

THE MENTAL WELLNESS CONVERSATION CURRICULUM: BETTER
UNDERSTANDING THE GAP BETWEEN FACILITATOR TRAINING AND COMMUNITY
CONVERSATIONS

by

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A thesis submitted in partial fulfillment
of the requirements for the degree

of

Master of Science

in

Community Health

MONTANA STATE UNIVERSITY
Bozeman, Montana

May 2024

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ABSTRACT

This thesis whether the MSU Extension Mental Wellness Conversation Curriculum (MWCC) is effective in terms of adequately preparing newly trained facilitators to lead their own community based MWCC conversations. The MWCC is a mental health and wellness conversation pedagogy designed to be delivered in rural communities by community volunteer facilitators. The Social Ecological Model (SEM) explains the nuance of this program and incorporates supporting studies that leverage community-based and volunteer-led techniques. The results from the volunteer training evaluation data, a pre-and post- survey, indicate a positive change in awareness, knowledge, and beliefs among the 24 facilitators regarding specific mental health and wellness content presented in the training. The results indicate high favorability from volunteers regarding their experience at the MWCC training and optimism about the future of MWCC as a mental health and wellness program. However, despite favorable and statistically significant improvements from pre and post training data, there has been stagnation among community volunteers leading their own MWCC conversations. In response to this finding, a follow up exploration into possible explanations was conducted. Results indicated the importance of volunteer training as a predictor of volunteer engagement success. Additionally, the following themes were explored to understand the impact they had on MWCC volunteer engagement: 1) the duality of agency and autonomy in volunteering, 2) the explanatory power of the Self-determination Theory as it relates to volunteer motivation, 3) the importance of volunteer recruitment strategies and clear objectives, 4) the value of skills-based volunteering, and 5) the importance of content delivery within a training to maximize future engagement. Minor adaptations to the MWCC training and evaluation efforts would be beneficial for improved volunteer engagement going forward. Future research suggestions include further exploring how social context and environmental factors may impact the success of community based MWCC conversations.

INTRODUCTION

Fifteen percent, or 46 million people, call rural America home (Centers for Disease Control, 2023). Rural communities make up a sizeable portion of the United States yet are historically underserved across the continuum including access to health care, social services, and mental health services (Baffour, 2011). As urban cores continue to grow and prosper, the divide between urban and rural communities continues to expand, and existing health disparities are becoming increasingly more evident among their populations (Pagaduan, 2021). Unfortunately, as urban health seems to be improving overall, rural health disparities have continued to grow, creating a deeper and more evident divide (Cosby et al., 2008). The reasons for these increasing rates of health disparities are innumerable. For example, rural Americans are more likely to participate in risky behavior including smoking, substance use and abuse, as well as engage in less physical activity and consume calorically higher diets (Richman et al., 2019). Additionally, rural individuals experience higher rates of poverty and lower health insurance rates (Centers for Disease Control, 2023). While these might seem like preventable lifestyle differences, many are the result of environmental factors, lower socioeconomic status, and other systemic social inequities only found in rural contexts (Richman et al., 2019).

Unfortunately, the COVID-19 pandemic has only exacerbated many existing disparities and further widened the gap between urban and rural communities (Cacari Stone et al., 2021). The COVID-19 pandemic has also intensified inequitable healthcare access for rural communities, making access to hospitals and preventable care more challenging.

Healthcare access often conjures up a specific amalgamation of images focused entirely on physical access and utilization. Beyond service utilization, the data suggests that *access* can be

conceptualized as having the tools, knowledge, and resources to identify what an individual's healthcare needs are (Coombs et al., 2022). In this way, *access* is viewed as a far more nuanced and complex concept and needs to include what might not be outwardly visible, often hidden within social and systemic structures.

Healthcare access can be distilled down into five categories that can serve both as barriers as well as opportunities to facilitate access (Coombs et al., 2022). The five dimensions of healthcare access as defined by Levesque et al., include: 1) acceptability, 2) approachability, 3) availability, 4) affordability, and 5) appropriateness (Levesque et al., 2013). Examples of these dimensions in action include: 1) healthcare literacy, 2) lack of available health services for individuals and families, 3) lack of appropriate healthcare providers in communities, 4) lack of affordability for the care they need and want, and 5) lack of available options for individuals and families to engage in healthcare systems that are culturally and socially appropriate for them. Unfortunately, as a result of increasing health disparities, rural Americans have a higher likelihood of dying from the five leading causes of death including cancer, chronic lower respiratory disease, stroke, and heart disease (Cacari Stone et al., 2021). Rural America is unique in health needs; solutions must be in alignment with the needs of each unique community, leveraging existing and available resources.

Mental health access specifically has proven to be exceptionally challenging for rural individuals. As of 2021, 8.6 million nonmetropolitan American adults reported having a mental illness which equates to roughly 22.7% of the rural population (Rural Health Information Hub, 2024). Of rural adults, 5.1% of this population, or 1.9 million adults, reported having thoughts of suicide (Rural Health Information Hub, 2024). Because so much of the United States lives in

rural America, improving social and economic conditions including increasing educational attainment, decreasing stigma and discrimination associated with mental healthcare utilization, improving socioeconomic status, as well as increasing access to mental healthcare provider(s) is critically important (Morales et al., 2020). Changing these structural and social barriers can have a substantive effect on this often-underserved population (Baffour, 2011). To understand what is going on within rural America, we must first ask – who, what, and where is considered rural?

What Does it Mean to be Rural?

For many, the idea of rural intimates a variety of imagery, including sparse barren landscapes, dirt roads, and farmland (Childs et al., 2022). It seems that despite the ease with which we conjure up these images of rural, defining it remains a far more challenging task (Childs et al., 2022). Sometimes the definition is thrown around so haphazardly it is impossible to arrive at a concise definition (Krout, 1986, as cited in, Childs et al., 2022). Defining rural has long been a complicated task. While rural America faces a litany of barriers related to health equity, often one of the greatest barriers is the overabundance of definitions available to define these regions. According to Childs et al., there are 33 federal definitions of rural (Childs et al., 2022), the three most utilized definitions and the distinguishing features of each are outlined in table 1.

Table 1. Common Definitions of Rural

	Unit	Definition
U.S. Census Bureau ¹	Population density	• Urbanized Areas (UAs) have a population of 50,000 or more. • Urban Clusters (UCs) have a population of at least 2,500 but less than 50,000 • No defined definition for rural, anything not urban is considered rural
Office of Management and Budget ²	Metro-nonmetro status of county	• A Metro area has a population of 50,000 or more. • A Micro area has a population of at least 10,000 but less than 50,000. • All areas not considered Metro are rural
Federal Office of Rural Health Policy ³	*Rural Urban Commuting Codes (RUCA)	• RUCA code assigned to each census tract • All non-metro counties considered rural • All RUCA codes 4-10 considered rural • Large Metro census tract with 400 sq. miles with 35 or less in population density per square mile, with RUCA codes 2-3

^{1, 2, 3} Adapted from (Health Resources & Services Administration, 2024)

Today, so much of America might not fit within these neatly packaged definitions of rural, leaving a cohort of our population caught in the cross hairs of being forced to ascribe to one or the other. If this seems problematic, it is, but why? Simply put, a variety of definitions leads to a variety of interpretations and thus a variety of applications. Additionally, rural communities are complex, and these definitions dilute the strengths, assets, and diversity of rural communities (Afifi et al., 2022). Varying definitions of rural can have significant impacts on resource availability, exacerbating disparities in education, health, and infrastructure (Childs et al., 2022). Numerous definitions can also lead to drastic issues with policy implementation dependent entirely on

whether a community is defined as rural or non-rural (Nelson et al., 2021). Moreover, these various classifications often influence funding allocations by the federal government which is often used in coordination to plan and monitor policy interventions (Childs et al., 2022). Solutions to issues in health are often prescribed from urban areas to rural areas based on how “rural” an area is considered and under certain definitions certain services are authorized. These various definitions can significantly impact service allocation, resource availability, education, and other social determinants of health. Importantly, policies focused on health care services are impacted by which rural definition is selected (Childs et al., 2022).

