ENHANCING RURAL YOUTH MENTAL HEALTH LITERACY: A CASE STUDY ON STAKEHOLDER PERSPECTIVES ON PROGRAM DELIVERY, OUTCOMES, AND STRATEGIES FOR IMPROVEMENT IN RURAL SCHOOLS

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by

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DEDICATION

To all the dedicated educators who have shaped me, including my own teachers, especially Wanda Lucas and the late Linda Hassinger, whose classrooms were filled with joy, wonder, and care. Their example inspired me to become a teacher and showed me how remarkable educators make lasting impacts.

In loving memory of the teachers in my own family, who gave so much of themselves to others. I especially honor my grandfather, Grover Anderson, a man of hard work and strong principles, and to my grandmother, Margaret Edwards, who was a product of the Great Depression, a teacher, and lifelong learner. She wholeheartedly believed in the power of public education to lift people up and serve the common good. I also want to acknowledge my aunt, Colleen Murphy, for her dedication to teaching and her ongoing inspiration and support.

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ABSTRACT

Youth suicide remains a significant public health concern in the US, with rural youth experiencing higher rates of suicide and limited access to mental health resources. Schools are often the primary setting for prevention efforts, yet rural contexts face unique barriers to implementing evidence-based mental health literacy programs (MHL). This qualitative case study explored the perceptions of three different types of stakeholders involved in delivering evidence-based MHL programs, like Youth Aware of Mental Health (YAM), in rural Montana schools. The purpose of this study was to identify the essential personnel, resources, and community factors needed to implement and sustain evidence-based MHL programs, while also exploring program outcomes and strategies for improving delivery in rural educational settings. This study also provided an opportunity to explore the possible expansion of the PROSPER model when used to guide the delivery of evidence-based MHL programs for youth.

Data were collected through semi-structured interviews with 16 YAM stakeholders. Findings revealed that effective program implementation relies on: the presence of designated and skilled personnel at a university-center and office to manage the program, along with community buy-in, local instructors, supportive community partnerships, and sufficient school resources as necessary elements for program delivery. Participants identified four program outcomes: increased student engagement and connection, improved access to credible mental health resources, greater help-seeking behaviors among youth, and a noticeable reduction in stigma surrounding mental health discussions within schools. Strong partnerships between schools, community organizations, and university-based centers were found to enhance funding stability, training quality, and program oversight. Participants also recommended allowing flexibility within program fidelity to strengthen local adaptation and expand the program's reach. However, challenges such as limited staffing, teacher turnover, and inconsistent resources were identified as barriers that threaten long-term sustainability.

This study concludes that evidence-based MHL programs can be successfully implemented and continuously improved in rural schools when supported by designated program personnel at a university-based office (PROSPER+), local expertise, and stable resources. Findings emphasize the importance of investing in rural education personnel and community partnerships to ensure equitable access to high-quality MHL education for youth.

CHAPTER ONE

INTRODUCTION

Youth Mental Health

Throughout the past two decades, American youth have reported an alarming rise in mental illnesses (Twenge et al., 2018), with one in five youth (ages three to 17) experiencing a diagnosable mental, emotional, or behavioral disorder (Cloutier & Marshaall, 2021; Kessler et al., 2005). These mental illnesses include a wide range of emotional problems which cause serious disruptions that interfere with an adolescent's daily life (Bitsko et al., 2022). The literature exploring the relationship between mental health and academic learning consistently demonstrates that students with mental illness are more likely to struggle academically, attain lower levels of education, and/or drop-out of school entirely, which could negatively impact their life trajectory (Brännlund et al., 2017; McLeod et al., 2012; McLeod & Kaiser, 2004). Depression, anxiety, and stress-related disorders have been on the rise among American youth, and between 2016 and 2020, rates of diagnosed anxiety and depression among children increased by 29 percent and 27 percent, respectively (Lebrun-Harris et al., 2022). Suicide is now the second leading cause of death among individuals aged 10 to 34 in the United States (CDC, 2021). The COVID-19 pandemic and subsequent shutdowns likely exacerbated the youth mental health crisis, so much so that in 2023, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association issued a joint declaration of a national emergency in child and adolescent mental health (Bruener & Bell, 2023). Given the scope and complexity of this crisis, a multifaceted approach is necessary to counter these concerning trends in youth mental health. Current efforts to address youth mental

health in the United States include initiatives to improve access to care, promote mental health literacy (MHL) education in schools, reduce stigma, and enhance early intervention and prevention strategies (Bruener & Bell, 2023; Singer et al., 2019).

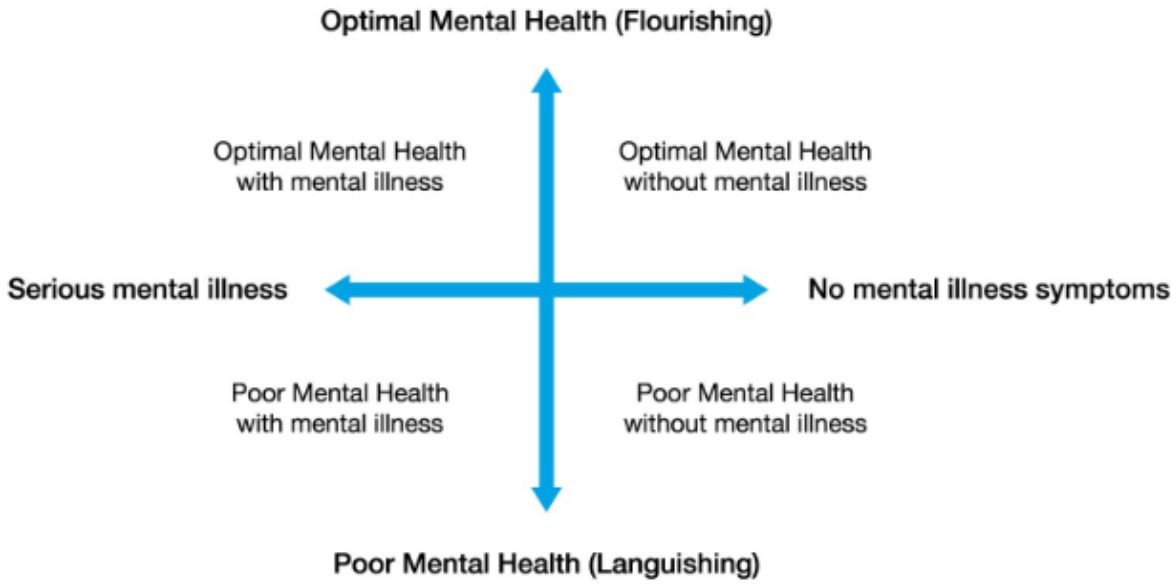
Defining Mental Health

Due to its complex nature, there is not one universally recognized or standard definition of mental health (Galderisi et al., 2015; Manwell et al., 2015). Organizations around the world, including the World Health Organization (WHO), have tried to define mental health, but have continually added or amended their definition as society's understanding of mental health has changed or expanded over time (Reed, 2024). This evolution underscores a broader understanding of mental health, encompassing emotional, psychological, social, durational, and behavioral dimensions, influenced by a complex interplay of biological, psychological, and environmental factors (Galderisi et al., 2015; Hermann et al., 2005; Manwell et al., 2015). Furthermore, the construct of mental health is highly subjective and individualistic in nature, and what constitutes good mental health may also vary widely by cultural and social differences (Galderisi et al., 2015; Kleinman, 1988).

Lamers & Keyes (2010) developed the dual-continuum model of mental health and mental illness to expand upon the notion that mental health is continually fluctuating, and to recognize that mental health is not merely the absence of mental illness (Figure 1). In this model, one continuum (the y-axis) represents mental health, ranging from optimal to poor mental health covering various levels of functioning and resilience. The other continuum (the x-axis) represents mental illness, ranging from no to severe symptoms and impairments (Lamers & Keyes, 2010). Significantly, the model acknowledges that individuals can experience differing levels of mental health and mental illness simultaneously, while also highlighting the importance

of addressing mental health concerns proactively, even in individuals who may not meet diagnostic criteria for a specific mental disorder (Lamers & Keyes, 2010). Having a wholistic understanding of mental health provides people with the ability to better understand their own well-being, reflect on their own experiences, or notice changing behaviors in themselves and others (DeFosset et al., 2017).

Figure 1: The Dual-Continuum Model of Mental Health and Mental Illness



According to the American Psychiatric Association (APA, n.d.), it is important to distinguish between mental illness and mental disorders. The APA asserts that mental illness is a general condition, while mental disorders are specific types of mental illness, such as anxiety and depression (American Psychiatric Association, n.d.). This study uses the blanket term *mental illness* when referring to diagnosable and clinical disorders in general and will use the name of the specific disorder when appropriate. The terms "mental health" and "mental or emotional well-being" are used interchangeably throughout this study. For this study, mental health is

defined as an individual's emotional, psychological, and behavioral well-being that is shaped by a multifaceted interplay of biological, psychological, and environmental factors.

Defining Mental Health in Adolescence

The Center for Disease Control (CDC) (2025) maintains that adolescence is the developmental stage between ages 12 and 19. Although the exact age range for what constitutes adolescence can vary slightly depending on cultural, social, or legal contexts, generally it spans these critical years of growth and development (Offer et al., 2013). For this study, the terms "young people", "youth," "adolescents", and "teens" are used interchangeably as they encompass the age range of the population of interest, 12–19 years old. Additionally, in this study, occasionally the term "students" is used when referring to adolescents, due to the context of evidence-based programs for youth being taught in schools. If specific age(s) are referenced in a previous study that are not 12-19 years, then the specific age range of the participants is noted.

For adolescents, defining mental health can be even more challenging due to the unpredictable nature of adolescence itself (Rapee et al., 2022). Adolescence is a period marked by significant biological changes, including hormonal fluctuating and brain development, which can affect mood regulation, impulse control, and emotional processing (Rapee et al., 2022). It may be difficult to discern between what is considered "normal" teenage angst or struggles and youth's symptoms and impairments that may be crossing the threshold into a diagnosable mental illness (Bitsko et al., 2022).

While most young people will not experience mental illness, they may encounter challenging periods and struggle with poor mental health. Pediatricians and clinicians note that mentally healthy youth have appropriate social and emotional development and do well in various settings including the home, school, and community (Bitsko et al., 2022). This means

that youth who experience a wide range of trying experiences and emotions may feel mentally unwell for a time, but that does not necessarily mean that they have a clinical mental illness. However, those who experience symptoms and impairments that interfere with their daily ability to function, especially for an extended duration of time, may have a diagnosable mental illness (Bitsko et al., 2022).

Adolescence is a common time for the onset of mental illness to occur (Kessler at al., 2005), which is why the adolescent years are an especially high priority for the targeting of mental health literacy (MHL) programs. Unaddressed mental health illnesses are the source of many behavioral, emotional, and learning issues for students (Kang-Yi et al., 2013). It is also important that youth who have not been diagnosed with a mental illness, to participate in MHL programs so they can better understand the signs and symptoms of common disorders and seek help for themselves and others if needed (Jorm et al., 1997; Lamers & Keyes, 2010).

Youth Mental Health in the US

Prior to the onset of the COVID-19 pandemic in early 2020, mental health experts were sounding the alarm on the increasing incidence of youth mental health illness (Glowinski & D'Amelio, 2016) as it was it was estimated that approximately 20% of youth had a mental health illness and 10% had such severe symptoms it impaired their ability to function at home, school, and in the community (Kessler et al., 2005). Adolescent mental health illnesses and suicide rates, although stable at the turn of the 21st century, began to steadily rise, and by the mid-2010s, studies reported high rates of depression, anxiety, suicidal ideation, suicide attempts, and suicide completions (Bitsko et al., 2022; Twenge, 2020). According to a recent youth suicide report from the National Vital Statistics System (NVSS) published by the CDC (2023), the suicide rate among young people (ages 10 to 24) increased 62% from 2007 through 2021.

Rural Youth Mental Health in the U.S.

At the national level, approximately 20.7% of all students are enrolled in rural schools, and in 13 states more than one in three students attend rural schools (Hartman et al., 2023). Roughly 7.3 million public school students are enrolled in rural school districts, which equates to more than one in every seven students across the United States (Hartman et al., 2023). Previous research has found that rural areas often face mental health care inequities (Hartman et al., 2023), as rural youth tend to have lower MHL, live in areas with higher mental health stigma, lack access to mental health resources (Stark & O'Connor, 2011), and die by suicide at rates that are higher compared to their peers in urban areas (Morales et al., 2020). Furthermore, youth in rural areas are almost twice as likely as their urban peers to complete suicide (Morales et al., 2020; Stark & O'Connor, 2011). Youth who reside in rural areas and struggle with mental health illness may experience additional obstacles to seeking and receiving mental health care than their urban counterparts with the same illness (CDC, 2021).

Recent research emphasizes the need for place-conscious policies to address rural inequities (Hartman et al., 2022). Additionally, increasing racial, ethnic, and socioeconomic diversity in rural communities highlights the importance of considering social and cultural factors alongside geographic barriers when designing educational programs, including evidence-based MHL programs and interventions (Hartman et al., 2022). By addressing both spatial and social dimensions of inequity, policymakers, educators, and program developers can work toward more equitable health and educational outcomes for all rural students.

Every rural community can be defined by a combination of geographic, historic, economic, and social characteristics. The uniqueness of the people, the geographies in which they live (plains, mountains, desert, etc.), the history of their community and region, and

economic factors converge to create great variability from one rural community to the next. Thus, the federal government has developed over a dozen definitions of rurality (Brenner et al., 2021). These definitions highlight different aspects of geographical places regarding the population density and distance from areas where many people live close together. While there is not one agreed upon definition or description that fully encompasses the complexities of what it means to be "rural", this study will use the National Center for Education Statistics (2006) Urban-centric locale codes (Table 1).

Table 1: National Center for Education Statistics Urban-Centric Locale Codes Definitions

Coding Terminology	General Description
City	Three city codes (large, midsize, small) based on populations size. City schools and districts must be inside urbanized area inside principal city.
Suburb	Three suburban codes (large, midsize, small) based on populations size. Suburban schools and districts must be outside principal city and inside urbanized area.
Town	Three town codes (Fringe, distant, remote) based on distance from urbanized area. Town schools and districts must be inside urban cluster.
Rural	Three rural codes (fringe, distant, remote) based on distance from urbanized area. Rural schools and districts must be census-defined rural territory.

This classification system is used to categorize the nation's schools based upon a combination of population density and distance from the nearest metropolitan center, using the three categories of: rural fringe, rural distant, and rural remote. This system of classification is appropriate for this study as: 1) all schools have already been assigned a recognized code; 2) distance and density are to particularly relevant to student access to mental health resources and supports; 3) distance and density are to particularly relevant to availability of adults to deliver mental health resources and supports; and 4) the study's findings may be applicable to other similarly situated schools and communities.

Montana is considered a rural state, with one midsize city (Billings with a population of approximately 100,000), and four small cities (Missoula, Great Falls, Helena, and Bozeman) (National Center for Education Statistics, n.d.). Most communities in Montana are considered rural remote, as they are more than 25 miles from an urbanized area. (National Center for Education Statistics, n.d.).

Rural Youth Mental Health in Montana

Unfortunately, Montana, along with other states along the Rocky Mountain Front, consistently reports one of the highest death-by-suicide rates per capita in the United States (Curtin & Garnett, 2023). According to the 2023 Youth Risk Behavior Survey (YRBS), 52% of youth surveyed in Montana reported feeling hopeless or sad for two weeks or more, which was the highest ever recorded, 22% had seriously considered suicide during the 12 months before the survey and 10% had attempted suicide during the same period (CDC, 2023). These findings were an increase from the 2015 YRBS survey, where 29.3% reported feeling hopeless or sad for two weeks or more, 15.5% of students had seriously considered suicide, and 8.2% of students surveyed had attempted suicide (CDC, 2015). Current data indicate that the youth rate of death by suicide in Montana is nearly three times the national rate (Montana DPHHS, 2024).

Universal Mental Health Literacy Programs

Mental Health Literacy (MHL) refers to the knowledge and understanding that people have about mental health and mental illness, including the ability to recognize symptoms of mental disorders, seek help and support, and promote mental health and wellbeing (Dias et al., 2018; Jorm et al., 1997). Jorm et al. (1997) first proposed the concept of MHL, as an extension of the term Health Literacy (HL), as studies have shown that people who do not have robust knowledge about their health conditions will experience worse health outcomes. The same is true

with mental health, where people who lack knowledge about mental health and mental illness, may be less likely to understand their condition, seek help, and recover (Jorm et al., 1997). Research suggests that evidence-based MHL programs are capable of increasing mental health knowledge, promoting non-stigmatizing attitudes and improving attitudes towards help-seeking behavior in different communities (Anderson & Pierce, 2012; O'Connell et al., 2021). An evidence-based program is one that has been scientifically tested through rigorous, systematic research to improve outcomes in a consistent and reliable way (Centers for Disease Control and Prevention, 2019). Such programs rely on proven strategies, adherence to program protocols, and ongoing evaluation to ensure effectiveness in real-world settings (Saunders et al., 2005).

Evidence-based universal MHL programs aim to provide general education about mental health and are designed for entire populations, regardless of whether participants are experiencing mental health difficulties (Singer et al., 2019). Some of these programs are aimed at increasing the MHL of the community by educating adults (e.g. Mental Health First Aid), while others specifically target young people (Kelly et al, 2007). There are programs that have been designed specifically for youth suicide prevention (e.g. Signs of Suicide), while others have been designed to improve overall mental health literacy such as: Sources of Strength, teen Mental Health First Aid, and Youth Aware of Mental Health (YAM). All programs, whether labeled as "suicide prevention" or "mental health literacy promotion" seek to prevent youth suicide, through raising awareness about risk factors and working to bolster protective factors against suicide, such as increasing MHL, belongingness and resiliency, and reducing perceived burdensomeness (Mann et al., 2021).

Schools as Partners in Increasing MHL in Youth

Scholars have long argued that schools are not just centers for academic learning, as they also play a crucial role in the holistic development of their students (Burroughs & Barkauskas, 2017: Noddings, 2005). Although the objectives and desired outcomes of public education have long been debated, Noddings (2005) states that the mere notion of public schooling was historically based on moral, social, and academic factors and thus, the purpose of education goes beyond intellectual achievement and includes the development of social, emotional, and ethical skills (Burroughs & Barkauskas, 2017: Cohen, 2006).

The term Social Emotional Learning (SEL) and MHL have been used interchangeably, and it is not surprising, as there is a substantial overlap between teaching MHL and the framework of SEL. However, while both MHL programs and SEL are essential for promoting well-being in students, they focus on different aspects of emotional and mental health education (Hoover et al., 2019). SEL refers to a structured approach designed to equip students with the essential life skills needed to thrive academically, emotionally, and socially (Hoover et al., 2019). MHL refers to the knowledge and understanding that people have about mental health and illness, including the ability to recognize symptoms of mental disorders, seek help and support, and promote mental health and wellbeing (Jorm et al., 1997).

Therefore, integrating MHL into educational settings, even if the school already has a SEL program, is crucial for promoting academic success and ensuring that all students can thrive both academically and individually (Burroughs & Barkauskas, 2017; O'Connor et al., 2018). It is well documented in the research that poor mental health has a profound impact on academic outcomes, affecting cognitive functioning, attendance, behavior, and overall engagement in the school environment (Brännlund et al., 2017; McLeod et al., 2012; McLeod & Kaiser, 2004). Schools that implement MHL programs can help students not only increase their mental health

knowledge, but also develop coping skills, resilience, and emotional intelligence, leading to better academic performance (Han & Weiss, 2005; O'Connor et al., 2018). Schools are a natural setting for collaboration across partners to promote student well-being and to support early identification and intervention for students with mental health concerns (Domitrovich et al., 2008; Hoover et al., 2019; Singer et al., 2019).

In under-resourced communities, and especially in rural areas, schools often are the one public institution accessible to all. Thus, public health experts recommend community programs such as peer group education and universal interventions delivered in schools, as an innovative and cost-effective solution for rural communities that lack access to mental health resources (Chen et al., 2018). Furthermore, schools are an appropriate setting for teaching MHL programs due to the accessibility of students, the structured context they provide to deliver such content, and the opportunity for early intervention (Brann et al., 2021; Krantz et al., 2023).

Youth Aware of Mental Health

One leading evidence-based MHL program is Youth Aware of Mental Health (YAM). YAM was developed in Sweden and was found to an effective suicide prevention program in the Saving and Empowering Young Lives in Europe (SEYLE) study (Wasserman et al., 2015). The SEYLE study was a large-scale randomized controlled trial in Europe that focused on suicide prevention in schools among adolescents. YAM aims to increase mental health literacy in youth and is designed to enhance skills and emotional resiliency needed to cope with stress and crisis through interactive role play (Wasserman et al., 2015).

To respond to Montana's alarming youth suicide rate and mental health crisis, especially in rural and remote areas, Montana State University (MSU) brought YAM to Montana in 2016. Although the results of YAM from the SEYLE Study were promising, researchers at MSU were

curious to discover if the program and study results could be replicated in rural settings, like Montana, where residents have reduced access to resources, lower levels of mental health literacy, and more access to lethal means (Stark & O'Connor, 2011). In 2016, the certified YAM Instructors all lived in Western Montana, and it was logistically impracticable, if not impossible, for them to deliver YAM, a program that is taught in five sessions over the course of at least three weeks, to the far-reaching corners of the vast state of Montana. Thus, MSU began to explore possible adjustments to program delivery which would adhere to the researched program protocols and ensure student safety purposes when discussing a potentially sensitive topic such as mental health (Kern, 2024).

MSU researchers were interested in whether YAM would be feasible, acceptable, and sustainable in rural settings when taught by trained MSU Extension Faculty. Findings indicated positive results, as school administrators found YAM to be feasible, especially when taught by local MSU Extension Faculty (Bailey et al., 2022). Youth reported high levels of acceptability for having the intervention in their school and were interested in participating in YAM again (Bailey et al., 2022).

Researchers noted that the traditional YAM Program delivery was logistically challenging to implement due to the large geographic size of Montana and the stringent protocols of the program (Bailey et al., 2022). Therefore, they recommended further research to better understand how to effectively deliver evidence-based MHL programs like YAM, designed outside the United States and in different rural and cultural contexts. While urban settings certainly have their challenges, it is more difficult to deliver evidence-based programs in rural and Tribal areas, due to geographical, logistical, and cultural factors (Bortz, 2019).

Purpose of Study

Given the unique challenges faced by rural communities, such as the high rates of youth death by suicide, limited access to mental health resources, geographic isolation, and heightened stigma surrounding mental health issues (Stark & O'Connor, 2011), there is a need for evidence-based MHL programs that can be tailored to and delivered in rural and Tribal places. Furthermore, there is a need to understand critical aspects of program delivery from the perspectives of various personnel who teach the program, advocate for bringing the program to the school, and administer the program. Previous research has shown that a person's role in a small community deeply influences how they are viewed by others, with factors like longevity in the community, trustworthiness, educational background, economic and social contribution, adherence to norms, and interpersonal relationships playing central roles in shaping perceptions (Budge, 2006). Therefore, those possibly complex and nuanced relationships could potentially have an impact on how evidence-based MHL programs, like YAM, are delivered and received.

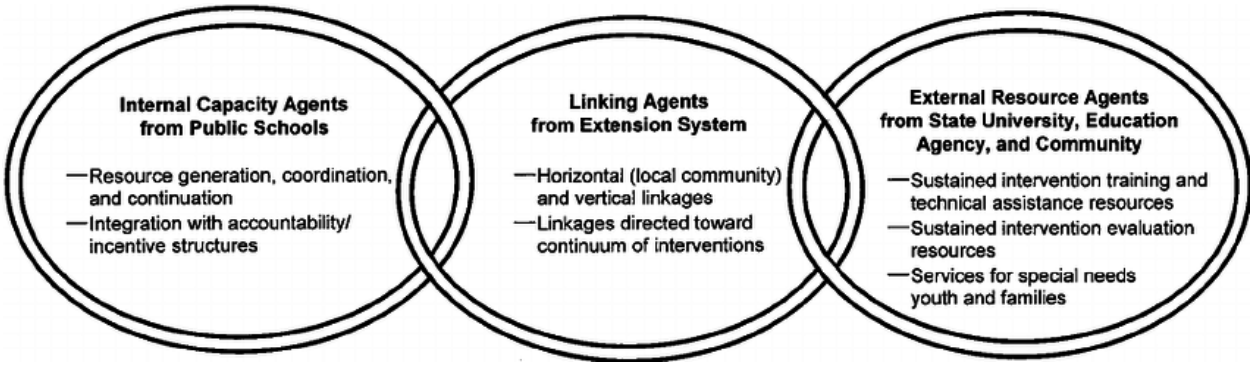
Lastly, most research on educational issues, including MHL, has been conducted in urban places from an urban perspective, which can often lead to "deficit" language when urban outcomes are compared and contrasted to rural outcomes (Atkin, 2003: Barnhorst et al., 2021; LaValley 2018; Varia 2014). When discussing rural areas, deficit language can unintentionally perpetuate negative stereotypes, diminish the value of rural communities, and focus solely on problems rather than assets (Atkin, 2003). Rural researchers Atkin (2003) noted that rural communities have often been subjected to urban programs, with issues of equity and access, rather than appropriateness dominating discourse. Similarly, including rural communities in research and dialogue is critical for ensuring that their unique challenges and opportunities are addressed in a meaningful way, while also recognizing that their experiences, perspectives, and

local knowledge can inform and enhance program design, implementation, and overall effectiveness in rural contexts (Hartman et al., 2022). Hartman et al. (2022) framework calls for policies and programs that are adapted to the specific strengths and needs of rural students and communities.

Theoretical Model: The *PROSPER* Community-University Partnership

The *PRO*moting *S*chool-community-university *P*artnerships to *E*nhance *R*esilience (PROSPER) Model is the theoretical framework chosen to guide this study (Spoth et al., 2004). (Figure 2). It has been argued that many programs may fail because systems were not put in place to support the continuation of the intervention after the grant cycle, or members of the community did not feel there was a need for the intervention or had an unfavorable opinion of program to begin with (Israel et al., 1998). However, the PROSPER Model represents the critical connections required among the infrastructure and supports in place with key community partners to enhance the capacity-building of land-grant universities and the state and local public education systems with the purpose of implementing quality and sustainable interventions, especially in areas with limited resources (Spoth et al., 2004). In this model, interventions for youth are based on needs identified by the school and the community, so that all interested parties support the programs and are invested in ensuring that they continue. Spoth et al. (2004) also outlined the significant roles of the capacity builders within the model as *linking agents*, *internal capacity agents* and *external resource agents*. All three of these agents work together to bring quality programs for students, with particular emphasis placed on the linking agents who can link schools' internal-capacity agents with their external resource agents (Spoth et al., 2004).

Figure 2: The PROSPER Model



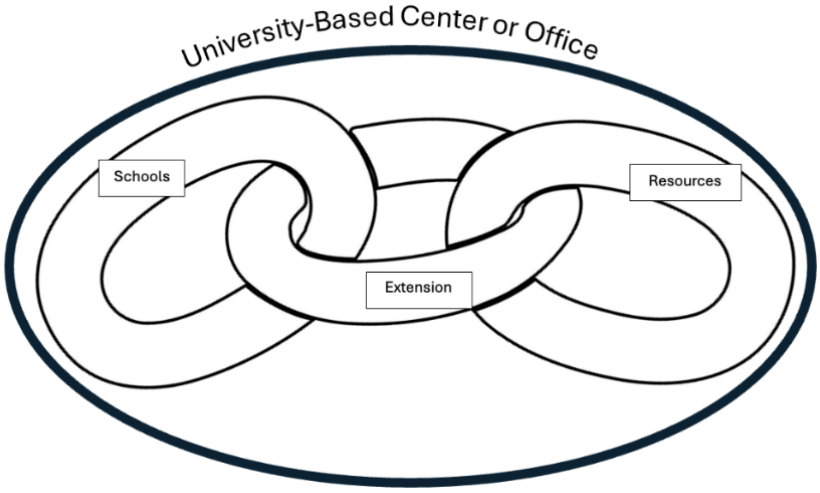
The PROSPER model clearly demonstrates how Extension Faculty can serve as a critical link between capacity agents in the community and external agents at the university in support of the delivery of evidence-based prevention programs. The PROSPER model also focuses on the role that linking agents (Extension Faculty) can play in linking local schools with state agencies that foster access to evidence-based programming and outlines the key components needed for universities, state agencies, extension services, and communities to collaborate in delivering programs to rural areas. However, PROSPER does not specify exactly who should take responsibility for program management and implementation, or how these partnerships should operate in practice.

Moreover, the PROSPER model does not fully account for the fact that Extension Faculty, especially in rural and remote areas, may not have the capacity to deliver every program on their own and that additional local individuals, such as community partners from hospitals, nonprofits, and others who share similar goals, are essential to supporting full program implementation. Extension Faculty are often further constrained by travel and budget limitations, as they are expected to deliver multiple programs on diverse topics across several communities and counties, making locally based support even more critical.

The *PROSPER*+ Model

Given the complexity of implementing evidence-based MHL programs for youth in rural and Tribal settings, this study saw the need to extend the original PROSPER framework by exploring the role of designated program personnel, housed within a university-based center or office, to provide oversight, especially when programs address sensitive topics or involve minors. The proposed PROSPER+ model identifies designated personnel within a university-based center or office as the primary coordinators responsible for overseeing program implementation, working closely with Extension Faculty, while also recruiting and coordinating other community partners or interested local individuals who can be trained to deliver the program in rural communities (Figure 3). The proposed PROSPER+ model explores the ways in which designated program personnel housed in a university center or office, may be able to provide structural capacity, administrative support, and oversight mechanisms necessary to ensure program fidelity, youth safety, and adherence to ethical and legal standards (Domitrovich et al., 2008; Fixsen et al., 2005; Israel, 1998). The PROSPER+ model may be especially well-positioned within land-grant universities, given their established Extension infrastructures and longstanding mandates to serve rural communities. Thus, the PROSPER+ model proposed to build upon the original PROSPER framework by recognizing the importance of collaboration among multiple agencies (including the land- grant university, state departments, extension services, and community partners), as they work together to make evidence-based programs sustainable in rural communities, and add the structures necessary for financial, programmatic, ethical, and administrative oversight.

Figure 3: Proposed PROSPER+ Model



This study explored the validity of the proposed PROSPER+ Model to identify the critical aspects the delivery of a evidence-based MHL program in rural communities in Montana from the perspectives of key stakeholders (Table 2): Instructors (Extension Faculty or a community member that are certified Instructors and teach program(s) to youth) Initiators (school personnel that advocated for MHL program(s) to be brought to the school), and Program Personnel (designated program personnel at MSU that are responsible for all aspects of program support). By gathering insights from stakeholders who are directly involved in evidence-based MHL program delivery, this study aimed to understand the needs of the community, how the program is brought to a community, the program's perceived outcomes, and suggestions to improve MHL program delivery in rural and Tribal contexts. Examining these perspectives allowed the study to assess how well the proposed PROSPER+ Model aligns with the realities of rural program implementation, including the challenges posed by limited resources, geographic isolation, and diverse community needs.

Table 2: Overview of Instructor, Initiator, and Program Personnel Roles

Instructor	• A person that is certified to teach an evidence-based MHL to the youth. • They could be a community partner, local MSU Extension Faculty, or any person interested in the community.
Initiator	• A person that is influential in bringing an evidence-based MHL program to the school and usually is school staff. • They could be a district administrator, school administrator, school counselor, or teacher.
Program Personnel	• A designated program person or persons housed in a university-based office or center that has established relationships with stakeholders and experience managing all aspects of an evidence-based MHL program.

Research Questions

The following research questions were designed to guide the study:

1. Who and what needs to be present for the delivery of an evidence-based MHL program in a rural school?

2. What outcomes of an evidenced-based MHL program in a rural school are identified by key stakeholders?

3. How could delivery of an evidenced-based MHL program in a rural school be improved?

Research Methodology and Design

Given the urgent need to reduce rising rates of rural and Tribal youth suicide, the methodology for this study required a flexible and problem-centered framework which could bring forth clear outcomes and practical implications for program implementation. Thus, this study used a pragmatic lens to identify the critical elements of bringing an evidence-based MHL program to the specific context of traditionally underserved communities in a rural state like Montana. Thus this qualitative instrumental case study focused on interviews with Instructors (Extension Faculty or a community member that are certified Instructors and teach an evidence-based MHL program to youth), Initiators (school personnel that advocated for the MHL program to be brought to the school), and Program Personnel (designated program personnel from a

university-based center, that have experience in managing an evidence-based MHL program) with direct experience implementing YAM in rural schools. Participants were invited to share insights from their involvement with YAM and as well other evidence-based MHL programs they have delivered in similar rural settings.

