Recommendations for Optimizing *xaʔtus* (First Face) for Mental Health Training: Insights from Key Informants

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Abstract: Native adolescents experiencing mental health challenges, including substance misuse, often prefer to seek support from their peers and other informal sources, which may be due to lack of access to, and cultural fit with, professional behavioral health services. xaʔtus (First Face) for Mental Health is a Tribal community-based intervention designed to strengthen networks of informal mental health support and open pathways to more formal support. We sought insights from key informants to optimize the planning, promotion, and delivery of First Face trainings to seven Tribal communities in the Northwest United States. We conducted three focus groups with (1) teens completing a residential chemical dependency program at the Healing Lodge of the Seven Nations (n = 10), (2) clinical staff representing the Healing Lodge's Behavioral Health Department (n = 9), and (3) community members representing educators and social service professionals at five of the Tribal nations that support the Healing Lodge (n = 6). Discussion generated planning, promotion, and training recommendations. Planning recommendations focused on showing respect for trainees' time by holding the training during convenient times and factoring in trainees' commitments to work and family, integrating the training into high school science or health education classes, and taking steps to protect trainees' physical safety in the age of COVID while avoiding "Zoom fatigue." Promotion recommendations highlighted community members' possible reluctance to become a First Face due to fear about the responsibilities associated with taking on this role and the need to emphasize the personal relevance of First Face training. In terms of training delivery, participants emphasized the importance of including engaging, interactive activities; instructing future First Faces in self-care; and acknowledging the impact of traumatic contemporary experiences on mental health, while at the same time preventing heated and distressing political debates. We describe our response to participants' recommendations and the rationale for those responses.

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INTRODUCTION

Experiencing mental health challenges, including substance misuse, is alarmingly common during adolescence and young adulthood. Globally, 31% of people aged 10-19 experience clinically significant psychological distress (Silva et al., 2020). In the United States, the median age of onset is only 11 years for anxiety disorders and 20 years for substance use disorders; fully 75% of mental health conditions are established by age 24 (Kessler et al., 2005). If unresolved, adolescent-onset mental health conditions can create lasting personal and social distress.

In any community, at any age, seeking support for mental health challenges can be a daunting experience. Rickwood and Thomas (2012) define mental health help-seeking as "an adaptive coping process that is the attempt to obtain external assistance to deal with mental health concerns" (p. 180). Formal (e.g., professional healthcare providers) and informal (e.g., friends and family) sources are potential pathways to help for mental health concerns. Informal mental health support is highly valued and often accessed (Brown et al., 2014; Jorm et al., 1997), potentially because it reduces perceived isolation and stigma and enhances one's ability to cope (as reviewed by Byrom, 2016).

The Role of Informal Mental Health Supports

Adolescents often prefer informal sources of support and/or experience barriers to formal support. For instance, in a study of teens aged 14-16, 73% of participants were able to recognize signs of depression in a vignette, and nearly all thought it would be helpful for the character in the vignette to see a doctor or other healthcare professional. However, less than half thought that seeing a doctor or other healthcare professional would be helpful if they were experiencing the same challenges (Hernan et al., 2010).

Fear, embarrassment, shame, and self-consciousness are common barriers to seeking formal help (Hernan et al., 2010). Some adolescents also report lacking trust in and therapeutic alliance with their primary care providers, who would otherwise be positioned to serve as a first line of professional mental health support (Corry & Leavey, 2017). Boys and young men in particular are often reluctant to seek professional help because doing so threatens their sense of aligning with masculine ideals (Dowel et al., 2021; Lynch et al., 2018). Both girls and boys often prefer seeking mental health support from their peers due to peers' relative availability, ease of access, and perceived positivity compared to formal sources (Burke et al., 2022).

