple options to select from at each Tribal community. Participants noted potential trouble holding teen trainees' attention over a lengthy session, with a possible solution being to integrate the training into high school science or health education classes. This approach would, of course, require permission and logistical support from schools serving Tribal teens.

With regard to the modality of training, participants acknowledged the threat to safety posed by in-person meetings as long as COVID persists but also warned against possible "Zoom fatigue." Zoom fatigue results from a combination of factors, including technical obstacles, difficulty reading the social cues of others, constraints on physical mobility, uncomfortable self-evaluation from seeing oneself on camera, and unfavorable comparison to life before the pandemic (Bailenson, 2021; Shoshan & Wehrt, 2021). In short, participants advised us that while moving our trainings online would be an obvious option for protecting trainees' physical safety, it would come with a substantial well-being cost. Some participants recommended that we host a separate online training for those who are unable or unwilling to attend an in-person training due to the threat to physical safety, lack of childcare, or other barriers. We are reluctant to create an entire live, online First Face training because we feel that the full experience demands in-person interactions. However, we will consider creating an on-demand training experience that we promote as a "mini" training rather than as a full replacement for the in-person experience. In other research, AI/AN people have noted that such virtual spaces can promote inclusivity by (1) welcoming those who would otherwise have trouble attending in-person (e.g., caregivers, people in rural communities) and (2) allowing members to bring "their full selves to the space, children, pets, and all" (Buckingham, Schroeder, & Hutchinson, 2023, p. 13). At the same time, however, we would need to ensure that members have the technological access to virtual spaces

(Buckingham et al., 2023). In addition, we will make the in-person trainings as safe as possible, possibly requiring masks, soliciting proof of COVID vaccination, and/or holding them outdoors.

Community members also highlighted potential problems with asking fellow community members to share their addiction and other mental health challenges with stakeholders representing social services and law enforcement. We appreciate this concern for future trainees' psychological safety. We are reluctant to follow through with the resulting recommendation—creating separate trainings for different stakeholders— because our past research regarding adolescent recovery environments suggests the need and desire for better communication across Tribal stakeholder groups (Whelshula et al., 2021). However, we can and will set ground rules for confidentiality around what is shared and caution trainees not to share any information that might have negative consequences for them or their families as part of our broader efforts to set boundaries around sharing personal stories.

Promotion Recommendations

All three groups of participants highlighted community members' possible reluctance to become a First Face due to fear about the responsibilities associated with taking on this role. This concern is justified. Informal mental health caregiving can place a substantial burden on the caregiver. This is especially true when the informal caregiving is offered frequently and when the recipient is experiencing a mental health condition of long duration (Byrom, 2017). One college student in Byrom's (2017) study described the burden of this responsibility in this way: "When I was trying to support her, it put a huge strain on my confidence and mental health, as I felt responsible for her; if I wasn't around to help her and something went wrong, it was my fault" (p. 205). Our curriculum does acknowledge the spiritual, emotional, mental, and even physical demands of mental health caregiving. However, it also conveys our vision of First Face assistance; specifically, we envision that First Faces will typically offer assistance on a more situational/ occasional basis than on an extended basis, in a way that parallels the provision of first aid. We also clarify in our curriculum that "serving as a First Face is not the same as being a professional healthcare provider or a traditional healer." Based on focus group participants' recommendations, in our promotional materials, we will take care to distinguish between a First Face and a professional mental healthcare provider. Also, we will specify that we envision First Face assistance to be offered on a situational/occasional basis and as bridge to professional help, perhaps using the analogy of a

layperson who provides first aid when the situation demands it. First aid might be a more helpful analogy than CPR or the Heimlich maneuver because we want to avoid making trainees, or potential trainees, feel that they will be responsible for saving lives. Specifically, we intend to train First Faces to always seek professional assistance in the event of any urgent medical situation or situation where the physical safety of the First Face or individual in crisis is at risk.