Findings from this study provided a deeper understanding of the context of mental health and MHL program implementation recommendations in rural areas (Creswell & Poth, 2018). The experiences and feedback from Instructors, Initiators, and Program Personnel can inform future adaptations or enhancements of MHL programs, especially in rural community contexts. The instrumental case study design provided a reasonable alternative to the traditional experiment, as a control group design is not an appropriate design to best answer the research questions. Furthermore, an instrumental case study approach supported the development of a nuanced understanding of the complexities of implementing MHL programs in rural settings.

Participants and Data Collection

Qualitative researchers have various recommendations for how many participants are needed to make up an adequate sample size (Baker & Edwards, 2012; Creswell, 2003; Guest et al., 2006). However, based on methodological considerations and past experience, a number of researchers have recommended that sample sizes in case studies range from 6 to 30 (Sharma et al., 2024). Guest et al. (2006) stated that 6–12 interviews are generally enough for one project, while Creswell (2003) suggests that 4-5 per case study is adequate. There are over 42 certified YAM Instructors in Montana and over 30 participating schools, thus this study utilized purposeful sampling and invited 16 people for interviews who have first-hand experience of working with evidence-based MHL programs and youth, either as a YAM Instructor who delivers the program to students, an Initiator who bring YAM to the school, or as Program Personnel that

have experience implementing evidence-based MHL programs, particularly those with strict protocol and reporting measures. Semi-structured interviews with these 16 people who have experience in bringing YAM or teaching YAM in their communities were sufficient to gather enough data to provide rich, in-depth insights into evidence-based MHL program delivery in rural places, while balancing the practical considerations of time, resources, and the scope of the study.

Data Analysis

Participants' responses to the interview questions were recorded after receiving their informed consent. I listened to the interviews and corrected minor transcription errors that the software made. Careful review of the interviews in this manner not only ensured accuracy but also provided an opportunity to reveal the depth of participants' experience and emotion, thus providing me with a more nuanced understanding of their perspectives. Transcripts were then sent to each participant, allowing them the opportunity to make any changes. Once approval for the transcripts from each participant was received, I conducted multiple readings of each participant's responses and began to segment each response by breaking the data into smaller sections, such as sentences, paragraphs, or dialogue segments (Creswell & Poth, 2018). Using In Vivo Coding for the 1st round, I carefully reread the segments, looking to highlight or underline words, phrases, key points, or divergent statements in margin notes that stood out as important (Lincoln & Guba, 1985). I created an initial set of codes by identifying key words or phrases directly from the data itself, rather than relying on pre-established theoretical frameworks (Creswell & Poth, 2018). In this way, In Vivo Coding uses the exact words or phrases from participants to capture the participants' authentic voice and experience (Saldana, 2021). For the second round of coding, I employed Focused Coding and began to develop categories while

looking for variances and connections within the data (Saldana, 2021). I created categories from the patterns which began to emerge that answered my research questions. To ensure validity of the categories, I had a second coder, unrelated to the study, code a portion of the data using the code book I created, and agreements and disagreements were recorded, and discussed (Constas, 1992).

Significance of Study

Rural youth in America are experiencing increasing rates of mental illness, and feasible and sustainable universal programing is needed. Many suicide prevention or MHL promotion programs have been designed for, and researched in, urban areas where several large schools in close proximity are available to implement programs (Barnhorst et al., 2021). Given that few options have been designed to meet the needs of rural youth, little consideration has been given to key logistics such as who can bring the program to the school, who can deliver it, and who will be responsible for funding, implementation, and evaluation. Thus, the findings from this study could be significant for the expansion of not only MHL programs, but any evidence-based program throughout the U.S. and the world. Thus, the findings from this study could contribute to the expansion of the PROSPER model (through PROSPER+) and offer critical recommendations for how to more effectively implement evidence-based MHL programs in rural contexts by highlighting practical insights from those who bring MHL programs into their communities and from those who deliver the programs.

The findings of this study will also help to inform the field of the best practices for possibly utilizing the PROSPER+ model to guide the dissemination of evidence-based MHL programs and the adaptations and scaling MHL programs in rural areas. This outcome will ultimately contribute to closing the mental health service gap in underserved rural communities.

Additionally, this study offers actionable insights for MHL researchers, educators, program developers, community partners and policymakers to adapt MHL programs to the unique needs of rural communities, contributing to broader efforts to promote youth mental health and resilience.

Operational Definitions

MSU Extension Agent/ Faculty- subject matter experts (and university employees) serving local needs in 56 counties and seven reservations with one mission: to improve the lives of Montana citizens by providing unbiased, research-based education to strengthen the social, economic, and environmental well-being of individuals, families and communities (Montana State University Extension, n.d.)

Mental Health Literacy- mental health knowledge and the ability to understand various mental health conditions and seek help.

YAM Instructor- a trained and certified adult who guides the youth through the YAM program.

Community Partner- a community member or organization that has a vested interest in evidence-based MHL programs either by supporting financially or having employees trained as an Instructor to deliver the program as part of their work duties.

Assumptions

This study operated under the assumptions that evidence-based MHL protocols, including YAM, were being adequately followed and that the program was delivered with consistency across different locations and times, ensuring that variations in outcomes are not due to discrepancies in implementation. It was assumed that participants in the study provided honest and accurate information during interviews. The study design also assumed that the program and

the research questions were culturally relevant and appropriate for the rural population being studied, allowing for accurate representation and understanding of the participants' experiences.

Limitations

The current study recognized the following limitations which shaped the study and its findings. First, every YAM Initiator, Instructor, and Program Personnel were not invited to contribute to the study. Rather, the study used purposeful sampling to develop a representative set of participants and their communities to share their experiences and their perspectives on their community's needs for evidence-based MHL programs. This representative set of participants may have been influenced by:

Social Desirability Bias**:** Participants may have provided responses they believed to be expected or socially acceptable rather than their true perceptions.

Self-Selection Bias**:** Those who agreed to participate may have particularly strong opinions (positive or negative), which might not represent the broader population of all YAM Initiators, Instructors, or Program Personnel.

Program-Specific Factors**:** The success or challenges of YAM in one school might not reflect the program's implementation in other schools.

External Influences**:** Factors such as district policies, school culture, or mental health stigma might affect perceptions and cannot be fully controlled.

Subjectivity of Perceptions: While perceptions are valuable, they might not always align with measurable outcomes of the YAM program, such as student mental health improvements or long-term program efficacy.

Considering these possible limitations, the semi-structured interview protocol was designed to mitigate these influences as much as possible. To address these potential limitations, the semi-

structured interview protocol included open-ended questions that allowed participants to share their experiences in their own words, minimizing the influence of social desirability and program-specific expectations. Additionally, purposeful sampling was employed to capture diverse perspectives across roles and communities, helping to provide a more representative understanding of YAM implementation and its perceived outcomes.

Delimitations

Deliberate delimitations were established to refine the scope and focus of the research. Specifically, invitations to participate in the study were only extended to individuals who have delivered an evidence-based MHL program, like YAM, in rural places. Thus, while some participants had similar positions and backgrounds at the school (counselor and administrator), Program Personnel were designated university employees who had direct experience with managing the various logistics associated with delivering an evidence-based MHL program such as YAM.

CHAPTER TWO

LITERATURE REVIEW

This chapter provides an overview of the relevant theoretical and empirical literature regarding mental health literacy (MHL) and suicide prevention among rural and Tribal youth in the United States. The first section offers an overview of the literature regarding youth mental health in the United States. The second section reviews the research regarding the impact of the COVID-19 pandemic on youth mental health. Section three provides an overview of the literature dealing with youth mental health in rural and indigenous contexts and the final section reviews the literature around community and school-based approaches to mental health literacy and suicide prevention.

Youth Mental Health in the United States

Prior to the onset of the COVID-19 pandemic in early 2020, mental health experts were sounding the alarm on the increasing incidence of adolescent mental health illnesses in the United States (Glowinski & D'Amelio, 2016). Adolescent mental health and suicide rates, although stable at the turn of the 21st century, had begun to steadily rise, and by the mid-2010s, teens reported high rates of depression, anxiety, suicidal ideation, suicide attempts, and suicide completions (Bitsko et al., 2022; Twenge & Joiner, 2018).

There are varying and multifaceted factors that experts believe have contributed to the rising rates of youth declining mental wellbeing and increasing mental illnesses. Many in society are quick to blame social media and the increased use of technology among teens as the culprit for declining youth mental health (Shannon et al., 2022; Twenge, 2013, Twenge & Joiner, 2018). While there are empirical studies that do show a correlation between excessive screen time and

highly depressive symptoms and at least one suicidal-related outcome, additional research and further studies are needed to confirm this conclusion (Abi-Jaoude et al., 2020, Shannon et al., 2022; Twenge et al., 2018).

Other researchers have reasoned that additional factors have contributed to the growing mental health crisis in teens beyond the use of technology, including increased academic pressure and homework loads (Galloway et al., 2013), the impact of climate change (Hrabok et al., 2020: Romanello et al., 2022), patterns of substance misuse, most notably opioids (Davis et al., 2017; McCabe et al., 2017), and the rising rates of income and societal inequity (Elgar et al., 2015; Kirkbride et al., 2024) to name a few. Mental illnesses, like depression and anxiety disorders, can significantly impact youth and their overall well-being, academic performance, relationships, and life trajectory (Bitsko et al, 2022).

Recent data reveals an alarming pattern: the youth (ages 10-24) suicide rate in the United States increased by approximately 36% from 2000 to 2020 (Twenge, 2020), and suicide is now the second leading cause of death for ages 10-24 (CDC, 2023). There is a growing discrepancy in deaths by suicide between urban and rural areas, with the suicide rates being almost twice as high in many rural regions in the U.S., especially in Alaska and states in Rocky Mountain West (Pepper, 2017; Runkle et al., 2023). Suicide rates in other rural areas of the United States also have a higher rate of completed suicides compared to their urban counterparts (Fontanella et al., 2015; Herrin et al., 2018; Runkle et al., 2023).

Definition of Mental Health

Mental health is a complex topic that is not easily defined, and consequently no definition of mental health has been universally accepted. However, one of the most commonly used definitions of mental health was developed by the World Health Organization (WHO)

organizations and has been updated several times, most recently in 2022 (Reed, 2024). The WHO (n.d.) defines mental health as "a state of mental well-being that enables people to cope with the stresses of life, to realize their abilities, to learn well and work well, and to contribute to their communities" (p. 9).

The WHO definition is certainly not without critique, which is why it has been revised several times since the WHO first defined health upon its founding in 1948 (Reed, 2024). Many have pointed out that there are key cultural concepts regarding mental health that were not considered (Galderisi et al., 2015), as cultures vary with respect to the meaning they impart to illness (Kleinman, 1988). Kleinman's (1988) work on the cultural view of mental illness emphasizes that mental health and illness are deeply embedded within cultural contexts, shaping how symptoms are experienced, conveyed, and understood. His insights highlight the need to consider cultural contexts when diagnosing and treating mental health illnesses. For example, somatization (expressing emotional distress as physical symptoms) is more common in some cultures due to stigma around mental health discussions (Kleinman, 1988). Cultural meanings and interpretations of mental illness also have real consequences in terms of treatment and recovery, as it could impact whether people will to seek treatment, how they cope with their symptoms, how supportive their families and communities are, and where or who they go when they do ask for help (O'Keefe et al., 2021; Satcher, 2001).

The WHO definition does not fully expound upon the nuances of having poor mental health, as one can still be a productive citizen and contribute to the community, while simultaneously struggling with mental health (Manwell et al., 2015). Poor mental health and mental illness are not the same, as mental health should be thought of as a range of mental wellbeing, whereas a mental illness is characterized by a clinical disorder that can alter an

individual's cognition, emotional regulation, or behavior (Manwell et al., 2015). Lamers and Keys (2010) expound upon this notion in their dual-continuum model of mental health and mental illness. The model emphasizes that mental health and mental illness are distinct but co-existing and interrelated dimensions rather than opposite ends of a single spectrum. This means that the mental health continuum ranges from flourishing (optimal well-being) to languishing (low well-being) and from the absence of mental illness to the presence of severe mental illness, including disorders like depression, anxiety, or schizophrenia (Lamers & Keys, 2010).

Having a common definition of mental health is important for research, policy, and practice (Manwell, et al., 2015), but it also is significant when educating people, and particularly youth, about mental health. Having a clear, understandable definition of mental health, including using clinical terms for disorders, provides youth with the proper language to describe their own symptoms, reflect on their own experiences, or notice changing behaviors in themselves and others (DeFosset et al., 2017; Jorm, 2012; Manwell et al., 2015). A common definition can also help to reduce stigma and discrimination surrounding mental health and mental illnesses because people who have a shared understanding of what mental health is, can help to reduce the misunderstandings and negative attitudes that can contribute to stigma and discrimination (DeFosset et al., 2017; Kelly et al., 2007). In light of these considerations, for the purposes of this study, mental health is defined as an individual’s emotional, psychological, social, and behavioral well-being, shaped by a multifaceted interplay of biological, psychological, and environmental factors.

Definition of Mental Health Literacy

Jorm et al. (1997) first proposed the concept of Mental Health Literacy (MHL) as an extension of the term Health Literacy. Studies have shown that people who do not have robust knowledge about their health conditions will experience worse health outcomes and the same holds true with mental health-if people lack knowledge about mental health and mental illness, they will be less likely to understand their condition, seek help, and recover (Jorm et al., 1997). Therefore, MHL refers to the knowledge and understanding that people have about mental health issues, including the ability to recognize symptoms of mental illness, seek help and support, and promote mental health and wellbeing (Dias et al., 2018; Jorm et al., 1997). Given that mental well-being has a broad range of important impacts across health, health risk behaviors, education, employment, and crime, researchers have recommended the use of a public health approach to increasing mental health literacy and prevention of mental illness (Campion, 2018). The societal and economic outcomes of individuals not seeking help for a mental illness are severe, leading to poorer quality of life, lost work productivity, increased costs to health services, and increased likelihood of suicide (Schlack et al, 2021; Wilson et al., 2010).

Mental Health During Child and Adolescent Development

The early years are a crucial period for brain development; providing young children with positive experiences and learning opportunities can have a profound impact on their cognitive, physical, social, and emotional development (Kieling et al., 2011). Disruptions to this developmental process can impair a child's capacities for learning and emotional regulation that carries into adulthood (Kieling, et al., 2011). Previous research has documented that mental illness among children and adolescents is associated with immediate and long-term physical health and chronic disease, health risk behaviors, social relationships, education, and employment (Bitsko et al., 2022; Colder et al., 2018; McLeod et al., 2012).

It is estimated that 1 in 6 children (ages 2 to 8) in the United States have a diagnosed mental or behavioral disorder (Bitsko et al., 2022). According to the National Institute of Mental Health (NIMH) (2022), mental illness in children and adolescents include several types of emotional and behavioral disorders, including disruptive disorders, depression, anxiety and pervasive developmental (autism) disorders. The most common disruptive behavioral disorders are attention deficit hyperactivity disorder, oppositional, defiant or conduct disorders in preschool and school age children (Ogundale, 2018). Approximately 10% of children aged 3 to 17 in the United States have been diagnosed with an anxiety disorder, and approximately 4% of children in the United States have been diagnosed with depression (CDC, 2024). The American Psychiatric Association (2013) defines anxiety as "excessive worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance)" (p. 189), and depression is defined as "persistent feelings of sadness and hopelessness and [loss of] interest in activities they once enjoyed for two weeks or more." Depression in children "can also present with a physical symptom such as chronic pain or digestive issues" (p.155). While 3% of males and 6% of females are diagnosed with depression, the prevalence of an anxiety disorder is higher among females, with 11% diagnosed compared to 9% of males (CDC, 2024).

The prevalence of early childhood mental illness is relatively low, and some argue even unknown, as many practitioners do not believe it possible or appropriate to diagnose a child at such an early age (Egger & Angold, 2006), as it is difficult to discern between developmentally normal behaviors and clinical disorders in young children (Egger & Angold, 2006; NIMH, 2022). Furthermore, children's emotional and behavioral responses can differ significantly from those of adults, and their symptoms may evolve as they grow (American Academy of Child and

Adolescent Psychiatry, 2015). What experts do agree upon, however, is the importance of early intervention, as the failure to address mental illness, including developmental, behavioral, and intellectual disorders, in children is a public health issue with wide-reaching consequences (Kang-Yi et al., 2013; Kieling et al., 2011; Patel et al., 2007).

Adolescence is a critical period of development, as young people experience a wide range of physical changes, including growth spurts, changes in body composition and chemistry, and the onset of puberty, that can have an impact on their mental and physical health and overall well-being (Das et al., 2016). Most mental illnesses begin during youth, although they are often diagnosed and treated later in life (Kessler et al., 2007; Patel et al., 2007: Schlack et al., 2021). Nearly 20% of young people (ages 10-19) in the United States have a mental, emotional, developmental, or behavioral disorder (Bitsko et al., 2022; Kessler et al., 2005), and 1 in 10 young people have a mental illness that is severe enough to impair how they function at home, school or in the community (Kessler et al., 2005). Mental illness is strongly linked to other health and development concerns in young people, notably lower educational accomplishments, substance abuse, poverty, violence, and poor reproductive and sexual health (Lombardo et al., 2018; Patel et al., 2007; Ridley et al., 2020).

By adolescence, the brain regions responsible for primary functions (e.g., sensory and motor) have fully matured while systems responsible for higher order functions are still developing (Gogtay et al., 2004; Stewart et al., 2017). The prefrontal cortical control system, related with impulse control, has not fully matured in adolescence and will not until early adulthood (Casey et al., 2008; Stewart et al., 2017), whereas the subcortical limbic systems, involved in reward-seeking appear to have reached maturity in adolescence (Casey et al., 2008) and even show exaggerated reactions compared to children and adults (Ernst et al., 2005). The

difference in development makes adolescence a particularly vulnerable period for the effects of increased emotional reactivity and risk-taking behaviors (Casey & Jones, 2010; Stewart et al., 2017). Additionally, while adolescents can be receptive to positive social and emotional learning, and behavioral modeling, the adolescents' developing brains, coupled with hormonal changes, make them more prone to depression and anxiety and more likely to engage in high-risk behaviors than either younger children or adults (Schwartz, 2009). Adolescence can be marked as a developmental period marked with increases in interpersonal stress, coupled with heightened emotional responsiveness and low emotion-regulation, and it is an important time to enhance protective factors against poor mental health, by educating youth about mental health to increase MHL, encouraging healthy habits and teaching and modeling coping skills (Rogers et al., 2019; Skinner et al., 2012).

Youth Mental Health and Learning

The literature exploring the relationship between mental health and academic learning consistently demonstrates that students with mental illness are more likely to struggle academically, attain lower levels of education, and/or drop-out of school entirely (Bradshaw et al., 2009; Brännlund et al., 2017; Durlack & Well, 1997, McLeod et al., 2012; McLeod & Kaiser, 2004). There is long-standing research that shows the correlation between students with mental illness and poor learning and academic outcomes, starting as early as elementary school and continuing into adulthood (McLeod et al., 2012; Schlack et al., 2021). According to an eight-year longitudinal study done in Australia, there is a strong relationship between positive mental health (no mental illness and high coping skills) and academic achievement (high marks on standardized tests in both reading and mathematics) measured in third grade (O'Conner et al., 2018). O'Connor et al. (2018) acknowledge that the concept of positive mental health is

subjective and hard to measure as many people could certainly fall within a range on a mental health spectrum, from no mental health issues to severe mental illness. Yet empirical studies have determined that mental health does impact academic achievement both concurrently and, in the future (Durlack et al., 2011; O'Connor et al., 2018).

Adolescent students, especially females, report higher levels of academic stress, or pressure to do well academically, and are consequently more likely to develop anxiety and depression disorders (Pascoe et al., 2020). Anxiety and depression can have a profound impact on learning outcomes, as students have reported having concentration difficulties, motivation struggles, poor social relationships, and trouble retaining information and completing schoolwork (McLeod et al., 2012; Pascoe et al, 2020). The ongoing stress in relation to education has a negative impact on all aspects of students' lives, including the ability to learn, education and employment attainment, and mental and physical wellbeing (Pascoe et al., 2020). Some students report that their anxiety was so severe, it is the cause they identified for leaving school altogether (Russell & Topham, 2012).

Adolescents from marginalized groups can be disproportionally impacted by poor mental health outcomes, as mental health, learning, socioeconomic status, and racial inequity are all interconnected (Meyer, 2003; Morales et al., 2020). These groups, including racial and ethnic minorities, LGBTQ+ individuals, and people with disabilities, are frequently subjected to chronic stress from stigma, microaggressions, and societal prejudice, all of which significantly impact academic outcomes and mental well-being (Crenshaw, 1991; Meyer, 2015). Additionally, many marginalized individuals face barriers to seeking help, including high costs, a lack of culturally competent providers, and historical mistrust of healthcare systems (Larson et al., 2017; Morales et al., 2020). The intersectionality of these challenges often amplifies their effects, highlighting

the urgent need for equitable access to mental health care and systemic change to address the root causes of inequality, as wealth and education already create a cycle of intergenerational inequality, and youth who have faced disparities in academic opportunities, also face inequities in mental health outcomes (Larson, et al., 2017; Reardon, 2013).

Youth Mental Health and Life Trajectory

Depression, attention problems, delinquency, and substance use have all been associated with receiving a lower degree of educational attainment (DeSocio & Hootman, 2004; McLeod et al., 2012; Rumberger, 2020) or dropping out of high school all together (Skinner et al., 2012). Depressive symptoms and conduct problems in youth have both been linked to higher school dropout rates, although there is stronger empirical evidence for conduct problems leading to school dropout (Lau et al., 2021). Dropping out of high school can have substantial negative consequences on an individual's life, as high school dropouts are 63 times more likely to be jailed than four-year college graduates, and on average live 9.2 fewer years than those who graduate high school (Sum & McLaughlin, 2009). According to the U.S. Bureau of Labor Statistics (n.d.), in the third quarter of 2023, full-time workers aged 25 and over without a high school diploma had median weekly earnings of $721, compared to $905 for high school graduates with no college education, and $1,499 for those with a bachelor's degree. The economic impact of dropping out cannot be overstated, as high school and college graduates make significantly more money than high school dropouts (Rumberger, 2020; Sum & McLaughlin, 2009). A study from New Zealand with 982 subjects found that students who had suffered from depression in their teen years (16-21) had greater rates of welfare dependence and unemployment, once again showing the negative and life-long impact mental illness can have on a person (Fergusson et al., 2008).

Research literature has demonstrated an association between certain mental health problems emerging in childhood and adolescents and adult misconduct (Wareham et al., 2012). Conditions classified as "externalizing" including Operational Defiant Disorder (ODD), Conduct Disorder (CD) and Attention-deficit Hyperactivity Disorder (ADHD) have been shown to be a precursor to troubling adult behavior, especially when there is an early age of onset (Langbehn et al., 1998; Wareham et al., 2012). Children diagnosed with ODD, a disorder marked by high disregard and aggression towards authority, are more likely to engage in more violent acts in adolescence and partake in deviant behavior as an adult than those who do not have ODD (Wareham et al., 2012). Children diagnosed with ADHD, a disorder marked by persistent inattention, impulsivity, and hyperactivity, have higher levels of delinquent and deviant behaviors in adolescence and adulthood than their neurotypical counterparts, especially when these disruptive actions begin in childhood (Moffitt 1988; Wareham et al., 2012). Conversely, studies have yielded less consistent findings regarding delinquency and violence in youth that have been diagnosed with conditions considered to be "internalizing", such as depression and anxiety (Wareham et al., 2012).

Using data from the *National Longitudinal Study of Adolescent Health*, Anderson et al. (2015) explored the effect that adolescent depression has on criminal behavior later in life. Teen depression tended to be correlated with violence in the form of self-harm (Wareham et al., 2012), as well as in crimes involving property damage (Anderson et al., 2015). Data estimates signify that those who suffer from depression during adolescence face a 4.7 percentage-point higher probability of committing a property crime, a 2.0 percentage-point higher probability of committing a violent crime, a 1.3 percentage-point higher probability of selling illicit drugs, and a 4.5 percentage-point higher probability of committing a nondrug crime during the past 12

months (Anderson et al., 2015). Adolescent depression is associated with an estimated minimum annual economic cost of approximately $227 million due to property crime (Anderson et al., 2015). Other studies have demonstrated that youths entering the criminal justice system have disproportionally higher rates of mental illness than the general population, with 46% of boys and 57% of girls having two or more forms of psychopathology (Teplin et al., 2006; Wareham et al., 2012). These studies again suggest the importance of prevention programs to help youth cope with their mental illness and seek treatment before their illness hinders their ability to finish school and to avoid criminal behavior.

Kang-Yi et al. (2013) stress the importance of early intervention and treatment for mental illness as providing students the help they need could increase academic achievement, reduce suspensions and drop-out rates, and could have a profound positive impact on learning and economic outcomes into adulthood. Regrettably, it is estimated that very few adolescents, up to 70% of those who have a disorder, can receive the help they need, due to stigma, lack of resources, or other cultural barriers (Kataoka et al., 2002; Radez et al., 2021).

Thus, public health experts recommend the delivery of community programs and universal interventions in schools, as an innovative and cost-effective solution for communities that lack access to mental health resources (Chen et al., 2018). They recommend that schools implement universal, evidence-based mental health programs to provide students with essential tools to navigate life's challenges while fostering resilience, emotional well-being, and academic success (Krantz et al., 2023; McPhail et al., 2024; Robles and Bronstein, 2020). Such evidence-based programs aim to empower students to recognize, understand, and manage mental health illness (Kelly et al., 1997) by reducing stigma and fostering a supportive environment (Wasserman et al., 2015), and encourage help-seeking behavior (Jorm, 2012; McPhail et al.,

2024). Research consistently shows that evidence-based MHL programs improve not only mental health outcomes but also increase academic performance and interpersonal skills (Gueldner et al., 2020). With the rising prevalence of mental illnesses among youth, schools are uniquely positioned to deliver these programs effectively, reaching students in their formative years and equipping them with lifelong coping strategies (Kang-Yi et al., 2013; Krantz et al., 2023; Singer et al., 2019).

Youth Mental Health After the COVID-19 Pandemic

Experts had expressed concern about rising rates of mental illness among children and adolescents prior to the COVID-19 pandemic, citing increasing prevalence and substantial unmet mental health needs that predated the pandemic-related disruptions (Glowinski & Amelio, 2016; Twenge et al., 2018). Although the full social, emotional, economic, and educational consequences of the COVID-19 pandemic are not yet fully understood, scholars note that its long-term impacts will continue to be examined across disciplines for years to come (Cohen et al., 2021; Pfefferbaum & North, 2020). In 2021, the U.S. Surgeon General issued a health advisory to alert the country that American youth were experiencing a national mental health crisis exacerbated by the COVID-19 (Health & Human Services Press Office, 2021). Early studies conducted at the onset and throughout the course of the pandemic noted increased mental health problems among youth, most notably depression and anxiety, with greater impact noted among vulnerable subgroups, such as those with pre-existing mental health illness, those with physical disabilities, racial and ethnic minorities, and sexual minorities (Hawes et al., 2022; Lee, 2020; Pfefferbaum & North, 2020). Social distancing guidelines and stay-at-home orders restricted face-to-face interactions, and for many families, work and school closures led to new or intensified economic, social, and emotional pressures and health concerns (Blackwell et al.,

2022; Gruber et al., 2021). At the same time, school closures and remote learning disrupted youth's education, as well as their social and emotional support networks that could have contributed to feelings of isolation and loneliness (Blackwell et al., 2022; Lee, 2020). Additionally, the shift to remote learning highlighted existing educational inequalities, and some students had limited access to resources that they typically utilized at school (Morales et al., 2020) including internet access, free and reduced lunch programs, transportation, mental health support, and educational tutoring (Blackwell et al., 2022).

The year 2020 was marked by significant political tensions in the United States, shaped by a highly contentious presidential election and widespread debate surrounding public health responses to COVID-19. During this period, political discourse related to mitigation strategies, such as mask mandates, vaccine rollout, and school closures, permeated many aspects of daily life and social institutions. Although experiences varied, some American youth were exposed to the broader implications of political division and uncertainty through disruptions to schooling, family dynamics, and community environments (Finkel et al., 2020; Wilf et al., 2023). While some young people responded to the crisis by engaging in activism and social movements to address issues such as systemic and racial inequalities including the widening income gap, healthcare disparities, and climate change (Wilf et al., 2023), others fell victim to not-so-civic engagement during the pandemic, which heightened exposure to online harassment and disinformation campaigns predominately on social media (Nally, 2022; Wilf et al., 2023). Research is urgently needed to understand how civic engagement, social media, and disinformation campaigns during the pandemic may have played a role in young people's mental health and wellbeing during the pandemic (Nally, 2022; Wilf et al., 2023).

Anxiety and Depression in Youth

In the United States, an analysis of data from the National Survey of Children's Health documented a 25% increase (from 9.4% to 11.8%) in the proportion of children who had anxiety or depression in 2020 compared with 2016 (Schnitzer et al., 2023). Historically, the statistics of anxiety in children have not readily been available, however following data trends throughout the late part of the 20th century and the 21st century indicates that anxiety disorders, including social and generalized anxiety, are the most common mental health conditions among youth, and affect approximately 2-7% of children and adolescents, and have a lifetime prevalence rate of 31.9% (Bushnell et al., 2019; Merikangas et al., 2011). Anxiety disorders often begin during childhood (Kessler et al., 2005) and may predict future mental health issues including depression, and substance use disorders (Bushnell et al., 2019). Early life trauma, neglect, poverty, insufficient parenting, and ongoing stress are among the environmental factors that contribute to the likelihood of developing anxiety, depression, and other stress-related disorders (Cohen et al., 2021; Kalin, 2021; Lippard & Nemeroff, 2023). Prior to adolescence, the incidence of these disorders is the same between boys and girls; however, as girls mature and go through puberty, they are approximately twice as likely as boys to be diagnosed with anxiety and major depression (Kalin, 2021). In addition to causing considerable suffering and impaired functioning, when severe, these illnesses can be life threatening (Kalin, 2021; Kessler, et al., 2005). Anxiety is often comorbid with other disorders, particularly depression (Bushnell et al., 2019), and if left untreated, clinical anxiety can lead to substance misuse and can predict future anxiety and depressive episodes into adulthood (Rapee et al., 2022).

Another study of adolescents in the U. S., which included four pre-COVID time points and a fifth post-COVID time point, anxiety and depression symptoms were significantly higher than what would have been predicted by previous trajectories, and deviations in individual

trajectories were associated with greater perceived impact of the pandemic (De France et al., 2021). De France et al (2021) emphasized the importance of understanding how preventive measures, such as physical distancing and other safety protocols, contributed to these mental health disruptions.

In the United States, the prevalence of depression among adolescents has been increasing over the past decade. According to the National Institute of Mental Health (NIMH), in 2021, an estimated 5.0 million adolescents aged 12 to 17 experienced at least one major depressive episode, representing 20.1% of this age group. The prevalence was notably higher among females (29.2%) compared to males (11.5%). Research suggests that depression tends to have a later age onset than anxiety (Miller & Campo, 2021). Data indicate that adolescent females are more likely to have both anxiety and depression, although figures may be deceiving due to males not disclosing their mental health struggles (Glowinski & D'Amelio, 2016). Early detection is critical as those who develop symptoms of depression in adolescence have a higher risk of reoccurring depressive episodes in adulthood (Patel, 2013; Schilling et al., 2007). The most common depression symptoms in adolescents are changes in appetite, loss of energy, and insomnia, whereas adult symptoms tend to present in loss of interest and poor concentration (Miller & Camp, 2021; Rice et al., 2019). Given that depression is strongly associated with suicide, increasing rates of depression among adolescents are especially worrisome, given that rates of youth suicide have also been increasing for well over a decade (Miller & Campo, 2021). The effective treatment of depression in youth should be viewed as a major health priority because it addresses a leading cause of sickness and death and could help control the disease in adulthood (Patel, 2013). The American Academy of Pediatrics updated its position on the need to

recognize suicide risk and included a recommendation to routinely screen youth aged 11 to 21 for depression (Glowinski & D'Amelio, 2016).