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Informal Mental Health Support within Native Communities

Informal sources of mental health support are especially essential within communities that have been robbed of financial and other resources, including American Indian and Alaska Native (AI/AN) communities. The U.S. government has chronically underfunded the Indian Health Service (IHS; Lofthouse, 2022). Funding shortages, lack of staff and equipment, and relatively long wait times contribute to gaps in healthcare services, including mental healthcare. These gaps, combined with high rates of poverty, lack of insurance coverage, institutional racism, and other multi-level factors, contribute to persistently worse health outcomes among Native people (Blue Bird Jernigan et al., 2020; Lofthouse, 2022).

In Native and other under-resourced communities, researchers and advocates have explored the value of community-based initiatives designed to provide laypeople with tools to support those who are experiencing mental health challenges or crises. The most widely known program of this type is Mental Health First Aid (MHFA; Kitchener & Jorm, 2002; Morgan et al., 2018). MHFA trains community members to identify signs of mental health crises, intervene when appropriate, and provide a bridge between informal and formal mental health support, when appropriate. MHFA is moderately effective in improving trainees' knowledge of mental health issues and confidence in providing help, with smaller effect sizes for encouraging supportive attitudes and the self-reported provision of mental health support (Maslowski et al., 2019).

The current study represents a continuing effort to broaden and strengthen informal mental health support networks and improve mental health literacy among Tribal communities in the Northwest United States. We represent the Center for Indigenous Research Collaboration and Excellence (CIRCLE). CIRCLE's clinical partner is the Healing Lodge of the Seven Nations, a 45-bed adolescent residential chemical dependency treatment center in Spokane Valley, Washington. The Healing Lodge serves residents ages 13-17 through its 90–120-day intensive inpatient treatment programs. Although the Healing Lodge's primary focus is on the AI/AN population, its services are open to all adolescents. CIRCLE's academic partner is the Division on Addiction at Cambridge Health Alliance, a Harvard Medical School teaching hospital.

xaʔtus (First Face) for Mental Health

Together with members of the seven Tribal nations that support the Healing Lodge, CIRCLE created a program designed to train community members to offer informal support for their family

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members, friends, and acquaintances experiencing mental health struggles and, when appropriate, provide a warm hand-off to formal mental health support. Our manualized curriculum, *xa?tus* (First Face) for Mental Health, is rooted in Tribal traditions, healing practices, and conceptualizations of wellness and mental health. *xa?tus* (pronounced *hah-toos*) is the Salish word for "First Face." In this context, it represents the first person to offer help and situational leadership in the event of a mental health challenge or crisis, such as a panic attack, possible addiction relapse, or traumatic flashback.

Based on the recommendations of working group representatives of the seven Tribal nations, First Face modules were created on the topics of addiction, trauma, depression and anxiety, self-harm, and interpersonal violence, with appendices providing extended discussion of self-care for the First Face, typical and atypical adolescent development, and intergenerational trauma. The need for community-wide education in these topics is apparent in representative epidemiological studies. For instance, Walls et al. (2021) found that by age 26, 77.3% of reservation-dwelling Native people in the Northern Midwest U.S. and Canada met the diagnostic criteria for a substance use or mood disorder, most commonly alcohol or marijuana use disorders. Both historical and contemporary mental health risk factors contribute to this risk. First Face training provides memorable and concrete action steps for the First Face to use when offering support for a mental health challenge or crisis. Each module is anchored with an engaging narrative illustrating a mental health struggle and the specific steps a First Face can take to offer informal support and connect the individual in crisis with more formal support, if desired. Healing Lodge residents contributed to these narratives and to the selection of manual artwork. First Face is designed for all Tribal community members but has a particular focus on adolescent struggles and optimal ways of responding to these struggles. First Face has elements in common with other community-based, culturally appropriate interventions designed with and for Native communities (Walters et al., 2020), such as the *Qungasvik* suicide and alcohol use disorder prevention program for Yup'ik Alaska Native communities (Rasmus, Charles, & Mohatt, 2014) and the Intertribal Talking Circle substance misuse prevention program for middle schoolers from three tribes (Choctaw in Oklahoma, Lumbee in North Carolina, and Ojibwe/Chippewa in Minnesota; Lowe et al., 2016; Lowe et al., 2022).