Additionally, based on participants' concerns in this area, we will consider developing a sustained opportunity for trained First Faces to discuss their experiences and provide mutual support. Trained First Faces could log onto a website or app that provides information and resources, including a refresher on the First Face steps, and receive peer psychological support from fellow trainees. Although a meta-analysis suggested that such interventions have very small beneficial effects on caregiver mental health, caregivers in the included studies all provided sustained care to adults experiencing chronic conditions, such as dementia (Sherifali et al., 2018). More research is needed to examine the impact of such an intervention on community members providing occasional/situational mental health support.

Another recommendation regarding promotion was to highlight the personal relevance of First Face training. We will act on this recommendation by providing language along the lines of, "*xaʔtus* (First Face) for Mental Health training will teach you skills for responding to mental health and substance use challenges that are common in Tribal communities such as yours." We also will highlight the various ways that one can act as a First Face, so that it is clear that there are many ways to increase personal relevance and comfort.

Delivery Recommendations

In another expression of concern for future trainees' psychological safety, focus group participants anticipated that discussions of systemic racism, war, COVID, and mass shootings could become heated and distressing. Indeed, according to a poll conducted in the spring of 2019, 85% of American adults believe that political debate in this country has become more negative and less respectful over the last several years (Pew Research Center, 2019). At the same time, focus group participants acknowledged the mental health toll of these issues and resulting need for a program like First Face. We will strike a balance by acknowledging the impact of these and other traumatic experiences on mental health. Thereafter, we will frame the training session as solutions-focused rather than as an opportunity for political debates.

Role playing is an effective, active training technique commonly used in counseling/ psychology and other helping professions (Gibbs, 2019). We anticipate that it will be part of the First Face training program, with Trainee A playing the part of a person in distress and Trainee B playing the part of a First Face (and vice versa). This activity will give trainees the opportunity to practice the First Face steps. It will also give trainees the opportunity to experience the First Face steps from the perspective of a recipient; more generally, playing the part of a person in mental health distress could meaningfully reduce stigma. We asked focus group participants how they expect trainees to receive this educational activity. Echoing published research in this area, focus group participants anticipated some awkwardness. Playing the part of the mental healthcare recipient is especially difficult; often, trainees lack the acting skills or desire to act out a mental health challenge or crisis, especially in public (Pomerantz, 2003). Awkwardness is exacerbated when trainees already know each other because it becomes more difficult to take on assumed identities (Pomerantz, 2003). Solutions offered in formal counseling/psychology training—substituting the role of the recipient with virtual reality or professional actors (Rogers et al., 2022)—are likely not feasible for First Face training. Additionally, these solutions would deprive trainees of the opportunity to take the perspective of someone who might one day receive their support. However, following participants' recommendations, we will try to minimize awkwardness by delaying the role-play activity until later in the training, when participants are more comfortable, and keeping it out of public display. We will also instruct trainees that no one is judging them on their acting skills, provide written cases in advance for trainees to review and familiarize themselves with, and provide tips for how to act out specific issues and mental health problems a First Face might encounter. An additional option is to set aside time for a trainer to act out the part of the First Face or individual experiencing a mental health challenge at the start of the role-playing activity before asking trainees to do so, which might also help reduce tension.

In addition to role playing, we will incorporate several other active learning activities into First Face training, minimizing the time participants spend passively receiving information. Some activities will ask participants to reflect privately on their own experiences to increase the relevance of the presented material. As participants intuited, active learning strategies are recommended in all adult learning, including mental health training (Beidas & Kendall, 2010).

Participants indicated that we could show respect to future trainees, in part, by offering instruction in self-care. This recommendation aligns with other research regarding the role of personal care in overall wellness with Native communities (Kading et al., 2019); it also aligns with

our creation of a manual appendix dedicated to the topic of self-care. This appendix explains why self-care for the First Face is essential, including possible emotional, mental, spiritual, and even physical challenges posed by providing First Face aid. It provides self-care strategies and tips, including a "four directions" wheel that includes strategies for protecting one's emotional, mental, spiritual, and physical wellness. We will address these topics directly in the training, as well.