Rather than utilizing a basic definition of rural, applying an asset and strengths-based lens expands the conceptualization of rural and its possibilities (Afifi et al., 2022). Examples of a more inclusionary rural definition include the Index of Relative Rurality (IRR) which plots rurality on a continuum from high rurality to low rurality and is unit and threshold-free (Waldorf & Kim, 2018). This definition, over other typology-based definitions allows for flexibility and conceptualizes rural within a broader context (Waldorf & Kim, 2018). Simply put, the IRR is a broad definition, allowing for far more nuance and flexibility while simultaneously acknowledging the extensive factors that might make a place rural, unlike the unit-specific typologies of most other definitions. The IRR questions the degree of rurality instead of whether a community is rural or urban (Waldorf, 2007). The foundation for the IRR suggests that it is important to consider a rural community’s proximity to resources, when designating an area as rural. The resource isolation scale factors in a rural community’s adjacency to other resource rich communities (Doogan et al., 2018). For example, if a rural community can access a resource-rich community with relative ease, it would be considered less isolated. Conversely, if a community is highly isolated, it lacks access

to extraneous resource-rich communities. Moreover, this isolation framework also takes into account the existing resources within each community, and the accessibility of said resources as well as extrinsic resources in surrounding communities (Doogan et al., 2018).

Complimenting the above definitions is the Rural Wealth Framework (RWF), a definition that renegotiates what it means to have wealth and reframes wealth in terms of assets (Afifi et al., 2022). These assets can be viewed as a community capital and include physical capital, financial capital, human capital, intellectual capital, political capital, natural capital, social capital, and cultural capital (Rural Policy Research Institute, n.d.). The IRR, resource isolation scale, and RWF conceptualize rural in a far more nuanced and flexible manner, factoring in all the specific ways in which a community might be defined as rural, each of these definitions can be found in table 2.

Table 2. Flexible Definitions of Rural

	Unit	Definition
Index of Relative Rurality (IRR) ¹	N/A	• Four dimensions of rurality: population, population density, extent of urbanized area, distance to closest metro area • Index is 0 to 1 with 0 being the most urban and 1 being the most rural place
Isolation Index ²	Census tracts	• Access to resources, extrinsic or intrinsic to community • Tracts resource access is determined on 1) available intrinsic resources or 2) adjacent tracts available resources
Rural Wealth Framework (RWF) ³	N/A	• Measurement of tangible and intangible wealth/capital • Assets viewed collectively to conceptualize well-being • Capital includes physical capital, financial capital, human capital, intellectual capital, political capital, natural capital, social capital, cultural capital

¹ Adapted from (Waldorf, 2007)² Adapted from (Doogan et al., 2018)³ Adapted from (Rural Policy Research Institute, n.d.)

The importance of more modulated definitions of rural cannot be understated; binary unit-base typologies have significant impacts on rural identity, resource allocation, and policy implications.

From Deficit to Strength Based

Of equal importance to defining rural is the deficit-based approach often applied to rural research and programming. While the attention on various health issues plaguing rural communities is important as it focuses funding, it also contributes to a continuation of rural stereotypes (Bourke et al., 2010). These stereotypes perpetuate a narrative among the public that rural health is at its core problematic (Bourke et al., 2010). This is of particular importance among rural communities with historically and systemically marginalized groups. Rural communities present a wealth of strengths that can be leveraged and used for their success. Rural individuals often share solid bonds as well as community strength and cohesion derived from shared events and experiences (Hall Lang et al., 2020). As Robert Meit, co-director of NORC Walsh Center for Rural Health Analysis stated in *Achieving Rural Health Equity and Well-Being: Proceedings of a Workshop*,

“Rural communities are close-knit. People know each other. They come to each other’s aid. They are resilient. There are a lot of positive factors about being in a rural community that can be leveraged” (Olson & Anderson, 2018)

A happy medium exists in acknowledging the challenges and disparities that exist within rural communities while also recognizing the inherent strengths of these communities and the individuals who call rural America home. Strengths based approaches can improve community engagement as well, cultivating positive and transformative relationships between researchers and the community (Rubin et al., 2012).

Community-based Healthcare

While rural communities present a plethora of strengths including close knit community bonds and distinct cultures, tightly held beliefs and stigmas attached to mental and physical wellness can pose challenges to designing and implementing preventative healthcare programs. Stigma towards mental healthcare utilization in rural communities is understood at both the public stigma level and self-stigma level, both impacting the other in profound ways. Ideally, mental health interventions target stigmas at both levels (Smalley et al., 2012). In a study conducted by Brems, Johnson, Warner, and Roberts (2006), they found that perceived stigma as a barrier to healthcare utilization was strongest in communities of 3,500 to 14,999 individuals (Smalley et al., 2012). This sentiment further typifies the importance of how a rural community is defined as per the discussion above. Of course, there are obvious barriers to healthcare implementation such as limited connectivity, limited providers, reduced federal funding for health programming, and reduced health literacy. Even though only 14% of Americans live in rural areas, these communities account for nearly two-thirds of Americas primary care health shortage areas (Waldrop & Gee, 2022).

Because of the clear gap in mental health resource availability, stigmas, and healthcare utilization rates, solutions to rural health equity need to involve creative solutions that challenge traditional healthcare paradigms. One evidence-based solution is community engaged healthcare. Community-based healthcare coordinates across multiple disciplines including health promotion, community psychology, health policy, and public health education and focuses on social and behavioral change as catalysts to improve health (Wallerstein & Duran, 2010). Community engaged healthcare can intervene at the crossroads of public and self-stigma and address both, in

tandem. Importantly, community engaged healthcare puts the community at the core of its own health and social systems and as the chief beneficiary, prompting community solutions, policies, and overall well-being (Schiavo, 2021). Through the coordinated mobilization of existing infrastructure, community members, available resources, and community knowledge, community-based and engaged healthcare offers an alternative to traditional preventative healthcare modalities.

Community volunteers can play an essential role in community-based healthcare, cultivating a sense of unity and empowerment among individuals while simultaneously addressing emergent health needs. This healthcare modality, through the utilization of volunteers, can improve access and social cohesion within communities. The core tenants of community-based and volunteer-led health programs rely heavily on leveraging social capital and collaborative care to provide programming and solutions (Castillo et al., 2019). Community health programming can provide services that empower communities in the process of coordinating services based on existing needs and leveraging community health workers, a commonly utilized volunteer strategy within community-based healthcare (Barker et al., 2021).

Two commonly utilized research paradigms leveraging this type of engagement include community-engaged research (CEnR) as well as community-based participatory research (CBPR) (Ortiz et al., 2020). CEnR is defined by the Centers for Disease Control as “the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people” (Penn State Clinical and Translational Science Institute, n.d.). CBPR, typically utilized in academic-community partnerships, emphasizes the importance of working in conjunction with

community as equal partners throughout the entire research process (Holkup et al., 2004). It is not necessary to specifically utilize either one of these research paradigms, but they provide a promising peak into the future of community-based programs at the academic, community, and partnership level.

When considering how to design a program model for rural America, it is imperative to reorganize and reimagine how traditional academic research is designed and implemented. Often, research and outside programming have been a troublesome prospect for marginalized communities because of the risk and potential for destabilization (Wallerstein et al., 2018). Some common concerns include a lack of autonomy for community members, power imbalances between those designing and implementing the program and program recipients, research without community benefit, and lack of cultural understanding (Cochran et al., 2008; Cook & Jackson, 2012, as cited in Wallerstein et al., 2018). Because of the sheer magnitude of the health need as well as the value systems that naturally exist within rural communities, designing programming requires a thoughtful and intentional approach which prioritizes all aspects of community and highlights the strengths of a rural environment. Fortunately, the power of public health and community-based healthcare is becoming increasingly more evident in rural communities. Community-led programs, reliant on local volunteers, have shown significant promise in addressing and improving issues of health equity and access among rural communities.

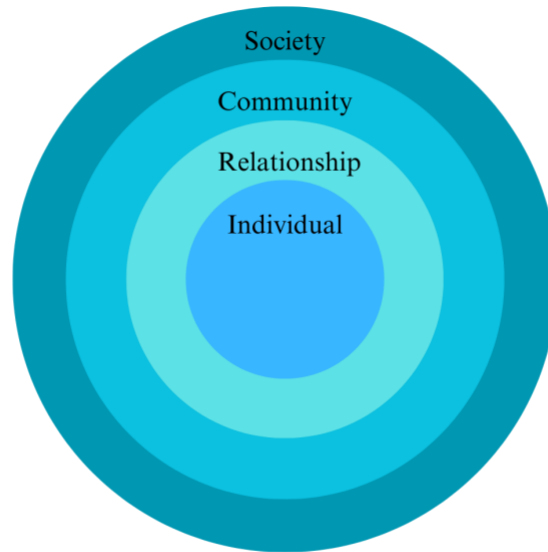
Community based healthcare can help communities identify and set priorities as well as foster a sense of community agency and ownership over the success of programming (Durrance-Bagale et al., 2022). Community-based healthcare programs can also often illuminate social

inequities and activate communities and leaders to identify structural determinants of mental health affecting their community (Castillo et al., 2019). Importantly, community-based programs cannot be viewed as the only solution to issues in health equity among rural communities. These programs are another tool in the toolbox and used with additional efforts. By utilizing volunteers and community-based programs, rural communities can begin to regain agency and close the ever-growing gap between needs and services utilization. From a theoretical perspective, how and why are community-based programs successful?