The Current Work

Before training community members in the seven Tribal nations on First Face, we sought advice from knowledgeable Tribal sources regarding the planning, promotion, and delivery of the training. Specifically, we conducted focus groups with Healing Lodge residents (who represent

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Native adolescents in recovery from substance use and mental health conditions), Healing Lodge staff (who represent behavioral health providers serving Native adolescents), and educators/social service providers within the seven Tribal communities that support the Healing Lodge. This last group of community members is knowledgeable of the experience of mental health struggles among families in their communities, as well as informal and formal support currently available within these Tribal communities.

In conducting these focus groups, we had three goals:

1. Understand focus group participants' thoughts and opinions regarding potential barriers to recruiting trainees and how we might overcome them.
2. Understand the potential impact of contemporary issues (e.g., COVID-19, racism, climate change, war) on a training program like First Face and how we can be sensitive to these issues.
3. Understand more general preferences for the training program and how we can reflect those preferences.

This paper describes our focus groups and the recommendations that emerged from them.

METHODS

Participants

Three non-overlapping groups of people participated in the focus groups. In total, 25 people participated.

The first group included 10 residents of the Healing Lodge. We recruited these participants by asking all current Healing Lodge residents if they would be willing to participate and provide feedback on our training plans.

The second group included nine staff of the Healing Lodge. We worked with the Behavioral Health Department Director, explaining the project and focus group purpose. One Healing Lodge staff member (CA) then sent an email to the Behavioral Health Department and invited all of them to participate in the focus group. We selected Behavioral Health staff members due to their professional experience in adolescent mental health/substance use.

The third group included six community members representing five Tribal nations. We recruited these participants via convenience sampling followed by snowball sampling.

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Specifically, we promoted the focus group in an email newsletter sent to community members who have previously participated or expressed interest in CIRCLE's work. Many of these people had previously participated in CIRCLE's strengths and needs assessments within the Tribal nations that support the Healing Lodge (Whelshula et al., 2021), either as participants in those assessments or as community members who attended a research dissemination meeting (or both). Participants were educators/coaches, medical and behavioral health providers, social service providers, cultural leaders/elders, and legal professionals. Additionally, we assembled a list of potential participants by searching the education and social service websites of all seven Tribes that support the Healing Lodge and directly emailing those whose email addresses were listed. When community members expressed interest in participating, we followed up by asking them to contact others in their professional circles who might be interested.

Focus Group Questions

The authors developed questions that addressed each of our three goals:

1. Understand focus group participants' thoughts and opinions regarding potential barriers to recruiting trainees and how we might overcome them.
    a. What concerns do you think Tribal members might have about signing up for a First Face training?
    b. Can you describe a training or other similar event that was surprisingly popular? What do you think made it work so well?
    c. What would make you more likely to sign up for a training? Are there practical issues that might impact sign ups?
2. Understand the potential impact of contemporary issues (e.g., COVID-19, racism, climate change, war) on a training program like First Face and how we can be sensitive to these issues.
    a. Lately, stress from the pandemic, climate change, war, and systemic racism have sometimes felt overwhelming, especially for communities that experience more than their fair share of harm. In what ways do you think concerns like this should be incorporated into the training, or not?
    b. In what ways do you think community engagement has changed from before the pandemic to now?

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   c. What could we do on our end to make people more comfortable attending an in-person training (i.e., mask, distance, ventilation, hand sanitizer)?
3. Understand more general preferences for the training program and how we can reflect those preferences.
   a. Tell us about your most favorite training and your least favorite training. What made them your favorite/least favorite?
   b. The First Face training will include sensitive topics related to mental health and addiction. Do you have any thoughts on how to make people more comfortable learning about and discussing sensitive topics?
   c. What are the main cultural considerations we should keep in mind when we design our training?