Youth Suicide

Youth suicide continues to increase at an alarming rate in the United States and is a growing and complex public health issue (Bertuccio et al., 2024; Curtin & Garnett, 2023; Krantz et al., 2024; Mann et al., 2021; Weinberger et al., 2018). Suicide is now the second leading cause of death among individuals between the ages of 10-14 and 25-34 (CDC, 2023). The suicide rate among people aged 10–24 remained stable from 2001 through 2007 and then increased 62% from 2007 through 2021 (from 6.8 to 11.0 deaths per 100,000) (Curtin & Garnett, 2023). According to the 2023 Youth Risk Behavior Survey (YRBS) conducted by the Centers for Disease Control and Prevention (CDC), approximately 20% of U.S. high school students had seriously considered attempting suicide in the past 12 months, and nearly 10% reported attempting suicide during the same period. A comprehensive understanding of suicide requires considering the intricate relationship between varying factors, including, but not limited to, race, ethnicity, gender, sexual orientation, socioeconomic status, religious and cultural beliefs, and geographic locations (Kirkbride et al., 2024).

Race, Ethnicity, and Suicide Risk.

Youth in the United States, especially those in marginalized communities, differ in their access to culturally appropriate mental health treatment, experiences of discrimination and historical trauma, and other factors that may be related to suicide risk (CDC, 2021). American Indian (AI)/Alaska Native (AN) youth experience resounding mental health outcome inequities, and they are almost 2.5% more likely to die by suicide than other racial and ethnic groups. The rate of suicide for both male and female AI/AN youths nearly doubled from 2007 to 2017 (Curtin & Hedegaard, 2019). AI/AN youth have the

highest rate of suicide overall (41.9 per 100 000 youths in 2020) while the rate of suicide has risen the fastest among Black youths (6.9 per 100 000 youths in 2010 and 12.9 per 100 000 youths in 2020) (Chaudhary et al., 2024). Non-Hispanic White individuals were the only population to show a decline in suicidal behavior since 2018 (Curtin & Garnett, 2023; Stone et al., 2023).

Gender and Sexual Orientation and Suicide Risk. While girls and women are more likely to attempt suicide, boys and males are much more likely to die by suicide (CDC, 2022). Historically, the higher rates of suicide deaths among male youths have been associated with a higher prevalence of externalizing disorders (e.g., conduct disorder, substance abuse disorder, deviant behavior) (Mergl et al., 2015; Miranda-Mendizabal et al., 2019) and a choice for highly lethal methods, most notably with fire arms (Connor et al., 2023Kposowa & McElvain, 2006; Stark & O'Connor, 2011). Contrarily, females are more prone to show internalizing disorders (e.g., anxiety, mood disorders) (Fergusson et al., 1993; Kalin, 2021) and may attempt suicide with less lethal means (Kposowa & McElvain, 2006). More recently, however, rates of suicide have increased among both sexes, rates among girls have increased disproportionately, with the ratio of male to female suicides among 10- to 19-year-olds declining since 2007, most likely because girls have increasingly chosen lethal means, such as hanging and suffocation (Miller & Campo, 2021). Lastly, during the COVID-19 shutdown, the United States saw an alarming spike in girls and young women going to the Emergency Room (ER) while in a mental health crisis (Radhakrishnan, 2022). The visit rate (514.4 per 100,000) for girls was more than twice the rate of ER visits among boys and young men (200.5 per 100,000). The rate of ER visits among girls in 2020 was approximately double compared to 2001 (244.3 per 100,000) (McElvain, 2008; Radhakrishnan, 2022; Stark & O'Connor, 2011).

Research consistently indicates that LGBTQ+ youth in the United States face significantly higher rates of suicide compared to their heterosexual and cisgender peers (Green et al., 2021; Johns et al., 2019; Meyer, 2015; Meyer, 2003). LGBTQ+ youth are faced with navigating their sexuality and gender identities, including coming out to others and fears of rejection and harm based on their LGBTQ identity, in addition to the general stressors of adolescent development (Green et al., 2021). "Minority stress", a concept developed by Meyer in 2003, explains the chronic stress experienced by individuals belonging to marginalized or stigmatized groups. Meyers (2003) proposed that minority stress differed from everyday stress, as it arises from societal prejudice, discrimination, and systemic inequalities. Youth who reported four types of minority stress had nearly 12 times greater odds of attempting suicide compared to those who reported none (Green et al., 2021). Transgender and nonbinary youth and American Indian/Alaskan Native youth have higher odds of reporting three or more minority stress experiences (Green et al., 2021). Furthermore, marginalized groups face disproportionately high suicide risks due to a complex interplay of social, economic, and psychological factors. Key contributors include discrimination, social stigma, limited access to mental health care, and the cumulative stress associated with systemic inequalities (Green et al., 2021; Meyer, 2015; Meyer, 2003).

Geographic and Location Suicide Risk. Adolescents in rural areas face more challenges with mental and behavioral disorders than those in urban areas with the same disorders (Graves et al., 2023; Morales et al., 2020), and the suicide rate in rural areas has increased 1.5 times faster than in urban areas (Graves et al., 2020). Individuals who live in rural communities are nearly twice as likely to die by suicide than their urban counterparts (Prazak et al., 2025; Runkle et al., 2023; Stark & O'Connor, 2011), and the Rocky Mountain West region of the United States

consistently reports the highest rates of suicide in the country (CDC, 2024). There may be such a disparity between urban and rural areas, as there are large populations who are considered at high risk for mental illness including American Indian/Alaskan Native (AI/AN) and veterans, and the rural settings have limited mental health resources, increased logistical barriers to receiving help, and increased access to lethal means (Mohatt et al., 2021; Morales et al., 2020; Varia, 2014). It should be noted that not all rural areas report higher than average suicide rates. For example, rural areas in New England, particularly in Vermont and New Hampshire, have lower suicide rates compared to other rural and urban parts of the U.S, as these regions often have more robust mental health services, social programs, and a higher level of community engagement (Casant et al., 2022).

Fear and Stigma Surrounding Talking About Suicide. There is a widespread misconception that talking about suicide could cause someone to become suicidal (Dazzi et al., 2014). Dazzi et al. (2014) conducted a literature review on the topic of talking about suicide and suicidal ideation in both adolescent and adult populations and found there was no statistically significant increase in suicidal ideation after talking about suicide. Other studies on this topic reported by Miller et al. (2009), provide compelling evidence that presenting information about suicide warning signs is unlikely to be harmful, consequently increases people's knowledge and awareness, and potentially could prove effective in preventing deaths by suicide. Nevertheless, a fear remains, especially among adults with low MHL, that talking about, or asking a person if they are thinking about harming themselves, could cause the person to act (Dazzi et al., 2014). However, it must be noted that it is crucial how we collectively approach and talk about suicide (Etzersdorfer & Sonneck, 1998), particularly with youth (O'Carroll et al., 1990; Padmanathan et al., 2019). There is substantial research supporting the notion that adolescents may be more

prone to suicide if they know someone who has died by suicide, including a celebrity or even a fictional character (O'Carroll et al., 1990; Swanson & Coleman, 2013) The "contagion theory", first proposed by Phillips (1974), focuses on the influence of media and publicized suicides on increased subsequent suicidal behavior. O'Carroll et al. (1990) found that adolescents may be particularly susceptible to this contagion effect, as more than 13% of adolescent suicides clusters (a group of suicides or suicide attempts that occur closer together in time and/or geographic location) are potentially explained by the phenomenon.

A 2013 study conducted in Canada further demonstrated how exposure to suicide, such as knowing someone who has died by suicide or media portrayal, can heavily influence youth mental health and emphasized the need for responsible and targeted prevention strategies to address this exposure and mitigate the effects of a suicide contagion (Swanson & Coleman, 2013). Moreover, after the release of *13 Reasons Why*, a television show geared toward youth that depicted a teen suicide, researchers found a 28.9% increase in suicide rates among U.S. youth aged 10 to 17 in April 2017, the month following the show's release (Bridge et al., 2020). The study suggests an association between the show's release and increased suicide rates, though it does not establish causation (Bridge et al., 2020). Conversely, a review in the International Journal of Neuroscience reported mixed results regarding the show's impact on suicidal ideation among youth (Leaune et al., 2022) While some studies indicated an increase in suicide and suicide attempt rates, others did not find significant effects, highlighting the complexity of media influence on adolescent mental health (Leaune et al., 2022).

Furthermore, the words we choose to use when talking about suicide significantly influences public perception, stigma, and the willingness of individuals to seek help (Padmanathan et al., 2019). For example, using the term "die by suicide" instead of "committed suicide" can reduce

stigma and encourage open conversations about mental health (Padmanathan et al., 2019). The American Foundation for Suicide Prevention (n.d.) stresses the importance of using accurate and sensitive terms when discussing suicide with youth, in order to foster a supportive environment, reducing stigma, preventing further suicides, and ensuring that those affected have access to the resources and care they need.

Suicide's Impact on School and Staff. Although additional empirical evidence on the impact suicide can have on other students is necessary, researchers have found that students who have lost a friend to suicide are 3.7 times more likely, and those losing an acquaintance are 2.2 times more likely, to report suicidal ideation (Singer et al., 2019). Due to these staggering statistics, Erbacher et al. (2023) recommend that schools do everything necessary to avoid a contagion response. Staff too are significantly impacted when there is suicide within the school. Teachers often bear the responsibility of looking for signs of depression and suicide in their students, often without adequate training to do so (Hatton et al., 2016). Teachers also are tasked with giving the news of the death of a student to the rest of the class, which can be emotional and daunting. Therefore, when considering a suicide prevention program, schools must include continuing education for staff and students alike, in the form of MHL with clear guidance on what to do when they suspect someone is considering suicide (Hatton et al., 2016).

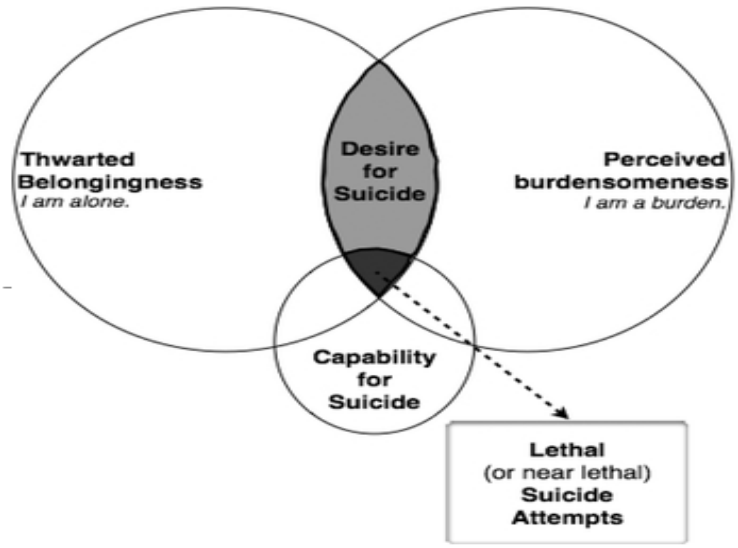
The Interpersonal Theory of Suicide

Identifying individuals at risk of suicide is difficult due to the complicated interplay of biological, psychological, social, and environmental factors (Van Orden et al., 2010). While certain risk factors are recognized, it remains challenging to predict and research suicidality, consequently making it harder to develop effective prevention strategies (Mann et al., 2021; Millner et al., 2020). Although there have been significant advancements in the past 100 years

on reductions in diseases that used to be the leading causes of death (tuberculosis, cancer, pneumonia), suicide remains a persistent and growing issue that continues to elude researchers, as we do not have a clear understanding of why people die by suicide (Millner et al, 2020). However, several theories have emerged concerning suicidal behavior, but more research is needed to fully understand suicidal behavior, especially in children and adolescents (Stewart et al., 2017; Vélez-Grau et al., 2022).

One of most prominent suicide theories that has emerged this century is The Interpersonal Theory of Suicide (Christensen et al., 2013; Stewart et al., 2017), which was proposed by Joiner (2005) and further expanded upon by Van Orden and colleagues in 2010. The Interpersonal Theory of Suicide (Figure 4) is a framework containing three constructs that are central to suicidal behavior, two primarily related to suicidal desire—thwarted belongingness and perceived burdensomeness—and one primarily related to capability—acquired capability for suicide, particularly increased physical pain tolerance and lowered fear of death (Joiner, 2005; Van Orden et al., 2010). The theory proposes that someone who perceives themselves as a burden, experiences social isolation, and has developed the capacity for self-harm may be more likely to die by suicide (Van Orden et al., 2010). Van Orden et al. (2010) explains that there is robust literature on other risk factors that contribute to suicidality (and connect these factors to an increase of perceived burdensomeness, a decrease of belongingness, and increase acquired capability for suicide). The largest factor for increased chances of suicidality is having a mental disorder, while other substantial risk factors include past suicide attempts, social isolation, family conflict, unemployment, and physical illness (Stewart et al., 2017; Van Orden et al., 2010).

Figure 4: Interpersonal Theory of Suicide



Assumptions of the interpersonal theory of suicide.

Joiner (2005) originally contended that hopelessness was also a major contributing risk factor, yet in the updated version of the theory, Van Orden et al. (2010) maintains that hopelessness may be the catalyst that drives a person from having suicidal ideations to an active desire for death by suicide. The theory further asserts that this capability is not acted upon unless death is perceived as desirable, while the person is simultaneously experiencing an intense sense of perceived burdensomeness paired with a sense of thwarted belongingness (Christensen et al., 2013; Van Orden et al., 2010).

The Interpersonal Theory of Suicide Explored in Youth Populations. While research is limited, there have been several studies exploring the Interpersonal Theory of Suicide in adolescent populations. Physical fights, sexual violence, dating violence, drug misuse (injectables and opioids) and concussions could be linked to suicidality because they involve exposure to physically painful experiences (Vélez-Grau et al., 2022), which can increase an

acquired capability for suicide (Joiner, 2005). A systematic literature review indicated that interpersonal violence, including dating violence and physical fights, strongly correlated with suicide attempts among adolescents (Miranda-Mendizabal et al., 2019).

Research also indicates an association between opioid misuse and mental health disorders, even after controlling for a wide array of other demographic and risk factors (Davis et al., 2017). Prescription opioid misuse was significantly associated with risky behavior in teens, including suicide attempts (Bhatia et al., 2020). In a study examining opioid exposure among teens, researchers found that there was a 52% increase in opioid related suicides since 2000 (Allen et al., 2017). The rate of opioid exposure attributable to suspected suicide increased by 52.7% among teenagers from 2000 to 2015 (Allen et al., 2017). Furthermore, people who use opioids are 14 times more likely to die by suicide compared to the general population (Rizk et al., 2021)

Results from a systematic review provide support for the association between multiple concussions and increased suicide risk among children (Fralick et al., 2019). Adolescents who reported concussions were more likely to report suicide attempts compared with those who did not report a concussion (Wangnoo et al., 2020). Although the association between violence exposure, injection/opioid drug misuse, concussions, and suicide attempts has been established, studies have been limited and additional research is necessary to further explore the Interpersonal Theory of Suicide in adolescent populations (Vélez-Grau et al., 2022).

Youth Mental Health in Rural Contexts

Defining Rural

According to "Why Rural Matters" (2023), a biennial report published by the National Rural Education Association (NREA**),** the number of children attending rural schools exceeds 9.5 million, or more than one in five students nationwide (Showalter et al, 2023). This means that more students in the U.S. attend rural schools than are enrolled in the 100 largest school districts combined **(**Showalter et al., 2023). However, what makes a place rural is not as straightforward as it seems, as there is not an unequivocal set of criteria used to define what is considered rural. To date, there is no single definition of rural in use by researchers or policy makers, as one must consider geography, access to amenities, population density, and cultural and economic factors (Coburn, et al., 2007). Rurality is not a monolithic construct, as there are differences within every school, community, state, or region (Coburn et al., 2007). Moreover, Azano and Biddle (2019) caution against using deficit narratives and metrocentric definitions when thinking about rural places and people. They emphasize the importance of recognizing the unique strengths, assets, and cultural complexities inherent in rural communities (Azano & Biddle, 2019). By shifting the focus from what rural areas lack to what they contribute, researchers and educators can better understand community dynamics and design programs that are contextually relevant and respectful of local values.

One way to define rural is by using a combination of geographic and population metrics. There are several U.S. federal agencies that utilize coding systems that classify rural and urban areas using county level data (Hawley et al., 2016; Isserman, 2005) of population and/or distance from major metropolitan areas. However, this definition lacks context, and thus Brown and Schafft (2011) recommend a multidimensional approach to defining rural spaces, which include,

population and settlement, economy, institutions, and socio-cultural aspects. Including and considering these factors will give a more precise and nuanced definition and understanding of what it means to be rural (Brown & Schafft, 2011; Hawley et al., 2016). For researchers contributing to the field of rural education or mental health, it is vital that they accurately describe all aspects of the place where they are conducting their work. Detailed descriptions of rural spaces make findings more transferable and could improve funding, resources, and practices for rural education and communities (Hawley et al., 2016).

Overall, providing details about the rural context helps to advance the field by reducing the vagueness around the concept of rurality (Hawley et al., 2016). Having a clear and consistent definition of rural helps ensure that resources and services are distributed appropriately and effectively across different regions, and that policies and programs are adapted to meet the unique needs of rural communities.

Every rural community can be defined by a combination of geographic, historic, economic, and social characteristics. The uniqueness of the people, the histories and geographies of the regions where they live (plains, mountains, desert, etc.), and economic factors converge to create great variability from one rural community to the next. These definitions highlight different aspects of geographical places with regard to the population density and distance from areas where many people live close together. Thus, while there is not one agreed upon definition or description that fully encompasses the complexities of what it means to be “rural”, this study will use the National Center for Education Statistics (2006) Urban-centric locale codes (Table 3).

Table 3: National Center for Education Statistics Urban-centric Locale Codes

Code	Organization	Coding Terminology	General Description
Urban-centric locale codes	NCES	City	Three city codes (large, midsize, small) based on populations size. City schools and districts must be inside urbanized area inside principal city.
		Suburb	Three suburban codes (large, midsize, small) based on populations size. Suburban schools and districts must be outside principal city and inside urbanized area.
		Town	Three town codes (Fringe, distant, remote) based on distance from urbanized area. Town schools and districts must be inside urban cluster.
		Rural	Three rural codes (fringe, distant, remote) based on distance from urbanized area. Rural schools and districts must be census-defined rural territory.

This classification system is used to categorize the nation's schools based upon a combination of population density and distance from the nearest metropolitan center, using the three categories of: rural fringe, rural distant, and rural remote (Table 4).

Table 4: National Center for Education Statistics Rural Locale Codes

Urban-Centric Classification System	Distance from an urbanized area with less than 50,000 people	Distance from an urban cluster with 2,500–50,000 people
Rural Fringe	Less than 5 miles from an urbanized area	Less than 2.5 miles from an urban cluster
Rural Distant	5–25 miles from an urbanized area	2.5–10 miles from an urban cluster
Rural Remote	More than 25 miles from an urbanized area	More than 10 miles from an urban cluster

This system of rural classification is appropriate for this study as: 1) the MHL program is delivered exclusively through local schools; 2) all schools have already been assigned a recognized code; 3) distance and density are to particularly relevant to student access to mental health resources and supports; 4) distance and density are to particularly relevant to availability

of adults to deliver mental health resources and supports; and 5) the study's findings may be applicable to other similarly situated schools and communities.

Rural Mental Health Disparities

Research indicates that rural children, particularly those from rural and small communities, are more likely to experience mental, behavioral, and developmental disorders compared to their urban counterparts (Anderson & Gittler, 2005; Blackstock et al., 2018; Morales et al., 2020). A study published in Pediatric Health, Medicine and Therapeutics found that rural children face health and healthcare disparities, rendering them a unique and vulnerable pediatric population (Bettenhausen et al., 2021). Preliminary studies confirm that the COVID-19 pandemic further exacerbated rural health disparities, as studies show that the lockdowns caused additional stress for rural pediatric populations who have greater access to firearms, higher rates of ER visits for firearm-related self-harm, and less access to community mental health resources than their urban peers (Arakelyan et al., 2022; Hoffman et al., 2021). COVID-19 interrupted in-person learning, social and community networks, recreational activities, and access to health care, which disrupted important routines, and limited access to resources and support systems (Samji, et al., 2022). In addition, for some students, the increased time at home could have potentially exposed them to more traumatic events, such as stressful home environments, food insecurity, unsupervised time, substance misuse, or increased violence (Ademhan et al., 2020).

Rural Poverty and Mental Health.

It is estimated that one and four people living in rural areas live in poverty (Bettenhausen et al., 2021; Kelleher & Gardner, 2017) and growing up in poverty can have a profound impact on a child's mental, behavioral, intellectual and developmental well-being (Kelleher & Gardner, 2017; Ridley et al., 2020). Rural youth living in

poverty, ages 2 to 8, have higher rates of parent-reported mental and behavior problems than their wealthier counterparts (Cree et al., 2018; Kelleher & Gardner, 2017). These same children tend to have less access to educational resources, including MHL and prevention programs that target the young before the onset of mental and behavior disorders (Kelleher & Gardner, 2017; Ridley et al., 2020). Given that there is less access to mental health care and treatment, and fewer people with specialized training in rural areas, rural youth are also less likely to receive the help they need (Kelleher & Gardner, 2017; Morales et al., 2020; Ridley et al., 2020), which can lead to mental illness and adverse life events for them in the future.

Youth who have been exposed to more adverse childhood experiences, regardless of where they live, are at a higher risk of developing mental health conditions (Kalmakis, & Chandler, 2015; Schilling et al., 2007). Adverse childhood experience (ACE), a term coined in 1997 as a result of the CDC-Kaiser Permanente study, is used to describe all types of abuse, neglect, and traumatic experiences that occur to people under 18 (Kalmakis & Chandler, 2015). Research indicates that childhood adversities associated with poverty are strongly linked to negative outcomes in adulthood, leading some scholars to argue that poverty itself should be recognized as an adverse childhood experience (Hughes & Tucker, 2018). Children exposed to higher ACEs, are more likely to perform poorly in school, abuse substances, have diminished educational and employment opportunities, and be at increased risk for chronic medical and mental health conditions (Kalmakis, & Chandler, 2015; Larson, et al., 2017; Ridley et al., 2020; Schilling et al., 2007). Low-income and youth from marginalized groups, especially from rural areas, who are exposed to higher ACE's are more susceptible for developing both mild and severe mental illness and have lower GPAs than their white peers who have also experienced trauma (Kalmakis & Chandler, 2015; Ridley et al., 2020; Schilling et al., 2007). A more recent

study explored the relationship between ACEs and youth suicide risk, and the research highlights that exposure to ACEs in childhood significantly increases the likelihood of developing depression, anxiety, and self-harm behaviors, which are critical risk factors for suicidal ideation and attempts among adolescents (Jones et al., 2024). The study underscores the importance of early intervention and mental health support for youth with high ACE scores to mitigate the elevated suicide risk associated with these experiences (Jones et al., 2024). Unfortunately, and like the academic/opportunity gap, not all children have access to the care they need, especially children in poverty, as there are marked disparities in access, utilization, quality, and funding of pediatric mental health care in the United States (Garcia, 2020).

Low Rates of Mental Health Literacy. Despite rising rates of youth mental illness and suicides, most youth lack access to accurate mental health information (Radez et al., 2021; Riebschleger et al., 2022), and unsurprisingly, report low rates of MHL (Kelly et al., 2007; Lincoln et al., 2017; Riebschleger et al., 2022). Youth who do not possess a great deal of knowledge about mental health and mental illness, are less likely to identify symptoms of poor mental health, have a lower perceived need of care, and are less likely to seek help (Crumb et al., 2019; Kelly et al., 2007). Adolescents who have not received mental health support or treatment are more susceptible to substance abuse, violence exposure, and increased suicide risk (Kelly et al., 2007; Patel et al., 2013). In addition, the prevalence of mental illness and death by suicide in rural areas may be a result of limited MHL, a problem that is compounded by limited access to service provides, geographic isolation, stigma and reluctance to receive help, and more readily available access to firearms (Cheesmond et al., 2019; Story et al., 2016; Wilson et al., 2010).

Help Seeking Barriers for Rural Youth. Correspondingly, help seeking behaviors are a vital component of MHL and receiving treatment, yet research shows that rural youth are less

likely to seek or receive help for mental health issues, than their urban counterparts, largely in part to fear of stigmatization (Blackstock et al., 2018; Cheesmond et al., 2019; Fontanella et al., 2024; Gulliver et al., 2010). Parents may be less likely to seek help for their children due to logistical barriers and lack of resources in their geographic area (Guerrero et al., 2019; Riebschleger et al., 2022). One in five children and adolescents need mental health services, yet most do not receive any services (Green et al., 2013; Merikangas et al., 2011). Approximately 60% of all US counties and 80% of all rural US counties do not have a single psychiatrist, and in frontier or remote areas, there may not even be a local physician (Guerrero, et al., 2019). The large distances rural residents must travel and the high costs to receive care are significant barriers to seeking help for mental illness (Blackstock et al., 2018). Such obstacles are problematic as early intervention is the most important means for prevention of chronic mental illness (Guerrero et al., 2019). A study conducted in rural Australia found that people were apprehensive to seek out help for mental illnesses due to worry that that the care will be unavailable when needed, about being treated unkindly, and not knowing exactly where to go (Gulliver et al., 2010).

Rural Youth Views on Seeking Help from Adults. Youth themselves may not feel comfortable going to adults with their mental health problems for various reasons, further demonstrating the importance that youth may place on the character traits of the adults they trust to go to with their problems (Gulliver et al., 2010). Qualitive studies from 9th and 12th grade student focus groups revealed that youth saw several perceived barriers to seeking help from adults in their school and communities, as they felt adults could have “dual roles” and may be “psychologically unavailable” or may seem “too busy” to be approached by the youth (Lindsey et al., 1998). In close-knit rural communities, privacy concerns can deter youth from seeking

help, as they may fear that their mental health issues will become widely known after seeking help from an adult with dual roles (Ferris-Day et al., 2021). For example, a local elementary teacher could also be someone's best friend's mom, the 4-H leader, a church leader, a volunteer, etc. Youth described that it may be difficult to go to an adult for help, if they know them outside of school in a different capacity, especially if they have a role as an enforcer (Ferris-Day et al., 2021; Lindsey et al., 1998). Youth also saw some adults as not able (or have enough knowledge) to have hard conversations about mental health or they felt that the adults were too busy to take the time to talk to them. Again, the impression or even experience that youth had could be vastly different than the adult in the same situation, and the adults could perceive themselves as being able and available to help the youth (Lindsey et al., 1998). Nevertheless, how the youth perceive an adult as a potential ally or someone that they can turn to for help is very important (Helms, 2003). Other common barriers regarding why youth may not seek out adults that emerged from the study were that adults are not trustworthy, may be out of touch, may be judgmental, dismissive, or unhelpful (Gulliver et al., 2010). Flanagan and Stout (2010) expounded upon those findings and highlighted again the importance that youth placed on the character and trustworthiness of adults in their school and communities.

Access to Lethal Means. Access to lethal means significantly increases the risk of youth suicide (Kivisto et al., 2021; Spitzer et al., 2024; Stark & O'Connor, 2011). A systematic review published in Epidemiologic Reviews highlights interventions aimed at reducing access to lethal means, such as firearms and toxic substances, which can lead to a decrease in suicide rates. Individuals living in rural areas have shown to have greater access to lethal means increasing the likelihood that a suicide attempt will result in death (Stark & O'Connor, 2011). Firearms remain the most lethal means of suicide and account for nearly half of all suicides among adolescents

(CDC, 2021). Given that adolescent suicide attempts are frequently linked to impulsive decision making, access to the most lethal method, firearms, may be a particularly volatile combination driving increased youth suicide (Vélez-Grau et al., 2022). The association between firearm ownership and suicide was approximately 2 times stronger among adolescents relative to adults and the presence of lethal means in the environment, especially in times of crisis, can facilitate impulsive decisions (Stark & O'Connor 2011). Empirical studies support the hypothesis that exposure to guns is associated with fearlessness about death, pain tolerance, and lifetime suicide attempts, but not with suicide ideation (Conner et al., 2023; Vélez-Grau et al., 2022). Furthermore, limiting access to guns through appropriate firearm storage weakened the relationship between suicide ideation and a future suicide attempt (Athey et al., 2025; Khazem et al., 2015; Kivisto et al., 2021). Policies mandating locks and safe storage were associated with a 13.1% (2.7%−22.3%) reduction in adolescent firearm suicide and an unexplained 8.7% (1.2%−15.7%) reduction in non-firearm suicide (Khazem et al., 2015).

Rural Attitudes and Stigma Surrounding Mental Health. Mental health stigma refers to negative attitudes and beliefs about mental illness and those who suffer from mental health problems (Link et al., 1987). Stigma can manifest in many ways, including through discrimination and prejudice related to perceptions about mental health issues (Liegghio, 2017; Link et al., 1987; Mukolo et al., 2010). Corrigan and Bink (2005) identified different types of stigmas that could contribute to why a person may not be seeking help for mental health issues. They defined structural stigma, as "the policies of private and governmental institutions that intentionally restrict the opportunities of people with mental illness and the policies of institutions that yield unintended consequences that limit options for people with mental illness" (Corrigan & Bink, 2005, p.482). They asserted that structural stigma leads to the "why try" phenomenon, when

people get frustrated that their mental health symptoms have not improved, and essentially give up (Corrigan & Bink, 2005). Corrigan and Bink (2005) also contend that self-stigma, defined as the negative attitudes, including internalized shame, that people with mental illness have about their own condition, prevents them from getting help. Lastly, those with mental illness may not seek help due to public stigma, as they fear what others will say and think about them (Corrigan & Bink, 2005).

The impact of stigma in rural communities also affects adolescents who experience mental illness. A study found that rural parents were less willing to seek services for their children in mental healthcare centers and schools (Liegghio, 2017). Likewise, other studies found that rural parents reported that they would likely not seek help for their child, as they feared they would be subjected to stigmatizing attitudes from other community members, especially school personnel, if they sought help for their child (Crumb et al., 2019; Van Der Sanden et al., 2015).

In a study regarding rural attitudes towards mental health and help-seeking behaviors, researchers reviewed eleven studies where rural participants identified potential reasons why rural citizens may not seek help for a mental health issue. They found that rural participants felt that stoicism, stigma, distrust (of others who could help them), and meaning (how much one viewed their struggles as problem) were main factors in why people in rural areas would not seek help for a mental health problem (Cheesmond et al., 2019). This study indicated there is a link between rurality and a hesitation to seek help for mental health, however there were limitations, and it is noted that rurality may not be the single contributing factor to such attitudes, and more research is needed (Cheesmond, et al., 2019). Either way, all students, especially those in rural

areas, could benefit from MHL programs that are designed to break down the stigma surrounding mental health and to encourage and teach students to ask for help.

American Indian Youth. Research consistently shows that rural adolescents in the US face significant disparities in mental health outcomes, despite the prevalence of mental illness being similar between rural and metropolitan youth (McCall-Hosenfeld et al., 2014; Morales et al., 2020) and that may be because of the higher percentage of American Indian/Alaskan Native (AI/NA) people that live in rural places (Garcia et al., 2020). AI/AN youth are also more likely to live in poverty, misuse drugs and alcohol, have attachment disorders, experience violence in their lifetime, and engage in other high-risk behaviors (Garcia et al., 2020). It is important to highlight that there is great variety within and between AI/AN communities, and not all Tribes are the same (O'Keefe et al., 2021). In addition, cultural concepts of mental illness and beliefs about why and how mental illness develops may have dissimilar meanings and interpretations among AI and AN people, and they may express emotional distress in ways that are not consistent with standard diagnostic categories (Brave Heart et al., 2011; Kleinman, 1988). Historical events such as forced relocation, genocide, and the disruption of cultural practices have led to collective trauma that is passed down through generations (Horse et al., 2003), and this trauma can increase mental health vulnerabilities, including a higher risk of suicide among youth (Garcia et al., 2020). Brave Heart et al. (2011) and LaFromboise (2006) encourage a return to indigenous healing practices to be incorporated into current mental health wellness and treatments to increase a sense of belonging and cultural connection for AI youth. Furthermore, the availability of culturally relevant mental health services is limited in many Tribal areas (Miller et al., 2021). It is crucial that mental health providers, preferably those who are Tribal members, are trained to

understand the social, economic, and historical contexts affecting AI youth (Hughes et al., 2019; Miller et al, 2021).