Social Ecological Model (SEM)

To understand how and why community-based programs can positively impact preventative mental and physical health, as well as long term health behavior change, analyzing the efficacy of such programs through the lens of the social ecological model (SEM) is useful. The SEM is often referred to as a theory, framework, or model; all of these are accurate descriptions and can be used interchangeably. On a macro level, this model conceptualizes health as broadly impacted by key factors within the world around us (Centers for Disease Control, 2022) such as our individual characteristics, relationships, community, and society. While there are multiple variations of the SEM, in its most simplistic form this model consists of four levels that build from the inside out (see figure 1).

Figure 1. Social Ecological Model



These factors around us, often referred to as ‘spheres’ of influence are individual, relationship, community, and society. On a micro level, the SEM fosters system wide interventions by looking at all the spheres of influence as a unit, as well as opportunities where focused programs might maximize their acceptability and sustainability (Moore et al., 2013). Evidence suggests community-based programs aimed at improving mental and physical health can have positive impacts across the SEM (Castillo et al., 2019).

The SEM is of great significance because it demonstrates how behavior is influenced across multiple levels as well as highlights the various levels where interventions might be focused to generate behavior change among a population (Caperon et al., 2022). The individual level refers to a person's individual characteristics such as age, income, education attainment, health history, coping skills, personal characteristics, and biological factors (Center for Leadership Education in Maternal and Child Public Health, n.d.). The relationship level, often

referenced as the interpersonal level, refers to the social relationships in an individual's life such as family, friends, partners, all those who contribute to life experiences directly (Centers for Disease Control, 2022). The third level is the community level which conceptualizes how our social environment, workplaces, schools, neighborhoods, and groups we belong to might impact our lives (Center for Leadership Education in Maternal and Child Public Health, n.d.). The last level is the society level which underpins which societal factors may play the most significant role in our health, either favorably or unfavorably (Centers for Disease Control, 2022). The societal level includes policies, education, economic conditions, cultural, and social norms that might create, maintain, or reduce inequalities (Krug et al., 2002).

There are numerous examples of the SEM at work within health programs. In a notable study conducted in Australia, an obesity prevention plan developed programs targeted at decreasing the obesity epidemic in children (Moore et al., 2013). The intervention targeted multiple levels of the SEM, such as utilizing activities that impacted school policies and guidelines to activities that promoted individual behavior change among the youth participants (Moore et al., 2013). Specifically, the 'Be Active, Eat Well' (BAEW) intervention resulted in significant change across the entire SEM such as; 1) improved nutrition and behaviors among youth participants, 2) increased community capacity to sustain obesity prevention, 3) improved school policies and environments (Moore et al., 2013).

The SEM can also be utilized as a guide and framework for which risk associated with specific disease and health conditions development can be better understood, such as a study conducted by Baral et al., 2013 which utilized this model to explain HIV epidemic dynamics. The SEM in this context acknowledges the impact that individual behavior has on disease spread

while also demonstrating the importance of the various other social and structural levels of the SEM (Baral et al., 2013).

There are two research questions that guide this thesis: 1) *Did the MWCC facilitator trainings impact the volunteer facilitators confidence, awareness, and knowledge of mental health and wellness topics as well as confidence leading a MWCC conversation?*, and 2) *Are there external factors that could be impacting the successful facilitation of MWCC conversations, and if so, how can the SEM be utilized to understand these factors?*

LITERATURE REVIEW

Community-based Health Interventions

While the below community-based programs were not designed through the lens of the SEM, their effectiveness can be analyzed with this framework in mind. In general, there are gaps in the literature when it comes to successful implementation and analysis of volunteer-led community based preventative health programs in rural contexts. The below community-based, volunteer-led programs have been documented as both successful as well as instrumental in the design and generation of other similar community-based preventative programs. The term lay health worker is often synonymous with community health worker and used interchangeably. Many community-based programs rely on the utilization of lay health workers (LHW) or community health workers (CHW). LHWs and CHWs are briefly trained volunteers who are trained to promote a particular area of health or assist in carrying out healthcare services. It is important to note that these individuals are not healthcare professionals (Lewin et al., 2010). There are numerous studies that have been conducted utilizing LHWs to supplement for existing health care gaps and to provide additional preventative care. Numerous studies have concluded that CHWs have important advantages over professionally trained health professionals such as improved trust with patients, cost saving, and enhanced cultural relevance of healthcare (Gilmore & McAuliffe, 2013, as cited in, Woldie et al., 2018). One example of a community-based intervention is the *Atmiyata* program.

The Atmiyata Program

The *Atmiyata* intervention is an evidence-based intervention that was conducted over a two-year period (2013-2015) in the Nashik district, in the state of Maharashtra India (Shields-Zeeman

et al., 2017). The program development and evaluation were funded through Grand Challenges Canada (Shields-Zeeman et al., 2017). The program was also implemented in partnership with BAIF Development Research Foundation, a local non-governmental organization (Shields-Zeeman et al., 2017). Today, *Atmiyata* is a widely known community-based intervention recognized by the World Health Organization. *Atmiyata* means shared compassion in the local language and is representative of the core value of the program (Shields-Zeeman et al., 2017). The *Atmiyata* program was developed as a direct response to the growing mental health crisis in India. The program targeted nearly 14,000 adults within the Peth block of Nashik district in Maharashtra (Shields-Zeeman et al., 2017). The Peth block was identified from census data from the Government of India as having heightened levels of socio-economic distress as well as a gap in available treatment options (Shields-Zeeman et al., 2017). Additionally, the BAIF Development Research Foundation, already has a rapport within the community from previous community development projects and programming (Shields-Zeeman et al., 2017). The target audience of the *Atmiyata* intervention are two distinct groups: 1) people experiencing emotional stress or common mental health disorders (CMDs), and 2) individuals with severe mental illness (Shields-Zeeman et al., 2017). The demographic population of the Peth area is almost entirely tribal populations (96%), all of which face social and economic deficiencies (Shields-Zeeman et al., 2017).

The *Atmiyata* program is a community-led intervention that focuses heavily on reducing stress as well as anxiety and depression symptoms in rural communities through the coordinated use of community volunteers (dubbed *Atmiyata* champions) to assist in the identification and delivery of mental health and social support to peer community members (within either of the target groups) struggling with their mental health (Joag et al., 2020). This program leverages

community volunteers to reduce existing treatment gaps and improve quality of life among their peers while tangentially improving community strengths and resources which ultimately improves community and individual well-being (Shields-Zeeman et al., 2017).

The *Atmiyata* program has four goals: 1) reduce treatment gap for common mental health disorders (CMDs), 2) improve mental health outcomes for those experiencing CMDs, 3) improve quality of life for those experiencing CMDs, and 4) improve access to social welfare schemes for individuals suffering from CMDs (Joag et al., 2020). Prior to implementing the *Atmiyata* intervention, a community needs assessment was conducted to identify community needs around mental and social health (Shields-Zeeman et al., 2017).

Atmiyata champions are local volunteers who engaged in over 40 hours of training over a three-week period to become community facilitators of the program (Pathare et al., 2023). Champions were identified by program staff. In total, 59 community facilitators (*Atmiyata champions*) and 264 community supporters (*Atmiyata mitras*) were trained over a seven-day intensive content-related training (Shields-Zeeman et al., 2017). *Atmiyata* mitras had one full day training and were paired with *Atmiyata* champions at a ratio of 5:1 (Shields-Zeeman et al., 2017). Some individuals who were prospective *Atmiyata* champions had to withdraw from the training because no pay was provided (Shields-Zeeman et al., 2017). Selection criteria for *Atmiyata* champions included commitment to work on a voluntary basis, strong communication skills, existing knowledge of their communities, a sense of pride in helping others, and a willingness to allocate time towards training (Shields-Zeeman et al., 2017). There were no literacy requirements for champions and monetary compensation was not provided, however all champions received a smartphone as an in-kind gesture (Shields-Zeeman et al., 2017).