These questions formed the basis of each focus group session. The Healing Lodge residents required some additional explanation about the questions. For instance, a facilitator helped residents understand the purpose of the First Face training by equating it with CPR and Narcan training, concepts with which they were already familiar.

Procedure

All three focus groups were facilitated online via Zoom. Authors MBR, CA, and MB facilitated all focus groups, with MBR serving as the primary facilitator. The focus groups lasted approximately 1 hour and 15 minutes. The Healing Lodge residents assembled in person (with boys and girls in separate rooms) with CA and MB providing in-person support, but the primary facilitator (MBR) appeared remotely via Zoom. Participants in the two adult focus groups all connected remotely.

Because we considered this work to be quality improvement rather than human subjects research, we did not complete a formal consent process. However, all focus groups members verbally gave permission to record the sessions. To preserve confidentiality, Healing Lodge staff (CA and MB) retained the recording of the resident focus group and provided the remaining authors with only a transcript, stripped of any identifying details.

The first author reviewed transcripts of all three focus groups to summarize participants' responses to our guiding questions. When necessary, she reviewed the Zoom recording of the two adult focus groups to better understand participants' responses. In the first stage of content

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analysis, she retained the original structure of the focus group questions and summarized themes that emerged across sessions in response to each question. In other words, she used a directed content analysis approach, identifying key concepts within predetermined categories (in this case, the original focus group questions; Hsieh, 2005). She did not require that all three groups (residents, staff, and community members) make the same observation in order for that observation to be included as a key concept; however, she observed that often, at least two groups, if not all three, responded similarly to focus group prompts. In the second stage, she imposed the broader categories of training *planning*, *promotion*, and *delivery* and identified recommendations that emerged across both sections and questions. Although validity/reliability checks are typically used when working with qualitative data, in this case the focus group questions and responses were fairly straightforward with minimal interpretation needed. Therefore, we did not impose such checks. Finally, the authors collaboratively examined each recommendation and developed a response to it. The co-authors had an opportunity at this point to move recommendations to different categories (e.g., from *planning* to *promotion*), but none did.

In terms of positionality, it is important to note that the first author is a non-Native researcher. She first became involved with Tribal participatory research when helping to complete a series of strengths and needs assessments with the seven Tribal nations that support the Healing Lodge; these assessments informed the development of First Face. She has been working with Healing Lodge for ten years. She recognizes her non-Native identity as a limitation in this work and is guided by the cultural knowledge and expertise of her Native colleagues, particularly co-authors CA and MW and working group representatives of the seven Tribal nations. To limit bias, she attempted to provide her colleagues with a straightforward summary of focus group members' responses, with minimal subjectivity.

The Northwest Portland-area Indian Health Board determined that this project did not meet the definition of human subjects research under the purview of the Institutional Review Board according to federal regulations. The Healing Lodge Board of Directors approved a resolution in support of publishing this manuscript.

RESULTS

The results are organized according to the three goals and their respective focus group questions.

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Goal 1: Understand focus group participants' thoughts and opinions regarding potential barriers to recruiting trainees and how we might overcome them.

Question 1: What concerns do you think Tribal members might have about signing up for a First Face training?

In response to this question, all participants from the three focus groups suggested that community members might be reluctant to sign up for a First Face training due to concern about what might be expected of them as a First Face. A Healing Lodge staff member described the concern this way: "Just like a sense of responsibility that you don't really want to have…. If the situation happens like that… and something goes wrong, then you feel that sense of responsibility." Another staff member suggested that we could alleviate this concern by setting firm boundaries around a First Face's responsibilities and communicating these boundaries—what a First Face will, and will not, be responsible for—in the training and even earlier, when promoting the training opportunity.

As we noted above, the facilitators tried to explain the concept of First Face training to Healing Lodge residents by comparing it to CPR or Narcan training. This might have created some confusion about the role of a First Face. For example, when asked why community members might be reluctant to attend a First Face training, one resident mentioned "being scared, you know, of being put in that situation of having to save someone's life."