Montana Youth and Mental Health

Montana is considered a rural state, with one midsize city (Billings with a population of approximately 100,000) and four small cities (Missoula, Great Falls, Helena, and Bozeman Missoula), and many rural areas classified as fringe, distant, and remote (NCES, n.d.). Unfortunately, Montana, along with other states along the Rocky Mountain Front, consistently report one of the highest death-by-suicide rates per capita in the United States (Curtin & Garnett, 2023). In fact, data from the National Vital Statistics Report in 2023 reported that Montana had the highest suicide rate in the nation (Montana DPHHS, 2023). According to the 2023 Youth Risk Behavior Surveillance System (YRBSS), a set of surveys that track behaviors that can lead to poor health in students grades 9 through 12, 42.8% of youth surveyed in Montana reported feeling hopeless or sad for two weeks or more, which was the highest ever recorded, and 25.7% had seriously considering suicide during the 12 months before the survey and 15.1% had attempted suicide during the same period. These findings were an increase from the 2015 YRBS survey, where 29.3% reported feeling hopeless or sad for two weeks or more, 15.5% had seriously considered suicide, and 8.2% had attempted suicide (CDC, 2016). In Montana, 2022 data showed that the youth suicide rate (ages 11-17) was 17.53/100,000, which was triple the national rate (5.24) for the same age group (Montana DPHHS, 2023). The highest rate of suicide was among American Indians (AI) (43 per 10,000), although they only constitute 6% of the population of Montana (Montana DPHHS, 2023). In 2023, 71% of youth suicides were completed by firearms (Montana DPPHS, 2023). Community and Tribal leaders, mental health professionals, and public health advocates in Montana continue to call for more comprehensive

suicide prevention strategies that are tailored to the state's rural and cultural context (Montana DPHHS, 2023).

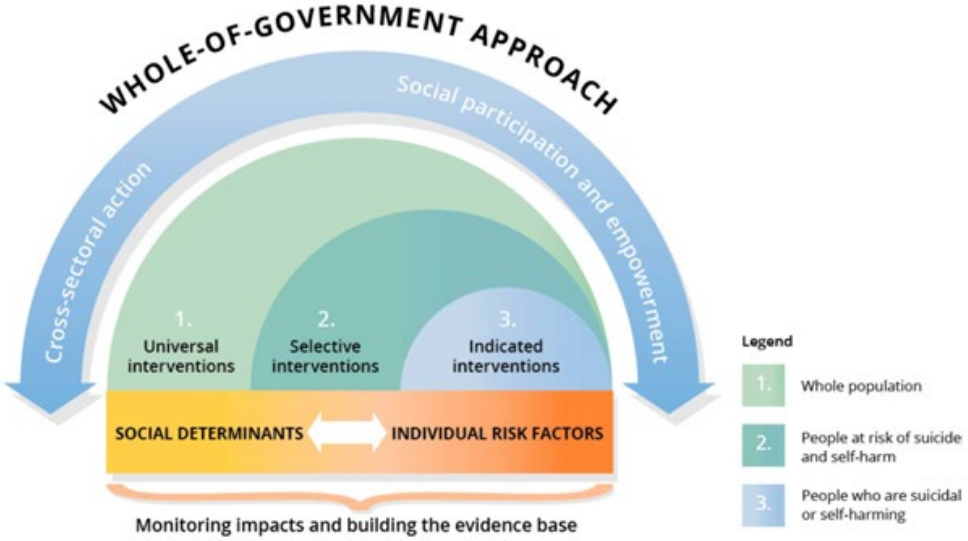
Community and School-Based Approaches to Suicide Prevention

Given the alarmingly high youth suicide rates in rural communities, experts have suggested that suicide should be considered a public health crisis, and view prevention efforts through a public health lens (Campion, 2018; Chen et al., 2018). Pirkis et al. (2023) contend that their model, "A Public Health, Whole-of-Government Approach to National Suicide Prevention Strategies," is necessary as it advocates for a comprehensive, cross-sectoral approach to suicide prevention. (Figure 5) This framework builds upon the foundational work of Solar and Irwin (2010), who emphasized that social determinants, such as education, income, housing, and community context, are key drivers of health outcomes and Kelly et al. (2007) who found that higher levels of social capital, including community trust, civic engagement, and social or political participation, were associated with lower suicide rates across populations. "A Public Health, Whole-of-Government Approach to National Suicide Prevention Strategies" model emphasizes addressing social determinants of suicide, alongside individual risk factors, and propose a model that integrates efforts across various government sectors, such as education, housing, and justice, to address these factors effectively (Pirkis et al., 2023; Kelly et al., 2007; Moscicki, 1997; Silverman & Felner, 1995). By aligning education and mental health initiatives within a broader public health framework, the approach supports early intervention, strengthens protective factors, and promotes community resilience, rather than suicide prevention efforts functioning in isolation (Pirkis et al., 2023).

In rural communities, a whole of government, public health approach can address the unique challenges posed by geographic isolation and limited access to mental health resources

(Figure 5). By coordinating efforts across education, health, and social service sectors, this model helps ensure that prevention strategies are comprehensive, increasing their potential effectiveness in reducing suicide risk among rural and Tribal youth.

Figure 5. A Public Health, Whole-of-Government Approach to National Suicide Prevention Strategies Model.



Public health experts further emphasize the value of community-wide programs such as adult education and universal interventions delivered in schools, as innovative and cost-effective solutions for program delivery and suicide prevention (Chen et al., 2018; Kelly et al., 2007). Research indicates that school-based interventions aimed at improving MHL and reducing mental health stigma have the potential to prevent mental disorders and promote mental well-being (Jorm, 2012). However, it is important to note that misconceptions about mental health and suicide continue to exist, and not all schools and communities are open to having mental health promotion programs (Kohrt et al., 2018). Previous research demonstrates that rural communities are more likely than urban communities to be apprehensive about teaching and focusing on mental health, as stigma surrounding the topic, especially on suicide, remains strong

(Barnidge et al., 2013; Blackstock et al., 2018; Goodcase et al., 2022; Morales et al., 2020). Of course, one cannot generalize all rural communities, as each is unique and diverse, and receptiveness to programming will vary over time and location.

An Approach Based on Community Needs

Suicide prevention efforts which have been successful have focused on mental health awareness, early intervention, reducing stigma, improving access to mental health care, and creating supportive communities (Kieling et al., 2011; Krantz et al., 2023; Purtle et al., 2025). Moreover, because mental illness can begin occurring at a young age, experts have argued that early intervention for teens' is critical in avoiding future disruptions (Bushnell et al., 2019). Levin et al. (2021) accurately point out that while it is important to have an evidence-based program to bring to a school, unless there are collaboration and engagement from stakeholders, especially parents across the community, it is not going to be accepted, sustainable, or impactful.

Community engagement is a process of building and sustaining relationships between community members, organizations, and institutions, and it involves a collaborative effort to work towards shared goals and address community identified needs (Israel et al., 1998; Ramandhan, et al., 2012; Spoth et al., 2004). Key attributes of successful community engagement include basing efforts on needs identified by communities, activating the assets and strengths of communities, identifying key stakeholders, establishing a stable infrastructure, sharing funding and authority over projects, focusing on meaningful outcomes, and fostering open communication, trust, and respect (Levin et al., 2021; Snavely & Tracy, 2002). Lastly, Israel et al. (1998) note that the program delivery should benefit all, not just the policy maker or researcher. Unfortunately, many communities have not mutually benefited from program

implementation and the corresponding research, and as a result, community mistrust towards institutions has grown and the health disparities remain (Israel et al., 1998).

Similarly, Spoth et al. (2004) recognized the importance of community engagement in bringing evidence-based programs to rural communities by bolstering the connections between public schools, universities, and communities. This is especially important if teachers are not allowed to teach the program due to program protocols, or if an outside facilitator is needed to assist with programing. Spoth et al. (2004) developed The PROmoting School-community-university Partnerships to Enhance Resilience (PROSPER) Model, which is designed to assist in the delivery of interventions, especially to youth, by connecting the existing infrastructure (i.e.-Extension Faculty at land-grant universities) and supports in place with key community partners (i.e.-government public health officials, parents and other stakeholders) to enhance the capacity-building of state and local public education systems. It should be noted that the interventions for youth are based on needs identified by the school and the community, so that all interested parties support the programs and are invested in ensuring that they continue (Spoth et al., 2004).

Community-wide Education

One of the most recommended approaches is a community-wide campaign to educate the public (Israel, 1998; Kelly et al., 2007). To educate the community, trust must be built through open communication and transparency, between stakeholders and those who are involved in implementing programs, teaching, or researching (Snavely & Tracy, 2002; White & Corbett, 2014). Engaging with a trusted community member, such as an Extension Agent from a land-grant university, can increase program acceptability and participation (Bailey et al., 2022). Once trust is established, community stakeholders are often more willing to allow educational programs to be implemented, especially when they have a clear understanding of what the

program or curriculum entails (Israel, 1998; Snavely & Tracy, 2002). Increasing MHL through education, implementing culturally appropriate or adapted mental health promotional programs, having influential people support the initiative, and having someone who has a mental health disorder speak out and share their story, are other effective methods to decrease misapprehensions about mental health (Kelly et al., 2007; Shahwan et al., 2022).

Evidence-Based Programs in Schools.

Given that the incidence of mental illness often begins in adolescence and greatly impacts the young (Kessler et al., 2005), many school districts have identified the need to implement mental health programs because they recognize that school can be an essential environment to identify and respond to youth at risk (Ayer & Colpe, 2022; Singer et al., 2019). Roughly half of the states in the US mandate suicide prevention in schools (Kang -Yi et al., 2013), and districts have been eagerly searching for evidence-based programs that are designed specifically for suicide prevention. Evidence-based refers to the collection of empirical evidence, obtained through rigorous scientific research, to inform decision-making and practice (Singer et al., 2019). There are challenges to finding evidence-based suicide prevention programs because studying suicide prevention with minors is a complex undertaking. It is difficult to set up control groups, attain parental consent for participation, and identify mechanisms of change in youth (Singer et al., 2019).

Program focus is another challenge which must be managed. For example, over the years, various terms or labels have been associated with MHL programs such as mental health promotion, suicide prevention, social-emotional learning, emotional regulation, or resiliency training (Hoover et al., 2019). While some evidence-based programs have been designed specifically for suicide prevention, MHL programs are often considered under the umbrella of

suicide prevention, as they raise awareness about risk factors and work to bolster protective factors against suicide, through increasing mental health literacy, increasing belongingness, and reducing perceived burdensomeness (Mann et al., 2021; Van Orden et al., 2010). Regardless of the specific terminology used, schools realize the value and significance of incorporating such programs into the school curriculum (Ayer & Colpe, 2022; O'Connor et al., 2018), as declining mental health can have a profound impact on all aspects of a student's learning and overall well-being (Singer et al., 2019). Research suggests there is a need to pay particular attention to communication with parents, as there has been a decline in trust in public institutions (including schools), worsened by all the complications and disruptions of COVID-19 (Cairney & Wellstead, 2021). Open communication with schools and communities about their needs and programing is vital to successful program delivery (Spoth et al., 2004).

Salerno (2016) makes several suggestions based on empirical evidence on how to best implement universal MHL programs into schools, including educating teachers and staff so they can serve as "gatekeepers" and refer students that may be struggling and educating the youth themselves to improve their own mental health literacy to help themselves and their peers (Salerno, 2016). Singer et al., (2019), complied the data which was available regarding suicide prevention programs to provide a prevention framework to present to schools with embedded multi-tiered systems of support (MTSS). MTSS is a familiar behavioral framework utilized by school districts across the United States where the level of intervention is determined based on the need of the students. Singer et al. (2019) utilized the MTSS framework to help schools understand and implement suicide prevention strategies at varying levels of intensity, aligning interventions with students' specific needs across universal (Tier 1), targeted (Tier 2), and intensive (Tier 3) support.

Universal Gatekeeper Programs for Staff. There are universal evidence-based programs available for staff to help them learn how to recognize signs of suicide in students, such as Question, Persuade, Refer (QPR) (Quinnett, 1995) and ASSIST (LivingWorks, 2011). These programs are known to be "gatekeeper programs" as they teach adults how to identify and respond to students that may be struggling and then how to screen and then refer the students to a mental health professional. Although they do educate staff on signs of suicide and what to do if they suspect a student is at risk, they have not shown how to reduce the rate of suicide in the student population (Springer et al., 2019). Nevertheless, experts argue the importance of having all staff adequately educated for them to identify the signs and refer students to the mental health professionals in the school to get the appropriate level of help (Hatton et al., 2016).

QPR and ASSIST are considered Tier 1 programs for schools, as teachers are trained to assess the entire study body (LivingWorks, 2011; Quinnett, 1995). Twenty-five states have mandated schools to have a crisis or suicide prevention plan in place, and QPR and ASSIST are often utilized within school response plans to assess the level of threat a student may be experiencing (Hatton et al., 2016). Once a student is identified, there are plans within each school to better serve those at-risk students identified for Tier II and Tier III support, including notifying parents, individual therapy, and outpatient care if needed (Erbacher et al., 2023; Springer et al., 2019).

Gatekeeping programs in schools could be a valuable approach in detecting students who may be suffering from mental illness that require subsequent care, but further research on both effectiveness and cost-effectiveness is critical (Ahern et al., 2018). Additional strategies are needed to increase the likelihood that students that need additional resources and support will

attend the follow-up meeting with a mental health professional after being identified by gatekeeping programs as needing more care (Ahern et al., 2018).

Universal Programs Designed for Students. Empirical evidence suggests that Tier I or universal programs may be more effective in schools, especially when compared to gatekeeper programs that identify students who may need additional support, and this may be due to the high levels of personal engagement universal programs provide, as adolescents may be reluctant to accept gatekeeper interventions (Hart et al., 2018; Wasserman et al., 2015). Examples of evidence-based, universal MHL programs include Signs of Suicide; Sources of Strength; teen Mental Health First Aid; and Youth Aware of Mental Health.

Signs of Suicide (SOS) (MindWise Innovations, n.d.) is an evidence-based suicide prevention program designed for youth. Schools often choose SOS because not only does it teach the students about mental health, but it also screens all students for depression and other risk factors associated with depression (Singer et al., 2019). SOS data have shown that youth who participated in SOS were less likely to report suicidal behavior and showed an improvement in MHL and knowledge (Schilling et al., 2016). A Connecticut study conducted in eight middle schools identified by the Department of Defense as having a high proportion of students with parents in the military, found that the SOS program decreased students' self-reported suicidal behavior 3 months following exposure to the program (Schilling et al., 2014). Students who reported pretest suicidal ideation in the intervention group reported fewer suicidal behaviors (ideation, planning, and/or attempts) at posttest (Schilling et al., 2014).

Sources of Strength, a peer-led, universal intervention in high schools, is a program that emphasizes eight “sources” of strength (mental health, family support, positive friends, mentors, healthy activities, generosity, spirituality, and medical access) and trains student peer leaders

alongside adult mentors to shift school culture and promote resilience. Wyman and colleagues (2025) report that the Sources of Strength program was effective in furthering protective factors such as youth-adult connections, help-seeking norms, and positive coping strategies, and ultimately reduced new suicide attempts by approximately 29%.

The teen Mental Health First Aid (tMHFA)program is a newer MHL program, and like Youth Mental Health First Aid and Mental Health First Aid, it aims to increase teens' mental health literacy, decrease stigmatizing attitudes towards individuals with mental illness, and improve help-seeking behaviors (Hart et al., 2018). tMHFA is designed for youth ages 16-18 and pilot studies for tMHFA in Australia found that the program is an effective and feasible program, that can be widely disseminated, and it can increase MHL in adolescents in the short term., However there is limited generalizability in the findings as the study did not include youth residing in rural areas (Hart et al., 2018). tMHFA is not widely used in Montana yet, and more robust research is needed on the program's effectiveness for rural and AI/NA youth.

The Youth Aware of Mental Health Program (YAM) is another universal or Tier 1 program that has shown promising results (Wasserman et al., 2015). However, Singer et al. (2019) incorrectly pointed out that YAM is not utilized in America. YAM has been implemented and researched in four states, Montana, Texas, Ohio, and Maryland. YAM was researched in the SEYLE study which was a large-scale cluster-randomized controlled trial across 168 schools in 10 European countries (Wasserman et al., 2015). The study compared QPR, YAM, and a control group that received information about mental health and found there were significant decreases in self-reported suicide attempts and severe suicidal ideation after twelve months for students who received the YAM intervention (Wasserman et al., 2015). When YAM was previously implemented in Montana and Texas, the researchers were not able to directly ask about suicide

attempts and ideation, but they did ask about risk and protective factors associated with suicide, and found that help-seeking behaviors, mental health literacy, and stigma surrounding mental health improved three months after the YAM delivery (Lindow et al., 2020). In addition, a feasibility and acceptability study conducted by Montana State University found that using Extension Agents to teach YAM was an effective way to improve the dissemination of YAM in rural areas, as the agents were skilled in delivery methods and working with youth (Bailey et al., 2022). A randomized controlled trial is needed in the United States to truly understand if the results would be comparable to the results of the SEYLE study in Europe.

Program Sustainability, Fidelity, and Acceptability in Schools

Educators Teaching Programs. One of the most highly recommended suggestions to schools, where possible, is to have school personnel teach MHL programs, as they often serve as the first point of contact for students and may notice changes in behavior or academic performance, which could be possible signs of emerging mental illness (Dimitropoulos et al., 2022). Having teachers implement MHL programs also reduces costs and increases the likelihood that the program will remain sustainable (Dinnen et al., 2024; Han & Weis, 2005). However, the majority of staff and teachers have a limited amount of mental health knowledge (Deaton et al., 2022; Walter et al., 2006; Yamaguchi et al., 2020) and are not necessarily confident in helping students with mental health problems. In fact, many are fearful that they may do "more damage than good" when trying to help students struggling with their mental health (Reinke et al., 2011; Yamaguchi et al., 2020). Unfortunately, teachers also indicated that a lack of available professional training and support were barriers to supporting students' needs (Dimitropoulos et al., 2022; Reinke et al., 2011). Most teachers in the United States begin teaching with little experience in mental health and have relied on school counselors or mental

health professionals within the schools to aid a student in crisis (Dinnen et al., 2024; Reinke et al., 2011). Pre-service teaching programs rarely include mental health courses, and that is especially true for those teachers that have been in the classroom for over two decades, as mental health has more recently been viewed as an important aspect of preservice educational curriculum requirements (Dinnen et al., 2024; Hatton et al., 2016).

To garner more information regarding how teachers felt about their role in suicide prevention and teaching mental health literacy programs, a study was conducted using a survey of 122 teachers participating in a pilot mental health promotional program. The study revealed that teachers overwhelmingly believed they should play a role in combating suicide, although there were significant barriers present that prevented them from intervening when a student was in a crisis or having suicidal ideations (Hatton et al., 2016). Such barriers included not feeling confident about mental health knowledge, fears of making a student feel worse, and fear of legal repercussions (Hatton et al., 2016). Therefore, in order to achieve successful implementation of MHL programs and suicide prevention programs, teachers need to be provided with in-service learning opportunities to improve their own MHL, increase their confidence when discussing mental health with youth, gain support from stakeholders, and understand how the program works and how it will be evaluated (Hatton et al., 2016; Reinke et al., 2011).

A literature review regarding the sustainability of universal mental health programs in school settings found that teachers are the key to ensuring a program’s success, although they warned program founders must be flexible in “real world” situations like school (Han & Weiss, 2005). The researchers also argued that it is imperative that teachers be provided with sufficient in-service development and have a complete understanding of the program's goals and assessments, as well as have the unwavering support of the administration, staff, community, and

other stakeholders (Han & Weiss, 2005). Such support includes relieving teachers of other responsibilities or providing them with extra time or resources to complete the program. If viewed as additional work, on top of all their other responsibilities, teachers may not complete the program with fidelity or simply not support having the program in the first place due to emotional burnout and having a low sense of personal accomplishment or limited opportunity to provide professional input (Han & Weiss, 2005). More recent studies have further expanded upon the notion that teachers need more training, support from administration, and additional time if they are going to be tasked with teaching not only their content subject, but about mental health as well (Dimitropoulos et al., 2022; Engler, 2023). Lastly, in order to address the mental health needs of students, there is a need for a systemic change, including additional funding, community support, better access to school-based mental health resources, and to bridge gaps in care to ensure comprehensive support for students (Deaton et al., 2022; Dimitropoulos et al., 2022; Engler, 2023; Han & Wess, 2005; Reinke et al., 2011).

Program Oversight for Fidelity. It is important that educators teach the program with fidelity; as such measures ensure program safety and efficacy (Han & Weiss, 2005). Ensuring program fidelity, or delivering interventions as intended, is crucial for the success of any evidence-based programs (Breitsenstein et al., 2010) and often requires oversight to ensure compliance (Durlak & DuPre, 2008). Moreover, when a program becomes established in the school curriculum and remains supported by stakeholders, it will more likely become feasible and sustainable. If program fidelity is not followed, it may be why interventions that work well in highly controlled trials may fail to yield the same outcomes when applied in real life contexts (Breitenstein, et al., 2010). Han & Weiss (2005) also noted the importance of utilizing a program specialist who can provide consultation for teachers while implementing and evaluating the

program. When administration allows, plans, and budgets for teachers to receive such consultation, teachers are guided and coached through the implementation and evaluation process. Such support is crucial to the teachers' ability to deliver the program in the way in which it was studied and intended.

Program Culture Adaptability. While most universal evidence-based programs have strict fidelity protocols, as youth safety is the utmost priority, there needs to be more research to explore ways youth universal evidence-based programs can be culturally adapted. Most, if not all, the MHL programs designed for youth have been developed and researched in urban areas overseas, in places with different cultures and varying views and beliefs regarding mental health and access to additional resources (Khan, 2005). Adapting evidence-based programs to fit local contexts is necessary but challenging. Over-adaptation can compromise fidelity, while under-adaptation can make the program less relevant to the target population (Durlak & DuPre, 2008). More research is necessary to discern if programs can be implemented following program protocol, while also being amendable to meet the needs of rural schools and communities.
In other mental health fields, most notably individual treatment for mental health conditions, there is literature available regarding what Kendall et al. (2008) refer to as "flexible within fidelity". This term refers to the fact that the evidence-based protocols were followed, yet there was room for contextual or individualized adaptation. Evidence-based protocols can be effective in a variety of settings, and they can be implemented flexibly and with fidelity (Kendall et al., 2008).

Lastly, another critique of strict adherence to protocols is that they are not applicable to youth with diverse backgrounds (Marrast, et al., 2016) and the research-to-practice gap is particularly large among minorities in the United States, demonstrated by lower utilization of

mental health services and lower quality of care (Kendall et al., 2008). Specifically, AI youth may have distinct perspectives on or approaches to mental health that may differ from the Western framework (Kleinman, 1998; O'Keefe et al., 2021). Therefore, interventions with AI/NA youth should be focused on cultural reassertion and revitalization by inviting local expertise to facilitate appropriate and meaningful cultural adaptations of evidence-based programs (Brave Heart et al, 2011; LaFromboise, 2006). Another strong suggestion to help improve mental health for Tribal areas is to train more Tribal members to become mental health professionals (Hughes et al., 2019; Miller et al, 2021). AI community mental health workers hold local understandings of history, culture, and traditional views of health and wellness and may reduce barriers to care while promoting Tribal health and sovereignty (Hughes et al., 2019; Miller et al, 2021; O'Keefe et al., 2021). Additional studies are needed to ensure that evidence-based programs are culturally acceptable and effective for rural AI/NA youth.

Conclusion

American adolescents have experienced increasing rates of mental illness, and a public health approach is needed to combat the alarming rate of youth suicide. This is particularly true in rural communities such as those in the Western Rocky Mountain region, where youth experience higher suicide rates due to a combination of geographical, socio-economic, and cultural factors. The region is characterized by vast distances between towns and limited access to mental health services, making it difficult for residents to seek timely care. The scarcity of mental health professionals, coupled with the stigma surrounding mental health issues, may be why many individuals decide against reaching out for help. A community-based public health approach is recommended to educate young people about mental health and increase their MHL so they can seek help for themselves and others. A growing body of literature highlights the

value of evidence-based MHL programs as effective tools for improving knowledge, reducing stigma, and promoting supportive behaviors among adolescents, with schools widely recognized as an ideal setting for implementation. Public schools provide consistent access to youth and offer a structured, developmentally appropriate context for addressing mental health, behavioral, and academic needs. Programs such as YAM exemplify evidence-based approaches designed to build MHL and resilience among students. However, because many evidence-based MHL programs were originally developed either outside of the United States or within urban contexts, limited research exists on their implementation, adaptation, and sustainability in rural and AI communities. This gap underscores the importance of examining how evidence-based MHL programs function within rural school systems and highlights the need for context-specific research to inform equitable, effective mental health prevention efforts. Accordingly, there remains a critical need for research that examines stakeholder perspectives, implementation conditions, and contextual factors influencing the success of evidence-based MHL programs in rural school settings.

CHAPTER THREE

METHODS

The methodology employed in this study used a pragmatic lens to develop a deeper understanding of how an evidence-based mental health literacy (MHL) program, such as Youth Aware of Mental Health (YAM), can be effectively delivered to rural students. The first section of this chapter outlines the context of the research and provides an overview of the community and program in which the study took place. The second section describes the participants who agreed to contribute to the study and explains the manner in which they were invited to participate. The third section details the methods that were used to discover the participants' perspectives related to rural youth mental health and the implementation of the evidence-based MHL programs, like YAM. The chapter concludes with a description of the methods used to code and analyze the data.

Research Questions

Considering the unique challenges faced by rural communities, such as limited access to mental health resources, geographic isolation, and heightened stigma surrounding mental health issues (Stark & O'Connor, 2011), there is a need for evidence-based MHL programs for youth that can be tailored to and delivered in rural places. Furthermore, to effectively deliver these MHL programs in a place-attentive and culturally responsive manner, there is a need to understand critical aspects of program delivery from the perspectives of the roles and experiences of various personnel who advocate for bringing the program to the school. Thus, the following research questions were developed to guide the current study:

1. Who and what needs to be present for the delivery of an evidenced-based MHL program in a rural school?
2. What outcomes of an evidenced-based MHL program in a rural school are identified by key stakeholders?
3. How could delivery of an evidenced-based MHL program in a rural school be improved?

Contextual Factors Informing the Study Methodology

The US has witnessed a sharp rise in youth experiencing mental illness throughout the last two decades (Bortz, 2019; Twenge et al., 2020). Approximately one in five youth (ages three to 17) have a diagnosable mental, emotional, or behavioral disorder (Bitsko et al., 2022; Cloutier & Marshaall, 2021), and one in ten have a disorder that severely impacts their ability to perform daily tasks (Kessler et al., 2005). Suicidal behaviors among high school students in the US have increased more than 40% since 2010 and is now the second cause of death for young adults (ages 15- 24) (Bitsko et al., 2022).

Research has also shown that rural youth are more likely to die by suicide than their urban counterparts (Graves, 2020; Graves et al., 2023; Prazak et al., 2025). Early intervention is critical in the adolescent years, as it may reduce the risk of suicide and lifelong problems associated with mental illness (Kieling et al., 2011; Krantz et al., 2023; Purtle et al., 2025). Therefore, addressing the increase in youth mental illness requires a comprehensive approach that involves taking these underlying factors into account. This includes promoting MHL, reducing stigma, providing access to affordable and culturally competent mental health services, fostering supportive environments within families and communities, and implementing preventive measures such as early intervention strategies in schools (Kieling et al., 2011; Read et al., 2018).

Rural communities, particularly those in geographically isolated areas, often face significant barriers to accessing mental health services, including long distances to travel for treatment, stigma, limited resources, and systemic inequities (McCall-Hosenfeld et al., 2014; Morales et al., 2020; Prazak et al., 2025). Furthermore, previous research has found that rural youth tend to have lower MHL (Jorm, 2012; Stark & O'Connor, 2011). This combination of challenges underscores the critical need for sustainable, evidence-based MHL programs that can be tailored to the specific needs of rural communities. This is particularly relevant to the state of Montana as the majority of schools in Montana are designated rural (National Center for Education Statistics, n.d.) and Montana students face significant mental health discrepancies and barriers to receiving help (Montana DPHHS, 2023). These challenges are critical to understand, especially when working to deliver mental health initiatives in Montana, including programs such as YAM, which aim to address some of these gaps in support for youth.

The PROSPER framework (Spoth et al., 2004) offers a helpful approach to understanding how universities, schools, and community partnerships can work together to foster resilience and well-being among rural youth by leveraging local strengths, building capacity, and implementing evidence-based prevention programs. This study examined the applicability of the proposed PROSPER+ Model in identifying the essential components required for effective delivery of an evidence-based mental health literacy (MHL) program in rural Montana communities, as understood through the perspectives of key stakeholders. The proposed model explores the ways in which designated program personnel housed in a university center or office may be able to provide structural capacity, administrative support, and oversight mechanisms necessary to ensure program fidelity, youth safety, and adherence to ethical and legal standards (Domitrovich et al., 2008; Fixsen et al., 2005; Israel, 1998).

Through a qualitative instrumental case study approach, this study collected data through one-on-one semi-structured interviews with 16 key stakeholders, including six Instructors (Extension Agents and community partners who teach an evidence-based MHL program like YAM), five Initiators (school staff who are instrumental in bringing the program to the school), and five Program Personnel (designated program personnel housed in a university-based office or center that are responsible for implementing evidence-based MHL programming). By grounding this study in the proposed PROSPER+ framework and utilizing an instrumental case study approach, the data collected through this methodology provided actionable insights for enhancing youth MHL programs in rural communities.

Research Design

A Pragmatic Approach

This study employed a pragmatic lens, as the pragmatic approach to research emphasizes practicality, relevance, and applicability (Creswell & Poth, 2018). According to Creswell and Poth (2018), a pragmatic approach allows researchers to focus on "what works" and this flexibility is especially valuable in applied research, such as exploring how evidence-based programs function in unique environments like rural communities. By focusing on outcomes and practical implications, a pragmatic lens ensures that the findings of a case study have both theoretical significance and real-world relevance. This study aimed to produce knowledge that would be useful and meaningful for addressing suicide prevention and MHL in rural youth. It is important to further understand the complexities of bringing evidence-based MHL programs to rural and Tribal communities. There is a critical need to understand the practical implications of MHL programs for youth where it may not only be difficult logistically to deliver programs, but persistent stigma surrounding MHL remains, and to develop meaningful, real-world solutions. In

addition, a pragmatic approach in research often involves engagement with key stakeholders to address research questions, interpret findings, and co-create solutions to ensure the research is relevant and responsive to their needs and perspectives (Creswell & Poth, 2018).

This study engaged key stakeholders (Instructors, Initiators, and Program Personnel) to further understand the increasing needs of rural communities and how to improve program delivery. While many of these stakeholders shared their experiences with the YAM program, several also discussed other MHL programs for youth and related experiences within schools and communities. These broader insights expanded the relevance of the study's findings beyond YAM or one single program and offered valuable considerations for the implementation of evidence-based MHL programs in general.

Instrumental Case Study

This study utilized an instrumental case study approach. This approach is especially valuable when the goal is not merely to understand the unique aspects of the case itself, but to use the case to explore and address larger research questions or gain a better understanding of policies, issues, or questions (Stake, 1995). Experts have indicated that by focusing on a specific case, researchers can generate findings that have direct relevance to practice, offering actionable insights for stakeholders seeking to implement similar programs (Stake, 1995). Thus, this study explored the case of the delivery of evidence-based MHL programs, like YAM, in rural settings from the perspective of the stakeholders most closely positioned to program delivery to develop insights into factors influencing MHL implementation in similar contexts.

An instrumental case study also enabled the exploration of contextual factors which impact the implementation of evidence-based MHL programs in rural Montana. By considering the specific circumstances, environments, and interactions within the boundaries of the case,

findings from this study will provide a deeper understanding of how these factors influence youth mental health and MHL programs (Stake, 1995).

Research Setting

The setting for the study was rural communities in Montana that have implemented youth evidence-based MHL programs, particularly YAM. These rural communities face unique challenges in delivering MHL programs and support. According to the National Center for Education Statistics (n.d.), Montana is considered a rural state, with one midsize city (Billings with a population of approximately 100,000), and four small cities (Missoula, Great Falls, Bozeman, and Helena). Most communities in Montana are considered “rural remote”, as they are more than 25 miles from an urbanized area. (NCES, n.d.). The "rural remote" designation highlights the geographic isolation that can affect service delivery, including access to resources. Rural areas often experience limited access to mental health resources, which can exacerbate mental health struggles, particularly among youth (Hartman et al., 2023; Stark & O’Connor, 2011).