Supervising the *Atmiyata* champions were individuals who are trained mental health professionals responsible for managing 40-50 *Atmiyata* champions each (Pathare et al., 2023). Once the champions were trained, they were assigned to a village and tasked with monitoring the community for distress as well as conduct 4-6 psychological analyses (Shields-Zeeman et al., 2017). If these analyses were not successful, *Atmiyata* champions would refer individuals to more specialized care (Shields-Zeeman et al., 2017). Each of these sessions are administered and delivered at the champions discretion and all are hosted in locations the participants choose such as their homes, village halls, temples, etc. (Pathare et al., 2023). The champions have support outside of their direct peers including a team of psychiatrists, public health experts and non-governmental workers who are all involved throughout the process and work directly with local governments to ensure that community champions feel empowered and supported to refer their peers to the correct resources (Shields-Zeeman et al., 2017).

This program was considered largely a success and can serve as an example for future community-based programs (Shields-Zeeman et al., 2017). Results from this intervention showed that those who utilized the *Atmiyata* program were clinically and statistically more likely to see improved rates of recovery from periods of distress (World Health Organization, 2021). Additionally, there was a marked improvement in depression, anxiety and CMDs overall for participants after three and eight months, respectively (World Health Organization, 2021). Importantly, quality of life reported by participants showed significant improvements after eight months (World Health Organization, 2021). It was found that this sort of intervention design is well suited for low-resource settings as it does not require additional outside resources or infrastructure (Shields-Zeeman et al., 2017).

Lay Health Workers (LHW)/ Community Health Workers

In a study conducted at the Arizona Prevention Research Center, researchers analyzed the effectiveness of the Linking Individual Needs to Community and Clinical Services (LINKS) program from 2017 to 2018 (Lohr, 2021). This program took place within three Arizona border counties: Pima, Yuma, and Santa Cruz, and involved partners from three federally qualified health centers as well as two county health departments (Lohr, 2021). Staff from the Arizona Community Health Workers Association (AzCHOW) trained community health workers in a behavioral health training program called Sonrisa as well as Mental Health First Aid (MHFA) (Lohr, 2021). The Sonrisa curricula addressed comorbid depression and diabetes among Latinos (Lohr, 2021). Throughout the program, CHWs were given the opportunity to participate in monthly trainings both from the AzCHOW staff as well as co-learning with their CHW peers (Lohr, 2021). The CHWs sought participants for the LINKS program by attending local health fairs and community events (Lohr, 2021). The CHWs provided emotional support as well as aided participants in navigating service utilization (Lohr, 2021). Throughout the process of relationship building between CHWs and participants, the CHWs also collected information via a questionnaire administered at baseline, three months, and six months to see what impact the relationship had on improving participant quality of life (Lohr, 2021).

The data was collected through three modalities: 1) social support inventory, 2) state hope scale, and 3) short form 8 (Lohr, 2021). This study found that emotional well-being indicators showed greatest improvements when their baseline intake scores were low (Lohr, 2021). Additionally, differences were found between males and females on the social support inventory (Lohr, 2021). The LINKS program likely impacts perceived social support and quality of life slightly more in men than women, however, the sample size for men (27) was small so further data

collection is needed (Lohr, 2021). There were notable improvements for the 189 LINKS participants across social support, quality of life, and perceived hopefulness (Lohr, 2021).

BACKGROUND

MWCC Development and Design

As per the discussion above, there is a growing mental health treatment disparity in rural America (Morales et al., 2020). Compared to urban individuals, rural individuals are less likely to utilize and receive care for mental health issues (Wang et al., 2005, as cited by, Pass et al., 2019). There are numerous explanations for the growing disparities in the mental health and wellness of rural individuals. The disparities that exist within mental health are also present in the physical health of rural individuals. Importantly, physical, and mental health intersect to compound existing conditions and exacerbate comorbidities. In fact, severe mental illness often correlates to higher rates of physical disease (Pass et al., 2019). Mental and physical health are inextricably connected to chronic illness and mental illness, and need to be examined in close tandem (Pass et al., 2019). The MWCC was developed as a response to the critical need for more innovation preventative care within the state of Montana.

This pedagogy factors in the importance of the SEM, recognizes the importance of rural barriers and boundaries, and focuses on community-based preventative care. The curriculum components were designed by Dr. Michelle Grocke-Dewey. Dr. Alison Brennan, Parker Webb and Katharine Sutphen. Lori Mayr managed all aspect of the curriculum design. The MWCC research team also collaborated with the Community Advisory Board (CAB), a group of individuals from across the Western Region of the United States with experience in counseling, human development, social services, etc. Throughout the development process of the MWCC, the CAB provided invaluable feedback and suggestions regarding the content.

The United States Department of Agriculture (USDA) began the Farm and Ranch Stress Assistance Network (FRSAN) in 2019; the intention of this new federal funding program was to connect communities in agriculture to established resources as well as provide funding to support new research avenues as well as develop new resources. The Western Regional Agricultural Stress Assistance Program (WRASAP) is the Western Region's FRSAN funded program. The WRASAP program was designed as having four components (research, networking, outreach, and direct services); the MWCC is one of the WRASAP funded outreach projects. To learn more visit www.farmstress.us.

The overarching goal of the MWCC is to normalize and facilitate discussions about stress, physical wellness, and mental health through informal community conversations, led by volunteer community facilitators. Unique to the MWCC, local community members are trained on how to lead conversations in their own community. These community members are referred to as MWCC facilitators or community facilitators throughout this thesis as well as MWCC materials. To become a MWCC facilitator, a volunteer is trained in both Mental Health First Aid (MHFA) and the specifics of how to facilitate and guide a MWCC conversation in their own community. By certifying community members in MHFA, facilitators are better prepared to handle certain sensitive topics that might arise during their own hosted MWCC conversations. Additionally, MHFA allows facilitators to have the tools and skills to act as mental health advocates and allies when emergent mental health needs arise within their community either before, during, or after MWCC conversations. The target audience of the MWCC is both the facilitators and community members who attend the facilitator-led conversations.

The MWCC consists of a deck of playing cards and a facilitators guide. The facilitators guide is a 63-page manual that contains accompanying content on mental and physical wellness, and stress. The guide is designed to be utilized in conjunction with the card deck at each MWCC conversation to provide supporting research-based information and discussion questions that the facilitators can leverage to support conversation among community members. Each card within the standard 54-card deck consists of content that fosters conversation through positive coping strategies and questions. There is no formal game that community members or facilitators must play; the cards are designed to simply foster conversation, regardless of whether a formal card game is played. However, simple games such as hearts, go-fish, or gin rummy, might be great games to play with the cards.

Each suit within the deck is dedicated to a different type of content including facts/explanations, tips/suggestions, discussion questions, and resources. All MWCC content is research-based stress management information. The numbers on the card correspond to a different theme such as nutrition, physical activity, breathing techniques, and specific coping strategies. The objective is for both the themes and health information to foster and promote conversation between community members regarding stress, mental health, and healthy lifestyle habits while ultimately highlighting the inextricable link between all these aspects of health. Facilitators receive multiple card decks to distribute at their local conversation events, and it is up to their discretion on how and where these community conversations take place. Facilitators, participants, as well as the general public can access more information on the MWCC via the website (https://www.montana.edu/extension/wellness/stress-management/mt_farm_stress_clearing_house/mwccindex.html).

The MWCC targets each domain of the SEM (figure 1) with specific attention to all SEM factors, particularly at the individual and community level. The MWCC looks to impart long term health behavior change at the individual level by targeting the surrounding factors of the SEM model. To start, in the immediate surrounding SEM sphere ‘relationships’ – the MWCC facilitates informal conversation with community peers which builds new relationships and/or strengthens existing relationships. The inherent conversation-based nature of the MWCC draws people together through strengthening social relationships- critical to managing and mitigating life’s stressors (Center for Leadership Education in Maternal and Child Public Health, n.d.). From a community lens, the MWCC conversations acknowledge the adverse impact of mental health on the overall community and frames community as a source for healing and strength. Because individuals are shaped by their direct social environment, creating a space within community that fosters social well-being can have significant impacts (Center for Leadership Education in Maternal and Child Public Health, n.d.). Lastly, because the MWCC is a federally funded program, data, and experiences from the MWCC conversations can be used to inform policy, allocate resources, and encourage conversations beyond our direct communities. All these incremental changes via the MWCC and across the SEM can lead to a societal shift in the way mental health and wellness is discussed and managed.

Training the MWCC Facilitators

The Mental Wellness Conversation Curriculum facilitator training has been administered to two separate facilitator cohorts, one in July 2023 and the other in December 2023 (table 3).