Finally, community members mentioned that some people might be reluctant to be trained as a First Face because it conflicts with the idea that they should "mind their own business," a feeling that is "hard to get over." When asked to elaborate, this community member said that "it's scary to delve into mental health, especially when it's the mental health of others." However, she also thought that "it's nice to have these trainings because sometimes you can just be fearful of doing the wrong thing." Other community members agreed with this last point, with one suggesting that "anyone who's on the front lines, that works with youth or adults in crisis or that could potentially be in crisis, should have all of these tools in their toolbox." Another mentioned a lack of trust in formal social services and the possibility that First Face training will fill a gap by strengthening informal social support. Building on that point, a community member noted that First Face training will be helpful because, in her experience, young people in her community want to talk about substance misuse and intimate partner violence but find that adults are afraid or unwilling to discuss these topics.

All three groups also suggested that a demanding time commitment could make people reluctant to sign up for First Face training. A Healing Lodge staff member suggested providing "a

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solid informational packet so that the person knows at least … what they're getting into, the time constraints, and how they would be able to help." Residents pointed to a need to minimize the time commitment as much as possible in order to keep teens engaged in the training. Community members agreed with minimizing the time commitment particularly for teen trainings.

Question 2: Can you describe a training or other similar event that was surprisingly popular? What do you think made it work so well?

The Healing Lodge staff and residents mentioned the need for training to be connected to one's personal experiences. One staff member recalled a particularly effective training that "really kind of tied everything together… being able to relate it to yourself. So it wasn't just someone yakking at you. Like you actually got to take those things and think about them and apply them to yourself…. " Picking up on this point, another suggested that we highlight the personal relevance of the training in our promotional materials: "A big obstacle, you know, is people find out about trainings or they get a flier in the mail. And if it doesn't seem relevant to them, then it's going to end up in the garbage." Relatedly, a resident offered that Narcan training was perceived as useful because it was relevant to his own life.

All three groups recalled past trainings that were effective in part because they were interactive. A community member mentioned that this will be especially important when training teenagers: "I think the most important part is keeping them engaged. I mean, if it's just sitting there listening, it's not really beneficial for them – they fall asleep or they throw on the hoodie and airpods, you know they're not listening." This community member described a past training that included effective icebreakers and recurrent interactive exercises that kept trainees engaged and socializing.

A Healing Lodge staff member who had previously completed White Buffalo Mending Broken Hearts training shared her view that this training "was absolutely riveting and emotionally powerful." This prompted other staff members to discuss past trainings led by facilitators who demonstrated high emotional intelligence by creating safe spaces for sharing sensitive information and modeling reflective listening skills.

Finally, all three groups discussed the need to provide food and breaks.

Question 3: What would make you more likely to sign up for a training? Are there practical issues that might impact sign ups?

All three groups brought up the issue of timing: not just how long First Face training would take, but whether it would be held at convenient times. The consensus across all three groups was that the training should be broken up into smaller sessions, but that this would be a delicate balance.

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While we should not try to conduct the whole training in a single day, spreading it up over too many days would result in trainees forgetting the material between sessions. Splitting it into two days seemed to be the preferred solution. Beyond that, there was little consensus regarding the optimal timing. Some Healing Lodge residents raised the possibility of completing First Face training during school hours, while some members of both adult groups raised the idea of holding the training over the weekend, which could help make the training more of a social event or even a weekend retreat.

This relates to the second point that all three groups made: different people have different needs, and we should provide options, both in terms of the timing and modality (in-person versus remote). With regard to timing, community members suggested that the training might need to be condensed for teenagers who have a shorter attention span, with the adult trainings expanded to cover intergenerational/historical trauma in more detail. Additionally, having separate training sessions for adolescents and adults could facilitate adolescent participation, as it would reduce fear of discussing sensitive topics in the presence of adults. We discuss remote training options in greater detail below (Goal 2, Question 3).