YAM is a universal, evidence-based MHL program that allows adolescents to develop life-long resilience skills shown to help young adults avoid high risk behaviors that can lead to poor academic achievement, substance misuse, depression, and suicide (Wasserman et al., 2015). YAM was originally researched, developed, and tested in Europe in primarily urban settings with larger, more standardized classroom structures. Although the program has demonstrated strong effectiveness, its implementation protocols can present challenges when applied in rural contexts. The official YAM program protocol requires five sessions to be delivered over three to five weeks, mandates that no school personnel be present during delivery, and requires two trained adults in the room at all times. The program also specifies that the instructor cannot be part of the

school and, ideally, should have no prior relationship with the students, which is an expectation that is nearly impossible to achieve in small rural communities where people often know one another. Additionally, YAM sessions were designed for groups of approximately 20 students, a structure misaligned with many rural Montana high schools where class sizes are often far smaller due to geographic isolation and population sparsity. Lastly, program materials must be delivered as designed and cannot be modified.

In the United States, YAM has been implemented in Montana and Texas. Data collected from participating schools in Montana and Texas in the 2017-2018 school year found that help-seeking behaviors, mental health literacy, and stigma surrounding mental health improved three months after the YAM delivery (Lindow et al., 2020). In addition, a feasibility and acceptability study conducted by Montana State University in 2018 with participating rural Montana schools found that using Extension Faculty to teach YAM was acceptable, feasible, and sustainable (Bailey et al., 2022). However, given that YAM was designed in Europe with European cultural and geographic settings in mind, researchers recommended further research to more fully understand the complexity of implementation in rural settings and how to best address the needs of rural communities and explore complex topics such as MHL and stigma and risk factors associated with rural youth suicide.

By focusing on rural schools that implement evidence-based MHL programs, including the YAM program, this study explored how a MHL program is being implemented in rural settings where resources may be constrained and identified the factors that contribute to implementation success and challenges. Additionally, rural communities often have distinct cultural and social dynamics that may influence the effectiveness of MHL programs (Stark & O'Connor, 2011). Thus, the rural setting of this study provided an opportunity to better

understand the specific needs and outcomes of YAM in a rural context, which can inform future program development and improve MHL among rural young people. Furthermore, by delimiting the scope of inquiry to the people directly responsible for bringing evidence-based MHL programs to their communities, including Instructors who teach the program in Montana, Initiators who bring the program, and Program Personnel who manage the program, this study sought to identify specific aspects of strengthening MHL program delivery in rural settings. which led to rich and nuanced insights that can contribute to theoretical understanding and practical application.

Positionality Statement

As a rural researcher, it is important to engage in reflexivity and share my positionality (Atkinson, 2007). As the researcher undertaking this study, I acknowledge the influence of my own background, experiences, and beliefs on the research process and outcomes. I am a middle-aged, white, ciswoman, mother of two, from a well-off family, and all these components inevitably shape my worldview and approach to inquiry. I was raised in Central Montana in a rural place that centered around the agricultural seasons and the local school. My experiences growing up in rural Central Montana have undoubtedly influenced the way I perceive and interpret the phenomenon of mental health and suicide prevention, especially in rural schools. The fact that I am the product of a rural school and community strengthens my research. I have firsthand experience of living long distances from amenities and not having equitable access to resources, including mental health resources. However, I do acknowledge that every community is different, and although I grew up in a rural Montana community, I may lack nuanced insight into the cultural, social, and economic dynamics that influence program delivery in each specific rural setting. I recognize that this fact could limit my ability to fully capture the lived experiences

and context-specific challenges faced by participants. Therefore, as someone who grew up in a small town and has taught in rural schools, I bring an insider perspective to the communities and educational contexts under study. At the same time, I approach the research as an outsider, positioned within a university-based role and guided by formal research protocols. This liminal positionality allows me to navigate both the lived experiences of rural education and the analytical perspective of a researcher, providing a nuanced understanding of program implementation and community dynamics.

Additionally, my academic training and experience as a rural teacher have provided me with a particular lens through which I analyze data and construct knowledge. I was a rural classroom teacher after graduating from college, and I witnessed the effects that poor mental health can have on students' overall wellbeing and on their ability to learn. I noticed my students were experiencing higher levels of anxiety and depression and it seemed as though they had a difficult time managing their stress. Unfortunately, in the short span of three years, the school I was working at experienced a suicide cluster, where seven students died by suicide. The impact of such tragedies was far-reaching. I remember telling a colleague that we needed to try to understand the root cause of these situations and implement more preventive measures. Naturally, not knowing enough about suicide prevention at that time, I was not remotely sure what such measures looked like. I recall feeling overwhelmed and unprepared to manage the growing mental health issues in my students.

In 2018, our family moved to Bozeman, Montana and instead of teaching, I accepted a position at Montana State University (MSU) to become the YAM Program Manager. While I am not a mental health expert, the past seven years, through my position and doctoral research, I have learned a great deal about mental health and youth, the need for universal and evidence-

based programs in Montana, and the large mental health disparities experienced by rural and AI students. I have had the great pleasure and opportunity to work with several tribes in Montana while implementing YAM. I have learned the importance of listening intently and respectfully to the needs of marginalized communities and letting their community leaders and Tribal elders take the lead. I view my position as being present to provide a service that is responsive to their needs and have implemented YAM only when invited to do so.

I recognize that my positionality may introduce biases or blind spots into the research process. Despite efforts to maintain objectivity, my personal beliefs and values may inadvertently influence decisions regarding study design, data collection, and interpretation of results. However, I am committed to transparency and reflexivity throughout this research endeavor. To address these limitations, I have employed several strategies to strengthen the validity and credibility of this research. First, I have continuously reflected on my positionality, engaged in critical self-awareness, and considered alternative perspectives to mitigate potential biases. I have prioritized a participatory approach, engaging diverse stakeholders through semi-structured interviews to ensure their voices are central to the study. Second, I have triangulated data from multiple perspectives to mitigate potential biases. Third, I have employed reflexivity throughout the research process to critically examine how my assumptions and positionality may have influenced the analysis of the data. By acknowledging these potential blind spots and actively working to address them, I aimed to produce findings that are both rigorous and representative of the realities in rural Montana communities.

Ultimately, by openly acknowledging my positionality as a researcher, I sought to enhance the trustworthiness and credibility of this study while contributing to ongoing discussions about the role of subjectivity in research. I remain committed to meeting the needs of

our students, schools, and communities, as I know first-hand how much rural students could benefit from programs that can increase MHL, reduce stigma, and encourage help-seeking behaviors.

Participants

Purposeful Sampling

After receiving approval from the MSU Institutional Review Board (IRB) to proceed with my study in June of 2025, I began the process of participant selection. I employed Purposeful Sampling, as it involves identifying and selecting individuals or groups of individuals that are especially knowledgeable about or experienced with a phenomenon of interest (evidence-based MHL program for youth, particularly YAM) (Cresswell & Clark, 2011; Patton, 2002). Purposeful sampling ensured that the participants were relevant to the research questions and possessed the specific expertise needed to provide meaningful insights (Patton, 2002). For this study, I chose to interview people directly involved in the process of bringing and delivering evidence-based MHL programs, like YAM, to rural schools in Montana. These participants have firsthand knowledge of programs and experience in program implementation and include Instructors (could be Extension Faculty or a community member that are certified to teach the program to youth), Initiators (school staff that advocated for the program to be brought to the school), and Program Personnel (designated program personnel housed in a university-based office or center that oversee program delivery).

Creswell and Poth (2018) recommend interviewing people with diverse perspectives to enrich case study findings. To that end, these three types of participants had differing roles and brought varying perspectives to the study: Instructors teach the program, Initiators help bring the program to the community, and Program Personnel oversee and support logistical aspects of the

program delivery. It was important to include perspectives from multiple roles within the study to capture the full range of experiences, responsibilities, and insights on evidence-based MHL programs impact participants across different contexts. Although YAM served as the primary program context for this study, many participants also had experience teaching or implementing other evidence-based MHL programs. By focusing on those with direct evidence-based MHL program involvement, most notably YAM, purposeful sampling enhanced the study's ability to generate nuanced, context-specific findings that contribute to a deeper understanding of program impact and the broader implications for MHL programs in rural communities (Cresswell & Clark, 2011; Patton, 2002).

Description of Participants

Instructors, Initiators, and Program Personnel each have unique experience bringing evidence-based MHL programs, such as YAM, to rural schools. This makes each group distinctly positioned to discuss the factors influencing implementation, outcomes, and potential improvements. Purposeful invitation to participate allowed for the deliberate selection of individuals, who are all over the age of 18, who would be able to provide rich, detailed information about the challenges and successes of delivering evidence-based MHL programs in rural settings (Creswell & Poth, 2018). Currently, there are over 42 certified YAM Instructors in Montana, over 30 Initiators connected to participating schools, and 10 university-centered personnel who have experience with managing evidence-based MHL programs.

Through purposeful invitations, I conducted one-on-one semi-structured interviews with 16 people (including six Instructors, five Initiators, and five Program Personnel) in the late summer and early fall of 2025. The number of participants were chosen in alignment with expert recommendations that sample sizes in case studies range from four to 30 (Sharma et al., 2024).

Hennink et al., (2017) stress that in qualitative studies, saturation often occurs within 12-20 interviews. Therefore, 16 participants was a reasonable choice that ensured I captured unique perspectives while gathering rich and meaningful information on evidence-based youth MHL program implementation. Table 5 provides additional details about the study participants, including their demographic characteristics, background and experience, and education.

Table 5: Description of Participants

	Demographics	**Community**	**Background & Experience**	**Education**
Instructors	4 Males 2 Females Age range: 30-75	4 Rural 2 AI	4 have over 7 years of teaching experience. 2 have over 3 years of teaching experience. 3 are Extension Faculty. 2 are community partners.	1 Bachelor 4 Masters 1 Doctorate
Initiators	3 Males 2 Females Age range: 35-60	4 Rural 1 AI	Participants have combined over 95 years of experience in education.	1 Bachelor 4 Masters
Program Personnel	2 Males 3 Females Age range: 40-70	5 Rural	All have extensive experience in program oversight, research, and grant management.	3 Masters 2 Doctorate

Overall, the 16 participants represented a diverse range of backgrounds, professional experiences, and geographic locations, reflecting the wide range of individuals involved in delivering and supporting youth evidence-based MHL programs in rural Montana. Three participants from American Indian communities were intentionally included to ensure appropriate cultural representation and to amplify voices that have been historically marginalized

in rural education and mental health research (Braveheart et al., 2011). The remaining participants (N = 13) identified as White or non-Hispanic.

To maintain gender balance, nine women and seven men were interviewed. There was a slightly higher proportion of women among the participants, which accurately reflects the current demographics of Instructors, Initiators, and Program Personnel in Montana. Participants' ages ranged from their mid-30s to 70s, capturing insights across different stages of professional experience. All participants held at least a bachelor's degree, with thirteen holding advanced degrees, including three doctorates and three graduate degrees specifically in the mental health field.

Instructors. Of the six Instructors who participated in the study, five had taught YAM for over seven years, and one had three years of experience. Four of the six instructors also taught at least one other evidence-based mental health literacy (MHL) program. One instructor was based in a small city, while the remaining five represented rural and remote areas across Montana. Two instructors taught YAM and other MHL programs in predominantly AI schools. Three of the instructors were Montana State University (MSU) Extension faculty, for whom teaching YAM was a component of their professional duties rather than an hourly position. The other three were either community partners or individuals that were simply interested in youth mental health and volunteered to be trained in the program to give back to their community and provide a much-needed service to the youth.

Initiators. Five Initiators were interviewed, including two from small cities and three from remote communities. These participants held various roles within the educational system, including a district administrator, a teacher, a school counselor, and two principals. Thus, they were able to provide perspectives from multiple levels of school leadership. Collectively, the

initiators had over 95 years of experience in education, offering valuable insight into how MHL programs are perceived, supported, and implemented within districts in Montana.

Program Personnel. Finally, five university-based program personnel spanning three departments, including two centers, at Montana State University were interviewed. Their perspectives provided essential university system-level insight into the development, implementation, and sustainability of evidence-based programs in rural communities.

Invitation for Participants

According to Creswell and Poth (2018), inviting participants to a study involves a series of important steps to encourage voluntary engagement, demonstrate that ethical guidelines are being followed, and to establish transparency and trust. To accomplish these steps, a list was generated of all those who currently serve as Instructors, Initiators, or Program Personnel. From this list, a representative subset of participants who were well-versed and knowledgeable about their community and evidence-based MHL programs such as YAM, were generated and those individuals were contacted via email with an invitation to participate in the study. The email briefly explained the purpose of the study and why they were chosen. As recommended by Creswell and Poth (2018), participants received a second email with a formal invitation that included detailed information about the study, including its purpose, participant roles, time commitments, methods of data collection, and any potential risks or benefits, ensuring transparency throughout the process.

After the participants confirmed that they wanted to be part of the study, they were provided with an informed consent form that outlined their rights, including voluntary participation, the ability to withdraw at any time, that the interview would be recorded, and the confidentiality of their information would be protected. The consent form also clearly stated that

all identifying information would be removed from the findings to protect participant confidentiality. Participants had to sign the informed consent form to be part of the study. MSU IRB protocols were followed, and the interview protocol ensured cultural sensitivity, tailoring communication to respect participants' backgrounds and experiences (Creswell & Poth, 2018). Finally, the interview protocol maintained open communication and addressed any questions or concerns participants may have had and reassured them of a clear commitment to ethical research.

Data Collection Procedures

Semi-Structured Interviews

After receiving signed consent forms from the participants for the study, I conducted one-on-one semi-structured interviews in late summer and early fall of 2025 with 16 differing YAM stakeholders, including 1) Instructors (certified YAM Instructors that have delivered the program to students in Montana that have varying backgrounds and roles in the community, 2) Initiators (school administration, school counselors, or other personnel that were involved in bringing evidence-based MHL programs to their school(s) and community, and 3) Program Personnel (designated program personnel housed in a university-based office or center that oversee program delivery). These interviews yielded rich, in-depth data regarding critical aspects of delivery of YAM and other MHL programs in rural areas. The interview questions were designed to align with the research questions to elicit each of the participants' views of the program's current delivery and impact, as well as their suggestions for how to improve YAM delivery and impact in the future. By amplifying rural voices and perspectives, this study helped to create impactful findings that could lead to actionable insights and equitable solutions for diverse communities. Finally, this approach balanced the need for comprehensive insights with practical considerations such as time, resources, and the scope of the study.

The interviews averaged approximately 45 minutes in length, ranging from just under 20 minutes to nearly 90 minutes. Ten interviews were conducted in person, while six took place via Zoom to accommodate the considerable travel distances between locations and participants' scheduling constraints during the busy summer months. The interviews were recorded to ensure accuracy, and all the participants agreed to be recorded.

Semi-structured interviews are commonly used in qualitative research and are the most frequent qualitative data source in health services and educational research because this method is effective for collecting open-ended data and exploring participant thoughts, feelings, and beliefs about a particular topic (DeJonckheere &Vaughn, 2019). The interactive nature of semi-structured interviews fosters a conversational environment, encouraging participants to share rich and detailed accounts of their experiences and perceptions (Naz et al., 2022). In addition, the semi-structured interview format was chosen as it allowed for flexibility to explore unexpected themes or follow up on significant points raised by participants (Creswell & Poth, 2018). Such adaptability was essential for capturing the complexity and uniqueness of the case, particularly in diverse and context-rich environments (Naz et al., 2022).

Data collection followed a prepared protocol to ensure all participants received the same information and interview questions (Appendix A) that aligned with the research questions and overall purpose of the study. A pilot test using the interview questions was conducted with one individual who was similar to the participants to evaluate whether the questions elicited the intended depth of responses, to identify any unclear questions, and to estimate the amount of time needed for each interview (Creswell & Poth, 2018; Majid, et al., 2017). As a result, slight adjustments with the wording of some of the questions to ensure they were applicable to any evidence-based MHL program, rather than focusing solely on YAM specifically. This

preparatory step enhanced the overall quality and reliability of the data collection process, aligning the interview structure with the goals of the study (Creswell & Poth, 2018; Majid, et al., 2017).

In addition, I kept field notes during the data collection process to record my initial impressions, participant interactions, contextual details, and nonverbal cues that could not expressed in the transcripts alone. The field notes also served as an opportunity for me to take part in reflexivity to ensure credibility and transparency of the inquiry process. Reflexivity is important as it recognizes that researchers are not neutral observers, their perspectives can shape how participants respond and how the data is interpreted (Berger, 2015). Cresswell and Poth (2018) emphasized the importance of keeping a journal during the research process to allow the researcher to remain aware of their positionality and potential biases

Data Analysis Procedures

Recording and Transcribing Interviews

Creswell and Poth (2018) noted that in case study research, it is vital to record and transcribe interviews to ensure accuracy and facilitate in-depth analysis. For this study, all participants provided written consent for me to record the interviews. All interviews were audio-recorded using the iRecord application, which provided high-quality, secure recordings for accurate transcription. Recordings were stored on encrypted devices accessible only to me, and all identifying information was removed during transcription to maintain confidentiality. Recording and transcribing ensured that I had the participants' responses verbatim, hence minimizing the risk of losing critical information or their words. Recordings provided a detailed and reliable account of the conversation, allowing me to revisit the data as needed during the analysis phase (Creswell & Poth, 2018). As DeJonckheere and Vaughn (2019) pointed out, recording interviews is so important, as

it allows researchers to capture participants' exact words, tone, and nuances, which are critical for understanding the context and meaning of their responses.

As outlined in the MSU IRB, I told participants that I would send them a copy of the completed transcription for their approval. Therefore, I relistened to the interviews and checked the transcript for accuracy myself. I carefully corrected errors, which were minor, and most often involved names of people, towns, and acronyms and removed any identifying information. For example, one participant said he wore “many hats” in his small community, but it was transcribed as “mini hats”. Although this image may be amusing, it does show how important it is to have accurate transcription. “Many and “mini” may sound similar but they have quite different meanings, and it was important to have the transcripts be as accurate as possible. After receiving their transcript of our interview, I allowed the participants ten days to alter, amend, or add anything else that they felt was important to the conversation. Only one participant wished to clarify a point that they made in their interview.

According to Lincoln and Guba (1985), transcribing interviews in a case study is essential for ensuring the accuracy, credibility, and rigor of the research. Verbatim transcription captures participants' exact words, expressions, and nuances, preserving the authenticity of their responses (DeJonckheere &Vaughn, 2019). This level of detail was crucial for maintaining the credibility of the data and ensuring that interpretations were based on what participants said. Transcripts also provided a permanent and accessible record that enabled further analysis, such as coding and thematic exploration, which is more manageable and effective with written text than with audio alone (Lincoln & Guba, 1985). Additionally, transcripts helped establish an audit trail, a key element for ensuring trustworthiness, by offering a transparent and reviewable record

of data collection and analysis processes (Lincoln & Guba, 1985). Such transparency allowed for triangulation and participant review, contributing to the study's dependability.

Creating and Assigning Codes

Once the interviews were fully transcribed, I thoroughly read and reviewed each transcript multiple times, often while simultaneously listening to the interview, and recorded in my field notes any nuances that the written transcription could miss, such as emotion or emphasizing certain words or points for example. Many participants used strong language to express themselves, and this became much more apparent while listening to their voices, rather than simply reading it in the transcript. For example, phrases that were notably striking from the participants were, "It should not be that hard to save kids" (Instructor 4) or "Do not plan on walking into a classroom in my school to teach a challenging subject and not give something back!" (Instructor 2) These examples reflected the passion and conviction of the participants when talking about their work with and connection to evidence-based MHL programs for youth in their communities.

Using In Vivo Coding, I began the analysis by segmenting the complete interviews into smaller, manageable sections (Creswell & Poth, 2018). I highlighted key words or phrases that seemed significant and noteworthy, coding line by line. The highlighted segments were labeled with the exact wording used by the participants, which allowed for the preservation of their authentic voices (Saldana, 2021). Codes were then created by identifying key words or short phrases directly from the data itself, rather than relying on pre-established codes or theoretical frameworks (Creswell & Poth, 2018). It was not uncommon for one sentence to have multiple codes. I also noted emerging codes that I felt directly answered the research questions.

After reviewing the codes generated through In Vivo Coding during the initial round, step two of coding involved the method of Focused Coding. Focused Coding involves identifying

patterns and recurring themes in the data (Saldana, 2021). To organize and make sense of the data, I created a detailed codebook in Excel that included each code, its working definition, and the participants' exact words to ensure transparency and consistency in analysis. I began by coding the Instructors' transcripts first, the Initiators second, and Program Personnel third and organized the data into three worksheets in Excel. In total, approximately 86 codes emerged during this initial process. Although the codes were overwhelmingly similar for Instructors, Initiators, Program Personnel, distinct codes unique to each group's background, responsibilities, and perspective within the program did emerge. For example, the Instructors talked at length about the students during delivery of the program because they were the only group interviewed that taught the program, and as a result, had more codes relating to student engagement. In contrast, Program Personnel had more codes regarding sustainability than the other groups.

After the codes from all three groups were reviewed and refined, the data were merged into a single comprehensive yet evolving codebook that reflected patterns across all participant groups. I reviewed the codes looking at obvious duplicates (i.e.- "no resources" and "lack of resources"), fixed inconsistent naming (i.e. "community buy-in and "community support"), and updated code definitions. From there, I started grouping related focused codes (i.e. "resources") into potential categories looking for variances and similarities within the data and connecting them to the research questions (Saldana, 2021). This process resulted in a final set of 16 codes, four categories, and three overarching themes that reflected the core elements of program delivery, implementation, and improvement (Appendix B). Through multiple rounds of comparison and refinement, I continually revisited the research questions to ensure that each category and theme represented a key component of the study's purpose and inquiry.

Saturation was reached after the third round of coding when reviewing the codes no longer produced new insights, suggesting that the perspectives of key stakeholders regarding rural MHL program delivery had been comprehensively captured. Overall, data condensation and summarization were essential for maintaining the rigor and quality of the research, enabling me to draw meaningful conclusions and develop a clear understanding of the study's findings (Miles & Huberman, 1994).

Lastly, Constas (1992) stressed the importance of involving multiple coders in the categorization process to assess inter-coder reliability. By comparing how different researchers apply categories to the same data, consistency and validity can be checked and improved (Constas, 1992). It is recommended that 10 to 25% of the total transcripts be double coded to establish reliability and consistency (O'Connor & Joffe, 2020). To enhance the trustworthiness of the qualitative analysis, a second coder independently coded three transcripts, or 18% of the total transcripts, representing each participant type, including Instructors, Initiators, and Program Personnel. The second coder, a doctoral student from a separate academic department, was engaged to review the interview transcripts and the developed codebook. They possessed advanced methodological training and relevant qualitative research expertise, providing an informed and independent perspective on the coding process. The second coder used the same codebook, which contained detailed code definitions and quotes from the participants to guide consistent application. After independently coding, I met with the secondary coder to review discrepancies, discuss differing interpretations, and refine the codebook for clarity. This process ensured consistent understanding and application of codes across transcripts. Once consensus was reached and the codebook finalized, I completed coding the remaining transcripts. The steps

taken to resolve disagreements and refine the codebook support the credibility and dependability of the study's findings.

Study Reliability

To safeguard reliability in qualitative research, particularly in instrumental case studies, it is imperative to implement detailed and consistent procedures throughout the study (Quintão et al., 2020). This study clearly defined data collection and analysis methods to ensure consistency in how data were gathered and analyzed, and thorough documentation of all research activities was maintained during the study period (Creswell & Poth, 2018: Silverman, 2013; Quintão, et al, 2020).

Creswell and Poth (2018) use the term "thick description" to explain the importance of offering rich, detailed accounts of the research context, participants, and setting. By employing these strategies, this study increased the reliability of the case study and ensured that the findings reflected the real experiences and perspectives of the participants. The study also maintained an audit trail, which involved keeping a detailed record of all research decisions, processes, and the data analysis procedures. This allows for transparency and provides others with the ability to follow my thought process and decisions throughout the study. It ensures that the research process can be traced and validated by others (Lincoln & Guba, 1985).

Silverman (2013) also points out the importance of respondent validation, or member checking to improve reliability in case studies. Member checking was part of the research design as all participants in the study had the opportunity to review the transcripts and clarify or add to their responses as needed. Providing the participants with an opportunity to review their responses was important in ensuring that interpretations accurately reflected their views.

To increase validity, several strategies have been recommended by researchers to enhance the credibility, trustworthiness, and rigor of the findings (Creswell & Poth, 2018: Silverman, 2013; Quintão, et al, 2020). One important approach is triangulation, which involves using multiple data sources, methods, or perspectives to cross-check and verify findings (Silverman, 2013). For this study, three different types of stakeholders were interviewed, each offering varying perspectives, roles, and backgrounds that contributed to a more comprehensive understanding of the phenomenon. The diversity of the viewpoints supported triangulation, allowing findings to be cross verified across participant groups.

Lastly, reflexivity was an important component in data collection and analysis. Reflexivity refers to the process whereby a researcher discloses their biases and experiences, so the readers understand the position from which the researcher undertakes the inquiry (Creswell & Poth, 2018). This was especially crucial in this study, as my position is unique as serving both as researcher and YAM Program Manager. By engaging in reflexivity, I was better able to manage personal biases, foster transparency, and ensure that the findings genuinely reflected the participants' perspectives rather than my preconceived notions (Lincoln & Guba, 1985).

In addition to the importance of reflexivity and disclosure of any potential bias, having a great deal of knowledge about the program and prolonged engagement in the field can be beneficial and can increase the validity and credibility of the study (Creswell & Poth, 2018). Spending extended time in the field helps researchers immerse themselves in the setting and gain a nuanced understanding of the social, cultural, and environmental factors that shape the participants' behaviors, attitudes, and experiences (Creswell & Poth, 2018). I have vast contextual knowledge which was critical for interpreting the data accurately. My experience with implementing evidence-based MHL programs in rural spaces allowed me to understand the

nuances of participants' references to specific aspects of the programs that a researcher without familiarity with MHL programs might not possess. In addition, having been raised in rural Montana, I bring insight into the social dynamics, community ethos, and the unique challenges of rural places, allowing me to interpret participants' perspectives with sensitivity and understanding. Furthermore, prolonged engagement in the field allowed for data saturation, which helped to ensure that the study captured the full complexity of the evidence-based MHL programs in underserved communities.

Conclusion

This chapter outlined the research design, a description of the participants, data collection procedures, and analytic methods used to explore the perceptions and experiences of those involved in implementing evidence-based MHL programs for youth in rural places. Strategies to ensure credibility, dependability, and ethical integrity in the research process were described. Together, these methods provided a foundation for understanding how evidence-based MHL programs, like YAM, are experienced in rural settings.

CHAPTER 4

RESULTS

The purpose of this chapter is to present the participants' perspectives on program challenges and support, the value and effectiveness of the program, and the opportunities for improving delivery and ensuring sustainability in rural settings. The chapter offers a brief overview of the study, the participants, description of the data analysis, and the results of the study which answer the three research questions.

Introduction

Since 2010 there has been a concerning rise in mental illness among youth in America, including increasing rates of suicide (Fontanella et al., 2024). Montana is no exception, as suicide rates are consistently higher in rural areas compared to urban regions (Montana DPHHS, 2024), a disparity linked to factors such as limited access to mental health care, greater geographic isolation, and persistent stigma surrounding help-seeking (Fontanella et al., 2024). The rural/urban suicide rate gap has widened in recent years, underscoring the urgent need for tailored prevention and intervention efforts in rural communities (Graves et al., 2020). Evidence-based mental health literacy (MHL) programs for youth have typically been developed and studied primarily in urban settings, where multiple large schools within close proximity create favorable conditions for program implementation (Barnhorst et al., 2021). In contrast, far fewer initiatives have been designed to address the unique realities of rural youth, where critical questions arise about how to bring a program into the school, who is qualified to deliver it, and who will assume responsibility for funding, implementation, youth safety, and evaluation.

Purpose of Study

The purpose of this instrumental case study was to garner insights to guide the expansion of youth MHL programs, as well as for scaling evidence-based programs across rural communities in the United States and beyond. In addition, this study sought to contribute to identifying best practices for applying the PROSPER+ model to the dissemination of evidence-based MHL programs in rural contexts, as well as guiding the possible adaptation and scaling of such programs across rural settings. The PROSPER (PROmoting School–community–university Partnerships to Enhance Resilience) model effectively highlighted the role of university Extension programs and state and community partnerships in sustaining evidence-based prevention programs in rural communities (Spoth et al., 2004). However, the proposed PROSPER+ model was designed to expand the original model and examine the importance of having designated program personnel housed in a university-based office or center dedicated to managing every aspect of grant and program administration, including funding oversight, implementation, training, and evaluation, while also emphasizing the importance of forming community partnerships to increase sustainability (Domitrovich et al., 2008; Durlak et al., 2008). Moreover, it was important to explore the reasons why a university should house an evidence-based youth MHL program, and the PROSPER+ model sought to provide a framework to examine the university's role in providing legal, ethical, and safety oversight to safeguard both youth participants and those involved with implementing the program (Fixsen et al., 2005; Domitrovich et al., 2008; Durlak et al., 2008).

Data Collection

After receiving approval in June of 2025 from the MSU IRB for the study and obtaining consent from the participants, data were collected through one-on-one semi-structured interviews

in the late summer and early fall of 2025 in rural towns (and two small cities) across Montana. Purposeful sampling was used to invite 16 adult participants in order to ensure that everyone who was interviewed was involved with implementing an evidence-based MHL program in a rural school throughout Montana, either as an Instructor (taught the program), an Initiator (instrumental in bringing the program to the school), or Program Personnel (oversaw all aspects of a program). The interviews lasted on average for 45 minutes, with the shortest being just under 20 minutes and the longest being almost 90 minutes. Ten of the interviews were conducted in person, while six were conducted over Zoom due to the large travel distances needed to reach some of the participants, or due to scheduling conflicts during a busy summer.

All participants signed consent forms and agreed that I could record the interview for accuracy. I used iRecord, a recording and transcription application, to generate initial transcripts. I reviewed the recordings carefully and corrected errors, which were minor, and most often involved names of people, towns, and acronyms. As outlined in the MSU IRB and in the consent letter signed by participants, all identifying information was removed from the interview transcripts to protect participant confidentiality.

Participant Demographics. The study included 16 participants representing a range of roles, including six Instructors, five Initiators, and five Program Personnel, from Montana who collectively added insights on implementing evidence-based MHL programs, like YAM, to youth in Montana. Three participants were from American Indian communities to ensure appropriate cultural representation and that diverse voices were included. The rest (N=13) of the participants were white or non-Hispanic. The youngest participant was in their mid-30's and the oldest participant was in their 70's. Lastly, all participants hold at least a bachelor's degree. Fourteen of the sixteen participants have advanced degrees. The study included nine women and seven men.

Data Analysis

The interviews were recorded and transcribed and once I reviewed and corrected the minor errors on the transcripts, they were sent to the participants to ensure accuracy. The participants had the opportunity to amend, retract, or add to their comments. Only one participant wished to add more information to clarify a response. Participants were assigned numerical identifiers based on their role in the study, Instructor, Initiator, or Program Personnel (e.g., Instructor 1, Initiator 1, Program Personnel 1), and are referred to by these identifiers throughout the findings. This approach ensured that individual responses could be linked to their role for analysis while maintaining anonymity.

Research Questions

The research questions were:

1. Who and what needs to be present for the delivery of an evidenced-based MHL program in a rural school?
2. What outcomes of an evidenced-based MHL program in a rural school are identified by key stakeholders?
3. How could delivery of an evidenced-based MHL program in a rural school be improved?

The findings are organized into three overarching themes which align with the corresponding research questions: (RQ1) Essential Personnel and Resources Needed by Rural Schools for Delivery of an Evidence-based MHL Program, (RQ2) Observed Outcomes of an Evidenced-based MHL Program in Rural Schools, and (RQ3) Improving Program Delivery and Sustainability. Within each theme, categories and codes derived from participants' responses are presented to provide a rich understanding of the factors influencing MHL program implementation in rural contexts. Representative quotes from participants are included to highlight key insights.