Table 3. Training Cohorts

Cohort	Training month	# of Facilitators	Training location
Montana	July, 2023	11	Bozeman, MT
Regional	December, 2023	13	Bozeman, MT

The July cohort is referenced interchangeably as the ‘Montana’ cohort, while the December cohort is referenced as the ‘Regional’ cohort. Each training was hosted in Bozeman, Montana over a two-day period. The Regional facilitator training consisted of a third day where facilitators brainstormed with the MWCC team on ways they could amend the content to fit the needs of their context and community. Facilitators in each training cohort stayed onsite at local hotels and participated in the training during the day. Meals and lodging were provided and funded by the WRASAP grant for both the July and December training. The training was amended for the second facilitator cohort: the days were split up to be half MHFA and half MWCC.

The first July cohort consisted of exclusively Montanans with eleven facilitators in total. These facilitators were trained to lead MWCC events in their specific communities throughout Montana. The December cohort consisted of thirteen regional representatives from across the Western Region (figure 2), as defined by the USDA. Facilitators from this region came from all over the Western region including Alaska, Guam, Arizona, Washington, Oregon, Colorado, and New Mexico. For each training, if facilitators were not already trained in MHFA, they participated in MHFA training on the first day of the two-day training period.

Figure 2. WRASAP Western Regional Map



EVALUATION METHODOLOGY

To evaluate the Mental Wellness Conversation Curriculum (MWCC), a paper-pre-training survey was administered prior to beginning the first day of training. Most individuals took this survey the night before in their respective hotel rooms. A second post-training survey was then administered at the end of the second (final) day of training for both the July and December training cohorts. Both pre and post surveys can be found in Appendix D-I. The pre-training surveys for each cohort contained IRB consent forms (Appendix B and C), qualifying their willing involvement in a research study as part of their participation in the MWCC training.

The pre-training survey consisted of five demographic items, four qualitative questions, and eight Likert-type scale items. The post-training survey consisted of eight Likert-type scale items identical to those on the pre-training survey, plus an additional six qualitative (open-ended) response items (Appendix F-G). Minimal alterations were made to the survey from July to December; all surveys can be found in Appendix D-G. Qualitative responses to survey items can be found in Appendix H and I.

Demographic question data were collected from both cohorts to capture commonalities, trends, and gaps where the MWCC team might improve outreach in the future to capture a more diverse facilitator training cohort. Demographic question items included questions about race, age, gender, profession, and educational attainment. Demographic data for both the Montana and Regional cohorts can be found in tables 4, 5, 6, 7, and 8, respectively.

Likert-type survey questions were selected for the survey because they are a commonly utilized psychometric scoring scheme to evaluate an intervention efficacy (Bishop & Herron, 2015). Each of the Likert-type scale questions evaluated how cohort facilitators felt about certain

aspects of the MWCC training content. Specifically, each Likert-type question assessed facilitators confidence, knowledge, and awareness associated with mental and physical wellness. Each Likert-type question began with the stem “At present” and with a ten-point scale, 1=*strongly disagree* to 10=*strongly agree*.

Once the surveys were collected, all survey data was entered into Qualtrics for storage. Qualtrics software was utilized for data collection, storage, and analysis of qualitative content; IBM SPSS version 29 was used for statistical analysis of Likert-type scale questions. A paired samples *t*-test was selected for statistical analysis to evaluate the effectiveness that the MWCC training had on each Likert-type question. A paired samples *t*-test compares the means of two different variables across a single group and is a valid measure of statistical significance when measuring change from one state (pre training) to another state (post training). The pre-to-post Likert-type items were first analyzed for the Montana cohort and next analyzed for the Regional cohort. The paired *t*-test analysis can be found in table 9 for the Montana cohort and table 10 for the Regional cohort.

To garner more feedback, in addition to the surveys, four facilitators from each cohort, eight in total, were contacted for brief semi-structured interviews in March 2024. The original IRB approval was amended and further approved to incorporate this ad-hoc follow up interview phase of data collection (IRB #: 2023-874-EXEMPT). Of the eight facilitators that were contacted, only four replied. Of those that replied, one was from the Montana cohort and three were from the Regional cohort. The reason that these interviews were added after the study had already begun was to garner additional input from facilitators regarding the training itself and the

feasibility of facilitators leading their own MWCC conversations. The questions for these semi-structured interviews can be found in Appendix J.

DATA AND ANALYSIS

Montana Cohort Demographics

Eleven individuals participated in the July facilitator training. Demographic information for these individuals can be found in the 'Montana' cohort column in tables 4-7. Demographic items on the pre-training survey included race, age, gender, profession, and educational attainment. Of the eleven facilitators in the July MWCC training, five (45.5%) were between the ages of 31 and 45, and six (54.5%) were between the ages of 46 and 64. There were two male (18.2%) and nine female (81.8%) facilitators. Each of the Montana facilitators identified as White when asked what ethnicity best describes their background. Of the eleven facilitators, three (27.2%) had a Master's degree or higher, four (36.3%) had a Bachelor's degree, one (9%) had an Associate degree, and three (27.2%) had a high school diploma or GED.

Regional Cohort Demographics

Thirteen individuals participated in the December facilitator training. Demographics for these individuals can be found in the 'Regional' cohort column in tables 4-7. Of the thirteen facilitators in the December MWCC training, three (23.1%) were under the age of 31, two (15.4%) were between the ages of 31 and 45, five (38.5%) were between the ages of 46 and 64, and two (15.4%) were over the age of 64, one (7.7%) participant declined to list their age. There were two (15.4%) male and eleven (84.6%) female facilitators. Of the thirteen facilitators, two (15.4%) identified as Hispanic or Latino, one (7.7%) identified as pacific islander, and ten (76.9%) identified as white. Of the thirteen facilitators, three (23.1%) had a doctoral/terminal degree, eight (61.5%) had a master's degree, and two (15.4%) had a bachelor's degree.

Combined Cohort Demographics

Collectively across both cohorts (24 facilitators), three (12.5 %) facilitators were between the ages of 18 and 30, six (25%) fell between the ages of 31 and 45, twelve (50%) fell between the ages of 41 and 64, and two (8.3%) were over the age of 65. Exactly half of all facilitators fell between the ages of 31 and 45. Overwhelmingly, the combined cohorts were mostly comprised of females with twenty (83.3%) identifying as female, and four (17.6%) identifying as male. Most facilitators identified as White with twenty-one (87.5%) identifying as so. Only one person identified as Asian or Pacific Islander (4.2%) and two identified as Hispanic or Latino (8.3%). Collectively, eleven facilitators (45.8%) had a Master's degree and six (25.0%) had a bachelor's degree. Three facilitators had a doctoral or terminal degree (12.5%) and one (4.2%) had an associate degree. Collectively, three facilitators (12.5%) had high school/GED as their highest level of education.

Both the Montana and Regional cohort had similar gender spreads. However, the Regional cohort had a wider breadth of represented age groups. The most notable demographic differences between these two cohorts were predominantly in education and occupation demographics. The December cohort more than doubled the number of facilitators with masters (8) and included three facilitators holding PhD/terminal degrees. There were three individuals who noted having a "master's degree or higher" within the Montana cohort. Additionally, the December cohort had no facilitators of which high school/GED was their highest level of education. Nearly one third of Montana facilitators had high school/GED noted as their highest level of education. As highlighted in table 8, there was more occupational variety among the Regional cohort as well. Nearly one half of the facilitators in the Montana cohort were representing the US Army.