Both groups of adults suggested that we consider offering incentives. Two adults (one in the staff group and one in the community member group) suggested providing a door prize to all trainees, and another suggested offering small prizes throughout the training to encourage participation. For example, everyone who responds to a discussion question might be entered into a raffle for a small prize.

Goal 2: Understand the potential impact of contemporary issues (e.g., COVID-19, racism, climate change, war) on a training program like First Face and how we can be sensitive to these issues.

Question 1: Lately, stress from the pandemic, climate change, war, and systemic racism have sometimes felt overwhelming, especially for communities that experience more than their fair share of harm. In what ways do you think concerns like this should be incorporated into the training, or not?

This question elicited a spirited discussion, particularly among residents. On one hand, members of all three focus groups cautioned against letting our training devolve into a contentious political debate. Members of all three groups seemed scarred by political arguments that they had

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previously witnessed or participated in. Some questioned whether the issues we noted were even relevant to the training. For instance, a resident said,

> I just feel like bringing in something that is not involved with a situation, such as war or some political cause, causes a lot of arguing. And in this type of training, when we're all supposed to be listening, trying to get at one unified idea, separating ourselves through political views or racial tension isn't the best idea…. Because there's no reason to separate us.

Another resident was concerned that too much discussion of racism might be triggering to him. In response, another suggested that our facilitator provide a trigger warning and the opportunity for trainees to step outside the room.

On the same note, a staff member said, "I would always just say that political stances would be something not to talk about. That's something that I know sometimes gets talked about and it is really upsetting because everybody does have their own beliefs and their own values and morals and opinions. So just be sensitive to that." A community member suggested that COVID-induced isolation has made it harder for people to hold difficult conversations and that, as a result, a great deal of sensitivity is needed in facilitating these conversations.

On the other hand, members of all three focus groups advocated for at least acknowledging these issues during the First Face training because of their impact on mental health. A resident put it this way: "A lot of things like the pandemic and racism *do* have an effect on mental health and you know, your society, and that's something worth talking about. But I feel like we should keep it more towards the mental health side and less of the political side." Another offered, "I don't really understand how you can offer a training specifically to Native American mental health without touching on systemic racism…. So I feel like the training would be incomplete if we didn't include that on the side with intergenerational trauma." Along these lines, staff members suggested that these very issues are what makes First Face training relevant and necessary for Tribal community members. One suggested making them part of the promotional material:

> I think that all of these issues are a big reason why people would want to come to the training because it answers one of the questions as to *why should I go?* Because so many people are impacted that you might be helping yourself, or you might be helping a family member, or you could be helping a friend by coming. And learning what you should do.

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> And so taking these issues and making them part of the flier to help make it more a reason why I should go just, it affects me and my family and my friends.

It might be possible to strike a balance between these two positions by acknowledging these issues and their impact on community mental health at the outset of the training and guiding the discussion towards solutions rather than division. As one staff member put it, "I think just have a gentle, validating approach. We have been through a lot. Just normalizing that can be like offering a warm blanket."

Question 2: In what ways do you think community engagement has changed from before the pandemic to now?

All three groups were in agreement that people are slowly getting used to socializing in person again and there is lingering fear of contracting COVID. A staff member suggested that people are more awkward now because, when it comes to in-person socializing, we are out of practice. This person continued,

> I know, as far as teenagers… they were able to hide behind computer screens and phones for two years. And so now they're trying to come out of that. I heard them talking the other day that it's a really big struggle getting called on in group and in school and how embarrassing it is…. But for me… it wasn't just COVID that happened. There were riots, there have been mass shootings. There's been a war. There's been everything. So I think there's such a divide… I really think there's such a divide because it wasn't just COVID, there was so much happening, like a snowball effect in the last two years.

Despite this theme of awkwardness and fear of in-person socialization, a resident offered that they have become more vocal about social justice since the pandemic began; we infer that this change happened in response to catalyzing events like George Floyd's murder. "I am not staying silent. I feel like before the pandemic, there was a lot more silence. Things need to be talked about, like Black Lives Matter and … we've gotten a lot better at that because of the pandemic. And because everyone was on social media and seeing all of that happened."