Additionally, the findings were organized by participant roles (Instructor, Initiator, and Program Personnel) to highlight the unique perspectives and experiences each group contributed to program implementation and to better illustrate how their distinct roles influenced their perspectives related to delivering evidence-based MHL in rural schools. Naturally, certain topics elicited more insights from participants based on their responsibilities and experiences. Organizing the data in this way also ensured that voices from each participant group were equally represented throughout the analysis.

Presentation of Findings

The findings highlight key insights on evidence-based MHL program in rural settings from participants (Instructors, Initiators, and Program Personnel). Illustrative quotes are included to highlight both commonalities and unique viewpoints across participant roles. The findings are organized under headings that directly correspond to and address each of the study's research questions.

Essential Personnel Needed by Rural Schools for Delivery of an Evidence-based MHL Program

Research Question 1 explored who and what needs to be present for the delivery of an evidence-based mental health program in a rural school setting. While participants acknowledged that delivering evidence-based MHL programs in rural areas presents significant challenges, they emphasized that implementation is feasible. To answer the first part of Research Question 1, *who* needs to be present for successful program delivery, participants revealed that there are four types of essential personnel including: a designated person at a university-center or office to manage the program; skilled local instructors; engaged community partners; and trained school staff.

Designated Program Personnel at a University-Center of Office. There was a strong consensus from all participants regarding the vital role a university-based center or office, in this case, the Center for Research on Rural Education (CRRE), plays in program management and delivery. Participants consistently acknowledged that the designated person that manages a program in a university-center or office is necessary personnel for successful delivery of evidence-based programs. Several participants noted that YAM was selected because it is an evidence-based program and the fact that it is supported by a designated program personnel member in a university-based office or center, provided credibility and reassurance to schools seeking a proven approach, particularly when addressing a potentially sensitive topic such as youth mental health. They noted that the CRRE also carefully manages liability for the YAM program by overseeing and following strict safety protocols, obtaining appropriate permissions, and ensuring staff are properly trained and supervised. Designated program personnel within the university office or center worked closely with the Montana State University Institutional Review Board (IRB) and the necessary Tribal IRBs to ensure all research activities were conducted ethically and in compliance with regulations for research involving minors. This collaboration ensured appropriate approvals, protections, and culturally responsive safeguards were in place prior to and throughout the study. In addition, participants talked about the importance of the way the CRRE provides and manages grant funding, communicates with schools and community partners, schedules program delivery and training, serves as the liaison between program founders and instructors, oversees program evaluation, and managing day-to-day operations. Evidence-based programs often require greater financial investment and oversight, and participants emphasized that their proven effectiveness and positive impact on youth mental health make these programs essential despite the challenges. The participants were

clear: without a designated person managing the program at a university-based center (CRRE) or office to manage the program, it would be nearly impossible to bring evidence-based programs to youth in rural settings. The Program Personnel especially stressed that program oversight at a university-based center is crucial for any evidence-based program. These participants are university employees who have, at some point, managed programs themselves. They recognized the critical role of having institutionally grounded structures in place to ensure structure, safety, sustainability, and credibility for these programs. Their key insights are summarized in Table 6.

Table 6: Role of a University-based Office for Evidence-Based MHL Programs

Unique Contributions of a University-Based Office for MHL Programs	**Participants' Perspectives**
Securing and Managing Program Funding	"The funding is so important. The center (CRRE) provides us with this program with no fee and then comes to us. I think that's invaluable." Initiator 2
	"Without you guys (CRRE) having gone after the grants, I wouldn't have a YAM program anymore." Instructor 2
	"Without MSU and the grants, it wouldn't happen. We don't have the funds to do it on our own." Initiator 5
	"Grants make it possible to implement YAM in rural schools without burdening the district." Instructor 1
	"Because we've been able to, by and large, support YAM through grants at MSU." Instructor 3
	"The help with the funding (grant) is so important." Initiator 3

Table 6 Continued.

Unique Contributions of a University-Based Office for MHL Programs	**Participants' Perspectives**
Providing Program Oversight	"You have to have someone. A center... To manage it all. We don't have YAM without the Center for Research on Rural Education. Without someone doing the training, recruiting people, writing checks, getting the money, etc." Program Personnel 5 "They (the CRRE) are doing all the work behind the scenes. You have to have someone to make sure that the program has enough structure and oversight. I mean, anytime we deal with youth or any audiences that, you know, are somewhat vulnerable. You know what I mean, you're doing things correctly, by the book." Program Personnel 4
Providing Program Credibility	"The Center helps to have the press releases, handouts, infographics ready to go…MSU supporting YAM has made it legitimate and easier to get it into communities." Instructor 6
Providing Program Research	"The handouts, the information, the research behind YAM is key." Initiator 2

Dedicated and Skilled Local Instructors. In addition to having a university-based designated person manage the program, participants also noted that having a skilled and dedicated local instructor is essential for program delivery. They highlighted that local instructors understand the unique context and culture of the community, particularly MSU Extension Faculty, who are typically community members themselves. Participants also said that the quality of the instructor matters. For example, they said that instructors that are objective and genuinely enjoy working with youth were essential personnel necessary for program delivery and

effectiveness. They pointed out that instructors do not have to be mental health specialists, they just need to be someone that the youth feel they can talk to.

Several instructors talked about the power of having a local person deliver the program. Instructor 5 emphasized that, “It helps to have local people doing the facilitating,” and Instructor 4 said, “Extension has taught students in small towns, and that has worked beautifully in our state.” Instructor 1 commented that both her and the assistant, “have recognizable faces” in the community. Others commented on the teaching traits and skills that local instructors should have. Instructor 2 commented, “You want to be there. You have to have interest in today's teens. They will know if you are real or fake…do not plan on walking into a classroom in my school to teach a challenging subject and not give something back.” Instructor 3 said, “Instructors have to be willing to recognize that mental health is important and willing to learn and make an impact on youth. You have to be vulnerable.” Instructor 5 felt that someone with an educational background may be better suited to handle the behaviors that come up in the classroom when teaching a program. “It is helpful to have a background as a teacher for classroom management. The ability to regain control and reign it in, without having an emotional rise yourself is key.”

Initiators echoed those sentiments around previous experience with classroom management. For example, Initiator 2 said, “If somebody comes in and they’ve never really worked with that age of student if the students tune them out, it doesn’t matter how good the content is.” Likewise, Initiator 3 said, “They need someone who understands kids. I think it is helpful to have people with an educational background. Also, someone who is caring.” Initiator 1 stressed that instructors need to be objective and not part of the school staff, especially in a small town, yet still understand the culture of small towns. They stated, “Having someone objective, you know in case you run into ‘I don't want to talk (counselor) because she knows my

mom' is so helpful. You (the instructors) understand this community, but you don't teach here… that's a good thing." Initiator 5 also highlighted the importance of a local instructor, "It is important that (the instructor) is from here, they know the community, the kids, the culture. They are from here, they know what is going on."

Program Personnel 2 also felt that local instructors, most notably MSU Extension Faculty, were key to program success. They noted that "The extension people are out there, in the rural communities, they can help you (teach)… and they need to relate to middle/high schoolers and have the ability to connect with kids." Program Personnel 1 also acknowledged the role that MSU Extension Faculty played in getting programs, particularly YAM, to remote areas in Montana, "Extension Agents can get to places in their county easier than someone located in Bozeman. They know their communities too." Program Personnel 4 said that local instructors are important because "Knowing people around the community and having administrators trust you is important." Program Personnel 3 noted that local instructors should have some kind of background "understanding adolescent development and experience with kids" to be an effective instructor.

Overall, participants felt that the local, yet skilled, instructors were the "heart of the program" and their ability to work with and connect with kids is one of the most important aspects of program implementation and sustainability in rural places. Many of them stated they believed someone with an educational background and experience could be helpful, but not necessarily a requirement. Participants overwhelmingly felt that the quality of the instructor and their ability to understand the community and relate to the kids they were teaching were essential elements of a successful delivery program.

Community Partners. A significant component of implementing an evidence-based MHL program in rural areas is the strength of community partnerships. Participants highlighted the importance of developing strong community partnerships, particularly with local businesses, medical professionals, and nonprofits with similar goals, as a key strategy for enhancing collaboration, resource sharing, and long-term program sustainability.

Three of the five Instructors have partnered with their county or Tribal Health Department and stated that their partnership has been invaluable. Instructor 1 stated that having the county nurse be a YAM assistant has helped destigmatize mental health and help-seeking behaviors. They stated, “Having the public health nurse involved really makes it clear that talking about your feelings is as normal as going to the doctor for a checkup.” Instructor 2 said that partnering with their health department has allowed YAM to train more instructors where teaching the program is part of their job, thus making the program “more cost effective and sustainable,” and Instructor 3 feels that they, “Are able to get into the schools because of my connection with the County Health Department.”

Initiators also recognized that community partnership is a smart way to approach program delivery, especially in rural places where resources are lacking. Working together to share or pool resources is essential. All Initiators stressed that the school’s community partners were important to bringing and keeping evidence-based MHL programs in schools. Initiator 4 stated, “Without community involvement and coordination, it would be a lot more difficult to put all of those things because you have to have access to professional providers, mental health providers, and you can't do that within the school system. That has to be a community effort.” Likewise, Initiator 2 said, “It was important to work with providers in the community and being able to offer resources or connect students with resources.” Initiator 3, when referring to community

partners becoming YAM Instructors said, “Qualified professionals from the community helping to relay this information is important.”

Program Personnel consistently talked about community partnerships, but their focus was primarily on sustainability and support for the county Extension Faculty. Three of the five Program Personnel noted that MSU Extension faculty often serve vast geographic areas and juggle multiple programs to meet diverse community needs, making it especially valuable to partner with others who share a common vision and commitment to improving youth mental health. Program Personnel 4 said, “Partner with local hospitals, it could be win-win for everyone. Help get their message out, help get your program taught, but also utilize their resources.” All participants communicated that it was good practice to join community partners to support program implementation in rural communities, especially in areas with high needs and very few resources.

Trained School Staff. Several participants pointed out that there are staffing shortages throughout the state. In rural areas, frequent staff turnover, such as new principals, teachers, or school counselors, makes it difficult to establish continuity, often forcing instructors, initiators, and program personnel to rebuild relationships and restart efforts to bring programs into schools. Instructor 3 noted, “We have had at least three superintendents and three to four principals and three counselors in the last few years.” Instructor 1 noted that their town has staff turnover every year, which resulted in them going directly, “To the school board to ensure that regardless of the superintendent or principal, our students can have the program (YAM).” Furthermore, participants noted that new or untrained school staff may be unfamiliar with the program’s content and procedures, leaving them uncertain about how to respond appropriately when students seek help. Initiator 2 said, “Huge staff turnover happens, so it important to continue to

update the staff about programs so they can understand their purpose and get on board…and even use the same language of the program so we are all on the same page"

Other participants noted that not every rural school has a certified school counselor or if they do, they often have to share with neighboring schools, which can impact program delivery. Most evidence-based programs require a school to have a clear safety protocol, which typically mandates the presence of a school counselor or designated staff member on site before the program can be delivered. Initiator 4 noted that schools may be apprehensive to even invite the program in without a strong school counselor, "You need to have counselors that can handle the uptick in help-seeking behaviors after a program like YAM. It is a good thing the students are seeking help. If you don't have a school counselor that is prepared, you should probably not have the program." Initiator 4 quickly pointed out that school counselors are primarily trained to support students with academic planning and career preparation and are not always prepared to focus exclusively on mental health concerns, "Our counselors aren't necessarily trained in mental health, so there is a disconnect between their training and their everyday reality." Initiator 4 went on to say that pre-service curriculum may need to be changed for future school counselors to meet the needs of the increasing mental health concerns of youth. "They are simply not taught all of this. Something probably needs to change at the collegiate level or what classes they take to better prepare them." Program Personnel 2 echoed that sentiment, "Counselors also have to see to students' academic and post-high school needs. They were not necessarily trained in mental health or crisis intervention."

Participants collectively agreed that it is critical to provide schools with trained staff who can provide guidance and connect students with appropriate help when needed. Having

identifiable and trained personnel not only reinforces the lessons taught through mental health programs but also ensures that students know where to turn if they are struggling.

Essential Resources Needed by Rural Schools for Delivery of an Evidence-based MHL Program

The data also revealed key insights into the second part of Research Question #1 regarding *what* must be in place to effectively deliver evidence-based MHL in rural schools. The evidence revealed four essential factors identified as critical to ensuring successful program implementation in rural settings: Responsiveness to School and Community Needs; School and Community Buy-in; Adequate Funding; and Flexible Program Structures.

Responding to an Identified Community Need. All 16 participants reported that their involvement in an evidence-based MHL program began because they were responding to their community's identification that their youth required mental health support and services. Eleven of the 16 participants specifically mentioned youth suicide as the driving factor in their decision to be involved in bringing a MHL program, like YAM, into their local schools. For example, Instructor 4 stated, "The school asked us to come in after a suicide cluster to provide support…I wanted to be on the preventative side of this. We knew we had to do something different." Initiator 2 said, "It was the outcry, that might be the wrong word, but from the community, that we need a training for mental health awareness…we were starting to see mental health issues very present in our kids." Likewise, Program Personnel 2 and 5 told me that they had specifically been asked by the school district to help them with the youth suicide problem. Program Personnel 2 commented, "The ripple effects of having anybody die by suicide within a community are profound. They began looking to us asking us what we could do about rural mental health." Overall, participants emphasized that their work in youth evidence-based MHL

programs was driven by the urgent need to address rising rates of youth suicide and mental health challenges and to ensure that young people have access to critical support, including approaching the problem as a prevention effort. In addition, the evidence was clear that youth mental health was a problem that was identified by the community, not necessarily a need identified by an outside entity telling the community what to do.

School and Community Buy-In. While identifying a community need is essential, it is equally important to secure support and buy-in for the proposed solution. School and community buy-in refers to the collective support, commitment, and active participation of educators, administrators, parents, and community members toward the successful implementation and sustainability of a program (Israel et al., 1998).

All sixteen participants, regardless of their role in bringing evidence-based programs to schools, repeatedly talked about recognizing the problem of youth mental health and then emphasized the importance of community and school buy-in. The participants expressed variations of the same idea, which can be summarized as follows: even the most well-researched and evidence-based program cannot succeed if the school or community does not support its implementation. Participants emphasized that community and school buy-in depended on several key factors, including: 1) building relationships and trust, 2) transparency, and 3) having local instructors who understand the community context. They also noted that 4) having an influential community champion to help open doors was often essential for gaining buy-in and successful program implementation.

Several Instructors emphasized that these four factors are even more true for Tribal communities, where trust and relationship-building are deeply rooted in cultural values and history, and where outside programs must demonstrate genuine respect, consistency, and

collaboration to be accepted. Instructor 2 stated, “A relationship has to be built with the school, and it has to be built on trust. Especially in Tribal communities.” Likewise, Instructor 5 said, “It helps to have local people doing the facilitating. If it is local they see it more as a we’re doing this for you or with you, where if it is someone from out of town, then they're doing it to you.”

Initiators all commented on the importance of having the communities’ support, but also having staff buy-in. They noted that educating the community and staff about the program and being as transparent as possible is key to getting programs approved and implemented. Initiators 2 and 3 essentially said the same thing, Initiator 2 “Buy- in from staff is the biggest thing, because, you know, it is taking some of the class time. Teachers need to know what the program is about.” Initiator 3, “For the teachers to buy- in, they need to know what is being taught. We need to have that language across the school.” Initiator 5 spoke about how it was important that he himself was educated about the goals of the program but noted the importance of having a local instructor who has built a relationship with the school based on trust, “Without her (the instructor), I am not sure we would be willing to have the program.” Therefore, the community, staff, and administration, and local instructors all must be on board to successfully implement an evidence-based program in rural schools.

Program Personnel echoed the sentiments of Instructors and Initiators regarding community and school buy-in, especially in Tribal Communities. Program personnel emphasized that communities must first recognize there is a problem and be open to seeking help. They noted that successful implementation often depends on a trusted local champion who can build trust and help bring the program into the community. Program Personnel 3 said “I can't go into a community as an outsider and deliver a message that some people do not want to hear, which feels very different than when the community is asking for services.” Program Personnel 4

noted that a community champion, someone who is trusted in the community and can act as an "agent of change" may be the right person to get a program into a school. They shared, "Having someone locally coming to you and saying, here is the problem and we are looking for a solution." Correspondingly, Program Personnel 5 emphasized that the administration, the community, or even the state government need to be incentivized to support evidence-based MHL programs in schools. Program Personnel 5 argues that if the school is not incentivized to address mental health, they will be incentivized "by someone else to address something else." They also argued that if the school needs to understand "That if mental health starts to go wrong in their school or behavior health, or substance abuse, it will screw everything up. It will derail whatever it was academically you were working on." Program Personnel 5 also goes on to say that a community champion is often needed.

> "You want a community to buy-in? You need a champion. Somebody that has the incentive to improve kids' mental health. The world runs on incentives. Someone needs to incentivize the school. They need to make the connection between student achievement and mental health…but if they don't exist, you're not going to be able to successfully bring these into that school. But if they do, you then need to help them find that program."

School and community buy-in for evidence-based MHL programs depends on multiple factors, including building trust, maintaining transparency, engaging local instructors, and relying on influential community champions to help facilitate program adoption. These elements collectively increase the likelihood that schools will welcome and sustain such programs.

Adequate Funding for Schools and MHL Programs. In addition to bringing a program to address a problem identified by the community and accepted by the community, adequate funding is needed not only for our schools in general, but also to deliver evidence-based MHL programs in rural settings. Without consistent funding, many rural schools lack resources and

adequate staffing to provide mental health support and services. Montana has one of the highest youth suicide rates in the country (Montana DPHHS, 2024), and with the pronounced shortage of mental health professionals, and counselors and teachers in the schools, students are left without access to critical support. Thus, to successfully deliver evidence-based MHL programs, rural schools need additional resources.

Instructor 1, 4, and 6 summed up the lack of resources in their areas by simply saying, "We do not have resources." Instructor 2 said, "We had no mental health programs in the school. But it felt important to bring YAM to a small rural community, such as mine." Initiator 4 stated that, "Teachers were scared… to give out grades to some kids because they were worried it would trigger something happening with that student, and we have no resources to provide if that student were to be dealing with a mental health crisis." Program Personnel 5 said, "For evidence-based programs resources are the biggest barrier. We have scarce resources in communities like this." Program Personnel 4 said, "Just recognizing the varying degrees of access is important. In so many communities, there just aren't any resources." Program Personnel 1 said, "One of the most precious resources is time, trained instructors, and money and a lot of these schools do not have any of these things. So many schools have no resources at all." The participants stressed that even if there was funding to bring evidence-based MHL programs to schools, there were very few resources available if a student was identified as needing extra support.

Additionally, the costs of programs can create challenges both for staffing and sustaining program delivery. Costs often include licensed materials, instructors, and implementation support to maintain quality and measurable outcomes. Additionally, evidence-based MHL programs for youth are expensive because they require ongoing training, program fidelity monitoring for safety, and evaluation to ensure effectiveness. Participants from each of the three

program roles identified cost as a significant challenge and highlighted that grant funding is what has kept many programs afloat. For example, Instructor 1 said when approaching administration about implementing a program, “It’s a lot easier of a conversation… when I don’t come in with a price tag.” This participant was explaining how they felt they were able to get into the school because they were offering the program for free due to grant funding support. Instructor 4 noted these expenses, “Evidence-based programs are expensive. It costs a lot for booklets, slideshows, posters, and the physicality of what we bring into the classroom. We need to pay instructors to drive across the state.” Initiator 2 noted that without some financial support from grant funds, their school would be unable to deliver programs, specifically YAM, “It certainly helps that program costs are partially covered through grant funds.” Initiator 5 said, “YAM is 100% vital to our school. I hope we can keep it going with funding.” Program Personnel 1 also said, “I suppose anyone could find some information online about mental health and teach it to kids, but in order to bring evidence-based programs, ones that we know are safe and can work, cost a lot of money.”

Regarding lack of substantial state funding for mental health programs and additional resources, Instructor 2 said, “It’s sad that its money that keeps us from saving lives….and in this day and age it is almost impossible for a school to have the means to fund programs.” Instructor 4 echoed that sentiment, emotionally stating, “It should not be this hard to save kids… there is no willingness by government officials to fund evidence-based programming.” Instructor 5 highlighted that American Indian students may have even fewer culturally appropriate resources, “There is a need for mental health support, especially in indigenous communities... I would love to see it happen (consistent funding), I am jealous of Texas and the state funds they receive, a firm fiscal support is what is needed.” Instructor 3 said, “It would be nice to have support from

the state or help in knowing how to implement a K-12 comprehensive MHL program." Instructor 1 pointed out that educational cuts to arts and humanities have hurt students in the classroom as well, "The classes that would have kids talk to their teachers, you know, classes you can express yourself, don't exist. Art is gone. Music is gone."

All five of the Initiators commented on the cuts to public education and how they have been harmful to their schools and young people. Initiator 4 summed up the perspective of all Initiators when saying, "We have a lot of needs. A growing number of needs in fact, but very few resources. With the school budget costs, programs can be cost prohibitive." Initiator 2 said, "Our funding is getting cut off and we may not be able to continue to fund this kind of thing (MHL programs)." Along the same lines, Initiator 3 said, "With all the cuts to education, it is scary. There was money allocated for mental health specifically, but it has just been cut."

Program Personnel participants also highlighted the importance of funding, including federal funds. Program Personal 3 commented, "Evidence-based programs and trainings are expensive…most of these agents don't have the kind of county level budgets where they can pay and I don't have the operations funding." Program Personnel 1 said, î The schools don't have enough money to train instructors or buy program supplies."

Overall, the participants acknowledged the importance of grant funding in keeping programs like YAM in schools. They also expressed extreme frustration about the lack of consistent funding. Additionally, they felt that educational cuts were detrimental to students and staff and played a role in preventing consistent implementation of evidence-based programs, which limit opportunities to support and protect young people.

Program Structures that Work in and With Rural and Tribal Contexts. Every evidence-based program has program protocols to safeguard youth safety and ensure fidelity of

implementation. Following a program protocol is essential to ensure that participants receive the same key components that made the program effective as researched. While program protocols help to ensure consistent and reliable results, they can make implementation more challenging, especially when trying to implement the program in diverse settings, cultures, and community contexts. According to the participants, it is important to implement a program that can work in rural and Tribal contexts.

Montana is the 4th largest state in the county geographically, yet is 43rd in population (U.S. Census Bureau, 2024), making it a uniquely challenging state for program implementation of any kind, as there are vast distances to cover in many sparsely populated areas. Fourteen of the 16 participants noted the challenges related to the sheer size of Montana to implementing a MHL program for rural youth, like YAM, including: the geographic size of state and the distance away from services.

Instructor 4 commented, “Europe has rural areas, but NOTHING like Montana. An immense, immense area to cover,” noting that although the founders of YAM in Sweden have no doubt been to rural places in Europe, they do not understand just how “far away from a town or small city some of these schools are.” Instructor 1 said, “We're so far away from anything.” Instructor 2 lamented that the long distance from their town to Bozeman (MSU) “Has prevented more in-depth training (for MHL programs)” that could benefit the community. Initiator 2 stressed that instructors often travel long distances and in unpredictable weather, “on horrendous roads”, which at times can make program delivery difficult if not impossible. Program Personnel 1 also noted the problems unpredictable weather can cause and said, “It’s not easy to get to schools. The weather and constraints of the program can be extremely difficult.” Program Personnel 1 also pointed out that YAM is taught in five sessions over the course of three weeks,

so instructors have to travel five times to the school, not just once. Program Personnel 3 similarly said, “Having to travel a 200-mile radius or coming over from the next town is a challenge, especially if the program requires several sessions, like YAM”. Program Personnel 4 noted that those that manage programs must weigh several factors when considering program delivery in remote towns, noting that the long hours of travel are both costly and time-consuming.

> “Even if we trained someone on campus (Bozeman), we can’t just jump over to Plentywood and teach on a Tuesday and come back, unless you can string that together with going to Glasgow on Wednesday, and Chinook on Thursday, which isn’t always feasible either.”

Participants consistently emphasized that the vast distances, harsh weather, and multiple required sessions can make delivering YAM or other MHL programs in rural Montana schools logistically difficult, costly, and time-consuming. Participants noted that rigid program structures can hinder implementation. These challenges force program staff to constantly weigh the importance of reaching isolated youth against the practical limits of travel, resources, and staff capacity.

In addition to logistical challenges, today’s divided and quickly changing political climate can also be a challenge for program implementation. For example, YAM’s policy of having no school personnel in the room made the program more difficult to implement and certainly has hindered program advancement. While the participants understood, and in most cases support, the reasoning behind the protocol of no school personnel present during YAM sessions, it has been a barrier to getting YAM into more schools, especially as the political climate continues to intensify in Montana.

Participants emphasized that YAM’s policy of not allowing school personnel in the room during sessions can sometimes conflict with the conservative movement’s push for increased

transparency and oversight in schools. In communities where there is heightened scrutiny over what is taught and by whom, this policy may raise concerns among parents or administrators who want direct visibility into classroom activities, even though the intent of the policy is to create a safe, open space for students to discuss mental health freely.

Both Instructor 2 and Instructor 6 teach in several schools in and around their community, and both shared that they are unable to get into one area school, due to the protocol of no school personnel in the room. Instructor 6 stated, "A community that could use this resource will not receive it. I can't get into the school because the content was being offered without school personnel in the room." Instructor 4 shared that they were worried about the program's future in Montana, especially as more conservative policies regarding outside speakers coming into the classroom increases, "I don't know what that's going to look like this year or next year. Things have gotten so frightening for schools in this climate. There is a lot of distrust, not necessarily from the school and sometimes it only takes on squeaky wheel from the community to undo years of progress." Instructor 5 said, "The biggest barrier is not having school personnel in the classroom. There are some trust issues. But it is important for kids to speak freely. School personnel are always available should the instructors need to get the kids some help."

Initiator 3 acknowledged the changing political culture could make programs like YAM harder to disseminate, "In our climate, politically right now, I think it is barrier. Parents may not trust the school, let alone an outside group coming in… and with the opt out option that is now required, I am worried fewer kids will participate in these needed programs." Initiator 5 revealed that they were concerned about no staff in the room initially but later realized that the students needed a forum to discuss mental health topics openly. "At first, I couldn't understand why staff

couldn't be in the room. I suppose I was worried. But after it was explained to me, and I got positive feedback from the kids, I understood."

Program Personnel 1 and 3 noted that there have been schools that participated in YAM in the past years, but due to changing school policies surrounding guest speakers, they were unable to get back into the classroom. Program Personnel 1 "Lately, there is pushback because of the political climate. Maybe not trusting what is going on in the classroom. We lost that school, even though we had been there since 2018. But it is the school policy versus the YAM program policy, and we are stuck in the middle…" Program Personnel 2 warned that if program protocols are too strict, "You can lose people. They may work great somewhere else, but it may not be what is necessary here."

In summary, participants expressed that the delivery of evidence-based MHL programs in Montana is shaped by a combination of logistical and contextual challenges. Vast distances, harsh weather, and strict program protocols can make program delivery time consuming, costly, and difficult to maintain. While participants understood and even supported the importance of preserving program protocols, they stressed that these requirements could pose challenges to sustaining YAM in schools or expanding into new districts, especially in the changing political climate of Montana.

Observed Outcomes of an Evidence-based MHL Program in Rural Schools

The following section answers Research Question #2 and outlines the participants' observed outcomes of evidence-based MHL programs, focused primarily on YAM. While there is self-reported student data on YAM in Montana to date there has not been a study on adult's perspectives on YAM outcomes, especially from the three varying perspectives of Instructors, Initiators, and Program Personnel. Participants in this study shared that they found YAM to be a

successful and beneficial program that had a profound impact on students, based on some measurable outcomes and as well as their personal experiences with the program. The program outcomes that participants identified were: 1) Increased Active Student Participation and Connection in YAM 2) Increased Access to Credible Mental Health Information and Resources; and 3) Improved Mental Health Literacy and Help-Seeking Among Youth, leading to 4) Decreased Stigma Surrounding Mental Health.

Increased Active Student Participation and Connection in YAM. Program evaluation data has demonstrated that students like YAM as indicated through their responses survey that 88% of students (n=515) reported that YAM should be taught in schools. Additionally, 70% said they learned more from the interactive components of the program, such as dilemma cards and role plays, than they would have from a traditional, teacher-centered methodology. (Center for Research on Rural Education, 2025). Several participants observed that YAM differs from other programs, particularly in its interactive and relational approach, which students tend to enjoy. This format allows students to engage in discussions and act out scenarios they have created, all within a safe and supportive learning environment. By allowing students to guide the topics and scenarios, the program fosters a sense of ownership and active participation in their own learning.

Naturally, the instructors had the most to share about the YAM sessions, particularly the role plays, as they are the ones with firsthand experience facilitating the program directly in classrooms. The instructors became animated and more impassioned when they talked about the impact that role-plays can have on students. All instructors reported that the student-led topics and discussions, along with the role-plays, are of great benefit to the students by encouraging

experimental learning and student growth and connection. The Instructors' key insights are summarized in Table 7.

Table 7: Value of Role Play in YAM According to the Instructors

Key Concept	**Participants' Reflections on the Value and Impact of Role-Play and Experiential Learning in YAM**
Empathy-Building	"The format is led by the students, you know, so they pick the scenarios. They really get into the role-playing side of things and having conversations talking about their feelings. They are building each other up and talking to each other through things... What is it like to be put in someone else's shoes? It's cool to see the growth." Instructor 1
Experiential Learning	"Anything that involves a class conversation and activity is best for teenagers. YAM is experimental…hands-on…. engaging. It's whole-body movement." Instructor 2
Student Engagement	"It's definitely good being able to visit, kind of create your own adventure so to speak, or design your own roleplay. The kids generally respond really well." Instructor 3
Safe Space for Learning	"It gives kids time to talk about (hard topics) with trained adults in the room and to actually practice or play around with the "whatifs" The aspect of play is different than what they are used to." Instructor 4
Student Empowerment	"The ownership belongs to the kids. We're just guiding…they determine where they're going and what they want to talk about. It just makes it worthwhile, you know, you can see that growth within them." Instructor 5
Collaborative Learning	"Students are interacting with each other, doing their own scenarios, I think they learn better coming up with authentic things they may encounter in their life." Instructor 6

Initiators and Program Personnel also spoke about the engaging, yet different nature of YAM compared to other MHL programs. Initiator 1 said that "They (students) talk about the lesson, it's an engaging lesson, they enjoy that experimental part of it…when I go into the classroom to teach a different lesson, they are bored." Initiator 5, who was initially skeptical of the "no school personnel in the room" protocol, said that YAM was different for the kids, and

they felt that the students are more willing to open up about what they are going through. They stated, “Having a separate space from school…kids feel more free to share.” Program Personnel 1 said, “I love that YAM gives the power to the students through student led discussions... I think on the role-play days is when you really see the impact that YAM can have on kids.” Program Personnel 3 said, “The kids do like the role-play. I think that’s how they can get engaged with it.” And Program Personnel 4 felt that the open discussions allowed opportunities for youth to discuss mental health in ways they may not have before, for example, “The ah-ha moments, where kids learn it is okay to have emotions.” Overall, participants emphasized the value of YAM’s role-play sessions, noting that they provide students with a safe and engaging space to explore new perspectives and practice real-life scenarios they could encounter.

Other participants focused on sharing how the students appreciated how the program provided them with the opportunity for growth and connection. Instructor 1 said, “I am delighted by the students that genuinely say thank you, and say, ‘I'm going to miss this’.” Instructor 4 stated, “The kids, they do like it. They may not like all the factual stuff that may come up, but they do like learning more. And when you ask what would you change about the program? They often say ‘Nothing’.” Likewise, Instructor 6 noted, “A lot of them (students) just have appreciation that someone is coming in talking about mental health, and that they have the opportunity to speak about it with their peers, role play about it and just have it addressed.”

Initiators also spoke about the students liking or appreciating YAM. Initiator 3 said “the kids seem to like YAM.” Initiator 5 also stated that they notice that the students really enjoy YAM and talk about what they learned. “They (students) look forward to the YAM Instructor coming. They know her and they like her. The kids have fun.”.