Demographic Data of MWCC Facilitators

Table 4. Age of Facilitators

Item	<u>Montana</u>		<u>Regional</u>		<u>Combined</u>	
	<i>Value</i>	%	<i>Value</i>	%	<i>Value</i>	%
18-30	-*	-	3	23.1%	3	12.5%
31-45	5	45.5%	2	18.2%	6	25.0%
46-64	6	54.5%	5	38.5%	12	50.0%
Above 65	-	-	2	15.4%	2	8.3%
No Response	-	-	1	7.7%	1	4.2%
Total	11	100%	13	100%	24	100%

*- denotes a value of 0

Table 5. Gender of Facilitators

Item	<u>Montana</u>		<u>Regional</u>		<u>Combined</u>	
	<i>Value</i>	%	<i>Value</i>	%	<i>Value</i>	%
Male	2	18.2%	2	15.4%	4	17.6%
Female	9	81.8%	11	84.6%	20	83.3%
Trans-gender	-	-	-	-	-	-
Non-binary	-	-	-	-	-	-
Prefer not to answer	-	-	-	-	-	-
Not listed, please identify	-	-	-	-	-	-
Total	11	100%	13	100%	24	100%

Table 6. Ethnic Identity of Facilitators

Item	<u>Montana</u>		<u>Regional</u>		<u>Combined</u>	
	<i>Value</i>	%	<i>Value</i>	%	<i>Value</i>	%
Asian or Pacific Islander	-	-	1	7.7%	1	4.2%
Hispanic or Latino	-	-	2	15.4%	2	8.3%
Native or American Alaska Native	-	-	-	-	-	-
White or Caucasian	11	100%	10	76.9%	21	87.5%
Multiracial or biracial	-	-	-	-	-	-
A race/ethnicity not listed here, please identify	-	-	-	-	-	-
Total	11	100%	13	100%	24	100%

Table 7. Highest level of Education of Facilitators

Item	<u>Montana</u>		<u>Regional</u>		<u>Combined</u>	
	<i>Value</i>	%	<i>Value</i>	%	<i>Value</i>	%
Doctoral/Terminal Degree*	-	-	3	23.1%	3	12.5%
Master's degree	3	27.2%	8	61.5%	11	45.8%
Bachelor's degree	4	36.3%	2	15.4%	6	25.0%
Associates degree	1	9%	-	-	1	4.2%
Highschool/GED	3	27.2%	-	-	3	12.5%
Less than high school	0	-	-	-	-	-
Total	11	100%	13	100%	24	100%

*The addition of doctoral/terminal degree as an independent choice, instead of “master or higher degree”

Table 8. Occupation of Facilitators

	Montana
1	Soldier and family readiness specialist
2	Soldier and family readiness specialist
3	Soldier/family readiness specialist w MTARNG
4	N/A
5	Health equity/outreach coordinator
6	Program Assistant
7	Director of Community Relations for Nonprofit
8	Holistic Health and wellness/fitness specialist/primary prevention
9	Lead soldier and family readiness specialist
10	US Army Human Resources
11	Registered Nurse
	Regional
1	4-H/Family and Consumer Sciences Agent
2	Educator
3	Professor of extension distinct Family and Consumer Sciences Agent
4	Farmer Hotline Operator
5	MSU Extension FCS Agent
6	Professor/Extension health specialist
7	Extension agent
8	Graduate student
9	Non-profit program director
10	Behavioral health specialist
11	Extension associate specialist
12	Program coordinator
13	Educator

Qualitative Data Analysis

Facilitators were asked a series of questions in the training post survey to measure how comfortable they were with the content after the training (see Appendix E and G for responses). One question asked, “Do you feel that this training set you up to lead a successful MWCC in your own community, why or why not?” All facilitators from both cohorts (24) stated that yes, they felt the training set them up to successfully lead their own MWCC. One participant stated, “Yes, very extensive and detailed and physically addresses all areas towards mental health

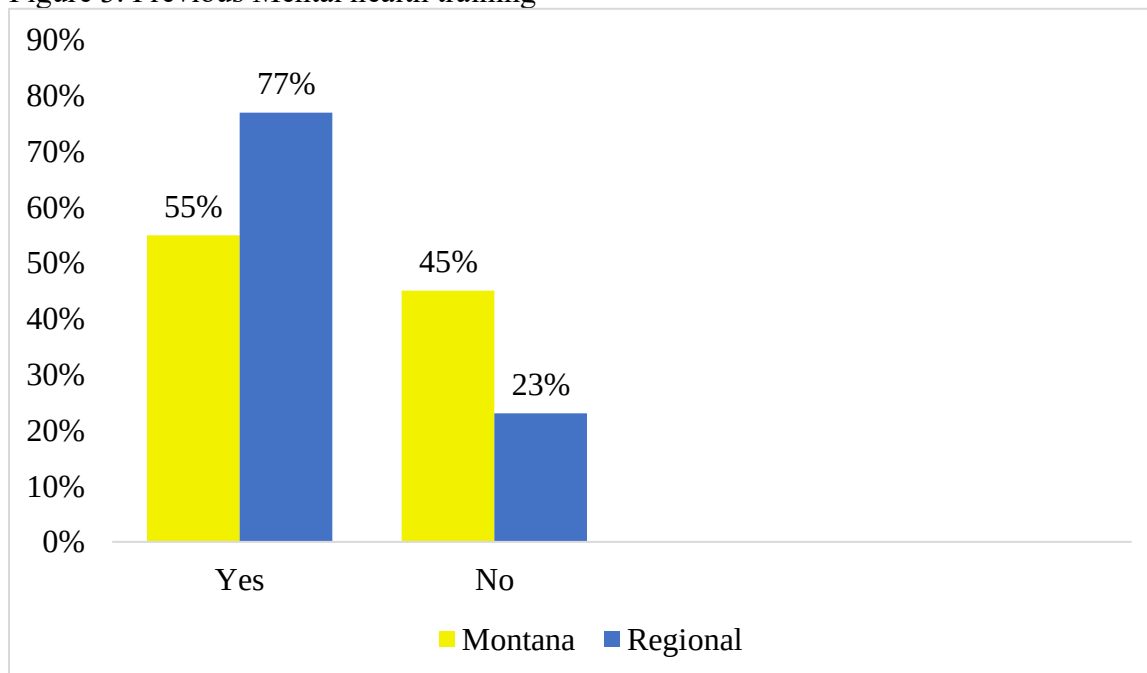
treatments”. (Montana cohort, no job listed). Another participant from the Montana cohort stated, “It’s a great start, would be confident to give an overview not an in-depth training” (Montana cohort, US Army HR). Another participant in the Montana cohort stated, “Yes, if I have the audience” (Montana Cohort, Soldier and Family Readiness Specialist). Within the Regional cohort, one participant answered the same question with “Yes, the extended training allowed time for dialogue and opportunity to engage the material in a manner that allowed learning confidence in comprehension” (Regional Cohort, MSU Extension FCS Agent). Anecdotally, each of these responses corroborates that the training was successful in improving confidence, knowledge, and awareness regarding the subject matter, but concerns were raised from the Montana cohort that they might not have the audience and that they needed further training to feel confident in delivering their own MWCC conversation independently.

When facilitators were asked the question “What skill, if any, do you need more training on?” four of the Montana facilitators responded with “N/A” and two responded with “Let me think/Can’t think of one for now”. Another participant stated, “I cannot think of one. I just need time to practice applying the skills that is something that can only be done through practical application and experience” (Montana Cohort, no job listed). Conversely, the Regional cohort gave a myriad of feedback regarding what additional skills they need more training on. One participant stated, “How to utilize the curriculum in a way that is specific to the populations I serve” (Regional participant, Extension Agent.) Interestingly, there were five participant responses from the Regional cohort that echoed needing more ideas for card deck implementation and how to play games. One participant stated, “I need to become more familiar

with how people typically use cards to offer different options of use” (Regional participant, 4-H/FCHS Agent)

There was a significant difference in the two cohorts as it relates to experience participating in mental health training (figure 3).

Figure 3. Previous Mental health training



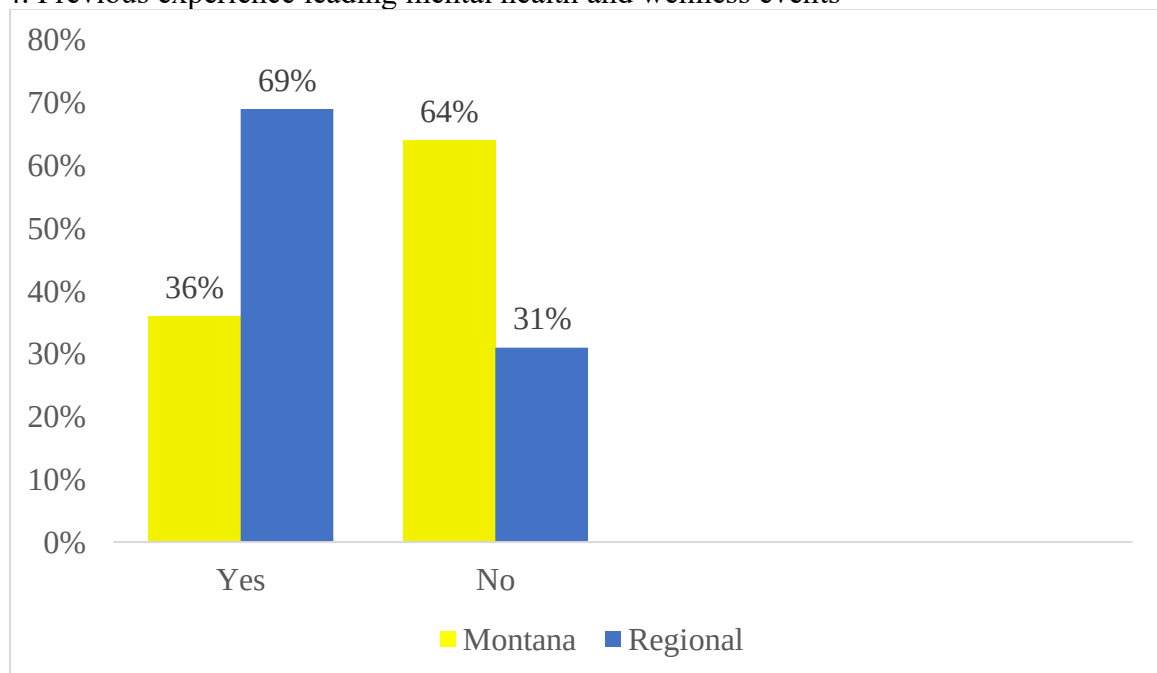
Of the Montana cohort, six (55%) indicated they had participated in a mental health training. Five (45%) of Montana cohort facilitators had never participated in a mental health training. Of those that had participated in a mental health training; one participant stated they had partaken in suicide prevention trainings, stress management trainings, mental health first aid; one participant stated they participated in Youth Health Mental Health First Aid (YHMFA); one participant stated that they had participated in annual assist/CARE training with the military; one