Also, despite lingering fear of COVID, community members were in consensus that members of their Tribes are ready to socialize again. Those who work in domestic violence mentioned, if anything, their services became even more essential during the pandemic. One offered, "It was hard because we get to know the people in our community and we're accustomed

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to talking up close and personal or giving a hug or at least a comforting hand on the shoulder or the arm, and COVID slowed down our work greatly." Another mentioned that Elders in her community, in particular, are excited to be able to safely gather again.

Question 3: What could we do on our end to make people more comfortable attending an in-person training (i.e., mask, distance, ventilation, hand sanitizer)?

Participants had some strong opinions about attending a First Face training in-person versus remotely (e.g., via Zoom). Some participants across all three groups indicated that even if remote access were available, they would prefer not to use it due to "Zoom fatigue." One community member put it this way:

> I think we're just tired of Zoom. It's hard to pay attention, it's hard to focus. I mean, I'm sitting here at my desk and I'm still fidgeting and I'm moving, thinking, 'Well, I could do this over here….' I have a hard time focusing and staying within the meeting. So for me, I think we're ready, you know. Let's just do it.

Likewise, some residents mentioned their difficulty staying focused during remote meetings, and a staff member mentioned that kids with attention deficit difficulties, in particular, struggle with Zoom. Another staff member expressed dislike of remote trainings that are "blah, blah, blah, for 60 minutes, you might as well have a double screen, so you can work on your other stuff."

At the same time, participants mentioned the benefits of at least providing a remote access option, including safety and convenience. A staff member mentioned childcare as a barrier to attending in-person trainings for those with young children and suggested a Zoom option for those who would otherwise be unable to attend. Across all three groups, the consensus was that we should provide a remote access option. As one resident said, "So like, basically, if someone needs to do online, they should be able to do it online. But if someone also needs to be able to come in, they can do that too.**"**

As far as other COVID mitigation strategies, participants were fairly evenly split between those who would prefer a mask mandate at an in-person event and those who would choose not to attend in-person if masks were required. At least one participant in all three sessions suggested trying to find an outside training location.

Goal 3: Understand more general preferences for the training program and how we can reflect those preferences.

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Question 1: Tell us about your most favorite training and your least favorite training. What made them your favorite/least favorite?

Participants discussed some of their least favorite training experiences. The common thread was a lack of engagement. As an example, one community member said, "I've actually been in a training before where the facilitator was talking about themselves a lot, for a long, long, long, long time and, you know, I left the training like, 'Okay, I didn't really learn any of the things that they said I was going to learn. Basically, I learned a life story." Another community member mentioned "boring" trainings that involve reading written materials rather than active learning. A staff member said, "Any training that I just have to sit there and listen – I'm out, I don't want to just sit there and have information fed to me. I want to be able to be involved somehow, or it has to be related to my job. Don't just give me the information, I can't stand that." Participants contrasted these least favorite training experiences with positive experiences marked by a mix of engaging small group activities, some of which are designed to appeal to shy participants (e.g., contributing their thoughts by writing on large Post-it notes). A resident mentioned a basketball camp that was especially fun and interactive. These responses echo responses to Goal 1, Question 2.

There was consensus across both adult focus groups that role playing can be an uncomfortable but valuable experience. One community member said, "I would feel a little exposed role playing. It kind of makes you come out from that little comfort area where you can hide. But I can see the benefits." Another added, "I would reluctantly do it, but it's not something that I'm like, 'Yes, let's role play!'" As to the benefits of this pedagogical tool, one community member, who works as a youth prevention specialist, put it this way: "In my opinion role play helps to prepare for the real moments. I like to say it's like running plays in practice – you can make the mistakes and fix them in practice. In the game, you cannot." Another community member discussed batterer intervention groups that use role play to teach participants how to ask for help. Working through these scenarios results in "phenomenal" group discussions. After further discussion, both groups agreed that role playing should be considered as part of the First Face training, but that we should make trainees more comfortable by assigning role play in dyads rather than in front of the entire group.