Increasing Access to Credible Mental Health Information and Resources. Another outcome of identified by participants, most notably Instructors and Initiators, was that evidence-based MHL programs like YAM provide youth with credible mental health information and resources. In particular, the participants felt that the YAM booklet was helpful, especially in many rural communities where students do not have access to resources. The YAM booklet was designed to fit in a pocket (so students could easily carry it) and it is comprised of six chapters that correspond with the themes in the YAM slide deck and on the posters. Each chapter provides credible mental health information and provides research-based tips on what the youth can do to improve their mental health. It also includes local, state, and national resources.

Several participants acknowledged that in the age of Tik Tok and social media, youth have endless information thrown their way, but nothing that is necessarily vetted. Instructor 4 said, “Students are inundated with messaging, but in YAM, we give them the booklet with the resources listed right away, and it has information that is legitimate… they can then compare it to what they hear or see online.” Similarly, Instructor 1 used the term, “peer reviewed information in your hand” when describing the booklets and went on to say the booklets are one of the “things that really helps” the students. Instructor 3 and 5 agreed, and said, “The books are certainly helpful. Good to remind them there are resources out there”, and “That’s why I like YAM. They get the booklet and resources right away with local, state, and national resources.

Improved Mental Health Literacy Among Youth. Instructors and Initiators noted that a key outcome of YAM specifically is that they see marked improvements in mental health literacy in youth. Mental health literacy (MHL) refers to the knowledge and understanding of mental health disorders, including their signs, symptoms, and treatments, as well as the ability to recognize, manage, and seek appropriate help for mental health challenges (Jorm et al., 1997).

Program Personnel also commented on improved MHL for the youth, but their comments were based on information they have heard directly from Instructors, Initiators, or from the self-reported student data compiled at the CRRE. One of the goals of YAM, and certainly any evidence-based MHL program, is to increase help-seeking behavior among the youth. Help-seeking behavior described by Instructors and Initiators ranges from parents telling the instructor that YAM helped their child reach out to them for help, to an increase in student visits to the school counselor, to the 988-crisis line, and the Montana SAFE app receiving more calls. Instructor 1 was approached by a parent in the community and the parent shared that because of YAM, their child had called and asked for a ride instead of getting in the car with a drunk driver, The parent told Instructor 1, "You gave my kid the courage to call me." Instructor 2 shared that school counseling department said that after the YAM program there are an increased number of students coming for help, "Our young people are self-identifying, self-reporting or reporting for friends." Instructor 6 said there has been "An increase in 988 calls in county…can we attribute that solely to YAM? Probably not. But some may see that as negative, but I see it as positive that they are reaching out."

Initiators also shared that they see an increase in help-seeking behavior for youth, especially after a YAM session. Initiator 2 and 3 both noted that there was an increase in the Montana CARES App use. The Montana CARES app provides a secure, anonymous reporting system that allows students, staff, and parents to raise safety, misconduct, or mental health concerns directly to schools. It also connects users to community resources and crisis support. Both Initiator 2 and Initiator 3 personally monitor the app and are notified when there is a safety concern or a student reaching out for mental health resources. Initiator 2 said, "We tend to see more kids coming to talk about mental health stuff with school counselors post YAM, as well as

a notable increase in use of Montana Cares App." Initiator 1 shared that they noticed that after YAM the students are empowered and knowledgeable. They shared, "They (students) knew all the steps of what to do...giving them that sense of agency, like they're not helpless. They know how to help a friend and help themselves." Initiator 5 said the message of help transcends the students and reaches even the adults, "You are never too old or too young to ask for help."

Program Personnel shared comments regarding the impact YAM has had on youth MHL, most notably, help-seeking behaviors, including finding a trusted adult during and after the program. Program Personnel 3 said, "Teaching them the adults who can help is really important. And helping them understand it is okay to ask for help." Program Personnel 1 said,

> "We have actually had students come and talk to the instructor and say, 'I'm struggling myself,' and we have heard of students disclosing they are suicidal to the instructor. They felt comfortable enough to trust the YAM Instructor… recognizing they have power to help themselves or friend is really great."

Program Personnel 5 commented on instances where students later reported that what they learned in YAM helped them seek help for themselves or others. Program Personnel 5 said, "We've heard students that have used what they learned in YAM later. They were exposed to a mental health crisis later and they knew what to do." It is encouraging that YAM has increased MHL and encouraged youth to seek help from a trusted adult for a friend or a group, and participants reported that an increase in help-seeking behavior in youth was a notable outcome.

Decrease in Stigma Surrounding Mental Health. With improved MHL, which encompassed knowledge, awareness, and help-seeking behaviors, participants also observed a reduction in stigma surrounding mental health among students. Stigma surrounding mental health refers to the negative attitudes, beliefs, and discrimination directed toward individuals experiencing mental health challenges, often leading to reduced willingness to seek help (Link et al., 1987). Although the participants identified the rural stigma surrounding mental health as a

barrier to getting MHL programs into schools, they conversely noted that they saw a decrease in such attitudes and behaviors after the students had participated in the YAM program. Thus, if schools can successfully get an evidence-based MHL program through the door, despite the fear or stigma surrounding the program, the evidence suggests that these programs have the potential to reduce that very stigma and foster a more open conversation about mental health for students.

The participants shared that they felt YAM helps normalize conversations about mental health and increases the students' knowledge and awareness and has helped the youth see it as something equally important as physical health. Instructor 1 echoed that while the "pull yourself up by your bootstraps" mentality is alive and well in rural Montana, however because of YAM, "I think it is getting better. When you are sick you go to a doctor. When you are experiencing a mental health crisis, you also go to the doctor. It's just as valid." Instructor 2 pointed out that to solve a problem, one must understand it first, and that happens through education. They stated, "Education needed to happen. Without knowledge, there is no power. The important thing now about YAM is that our students are talking about mental health… it creates accuracies… it creates normalcy." Instructor 3 also felt that YAM normalized mental health and made it a topic that is less taboo to discuss. They said, "Mental health, suicide, those were things that were talked about in hushed tones or behind closed doors…and I think we have come a long way. "

Initiators spoke to the fact that their students want even more support for mental health after having YAM. Initiator 3 said that not only is mental health normalized, the "Students pushed to form mental health support groups and wanted to invite State of Mind (another program) into the school." Initiator 4 spoke to the fact that evidence-based programs not only help students, but they help parents and the community as well.

> "Prior to bringing in these programs, it wasn't an open conversation. Suicide was not something that we talked about. I think that parents were afraid to talk to their kids

> because they thought that if they talked to them about it, something's going to happen. We know that talking about and educating people about suicide is helpful."

Program Personnel reiterated many of the same points that the Instructors and Initiators did. Program Personnel 3 and 4 talked about the importance of talking about mental health, particularly depression with youth, and that there was help available. Program Personnel 3 said, "Teaching the kids what depression is and that it is treatable is huge." Lastly, Program Personnel 5 spoke passionately about why they feel evidence-based MHL programs are so impactful for young people. They emphasized that, statistically speaking, everyone will encounter someone with a mental illness at some point, making it essential for all individuals to understand how mental health challenges can affect themselves and others.

> "Mental Health Literacy helps students manage their own mental health and deal with the mental health conditions around them. Understanding their parents' mental health, their siblings, all the things that could mess up a student's trajectory. They are going to be involved with multiple people every day that meet criteria (of having a mental health condition) and how are they going to navigate that? Understanding mental health is important for succeeding in life… Something has to effectively stop the bleeding. It's like, hey, this is my mom, she struggles with this. She just kind of acts this way. Hey this is my brother, he is just that way, it's not my fault, but I know how I can support him. But that's it. So just that base knowledge of how to navigate through that. It is one of our biggest personal and societal challenges."

Recommendations for Improving Program Delivery and Sustainability

To improve program delivery and sustain programs like YAM across Montana and other rural regions worldwide, it is essential to address the accessibility, effectiveness, and long-term viability of mental health initiatives in these communities. Participants noted the distinctive challenges rural areas face, such as geographic isolation, limited resources, and staffing shortages, and explored strategies to adapt and sustain program delivery accordingly. Data analysis revealed the critical need for sustainable funding approaches, as well as the need for

greater flexibility in program delivery, training, and cultural adaptability, to ensure programs can continue where they are already established and expand to reach more youth in rural settings.

Reliable Funding Streams. Participants acknowledged that evidence-based programs are expensive and time-consuming, and they recognize the need for reliable funding mechanisms to keep these vital programs going. Without consistent and sustainable funding, the programs risk being discontinued, leading to the loss of valuable community trust, trained personnel, and programming momentum. This instability can hinder progress in improving youth mental health outcomes and reduce the overall impact of prevention efforts in rural communities. Instructor 1 summed up the lack of consistent funding, "Funding is always the piece that makes or breaks it. We can get teachers on board, we can get students interested, but if there's no money to cover training and materials, it just stops." Instructor 4 said, "We're already stretched thin, and when it comes down to choosing between programs, schools pick the one they can actually afford to sustain." All of the Initiators spoke to the importance of funding, and fear that with additional education and federal cuts looming, evidence-based MHL programs will not continue. Initiator 3 said, "Without stable funding, you're patching it together year to year, and that makes it fragile." Program Personnel 2 also noted that, "The federal grants are great, but when they end, you're scrambling. Schools need to know this isn't going to disappear in two years." Program Personnel 1 noted that with the recent federal funding program cuts, "YAM is not immune to the federal funding disappearing at any moment."

Although participants did not pretend to have all the answers regarding who is going to pay for evidence-based MHL programs, they did stress the importance of connecting with a community partner with shared goals and resources. Personnel 4 said that Extension Faculty often collaborate with community partners to keep program afloat. For example, in one

community, “An agent worked it out with a community partner to cover the cost of books.” Program Personnel 5 suggested that there needs to be pressure on the local and state governments to fund mental health programs, and it may come through the university-based center or partnering with advocacy groups to make sustainable changes.

> “You need people, at the center, or somebody that is having real world conversations about these programs, whether to administrators, community members, parents, OPI, to the Republicans on the Health and Human Services Committee, the Education Committee…somebody has to convince the governor that this matters… there has to be advocacy groups working to create incentives for policy makers.”

Participants highlighted the need for the state to prioritize funding evidence-based MHL programs if they want to address the high suicide rates of Montana. Participants pointed out that relying on federal grants is no longer feasible or sustainable and they feared that vital programs like YAM may likely not continue without stable funding.

Program Flexibility. Participants consistently repeated the need for “common sense” program flexibility during the interviews as one of the suggestions for ways to improve program delivery. Instructors and Program Personnel offered clear insights, as they have spent a significant portion of their work ensuring programs are delivered with fidelity. They reported often feeling like they are trying to fit “a square peg into a round hole” when navigating the unique constraints of rural schools. Almost all participants recognized that for evidence-based MHL programs to grow and thrive in rural areas, there must be what Kendall et al. (2008) referred to as “flexibility within fidelity”. From their perspective, Instructors, Initiators, and especially Program Personnel need to have room to make slight adaptations to the program to better fit the needs of rural schools. Participants were clear and in agreement that these adaptations could not be so drastic that it would change the program’s core components or intended outcomes.

Instructor 1 stated, “The inflexibility with the protocol is a barrier. To run a program successfully, it needs a personalized touch. Keep the program within the structure needed to be that program, but also the ability to be flexible to adapt to the local community.” Instructor 6 suggested that the program needs to allow for “reasonable flexibility” as determined by the professionals running or teaching the program.

Program Personnel acknowledged that evidence-based programs can be harder to implement and that may be why some schools decline bringing programs into their schools. One participant shared, “The challenge with research-based programs is fidelity versus flexibility… schools often feel like evidence-based models are too rigid and not adaptable to their context.” Program Personnel 5 argued complete fidelity is not even necessary or maybe attainable, as it keeps many schools from receiving the program.

> “Perfect alignment with fidelity is impossible. But let's do as much fidelity as we can. We'd rather get the content in as good of a way as we can, but we have to realize that pure fidelity is not beneficial to the students or the schools. We need to be more flexible to reach more people.”

Program Personnel 4 and 2 echoed similar sentiments, insisting “We do want to deliver a program that follows program parameters, but we know our communities and what will be relevant to them” and “Reasonable and common sense flexibility is needed…in timing or scheduling of classes, allowing personnel to stop by the room- some freedom to work that out with specific school is necessary.” A summary of the participants’ recommendations for program improvement is presented in Table 8.

Table 8: Adaptations to Make the YAM Program More Flexible for Rural School

Core Concept	**Recommendations for Program Improvement**
Responsive Scheduling	• Allowing a shorter time frame to deliver the curriculum if necessary

Table 8 continue.

Core Concept	Recommendations for Program Improvement
Responsive Scheduling	• Example – the program is taught over the course of two weeks, as opposed to 3 to 5, but not all in one week.
Session Timing	• Allow Instructors (with consent from Program Personnel and School) to shorten the length of the YAM sessions if a class size is very small (YAM was designed with 20-25 students in a class) • Example- combine role-play sessions 3 and 4 because the students have had plenty of opportunities to role play. The students will have completed the curriculum as designed, but perhaps in a shorter time period.
School Staff in Room	• Allow school staff or administration to come in for short periods of time, with the caveat that role-plays may be hard to understand without knowing the context. • Example- administrators often observe teachers during their lessons, and many expect to do the same with guests in the building.
Culturally Relevant Situations and Visuals	• Allow Instructors (with approval from Program Personnel and School) to add more culturally or locally relevant materials. • Example-new dilemma cards for the students to discuss and add graphics that are meaningful to the students and/or the community.

In summary, the participants were emphatic that "reasonable" and "common sense" flexibility must occur for program sustainability and growth. In other words, program flexibility is crucial in rural settings, where limited resources, staffing constraints, and scheduling challenges can hinder implementation. Allowing thoughtful adaptations helps ensure programs remain practical and sustainable while preserving their core effectiveness and fidelity.

Training Flexibility. Participants also suggested some changes to the YAM Instructor Training. Three key areas of training flexibility emerged from the data: 1) participants felt that it would be imperative to have some virtual options, 2) they recommended additional sessions on

classroom management to help instructors with disciplinary issues they may face in the classroom, and 3) they wanted to have more discretion in choosing the materials and videos that were shown during the training to better reflect the cultural diversity of Montana.

Currently, the YAM Instructor Training is an in-person week-long training course, which can be expensive and time consuming, especially for people who are not implementing YAM as part of their primary job responsibilities, as they must take personal time off to attend. Even for those where YAM is an extension of their job duties, a week away from home can be difficult for many to manage, especially when accounting for the long drive across the state to attend the training. Program Personnel 1 noted that, "The training was difficult for me to attend due to having small children and trying to keep up with my job, even if YAM was part of my work." Program Personnel 4 noted that, "Virtual options are always nice, especially when there are large distances to travel. It can save on money too, as you do not have to get people hotel rooms."

Participants also suggested that a classroom management session be added to the YAM Instructor Training, as five participants noted how the training does not really prepare Instructors for the behavior they may encounter in the classroom when delivering the program. Instructor 1 said that she did not have any previous educational experience, and she found the behavior difficult to manage, and a "crash course in classroom management" would be helpful. Program Personnel 4 also thought classroom management was important, as Instructors need to create a safe environment for students to feel able to share. They shared, "Classroom management training should be part of it, because you're not just teaching content, you are holding space for conversation." Program Personnel 1 suggested,

> "I think classroom management needs to be addressed at the training…we can't pretend like this is going to work out perfectly every time…that is a fairy tale, but that's not how it works. It can be very overwhelming for someone that has never been in a classroom. Also, I think the YAM Trainers need to have experience teaching in Montana schools…someone that has that relevant experience."

Lastly, Instructors 2 and 6 spoke about allowing space in the training for rural and American Indian voices and representation. In one particular session, trainees watch clips from Tik Tok, movies, or shows that depict life as a teenager. These clips mostly come from a European perspective, given that YAM was designed in Sweden. The participants noted that having videos and clips that showed rural and American Indian youth would be beneficial for local trainings. Instructor 4 said, "I would appreciate more regional autonomy when planning the training. Including more clips representing the population we are dealing with rural or Native youth." Instructor 6 stated that perhaps there should be clips of youth from Montana participating in YAM to better prepare Instructors for the classroom, "In training, adults act like kids. Maybe we need recordings of actual Montana students doing YAM. Having a component of just normal adolescent behaviors and seeing examples of what is not normal." Overall, the theme of reasonable program flexibility remained a persistent point when talking about improving program delivery in rural contexts.

Cultural Adaption for Program Materials and Visuals. Cultural Adaption for Program Materials and Visuals. Participants also expressed that having local autonomy or some reasonable flexibility about program visuals and materials would also improve program delivery in rural spaces, specifically for American Indian youth. American Indian youth in particular, so often do not see themselves or their culture in educational materials. Instructor 2 said,

> "My biggest challenge is I don't personally care for the new look of the new YAM program… pastel walnut thing has zero interest for the kids. The glass that is almost breaking…what does that even mean? They can't handle stress? They are broken? The lone boat floating, does that mean they are alone in the sea? What message do those graphics send? I don't think any of those graphics speak to our kids. If we are trying to depict a message through the visuals, I am not sure they line up with our goals in YAM."

Instructor 4 also thought the graphic or visuals do not reflect the average Montana student and certainly not American Indian youth. They shared, "We need something that looks more like Montana, something recognizable. Something local that grounds them. It would be cool if they had some things that they noticed in the background that pertained to Montana."

Program Personnel 1 also mentioned that the visuals and graphics on the Power Point and poster could be changed to improve program delivery.

> "Can I be frank? I'm not sure the power point visuals speak to anyone. I don't personally understand the visuals. I think we could do a better job. The imagery in the power point and on the posters is very abstract and I am not sure what the intention of the images are. I think no matter who is looking at them, I don't think they speak to any 15-year-old. I think something more concrete or specific to the topic would be better. The message of YAM is great, but I think graphics and use of materials could be specific to each community we are working with."

Participants felt the message of YAM was impactful, but that program visuals and materials should reflect the culture and lived experiences of the youth they serve. These adaptations may include incorporating local language, imagery, traditions, or examples that align with community identity. Cultural relevance is essential because it enhances engagement and ensures that mental health messages resonate in meaningful ways.

Emerging Insights on Emotional Engagement and Share Commitments to Improve MHL for Youth

Throughout the interviews, participants often expressed strong emotional connections to their work in youth mental health and suicide prevention. Many described personal experiences with loss, concern for their students, or a deep sense of responsibility to make a difference in

their communities. For example, statements like, “I grew up in a rural community. I wanted to bring a program to the students that I didn't have growing up” (Instructor 1) and “If we save one life, then it’s worth it.” (Initiator 2) were common.

Participants working with Tribal youth were particularly expressive when sharing their experiences and stories. They were committed to protecting the young people in their communities, as they were fully aware of the challenges and traumas their students had already endured. They approached their roles with genuine care and vigilance, emphasizing that their students had been through “significant hardships” and “unspeakable trauma” (Instructor 2). Initiator 5 explained that their community may be “quiet at first” and “you have to build trust”. Instructor 5 noted that they got involved in evidence-based programs because their elder asked them to, “I was born and raised here. How could I say no to one of the few people who have known me my entire life?” This emotional engagement underscored the seriousness with which participants approached their roles and reflected a shared commitment to their communities and improving youth well-being across rural Montana. The intensity of these emotions also revealed the human dimension of implementing MHL reminding both participants and the researcher of the profound impact such work carries beyond policy or outcomes.

Conclusion

Sixteen participants (six Instructors, five Initiators, and five Program Personnel) participated in one-on-one semi-structured interviews about evidence-based MHL program for youth in Montana. Chapter 4 presented the findings of this study, organized around three central themes that correspond to the research questions: (1) Essential Personnel and Resources Needed by Rural Schools for Delivery of an Evidence-based MHL Program, (2) Observed Outcomes of

an Evidenced-based MHL Program in Rural Schools, and (3) Recommendations for Improving Program Delivery and Sustainability. The data revealed the essential components and stakeholders required for implementing evidence-based MHL programs in rural schools, the perceived outcomes of these programs on students and school communities, and strategies to improve their delivery. Through participants' perspectives, the findings reveal the complex interplay of rural community dynamics, resources, attitudes surrounding mental health, community and school buy-in, and program fidelity necessary for success, while emphasizing the importance of flexibility, sustainability, and cultural relevance in meeting the unique needs of rural settings.

CHAPTER 5

DISCUSSION

Introduction

The purpose of this instrumental case study was to gather insights to inform the delivery of youth mental health literacy (MHL) programs and support the scaling of evidence-based initiatives across rural and indigenous communities in Montana, the US, and beyond. Additionally, the study sought to explore the value of the PROSPER+ model and identify best practices for applying the PROSPER+ model to the dissemination of evidence-based MHL programs, while guiding their adaptation and sustainable implementation in rural contexts. The study was grounded in the theoretical principles outlined in the PROSPER model (PROmoting School-community-university- Partnerships to Enhance Resilience) which emphasizes the role university Extension programs and collaborative partnerships among state entities in maintain evidence-based programs (Spoth et al, 2004). Building upon this framework, PROSPER+ sought to explore the added value of having designated program personnel housed in a university- center or office to oversee program management, including funding, implementation, training, and evaluation, while fostering strong community partnerships to promote long-term program sustainability (Fixsen et al., 2005; Domitrovich et al., 2008; Durlack & DuPre, 2008).

Through purposeful sampling, one-on-one interviews were conducted with 16 participants who had experience implementing evidence-based MHL programs in rural places, including Instructors (those that teach the program), Initiators (those that were instrumental in getting the program into the school), and Program Personnel (designated staff in a university-center of office that oversees the program). These individuals were invited to participate as they

represent those who have first-hand experience implementing evidence-based MHL programs in rural settings. This decision was guided by the belief that those who are closest to the challenges of program delivery, particularly in geographically isolated and culturally distinct rural communities, have the most accurate and practical insight into solutions. This chapter presents a summary and interpretation of the results of the investigation and provides an evaluation of the approach used to collect and analyze the data. Finally, this chapter describes the study's contributions to literature, its implications for professional practice and possible avenues for further study.

Summary of Key Findings

The research questions which guided this study were:

1.Who and what needs to be present for the delivery of an evidenced-based MHL program in a rural school?

2. What outcomes of an evidenced-based MHL program in a rural school are identified by key stakeholders?

3. How could delivery of an evidence-based MHL program in a rural school be improved?

The evidence revealed key findings aligned with the corresponding research questions. First, (RQ1) participants' responses clearly identified the essential personnel and resources needed to deliver an evidence-based MHL program in rural and Tribal contexts. They highlighted the critical role of the designated person at a university center or office to oversee program implementation, the need for local and dedicated instructors, the role of strategic community partnerships, and the need for sufficient school resources and trained school staff. Participants emphasized that before working with youth in a school, the program must: 1) be aligned with the

community's identified needs; 2) secure school and community buy-in; 3) work well in a rural context; and 4) have sufficient funding to sustain program implementation.

Evidence from the study also identified observed outcomes of an evidence-based MHL program in rural schools. Participants' responses reflected the positive impacts of program delivery, including: 1) increased active student engagement and connection; 2) increased access to credible mental health information and resources; 3) improved MHL and help-seeking; and 4) decreased stigma surrounding mental health. Participants noted that these shifts contributed to a more supportive school climate where conversations about mental health and help-seeking behaviors became normalized.

Finally, evidence from the study provided insights into how program delivery and sustainability could be improved for rural and Tribal communities. Participants' responses highlighted the need for increases in: 1) reliable funding sources; 2) program and training flexibility; and 3) local autonomy over program graphics to better reflect the cultural context of rural spaces. Participants underscored the importance of the need to make reasonable adaptations to the program to fit community needs while stressing that this flexibility needed to be aligned with fidelity to program principles. Participants emphasized that sustainability depends on both institutional commitment and continued collaboration between schools, community partners, and universities.

Interpretation of Findings

Essential Personnel Needed by Rural Schools for Delivery of an Evidenced-Based MHL Program

The findings from this study clearly demonstrate the importance of who is needed to implement evidence-based MHL programs in rural places. The evidence revealed that effective

program delivery in rural and Tribal settings rely not merely on the program personnel that manage the program, the presence of local instructors, community partnerships, and trained school staff, but also is a result of the interplay of these elements to ensure a culturally responsive and credible program approach.

Designated Personnel at University-Center of Office for Program Support. The findings of this study revealed that having designated program personnel housed in a university-center or office, like the Center for Research on Rural Education (CRRE) is crucial to successful implementation of evidence-based MHL programs in rural and Tribal communities. Participants emphasized that this structure not only ensures accountability, coordination, and credibility, but also provides the administrative capacity and ethical oversight necessary when working with minors and addressing sensitive topics such as mental health and suicide. It was particularly important for designated program personnel to coordinate with Tribes, which are sovereign nations, and work closely with Tribal Councils, Tribal IRB committees, and schools before bringing an evidence-based program to Tribal communities. Universities are uniquely positioned to assist with this process, as they have access to specialists and resources that can provide additional guidance for working respectfully and effectively with Tribal communities, ensuring a culturally responsive implementation.

These findings are consistent with research showing that universities are uniquely equipped to provide oversight, training, administrative support, and infrastructure for evidence-based programs (Durlak & DuPre, 2008; Domitrovich et al., 2008; Fixsen et al., 2005; Han & Weiss, 2005; Israel et al., 2010). In addition, universities also have legal and administrative offices that are proficient at handling contracts with program founders, overseeing program liability, providing data security, enforcing IRB protections and guidelines, and ensuring

compliance with state and federal regulations (Fixsen et al., 2005; Israel et al., 2010). Without the personnel time and effort dedicated to management and leadership, there would not be funds to run the program, nor would there be anyone ensuring the program was being delivered properly and safely in schools (Domitrovich et al., 2008; Fixsen et al., 2005;).

The PROSPER model (Spoth et al., 2004) outlines the key components needed for universities, state agencies, extension services, and communities to collaborate in delivering programs to rural areas, but it does not specify exactly who should take responsibility or how these partnerships should operate in practice. Moreover, the model does not address the heightened oversight required when working with minors or the inherent risks involved in implementing programs that address sensitive topics such as mental health and suicide.

Participants noted the importance of having a center or office overseeing program delivery, especially for "vulnerable populations" such a minors and American Indian or Alaskan Native students. They emphasized that all programs have varying degrees of risk, therefore there is a need for different degrees of oversight. For example, they compared a tree trimming program to a youth mental health program. While both programs involve potential risks, the nature and severity of those risks differ significantly. A tree-trimming program, where participants may use sharp tools or work at heights, involves tangible physical risks that can typically be mitigated through safety protocols, supervision, and proper equipment. In contrast, a youth mental health program presents a different set of challenges, as it addresses sensitive subject matter, engages a vulnerable population, and operates in communities where stigma and misconceptions about mental health may persist. These complexities increase the ethical and emotional risks associated with implementation, particularly when working with minors.

Given these types of factors, participants identified a critical need for a university-based center or office, particularly at a land-grant university, to provide careful and continuous oversight of implementation of evidence-based youth mental health literacy (MHL) programs. Such oversight helps ensure that the program is delivered ethically, safely, and with cultural and developmental appropriateness. Participants also recognized that while other entities, such as non-profits, could technically house evidence-based MHL programs for youth, they often lack the necessary capacity and infrastructure that universities are able to provide (Israel et al., 2010; Domitrovich et al., 2008).

Furthermore, effective implementation requires "flexibility within fidelity" (Kendall et al., 2008), that is, adhering to the program's core components and theoretical foundations while allowing for thoughtful adaptations that reflect the unique needs, cultural values, and contextual realities of the participating communities. Oversight by designated program personnel housed within a university-based center can help to facilitate this balance between maintaining fidelity and exercising flexibility. This balance is critical to ensuring both the integrity and relevance of the program, ultimately enhancing its potential to achieve meaningful and sustainable outcomes.

Overall, the evidence from this study demonstrates the need for designated program personnel housed within a university-based center and supports the PROSPER+ framework, which highlights the essential role of a university office or center in managing and supporting the implementation of evidence-based (MHL) programs. These findings expand upon the original PROSPER framework by clarifying who is responsible for program management and oversight, illustrating that designated university-based personnel are necessary for the delivery of evidence-based MHL programs. In rural contexts where resources are limited, programs like YAM are often delivered by a mix of Extension Faculty and community partners; however, because

Extension Faculty are responsible for a wide range of programming and cannot focus exclusively on youth mental health, it becomes essential to engage additional partners and establish designated program personnel within a university-based office or center, particularly within a land-grant university, to coordinate efforts, strengthen continuity, and serve as the central link that brings all stakeholders together.

Moreover, the results validate the proposed PROSPER+ framework by providing empirical support for the addition of program personnel from a university-based center or office as an essential structural component for the delivery of rural MHL programs to bridge research, practice, and community collaboration. Lastly, the PROSPER+ model could be adapted by any university with established infrastructures for program oversight, yet it is most ideally suited to land-grant institutions, where the Extension system provides the community-embedded networks and outreach capacity essential for effective program implementation and sustainability.

Dedicated and Skilled Local Instructors. Another study finding that has meaningful implications for rural schools and community partners is the importance of having local and skilled instructors trained to implement evidence-based MHL programs. Local instructors are best positioned to understand a community's needs, values, and culture. Their established relationships with students, parents, and staff create a foundation for meaningful engagement and credibility. Having local instructors deliver evidence-based MHL programs also increases sustainability, as their presence reduces potential cultural and logistical barriers. For Montana, having local instructors who can deliver YAM as part of their job duties has been significant to sustaining YAM sites.

MSU Extension Faculty has played a crucial role in bringing evidence-based MHL programs to remote and frontier places throughout the vast state of Montana. This finding is

consistent with research indicating that implementing YAM through MSU Extension in Montana is both feasible and sustainable (Bailey et al., 2022).

Along with MSU Extension Faculty being local instructors and knowledgeable about the culture of their communities, having them deliver programs within their designated area is also cost effective, as there are no additional funds needed to cover the costs of their time or travel. As part of the land-grant university system, Extension Faculty serve as the outreach arm that bridges research and community practice by providing education, resources, and programming designed to address local needs across the state. In alignment with their mission, Extension Faculty also ensures that communities have access to current, research-based knowledge and practices serving as a vital link between the land-grant university and the public (Spoth et al., 2004). Both Spoth et al., (2004) and Israel et al. (1998) stressed that community-driven approaches enhance program credibility and engagement, especially in small rural settings were personal relationships shape participation.

Another key insight from the findings is that utilizing local instructors is especially important for Tribal communities, as local instructors most likely share cultural knowledge, language, and community norms that may not be known by an outsider. The findings in this study suggest that Tribal communities place high value on trusted local instructors and may be skeptical of new programs proposed by external groups. This response is in part due to historical trauma and past experiences of exploitation. One participant noted that local instructors help to ensure that they are engaged in a program “for you and with you,” as opposed to an “at you” approach. Braveheart et al., (2003) and LaFromboise et al., (2006) emphasized the importance of community-based interventions to navigate historical trauma and respect traditions. These findings suggest that policy and practice should prioritize the recruitment and retention of local

instructors. Recognizing and investing in local instructors not only strengthens program credibility and sustainability but also lays the groundwork for broader community support for long-term evidence-based MHL programs and initiatives.

Community Partnerships. Likewise, the findings of this study underscore the importance of strong and strategic community partnerships for implementing evidence-based MHL programs in rural contexts. These findings align with the PROSPER model, which articulates how the success of evidence-based MHL programs in rural settings depends heavily on strong school and community partnerships that align with community needs, engaging the community through collaboration between local teams and university-based program personnel (Spoth et al., 2004). In the context of this study, rural schools, communities, the CRRE, and other state or local entities have partnered together to bring evidence-based MHL programs to rural and Tribal schools. At present, the CRRE maintains partnerships with MSU Extension, local nonprofit organizations (including the Montana chapter of the National Alliance on Mental Illness and Tribal Health Departments), as well as the Montana Department of Health and Human Services, to ensure the provision of both funding and qualified instructors necessary for effective program implementation. These partnerships provide access to local instructors, necessary resource sharing, and ongoing support, reducing the probability of program disruption. Moreover, engagement with trusted community members develops long-term buy-in from students, parents, and staff, which is essential for maintaining program continuity in rural settings. As highlighted in the literature, community-driven implementation strategies are linked to higher program fidelity, higher rates of participant acceptability, and sustained positive outcomes (Durlak & DuPre, 2008; Fixsen et al., 2005; Israel et al., 1998).