participant said they had participated in nothing very formal but some army training; and one participant stated they had done MHFA for both youth and adults.

Conversely, ten (77%) of the Regional facilitators had participated in a mental health training before, indicating that there was a breadth of previous mental health training among the Regional cohort. One participant took safe talk through NMSU as well as mental health first aid; one participant took a suicide prevention and awareness training; one participant had experience C-SSRS [Columbia Suicide Severity Rating Scale]; one participant took MHFA, one participant was a trained counselor, and one participant was trained in QPR and MHFA. Only three (23%) of Regional facilitators had never participated in a mental health training.

The gap was even wider when facilitators were asked if they had any experience leading a mental health or wellness event (figure 4).

Figure 4. Previous experience leading mental health and wellness events



Four (36%) of facilitators from the Montana group said they had previously led a mental health or wellness event while seven (64%) said they had no experience leading a mental health or wellness event. Of those that had led mental health or wellness events, one participant stated they led support events for deployed soldiers' families; one participant had led the stepping on program; one participant was an MHFA instructor; and one participant was a certified health and fitness director, health coach, health promotion specialist, and held other fitness instructor roles.

Of the Regional cohort, nine (69%) stated they had experience leading a mental health or wellness events, while only four (31%) signified that they had no experience leading a mental health or wellness events. Of those that said they had experience leading mental health and wellness events: one participant was a fitness and wellness instructor with over 20 years of experience; one ran a wellness and diabetes program as well as chronic disease management; one had experience leading YAM and QPR, one participant had led stress management programming; one was working towards becoming a registered horticultural therapist as well as running youth programming; one has been running mental wellness workshops in agriculture for two years; one was a mental health program lead; one led MHFA and QPR; and lastly one led QPR in Spanish/English, led group discussions and did case management. These ratios are nearly exact opposites of one another signifying the substantial difference in previous experience and training among these two cohorts

Quantitative Analysis of Montana and Regional MWCC Trainings

To analyze whether there was a change in Likert-type scale data from pre-survey responses to post-survey responses for each cohort, a paired samples *t*-test was run using IBM SPSS. Tables 9 and 10 provide descriptive statistics and paired samples *t*-test results for each of the eight Likert-type scale items from the Montana and Regional trainings from pre training to post training. Using Bonferroni correction for multiple comparisons, the *p*-value for a significant paired samples *t*-test has been adjusted to $p \leq .00625$. Bonferroni correction was utilized to reduce the likelihood of a Type 1 error. In other words, when conducting multiple tests, there is a significant likelihood of observing one significant result by chance, also known as the problem of multiple comparisons. The Bonferroni correction addresses this issue.

Montana Cohort

Using this adjusted *p*-value for the Montana cohort data (table 9), statistically significant improvements occurred for all items except item two (“I am aware of existing mental health and wellness resources in my community”) and item four (“I am confident in my ability to make recommendations and referrals to individuals regarding available resources”). Items that showed the most improvement from pre to post training for the Montana cohort include items 1, 3, and 8. Item 1 (“I am confident in my ability to lead a mental health wellness event in my own community”), item 3 (“I am aware of how to utilize existing mental health and wellness resources in my community”), and item 8 (“I am aware of strategies that promote mental wellness”).

Table 9 Paired samples t-test result for Montana training

Item	<u>Pre-training</u>		<u>Post-training</u>		Paired Samples <i>t</i>	<i>p</i> -value
	<i>Mean</i>	<i>SD</i>	<i>Mean</i>	<i>SD</i>		
1. I am confident in my ability to lead a mental health and wellness event in my own community.	5.36	2.11	8.55	1.57	-4.47	0.001*
2. I am aware of existing mental health and wellness resources in my community.	6.27	2.20	8.27	1.56	-3.40	0.007
3. I am aware of how to utilize existing mental health and wellness resources in my community.	6.09	1.97	8.45	1.37	-4.10	0.002*
4. I am confident in my ability to make recommendations and referrals to individuals regarding available resources.	6.91	2.39	8.45	1.39	-2.05	0.068
5. I can identify and name some positive coping skills.	7.00	2.32	9.09	0.94	-3.82	0.003*
6. I can identify and name some negative coping skills.	7.73	1.68	9.09	0.94	-3.75	0.004*
7. I understand the connection between mental wellness and physical wellness.	7.55	2.07	9.00	1.10	-3.53	0.005*
8. I am aware of strategies that promote mental wellness.	7.09	2.21	9.00	1.10	-4.01	0.002*

* *p*-values that are significant with Bonferroni correction ($p \leq .00625$)

Regional Cohort

In applying the same adjusted *p*-value for a significant paired t-test of $p \leq .00625$ to the Regional cohort (table 10) revealed statistically significant improvements for all items except for one, (“I am aware of existing mental health and wellness resources in my community”). Items 1, 5, 6, 7, 8 all had the most improvement from pre to post training. Items 1 and 5-8 all shared a *p*-value of .001. These items of most significance are as follows: item 1 (“At present, I am confident in my ability to lead a mental health and wellness event in my own community”), item

5 (“At present, I can identify and name multiple positive coping skills”), item 6 (“At present, I can identify and name multiple negative coping skills”), item 7 (“At present, I understand the connection between mental wellness and physical wellness”), and item 8 (“At present, I understand the connection between mental wellness and physical wellness”).

Table 10. Paired samples t-test for Regional training

Item	<u>Pre-training</u>		<u>Post-training</u>		Paired Samples <i>t</i>	<i>p</i> -value
	<i>Mean</i>	<i>SD</i>	<i>Mean</i>	<i>SD</i>		
1. At present, I am confident in my ability to lead a mental health and wellness event in my own community.	6.62	1.50	8.69	.947	-5.20	0.001*
2. At present, I am aware of existing mental health and wellness resources in my community.	7.00	2.24	7.92	2.10	-1.72	0.111
3. At present, I am aware of how to utilize existing mental health and wellness resources in my community.	6.23	2.20	8.00	1.87	-3.57	0.004*
4. At present, I am confident in my ability to make recommendations or referrals to individuals regarding available resources.	6.38	2.33	8.23	1.92	-3.49	0.004*
5. At present, I can identify and name multiple positive coping skills.	7.31	1.55	9.31	1.18	-5.89	0.001*
6. At present, I can identify and name multiple negative coping skills.	7.00	1.96	9.15	1.345	-5.78	0.001*
7. At present, I understand the connection between mental wellness and physical wellness.	7.31	1.75	9.85	.376	-5.34	0.001*
8. At present, I am aware of strategies that foster mental wellness.	7.23	1.64	9.69	.480	-5.18	0.001*

**p*-values that remain significant with Bonferroni correction ($p \leq .00625$).

Statistical Implications

These findings are statistically significant and demonstrate a positive change in attitudes, beliefs, and knowledge associated with the training as evidenced by facilitators responses to Likert-scale data. Both groups did not demonstrate statistical improvement on item 2 (“At present, I am aware of existing mental health a wellness resources in my community”), the Montana cohort had a *p*-value of 0.007 while the regional cohort had a *p*-value of .111. Item 2 is of particular interest as this suggests given the difference in *p*-value(s), the Regional cohort seemed to get less information from the training regarding existing mental health and resources in my community.