Finally, we will act on participants' recommendations to acknowledge a "mind your own business" mindset. This mindset might reflect a desire for health privacy that is particularly acute in small, rural communities, especially communities with extended kinship networks (Tassell et al., 2012). First, we will acknowledge the cyclical relationship between this mindset and mental illness stigma—how stigma deters people from talking about their own mental health struggles or asking about others' struggles, and how this secrecy reinforces stigma. To illustrate, a young person recently released from a mental health inpatient unit described his reluctance to discuss his struggles by saying, "I wouldn't go telling people my business." On the other hand, he noted that he would not be reluctant to discuss hospitalization for a physical health problem (Byrne & Swords, 2015, p. 69). Discussing this distinction between mental and physical health might be helpful for trainees. In an early segment of First Face training, we will ask trainees to consider the analogy between providing support for a mental health challenge and rendering first aid. Could they imagine someone being reluctant to provide the Heimlich Maneuver for fear of invading someone's privacy? What might be the effects of such a mindset? We will explain that it is possible to offer informal mental health support while at the same time protecting recipients' privacy and respecting their boundaries. Our narratives, which anchor each module and demonstrate how to be a First Face, illustrate how a First Face can protect a care recipient's privacy to the extent possible.

Limitations

To limit the burden on participants, we reduced the focus group questions down to those we considered most essential. Many other questions might have led to fruitful discussion, such as which mental health concerns are particularly relevant to their own communities, and what they would most like to see covered in the trainings.

Due to their experience in mental health and social services, our participants might have been more interested in First Face training than the population of future trainees. Including a group

of Tribal community members who do not have particular experience or interest in these areas might have resulted in different recommendations.

Following through on some focus group participants' recommendations or ideas that grew out of them, such as developing a separate on-demand version of the training and creating a virtual forum for ongoing education and peer support, would require additional sources of funding and might therefore not be feasible. Other recommendations, such as embedding the training into Tribal teens' schooling, would require substantial coordination with other parties.

As we discussed above, the first author independently summarized participants' responses to the focus group questions. Although their responses were straightforward with relatively little room for interpretation in comparison to most qualitative data, researcher bias is always possible and compounded by the independent process used in this study. In the interest of transparency, we include all participant observations in Table A1 along with the agreed-upon categorizations (planning, promotion, or delivery).

Finally, it is unclear whether these findings are generalizable beyond the communities of interest. Our intention was to improve the planning, promotion, and delivery of training only to these particular communities, and we did not attempt to recruit focus group members who would adequately represent other communities or settings.

CONCLUSION

Culturally acceptable and feasible interventions are necessary to alleviate persistent health disparities affecting Native people. A limitation of many existing interventions is their focus on the individual level, rather than the community or policy levels (Blue Bird Jernigan et al., 2020). We designed *xaʔtus* (First Face) for Mental Health as a community-based intervention to strengthen networks of informal mental health support. For some Native people, informal support might be a preferred alternative to professional treatment approaches that are rooted in western concepts of health and illness and, therefore, culturally inappropriate. For others, informal support might be a bridge to more formal support. Our next steps are to plan, promote, deliver, and evaluate First Face trainings in seven Tribal communities.

A strength of this work is its incorporation of voices of multiple stakeholders, including teens in recovery from substance use disorders and other mental health conditions, alongside their providers and educators/social service professionals from some of their home communities. Focus

group participants provided valuable insights regarding how the training might be received by Tribal community members. Their responses to many focus group questions show concern for future trainees' physical and psychological safety, including recommendations for minimizing the burden that future trainees will assume, optimizing trainees' time involvement, and making the training interactive and engaging. As we will explain to trainees, we are hopeful that raising the collective knowledge and skills of a community to respond to mental health challenges will broaden the network of people who are capable of providing occasional mental health support to their community members, thereby meaningfully reducing the burden on any particular First Face.