Trained School Staff. Another finding that emerged in the study was the recognition of the teacher and counselor shortage in rural schools in Montana and the importance of having trained staff available to respond to the needs of students that may approach them for help. These insights reinforce the idea that frequent staff shortages or turnover can hinder the development of program delivery, as Instructors or Program Personnel may have to start the process of program implementation over with new school staff.

Existing research underscores that high staff turnover can be detrimental to student academic outcomes and the overall school climate (Carver-Thomas et al., 2019; Farahmandpour & Voelkel, 2025; Ronfeldt et al., 2013). Participants in this study highlighted that frequent teacher turnover and staffing shortages disrupted the continuity of YAM implementation and created challenges in sustaining program momentum. In rural schools, where staffing resources are limited and replacing personnel may be difficult, these disruptions can have an intensified impact. Further research is needed to examine how school staff turnover and shortages specifically affect the mental well-being of students and the implementation of evidence-based MHL programs in rural settings.

In addition, properly trained staff are essential for creating a trustworthy environment where students feel safe to seek help and that adults can get them to the right resources. Most quality MHL programs will encourage youth to seek help from a trusted adult, however, if those adults are unsure what to do, the student may not get the help they need (Kelly et al., 2007). While all educators do not need to be mental health professionals, all need to have enough training to feel confident in their ability to listen and respond to their students' needs until they can get them to the school counselor or professional help. Youth Mental Health First Aid (YMHFA) was designed with this very concept in mind, similar to first aid training for medical

injuries, the program teaches adults who work with young people how to notice early signs of mental health problems and give support, until the young person can get professional help (Jorm, 2012). Previous research indicates that many educators may feel apprehensive about addressing students' mental health needs, often fearing that their efforts could inadvertently cause harm (Yamaguchi et al., 2020; Reinke et al., 2011). This lack of confidence is compounded by limited access to professional training and ongoing support, which participants identified as significant barriers to effectively assisting students who are seeking help (Dimitropoulos et al., 2022; Reinke et al., 2011).

Findings from this study highlight the need for policy and practice initiatives that enhance MHL training for teachers, whether through improved preservice training programs or district-led professional development, ensuring that educators are prepared to support student mental health effectively within schools. This is especially true for rural schools, where resources may be scarce or located a significant distance away, and the school counselor may not be on site full-time due to shared responsibilities with neighboring schools; these types of circumstances make it critical for teachers to have the knowledge and skills to support students' mental health in the counselor's absence or until the student can get to a practitioner for help.

It is vital that the school staff, especially the school counselor, are sufficiently trained in how to respond to students that are in a mental health crisis or coming to the adults to ask for help. Although participants in this study perceived that school counselors, particularly those who were certified more than two decades ago, may not have received extensive training to address student mental health concerns, contemporary counselor preparation programs have increasingly prioritized this area in current curriculum. According to the American School Counselor Association (ASCA) (2022), school counselors now operate across academic, career, and

social/emotional domains, providing instruction that "proactively enhances awareness of mental health; promotes positive, healthy behaviors; and seeks to remove the stigma associated with mental health issues." The good news is that current school counselors are well prepared to support student wellness in addition to providing high quality academic and career advising.

Essential Resources Needed by Rural Schools for Delivery of an Evidence-based MHL Program

The findings from this study also clearly identified the resources necessary for MHL program implementation in rural contexts including community agency and engagement; cultural alignment; and adequate funding. Rather than simply providing personnel or resources, successful program delivery depends on communities having a continuous voice in the process of program implementation in their school. This emphasis on local input underscores that program delivery is not only determined by the curriculum, but also by the degree to which the program goals resonate with the community's needs, leaders, and values.

Community Agency and Engagement. A reoccurring theme that was expressed by participants was that to effectively deliver an evidence-based MHL program, communities must first identify a clear need and then intentionally invite individuals or organizations to support its implementation. This process is inherently intertwined with both community and school buy-in, which are equally critical for fostering engagement, trust, and long-term support. Participants noted that they could have, "the best program in the world" but without community and school support, they would not have the opportunity to deliver it to the adolescents. These findings align with research on effective and sustainable programming in rural contexts, which highlights that communities should first identify the specific needs they wish to address and actively participate in the process of bringing in programs to ensure meaningful and lasting impact (Spoth et al.,

2004; Israel et al., 1998). Likewise, community engagement is vital throughout all steps of the implementation process, including identifying key community partners, sharing resources, and having open and honest communication (Levin et al., 2021; Snavely & Tracy, 2002), while both parties mutually benefit from the partnership (Israel et al., 1998).

Communities that do not want to implement programs, even if they are backed by research, can cause frustration for people who want to help solve a problem. For example, even when data clearly indicates a persistent problem, like youth suicide, introducing programs can be challenging, because if the community does not perceive the need or is not willing to engage, directed programs are unlikely to gain traction or be successfully implemented. Naturally, this creates a paradox, because communities may not let evidence-based MHL programs in due to fear and stigma surrounding youth mental health and suicide, but it is extremely difficult to reduce stigma if programs are not allowed in to address it.

In practice, program developers or leaders seeking to implement initiatives in schools or communities should engage without assumptions, prioritizing careful listening and responsiveness to the unique needs and concerns of each community. Often it takes a "community champion" or an influential person or group to be incentivized to bring an evidence-based MHL program in a community. One participant stressed that the key to getting communities to allow evidence-based MHL programs in their schools was to make the connections between poor mental health and youth outcomes, both academic and social. Extensive research demonstrates a strong connection between poor mental health and negative life outcomes, including lower educational attainment, reduced employment opportunities, and diminished social and emotional well-being (Bradshaw et al, 2009; Brännlund et al., 2017; Durlack & Well, 1997, McLeod et al., 2012). Adjusting the approach, focus, or language in

response to community feedback helps build trust, demonstrates cultural sensitivity, and increases the likelihood of buy-in and successful program implementation.

Furthermore, consistent with Azano et al. (2021), building trust in rural communities requires program implementers to recognize the complexity and diversity of rural families, including the wide range of beliefs, identities, and perspectives they hold. Rather than approaching families from a deficit or judgment-based lens, sustained engagement is fostered when program implementers seek to understand family and community contexts, respond with empathy, and respect viewpoints that may differ from their own. Applying this approach to MHL programming supports stronger school–community relationships, increases local buy-in, and ultimately enhances student well-being and program effectiveness in rural settings.

Cultural Alignment. Correspondingly, the analysis of the data suggests that successful implementation of evidence-based MHL programs depends on aligning program protocols with the unique cultural and logistical characteristics of each community. The participants spoke specifically about the changing political climate in Montana post the COVID-19 pandemic, and the increase in distrust in institutions, and the subsequent cuts in funding for education and mental health supports. They voiced their frustration with the misinformation that circulated such as evidence-based MHL programs were “liberal nonsense” and not vital programs that teach students about mental health knowledge and help-seeking behaviors.

More research is needed to fully understand the changing perspectives on science, education, and institutions, as a result of far-reaching impacts of the COVID-19 pandemic in the US. However, this study’s findings align with research from Australia that notes the pandemic intensified societal distrust in institutions, as misinformation and anti-intellectual attitudes intersect with educational disruption (Nally, 2022). In rural communities, where skepticism of

external entities can already exist, even evidence-based MHL programs, like YAM, may face resistance. Nally (2022) argues to regain trust and reel back misinformation, there needs to be a widespread effort to improve digital literacy and a more focused effort to engage communities in open and honest dialogue to rebuild trust and ensure that programs are culturally relevant and respond to community need.

Because of historical trauma and previous experience of research exploitation, Tribal voices in the planning and implementation process of program delivery are especially significant. Genuine engagement with Tribal communities ensures that program delivery will be culturally respectful and positioned to build trust, not cause additional harm. Israel et al. (1998), emphasized that research should create tangible benefits for a community, as opposed to communities being used to publish a paper. As a participant noted, Tribal communities have long been a "fishbowl" with outsiders looking in, and community engagement ensures that program delivery is a collective and coordinated effort between Tribal communities, program coordinators, researchers, and schools.

An interesting paradox emerged in the data, as participants empathized that the credibility and institutional backing of MSU were instrumental in them gaining access to schools to implement evidence-based MHL programs. Yet, they also described a growing climate of distrust and misinformation surrounding mental health and education. This duality highlights the complexity of implementing evidence-based programs in current rural contexts, where trusted institutional support can both allow the program in and also face resistance amid skepticism.

Adequate Funding for Schools and Evidence-based MHL Programs. Lastly, one major aspect of program delivery is adequate funding, which is extensively documented in the research (Isreal et al. 1998; Scheirer, 2005; Spoth et al., 2004; Warner et al., 2020). Without stable and

sufficient financial resources, programs struggle to maintain the essential components of effective implementation, such as recruiting and retaining quality instructors, providing consistent training, and expanding into new schools (Durlak & DuPre, 2008). Although evidence-based programs are costly, they should be prioritized because their effectiveness has been empirically demonstrated, making it more likely that the investment results in meaningful, measurable improvements (Singer et al., 2019). Evidence-based programs are inherently expensive to operate, in part because they require dedicated personnel to oversee, coordinate, and monitor the program. While these administrative and oversight costs can be substantial, they are crucial to ensuring that programs are implemented with fidelity across diverse sites to achieve desired outcomes (Durlak & DuPre, 2008). Sustainable funding ensures that evidence-based MHL programs, like YAM, can continue beyond initial grant cycles and remain accessible to youth in underserved areas. Israel et al. (1998) emphasized that long-term community partnerships require ongoing investment of time and resources, while Spoth and Greenberg (2011) demonstrated that limited financial resources can hinder program adoption and sustainability, particularly in rural communities.

Participants in this study echoed these findings, noting that reliable funding streams are necessary to cover instructor compensation, travel costs, and materials, and to allow for planning and coordination at both the local and state levels. Ultimately, adequate funding is not only a logistical necessity but also a reflection of a state's commitment to prioritizing youth mental health and supporting equitable access to preventive interventions across all regions.

These findings have important implications for policymakers and educational leaders, particularly in rural and Tribal contexts. Based on the evidence from this study, if lawmakers are serious about reducing youth suicide, or suicide in the general population as well, they should

invest heavily in preventative efforts. Building on Pirkis et al., (2023) Whole-of-Community Approach, the state and federal government needs to work collaboratively to provide comprehensive services that protect individuals from the social determinants, such as education, income and employment conditions, housing, social inclusion, access to health services, and cultural norms that elevate suicide risk. This is an especially critical priority when considering the unique historical, cultural, and socioeconomic factors impacting Tribal communities.

Given the rising rates of income inequality and its strong association with disparities in access to care, it is essential that both the state and federal governments prioritize sustainable funding for mental health support, whether that be preventive evidence-based MHL programs, or targeted funds for clinical care. Unfortunately, the current administration just halted approximately $1 billion dollars allocated under the Bipartisan Safer Communities Act (2022) for schools to support hiring and training school mental health professionals in rural and low-income districts. Furthermore, a report from the Montana Healthcare Foundation (2025) analyzing the impacts of the "Big Beautiful Bill" on Medicaid estimated that approximately 31,000 Montanans could lose coverage, including roughly 27,000 low-income adults and nearly 4,000 children. This loss of Medicaid coverage could disproportionately impact rural areas, where mental health resources are already limited, creating an additional barrier for young people and other vulnerable populations to access the care and support they need (Montana Healthcare Foundation, 2025). The full impact of these substantial cuts to social and health programs remains uncertain, however current evidence does not support such reductions as an effective strategy for enhancing MHL or preventing youth suicide (Bruener & Bell, 2023; Campion, 2018; Chen et al., 2018; Jones et al., 2024; Kelly et al., 2007; Krantz et al., 2023;

Mann et al., 2021; McLeod et al., 2012; Moscicki, 1997; Pirkis et al., 2025; Silverman & Felner, 1995; Singer et al., 2019)

Therefore, the implications for policy moving forward to improve outcomes for youth suicide is adequate investment from the state or federal government in prevention efforts. Addressing factors such as poverty, limited access to care, housing instability, and educational inequities should be a top priority (Pirkis et al., 2025). Additionally, having a reliable funding stream allocated for evidence-based MHL programs to reach all youth, regardless of socioeconomic status or geographic location, will help to mitigate the widening access gap to mental health resources. Furthermore, by supporting evidence-based MHL programs through consistent public funding, governments can promote equity, reduce long-term social and economic costs, and address the root contributions to mental health outcomes in traditionally underserved communities.

Observed Outcomes of an Evidence- based MHL Program Outcomes in Rural Schools

Findings from this study revealed participants' perceptions of program outcomes and the interrelated factors that influence the effectiveness of evidence-based MHL programs in rural settings. Engaging directly with those involved in program implementation provided critical insights into observed changes in student engagement, including increases in help-seeking behaviors, and overall MHL. These results are consistent with prior studies on YAM in the US, which found that students reported increased MHL and greater willingness to seek help for mental health concerns (Center for Research on Rural Education, 2025; Lindow et al., 2020). These findings were particularly noteworthy, given the growing challenges surrounding conducting sensitive research with minors.

In practice, these outcomes are significant because they suggest that evidence-based MHL programs can foster not only knowledge about mental health but also contribute to supportive social environments in schools, where students feel connected and empowered to seek help. These findings are particularly noteworthy in the era of "The TikTok Kid," as one participant phrased it. While youth have access to more information than any generation before them, social media is also ripe with misinformation, particularly surrounding mental health (McCashin & Murphy, 2022; Wang & Togher, 2024). Research indicates that TikTok is a widely used platform among youth for health-related information, including mental health, but much of the content comes from individual creators rather than verified public health or professional sources (McCashin & Murphy, 2022). While these videos generate high engagement, the limited presence of credible sources raises concerns about misinformation and the accuracy of mental health guidance accessible to adolescents. In practice, this underscores the value of evidence-based MHL programs like YAM, which provide youth with reliable information and resources, helping counter potential harm from social media and promoting informed help-seeking behaviors.

From a policy perspective, these findings highlight the value of sustaining and expanding evidence-based MHL programs, like YAM, demonstrate measurable impacts on increased MHL. The increase in help-seeking behavior and the corresponding decrease in stigma surrounding mental health are particularly significant for understanding the impact of evidence-based MHL programs in rural and Tribal schools. For some students, evidence-based MHL programs may be their only exposure to the topic, as well as their only resource due to the lack of mental health resources, especially in rural and Tribal areas. Future studies could explore which program components most directly influence help-seeking behaviors and stigma reduction, and whether

these outcomes are sustained over time, particularly in rural and Tribal contexts where access to mental health resources is limited and stigma may be more deeply entrenched.

Recommendations for Improving Program Delivery and Sustainability

The findings highlight the ways in which program funding, training, design, and implementation must be responsive to local contexts, including logistical realities and cultural values. These insights provide guidance not only for practitioners seeking to optimize program delivery but also for policymakers and researchers considering how to support sustainable, culturally responsive mental health initiatives in rural settings. By examining these suggestions, the study moves beyond describing program outcomes to exploring actionable strategies that can enhance engagement, relevance, and long-term impact within diverse rural and Tribal communities.

Participants noted the logistical and cultural barriers they face in implementing evidence-based MHL programs across a massive state like Montana. This aligns with research from the National Rural Education Association (NREA), which highlights that rural students face unique challenges in accessing high-quality educational and mental health resources, making equity considerations essential for program implementation. Spatial equity focuses on how geographic isolation, long travel distances, and limited local services constrain access to evidence-based programs, while educational equity emphasizes the need to account for social, cultural, and demographic diversity within rural communities (NREA, 2022). These intersecting inequities directly affect evidence-based MHL program delivery, as rural schools often contend with limited personnel, fewer mental health professionals, and reduced funding, all of which can hinder program fidelity and sustainability. Furthermore, the increasing racial, ethnic, and socioeconomic diversity in rural areas requires that MHL programs be culturally responsive and

tailored to meet the needs of all students (Hartman et al., 2022). Incorporating both spatial and educational equity into program design can improve accessibility, engagement, and effectiveness of MHL initiatives, ultimately promoting equitable mental health outcomes for rural youth (NREA, 2022) while supporting sustainable partnerships, local buy-in, and community-relevant adaptations.

The geographic realities of Montana can make program implementation difficult, as instructors may have to travel long distances and could encounter inclement and unpredictable weather. If bringing an evidence-based MHL program to a rural area, it must logistically work to be sustainable. For practice, this means that program founders and program personnel must be able to be flexible and responsive in rural spaces, allowing some discrepancies in training and scheduling to fit in with rural contexts. A program may fail to achieve its intended impact if logistical challenges are not met with reasonable adaptations, to prevent ineffective implementation.

From a practice perspective, these finding highlight that even well-designed evidence-based MHL programs require reasonable adaptations to meet the unique logistical and cultural needs of rural and Tribal schools. Program protocols are important because they provide a structured framework that ensures consistency, fidelity, and quality in program delivery (Kern, 2024). However, all programs' sites are unique, and there should be some room for slight adaptations to better fit the needs of rural and Tribal students and schools. Participants reiterated that these adaptations or adjustments do not need to be so severe that they do not follow the basic tenants of the program. In fact, these findings align with what Kendall et al. (2008) referred to as "flexibility within fidelity", emphasizing the need to maintain core components of a program,

while allowing adaptations to fit the unique logistical, cultural, and contextual needs of schools and communities.

Much of the existing evidence for YAM appears to be established at the overall program level rather than at the level of specific program components, and there is limited empirical research that isolates individual elements to determine which components are essential and which may be adaptable without compromising outcomes. Similarly, while the requirement that no school personnel be present is grounded in broader stigma-related research, it has not been explicitly tested within YAM through comparative implementation studies that examine differences in outcomes with and without school personnel in the room. Collectively, this feedback underscores the need for future research that rigorously examines YAM's core components, tests flexibility within specific elements, and evaluates culturally and contextually responsive adaptations while maintaining program fidelity. Findings from this type of research would make it possible to introduce reasonable adjustments, such as alternative scheduling or administration observation opportunities, which were also evidence-based thereby supporting program adoption and ensuring that students are meaningfully engaged.

Correspondingly, incorporating culturally relevant content is essential for fostering a sense of belonging, connection, and relevance, particularly for American Indian students who rarely see their identities reflected in standard program materials. These adaptations are not merely cosmetic; they directly impact student engagement with the program materials. Research consistently emphasizes the importance of students being able to see themselves reflected in program materials (LaFromboise et al., 2006); however, YAM materials were developed in urban European contexts and do not necessarily reflect rural or Indigenous lived experiences, and there is little evidence examining how this mismatch may affect engagement or outcomes.

Representation fosters connection and reinforces cultural pride, particularly in these communities where historical exclusion has contributed to mistrust and disengagement (LaFromboise et al., 2006). Lastly, program founders should recognize that their curriculum may be implemented in diverse settings and reach youth with varying backgrounds, needs, and experiences; therefore, the most effective programs should build in space for thoughtful cultural adaptations while maintaining fidelity to the core components of the program.

Lastly, flexibility is also necessary when training local instructors. Program developers should build reasonable flexibility and local autonomy into training protocols to better support instructors' needs and prepare them for the practical realities of the classroom. Training that allows for adaptation based on instructors' experience levels and backgrounds can increase their confidence and effectiveness. Incorporating culturally relevant examples and discussions in the training ensures that instructors are equipped to connect with diverse groups of students in meaningful ways. Taken together, flexibility and cultural representation help create an instructor training process that is responsible, inclusive, and better aligned with the communities being served.

These recommendations also reinforce the validity of the PROSPER+ framework, which emphasizes the importance of designated program personnel, housed within a university-based center or office, to provide oversight, administrative support, and structural capacity. By highlighting the need for a designated person to coordinate the needs for reliable funding, flexibility within program fidelity, and cultural responsiveness, participants' insights illustrate how PROSPER+ can guide practical decision-making while maintaining core program integrity. The framework's focus on centralized support aligns with participants' calls for adaptable, context-sensitive implementation strategies, demonstrating that university-based personnel are

well-positioned to facilitate collaboration between program instructors, program founders, schools, community partners, and Tribal entities.

Researcher's Reflections on the Emotional Engagement of and Shared Commitments of Participants

The study also brought to light an unexpected but significant finding that warrants attention. This study revealed the deeply emotional nature of the interviews, which was something I had not anticipated. While my original motivation for engaging in this work stemmed from my own experience as a teacher affected by a suicide cluster, as well as a deep belief in the importance of youth MHL and suicide prevention in Montana, I found that the logistics and daily tasks of implementation had, over time, distanced me from the heart of the work. During the interviews, the raw emotion and unwavering commitment expressed by participants profoundly moved me and reminded me of why this work matters. During the interviews, I was moved to tears, and often the participants themselves were crying as they shared their experiences. I am profoundly grateful for their willingness to be vulnerable and to share stories that were clearly so meaningful and personal to them, trusting me with insights into their experiences and at times, stories of profound loss. These moments became a truly meaningful outcome of the research, highlighting the power of human connection and shared purpose in addressing youth mental health and youth suicide in Montana.

I am especially grateful to my participants who work with American Indian students. As an outsider and a white woman, I can never fully understand the hardships their communities have endured, and I do not take for granted their willingness to speak with me, especially given the long history of marginalization, mistreatment, and exploitation that their people have faced. Their trust in sharing insights and experiences that are deeply personal and culturally significant is something I hold with profound respect and gratitude. The participants who worked with

American Indian youth expressed a deep sense of responsibility and were fiercely and rightfully protective of their students. This realization emphasized the importance of implementing programs that honor the cultural identities, values, and lived experiences of the youth they serve, so that future initiatives are not only evidence-based but also genuinely inclusive and responsive to the communities most affected.

Limitations of Findings

While this study provides meaningful insights into the implementation and perceived impact of evidence-based MHL programs for youth, like YAM, several limitations of the findings should be acknowledged. First, the perspective represented in this study does not encompass all the people (Instructors, Initiators, or Program Personnel) that are implementing evidence-based youth MHL programs across Montana. As a result, the views shared may not fully capture the diversity of experiences that exist in other communities or contexts.

Furthermore, suicide prevention is a multifaceted and complex issue that extends far beyond any single program or prevention effort. Evidence-based MHL programs are just one component within a much broader framework of prevention that includes access to resources, community engagement, and larger systemic supports. While these findings provide valuable insights into one part of the approach, they should not be interpreted as representing a comprehensive solution to suicide prevention.

Lastly, it is important to recognize that the participants in this study were individuals who had already bought into having an evidence-based MHL program in their school or community. Their commitment to youth MHL and suicide prevention likely influenced the positive perspectives and experiences they described. Voices of those who are skeptical, hesitant, or resistant to implementing evidence-based MHL programs were not captured. Understanding their

perspectives would provide a more balanced and thorough view of barriers to program adoption and sustainability. Future research should intentionally seek to engage with those who have opted not to allow evidence-based MHL programs into their schools and communities, to better understand the underlying reasons for their apprehension and to identify strategies for improving outreach, trust, and program accessibility and acceptability in rural and Tribal contexts. Continued engagement with both supportive and hesitant stakeholders will strengthen the scalability and sustainability of evidence-based MHL programs across diverse communities.

Conclusion

The purpose of this instrumental case study was to explore the perceptions of key stakeholders, including Instructors, Initiators, and Program Personnel, regarding the implementation of evidence-based youth MHL programs in Montana. Specifically, the study sought to identify essential personnel and resources necessary for implementation, the perceived outcomes of the program, and recommendations to improve program delivery in rural contexts. Findings revealed several interrelated factors shaping implementation, including designated personnel at a university-based center or office managing the program, local and skilled instructors, adequate and sustainable funding, and "flexibility within fidelity" to allow for cultural relevance and community alignment. The need for reliable funding streams, culturally responsive materials, and program adaptability emerged as critical for addressing the unique challenges of rural and Tribal communities. Across participants there was a clear recognition that evidence-based MHL programs are beneficial for youth, as they increase student engagement and connection, provide credible mental health information and resources, and increases MHL, including help-seeking behaviors among youth. These findings collectively highlight that

implementation is not a one-size-fits-all process but rather one that must reflect the cultural, logistical, and relational realities of each community.

Additionally, this study built on the principles of the original PROSPER framework (Spoth et al., 2004), and explored the validity of the PROSPER+ model that emphasizes the added value of housing program personnel within a university-based center or office to oversee training, fidelity, funding, and evaluation of evidence-based MHL programs (Durlak et al., 2008; Domitrovich et al., 2008; Fixsen et al., 2005). The findings of this study reinforce the PROSPER+ approach by illustrating how program personnel housed in a university center or office can serve as hub for program implementation, ensuring that rural communities receive the support needed to implement evidence-based MHL programs safely, effectively and sustainably.

In summary, this chapter interpreted the findings in relation to existing literature and theory, drawing on implications for future practice, policy, and research. Taken together, the findings from this study underscore the importance of local engagement, collaborative partnerships, and adequate funding for ensuring equitable access to evidence-based MHL programs for youth in rural and Tribal communities. By adopting the PROSPER+ model, program leaders and policymakers can strengthen the bridge between research and pragmatic practice, ultimately improving the mental health and wellbeing of youth across traditionally underserved rural and Tribal communities.

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APPENDICES

APPENDIX A

INTERVIEW PROTOCOL

Interview Protocol

Interviewee:
Interviewee's relationship to study:
Place:
Date:
Start Time of Interview:
End Time of Interview:
Duration of Interview:

Thank you for agreeing to meet with me for this interview. I value your thoughts and experiences, and I appreciate the time you are taking to talk with me. As you know, there is a significant need for evidence-based mental health literacy programs that can be tailored to and delivered in rural places. Mental health literacy refers to the idea that the more knowledgeable someone is regarding mental health, the more likely they are to get help for themselves or others. The goal of many of these youth mental health promotion/suicide prevention programs is to improve or increase MHL. I am interested in developing a deeper understanding of how a mental health literacy program such as YAM is brought to a rural community, the impact that a program such as YAM has in a rural setting, as well as suggestions for ways we could improve MHL program delivery in rural contexts.

I think we have a significant need to understand critical aspects of MHL program delivery in rural schools and communities from the perspectives of various personnel who advocate for bringing the program to the school, who teach the program, and those who administer the program. I also believe that it is critical to include rural community members in the research to ensure that their unique challenges and opportunities are understood and used to improve program delivery in rural places.

Given your experiences in rural schools and communities, your perspectives are really valuable to me. During this interview, I will ask you several open-ended questions, primarily in three areas:

1. Essential elements for program delivery
2. Outcomes Identified by Stakeholders
3. Improving Program Delivery

You may choose not to answer any, or all, of the questions. I will be recording the audio of this interview, transcribe it verbatim, and will give you a copy of the transcript for approval. Your replies are confidential, and you will not be identified individually. All names will be removed from transcripts.

Introductory Questions

1. To start our conversation, please tell me your name and where you currently live.

Probes:

a. How many years have you lived in this community?
b. How do you describe your role in the community?

2. How would you describe your role in relation to YAM as a mental health literacy (MHL) program?
    a. Probes:
    b. What sparked your involvement with YAM?
    c. What do you enjoy about your involvement with YAM?
3. What has been your experience with implementing or supporting other MHL programs in rural schools?
    a. Probes:
    b. What sparked your involvement with this other MHL program?
    c. What do you enjoy about your involvement with this other MHL program?

Research Question 1: Necessary Elements for Delivery

3. From your perspective, what types of resources (e.g., staff, funding, materials) are essential for successfully delivering an evidence-based MHL program such as YAM in a rural school?
4. What qualifications or training do you believe instructors or facilitators need to effectively deliver the program?
5. What role does school leadership and community involvement play in supporting MHL program delivery?
6. What types of external support (e.g., partnerships, state or federal resources) are needed to enhance program delivery?

Research Question 2: Outcomes Identified by Stakeholders

8. What do you consider the most significant benefits of implementing an MHL program, such as YAM, in a rural school?
    a. Probes:
    b. For students?
    c. For staff?
    d. For the community?
9. How do you measure or observe the success of the program?
    a. Probes
    b. Among students?
    c. Among staff?
    d. Among the community?
10. Can you share examples of any specific positive outcomes or success stories associated with the program?
11. What unintended outcomes—positive or negative—have you observed?

Research Question 3: Improving Program Delivery

12. What aspects of MHL and/or YAM program delivery do you think work well in rural schools?
    a. Probes:
    b. For students
    c. For staff
    d. For the community

13. In your opinion, what barriers or challenges hinder the effective implementation of MHL/YAM programs in these settings?
    a. Probes:
    b. For students
    c. For staff
    d. For the community

14. How could MHL/YAM programs be better adapted to meet the needs of rural schools and communities?
15. What additional support, training, or resources would enhance the delivery of MHL/YAM programs?
16. Are there specific strategies or innovations you believe could improve MHL/YAM program effectiveness in rural areas?
17. What advice would you give to someone looking to implement an evidence-based MHL program in a rural setting?

Concluding Question

17. What else would you like me to know about MHL programs in rural schools and communities that I haven't asked you about already?

Thank you so much for talking with me today and sharing your insights and perspectives for this research project.

APPENDIX B

CODEBOOK: CODES AND DEFINITIONS

RQ#1 Who and what needs to be present for the delivery of an evidence-based MHL program in rural schools?

Essential Personnel Needed by Rural Schools for the Delivery of Evidence-Based MHL Program	
Code	**Definition**
University-center or office Program Support for Evidence-based MHL Programs	Participants highlight the importance of a designated center staff overseeing the program. Funding, data collection, oversight, training, scheduling, etc..
Dedicated and Skilled Local Instructors	Participants note that dedicated and skilled local instructors help the program be accepted, be sustainable, and be seen "as something being done for and with you, not at you." Instructors should be skilled.
Community Partners	Participants highlight the importance of developing strong community partnerships, particularly with a community champion, local businesses, medical professionals, and nonprofits with similar goals, as a key strategy for enhancing collaboration, resource sharing, and long-term program sustainability
Trained School Staff	Participants reference the need for school personnel, including counselors and other staff, to be adequately trained to recognize and respond to students experiencing mental health challenges. Participants emphasized that, due to high staff turnover and shortage in rural schools, maintaining a consistent presence of trained professionals is essential to ensure continuity of support and timely intervention for students in need.
Essential Resources Needed by Rural Schools for the Delivery of an Evidence-based MHL Program	
Responding to an Identified Community-Need	Participants stress that it is best to have a community invite them in. They brought evidence-based MHL programs into the community, as mental health/suicide prevention was an identified need of the community.
School and Community Buy-in	Participants emphasized that community and school staff and/or district leadership support are crucial to the program. Participants emphasize trust and transparency and a community champion.

Adequate Funding for Schools and MHL Programs	Participants highlight that funding cuts impact schools and their ability to provide evidence-based MHL programs and mental health support in general.
Program Structures that Work in and With Rural and Tribal Structures	Participants note that it is important to implement a program that can work in rural and Tribal contexts, taken into consideration, barriers like distance, weather, conservative views on education, program protocols, ect.
RQ#2- What outcomes of an evidence-based MHL program in a rural school are identified by stakeholders?	
Observed Outcomes of an Evidence-based MHL program in Rural Schools	
Increased Active Student Participation and Connection in YAM	Participants highlight that the interactive and student-centered aspects of YAM led to higher levels of student engagement and connection.
Increased Access to Credible Mental Health Information and Resources	Participants note that the mental health information and resources provided in YAM are credible in an era where youth have so much information at their fingertips (TikTok era), but not necessarily all sources are accurate.
Improved MHL Among Youth	Participants highlight that students' MHL improves, including knowledge about mental health and help-seeking behaviors. his includes reaching out to trusted adults, peers, counselors, or other resources (988)
Decrease in Stigma Surrounding Mental Health	Participants perceptions that the implementation of YAM, led to more open conversations about mental health, reduced shame or fear associated with seeking help, and greater acceptance of discussing emotional well-being among students and school
RQ#3 How could delivery of an evidence-based MHL program in a rural school be improved?	
Recommendations for Improving Program Delivery in Sustainability	
Reliable Funding Streams	Participants highlight the importance of a sustainable stream of program funding to continue to off-balance the costs or continue evidence-based MHL programs at no or little cost to schools.
Program Flexibility	Participants emphasize the importance of adhering to program protocols to maintain

	fidelity, while also advocating for reasonable flexibility and instructor discretion to adapt to rural school realities and student needs.
Training Flexibility	Participants suggest that local autonomy and flexibility around the training for evidence-based MHL programs would better meet the needs of what rural instructors will face in the classroom.
Cultural Adaptation for Program Materials	Participants emphasize that tailoring program materials, or visuals to reflect the cultural values, beliefs, and lived experiences of the communities being served would improve the programs, particularly in Tribal context to increase engagement, and promote relevance.