Question 2: The First Face training will include sensitive topics related to mental health and addiction. Do you have any thoughts on how to make people more comfortable learning about and discussing sensitive topics?

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Many of the residents have experience discussing sensitive information in group settings and based on that experience they advised us to "be patient and understanding" and watch for signs that someone is becoming uncomfortable. "Understand when you're crossing a line, like maybe seeing visual cues or even the way they're talking, the way they're acting, their body language, anything like that, just seeing how they're feeling in the moment, seeing whether they're comfortable or not, and adjusting what you're saying to that." This relates to the importance of the facilitator's emotional intelligence, a topic that came up in response to Goal 1, Question 2. Another resident offered, "There's just some people like, no matter, you know, how comfortable you want them to be, they're not really comfortable talking in front of other people. So here we have one-on-one sessions so that we can go talk to somebody privately about what we have going on." Adult participants agreed that some trainees will be uncomfortable if called upon to share personal experiences of trauma.

A resident advocated for creating a safe space from the outset of the training: "[Some people are] scared of being judged or of people thinking about them differently. So just letting them know that, whatever they say, they're still going to look at them the same. And like, there's just a safe place to talk about trauma, and what they say will stay in confidence." A community member suggested that some Elders might be positioned to create this safe space.

On the topic of creating a safe space, Healing Lodge staff and community members emphasized the importance of normalizing mental health struggles. Acknowledging the widespread prevalence of mental health struggles from the outset of the training could help trainees feel more comfortable contributing to group discussions. This led into a discussion of setting boundaries. Some staff members acknowledged the importance of sharing lived experiences but cautioned us to mention from the outset that

> Our goal here is to give you this training versus having group therapy. Soliciting their stories needs to be done in a way that's not encouraging people to talk for hours and hours and hours and traumatize other people with what they have going on. Engage people in their own stories, but don't let it turn it into a self-therapy session.

This staff member suggested that we provide clear parameters at the beginning of the training to avoid this situation.

Finally, community members suggested that we consider siloing the training, with mental health professionals, community members, and teens all participating separately. The rationale was that

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> Community members might be reluctant to talk in front of professionals… like it could be like me, a prevention worker, or a child support or enforcement worker, or a Tribal police officer, and then you have some community members who don't want to say anything that might incriminate themselves. And then the same with kids. If you have kids and mixed with adults, they're going to be like, 'Well that person knows my mom or dad or whatever.' So, I think if you want the best result, [creating separate trainings] would be the best way to go.

Question 3: What are the main cultural considerations we should keep in mind when we design our training?

In response to this question, participants in all three focus groups spoke about respect. They emphasized that it is essential for the facilitator(s) to show respect for trainees. Recognizing that different people have different learning styles, contribute in different ways, and hold different religious/spiritual beliefs was noted as an important way to show respect. Participants noted that facilitators can also show respect by making the best use of participants' valuable time and mental capacity (in other words, not overloading trainees with information). Finally, participants mentioned that the facilitator(s) can show respect by being inclusive, discussing the role of intergenerational/historical trauma in contemporary struggles, and offering instruction in self-care.

Results Synthesis

We summarize these recommendations and our responses to them in Table 1. We organize the recommendations into three major categories: *planning*, *promotion*, and *delivery* of the First Face training. We address each in the discussion below.

DISCUSSION

We designed *xaʔtus* (First Face) for Mental Health training to broaden and strengthen informal mental health support networks within Tribal communities while potentially providing a bridge to more formal support. Focus group participants' knowledgeable about the needs and priorities of future trainees provided a number of helpful recommendations regarding the planning, promotion, and delivery of this training. Many of these recommendations reflected participants' 2+ years of living with the COVID pandemic. We were struck by the commonalities that emerged

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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

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(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

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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.

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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

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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

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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

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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.

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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.

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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.

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