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CONFLICT OF INTEREST

The authors declare that they have no conflicts of interest.

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APPENDIX

Table A1
Participants' recommendations and our responses to them as organized into planning, promotion, and delivery categories

Category	Recommendation	Mentioned By	Our Response
Planning	Plan to provide food and breaks	All 3 groups	We will provide food and breaks.
	Hold the training at a convenient time; show respect for trainees' time by making the training no longer than it must be; consider an in-school option for teens	All 3 groups	We plan to provide First Face training over two consecutive days but will consider offering options so trainees can choose the time that is most convenient for them (e.g., 2 weekend days, 2 work days); we will also consider providing in-school sessions for teens.
	Acknowledge the potential for Zoom fatigue alongside trainees' fear of contracting COVID	All 3 groups	We will consider offering a hybrid approach, including a live training at each community alongside a remote, on-demand option. Ideally, the live training will happen in an outdoor location.
	Train community members, mental health professionals, and teens separately	Community members	While we acknowledge the rationale for this suggestion, we believe there is value in bringing different stakeholders together to share their perspectives. We will plan to offer combined training sessions but, as mentioned above, might also offer an in-school option for teens. We will provide ground-rules for confidentiality within the training.
Promotion	Highlight the personal relevance of the training	[ORG] staff and residents	In promotional materials, we will provide relatable examples of situations in which First Face training will be helpful.
	Explain the responsibilities of a First Face	All 3 groups	In promotional materials, we will clearly communicate the range of ways in which someone can be a First Face, taking care to distinguish between a First Face and a professional healthcare provider.

Table A1
Participants' recommendations and our responses to them as organized into planning, promotion, and delivery categories

Category	Recommendation	Mentioned By	Our Response
Delivery	Acknowledge the "mind your own business" mindset	Community members	We will acknowledge this mindset at the outset of the training and its cyclical relationship with stigma. We will explain the need for providing informal social support in a way that respects community members' privacy and personal boundaries.
	Make the training interactive and engaging	All 3 groups	We will create a training session that combines lectures with frequent interactive activities.
	Provide incentives	Community members, [ORG] staff	We will provide incentives for completing pre- and post-training surveys. We will consider providing small gifts (swag) to those who participate in the training.
	Avoid contentious political debates	All 3 groups	We will strike a balance by acknowledging the impact of these traumatic experiences on mental health and frame the training session as solutions-focused.
	Acknowledge the mental health toll of racism, war, COVID, mass shootings, and other traumatic experiences	All 3 groups	
	Role playing can be uncomfortable but valuable	Community members, [ORG] staff	We will incorporate role playing into our portfolio of interactive activities but will minimize trainees' discomfort by offering it after trainees have gotten comfortable in the training environment and in dyads rather than before the whole group. With trainees' permission, facilitator(s) will observe the role playing to learn the extent to which essential skills are being learned. We will consider providing a tip sheet that trainees can reference during the role-play activity. It will give suggestions for playing the part of a First Face or someone experiencing a mental health crisis.

Table A1
Participants' recommendations and our responses to them as organized into planning, promotion, and delivery categories

Category	Recommendation	Mentioned By	Our Response
Delivery	Elicit lived experience to make the training more relevant and meaningful, but minimize potential harm	All 3 groups	We will weave fictional stories into the training sessions. On a limited basis during group discussion, we will offer the opportunity to share personal stories, but at the outset of the training we will set boundaries regarding the purpose and confidentiality of these stories. We will also provide time for trainees to reflect privately on the relevance of the training material to their own lives. No trainee will be required to share any personal experiences.
	Offer training in self-care	[ORG] staff	We will provide a training module on the topic of self-care, including a review of specific self-care strategies for the First Face.