The Montana cohort started off with a lower mean from the pre-training survey (6.27), while the Regional cohort started off with a slightly higher mean at pre training survey (7.00). This suggests that the Regional cohort started off with slightly more awareness regarding available resources in their communities. The Montana cohort post-training survey mean for item 2 was 8.27 while the Regional cohort mean for item 2 was 7.92. Though the Montana cohort started with less awareness of existing mental health and wellness resources, they gained more overall throughout the training than the Regional cohort as it relates to item 2.

The Regional cohort consisted of facilitators from all over the rocky mountain west. It is possible that because facilitators came from all over the country to participate in the training, less conversations occurred among facilitators and with MWCC staff regarding specific resources available in their own respective communities, because there were no shared threads of location across the facilitators. It is possible that more conversations were had among the Montana cohort regarding item 2 which led to a slightly better improvement. These facilitators likely had

contacts, peers, and resources that they shared amongst one another throughout the training as well with MWCC staff. These findings for item 2 across both cohorts demonstrates an increased need to devote time to resource sharing and conversations around mental health and wellness resources. Interestingly, item 3 was statistically significant for both the Montana and Regional cohorts and was very similarly worded to item 2, with the only difference being the adage of asking facilitators their ability to utilize available resources (“I am aware of how to utilize existing mental health and wellness resources in my community”). One could conclude that this response from both cohorts merely represents comfortability navigating and utilizing what resources are available. The evidence suggests that facilitators of both cohorts did not improve their awareness of resources (item 2) but that they did show statistically significant improvements on how to utilize resources (item 3). It is possible that these similar questions confused facilitators, item 2 could have been omitted from the survey and been a part of a group discussion. It is obvious that in the future, further conversation is needed regarding available resources for all training cohorts.

Additionally, the Montana cohort had no statistical improvement in item 4 (“I am confident in my ability to make recommendations or referrals to individuals regarding available resources”). There were no mental health providers in the Montana cohort like there were within the Regional cohort. This lack of directly related professional experience likely contributed to the Montana cohort not noting an improvement in item 4. Moreover, this highlights the importance of professional experience as it relates to comfortability in making referrals and recommendations.

Interestingly, both the Montana and Regional cohort demonstrated an improved confidence in item 1 (“I am confident in my ability to lead a mental health and wellness event in my own community”), both with a p -value of .001 but neither group has led an MWCC event to date.

In responses to research question 1 (*Did the MWCC facilitator trainings impact the volunteer facilitators confidence, awareness, and knowledge of mental health and wellness topics as well as confidence leading a MWCC conversation?*), these significant statistical findings indicate that the MWCC facilitator trainings did impact the volunteers’ awareness and knowledge of mental health and wellness topics as well as confidence in leading an MWCC conversation.

While we can reasonably conclude that the training was effective at improving awareness, knowledge, and confidence regarding the material content, research question 2 (*Are there external factors that could be impacting the successful facilitation of the MWCC conversations, and if so, how can the SEM be utilized to understand these factors?*) is a little more nuanced and will be analyzed in the discussion section of this thesis. Although there were two items (item 2 and item 4) that did not show statistical improvement among the Montana cohort, six items did show statistical improvements. Similarly, the Regional cohort showed statistical improvements across seven items except one (item 2). While the training was largely successful, a critical component to the MWCC is the importance of community facilitators leading their own MWCC. An examination into duality of overall positive trends across training data yet minimal follow-through among community facilitators can be found in the interpretation section.

DISCUSSION

The MWCC has been well received throughout Montana as well as regionally and nationally. Demand for the curriculum continues to expand beyond the confines of its anticipated use. Numerous groups and leaders have asked for specific adaptations to meet the needs of the community or population they wish to serve. Examples of specific adaptations and modifications include 1) a youth version that will be created in collaboration in collaboration with Montana 4-H, 3) a Native version currently in its very early stages, led by a Fort Belknap representative in conjunction with local tribal members and lastly, 3) a Spanish version designed by a bilingual collaborator.

The MWCC team would like to continue dispersing the card deck and curricula with the long-term goal of fostering numerous MWCC conversations in rural communities both locally and nationally. Because the end goal is to disperse the curricula as much as possible, it is imperative that both the volunteer community facilitator role as well as the training be scrutinized for effectiveness. There are two critical components necessary to consider the MWCC training a success: 1) effective training and transference of MWCC content to community facilitators and 2) community facilitators effectively leading MWCC conversations with community members. These two seemingly disparate concepts are tightly connected when conceptualizing the overall effectiveness of the MWCC training because ‘effectiveness’ of the MWCC is reliant on both components working in tandem to disseminate the MWCC. If the data suggests that community facilitators statistically improved their knowledge, beliefs, awareness, and knowledge of the MWCC, where can we improve to ensure that community facilitator continues to then lead to MWCC conversations?

These two cohorts had different demographics, educational attainment, and varying occupations, among other factors. While these two groups were quite different, unpacking their experience and comfortability with the content both before and after training is imperative to understanding their volunteer engagement with the MWCC after training. Additionally, the stark contrast in enthusiasm and follow up between the two groups might indicate that either the content needs to be modified to be more suitable to a wide variety of audiences or that the MWCC needs to be administered to a narrower audience of volunteer facilitators. To better curate the MWCC curriculum to be more approachable and transferrable to a wide variety of audiences, facilitators, and contexts, an understanding of the strengths and limitations is necessary.

Exploring Facilitator Engagement Using the SEM

The long-term success of MWCC is reliant on ensuring that community facilitators feel equipped, enthusiastic, and comfortable leading their own MWCC event. Several key factors could be influencing facilitator engagement and provide opportunities for improvement, and each of these factors can be understood through the framework of the SEM. Beginning at the individual level and working outward, the following factors provide opportunities to improve facilitator engagement and ultimately improve the likelihood of MWCC conversations occurring. These factors, beginning at the individual level include: 1) the role of agency and autonomy, 2) explanatory power of self-determination theory, 3) skills-based volunteering, and at the relationship level: 4) recruitment strategies and objectives, and 5) content delivery. Focusing on these five factors as analyzed through the SEM could lead to improved facilitator engagement and more substantive impact of the MWCC in the long term. More research is needed at both the

community and societal levels to glean how external factors (i.e. social, economic, political, environmental) could be impacting the ability of a MWCC facilitator to host local community conversations.

Individual

It is important to note that while each of these factors explore specific characteristics of facilitators, it is not meant to be utilized to exclude certain specific volunteers but rather as an additional tool and mechanism with which to get curious about volunteer make up as well as how to improve the experience for each volunteer. The three individual factors that will be covered are: 1) agency and autonomy, 2) intrinsic motivation and its role in the self-determination theory, and 3) skills-based volunteering.

Agency and Autonomy

Allowing for agency and autonomy of facilitators was at the forefront of MWCC curriculum design and implementation. At the core of the MWCC is the belief that within rural communities, mental health and wellness interventions are best administered by those within community and with minimal outside interference. Autonomy, as it relates to volunteer engagement requires individual faculty and self-initiative (Deci & Ryan, 2020, as cited in, Fernandes & Aires De Matos, 2023). Additionally, evidence suggests that fostering autonomy among volunteers is a strong predictor of long-term volunteer engagement and work ethic (Bidee et al., 2013). Moreover, when volunteers' essential needs are met and volunteer duties align with their values, they feel more invested in the long-term success of the volunteer activity as well as an increased likelihood of contributing their own knowledge and resources to the overall volunteer objective,

fostering co-creation (Fernandes & Aires De Matos, 2023). In a study conducted by Fernandes & Aires de Matos, which analyzed survey data from 450 Non-profit organization (NPO) volunteers, they found that volunteers perceived autonomy, relatedness to volunteer work, and competence, as all strong predictors of volunteer engagement (Fernandes & Aires De Matos, 2023). If autonomy is important to volunteer engagement, and the MWCC indeed prioritized autonomy as an essential component of the design, could too much autonomy be a bad thing? How can the importance of autonomy in volunteer engagement be better understood through the utilization of the SEM?

At the individual level of the SEM, autonomy includes and can be influenced by a variety of variables including an individual's beliefs, values, age, and occupation. Given that each volunteer facilitator comes from a unique individual background, occupation, and life experience, it is imperative to consider these individual characteristics that might be influencing their autonomy as it relates to their willingness to lead MWCC conversations. Certain characteristics, such as occupation, age, and beliefs around mental health can certainly play a role in autonomy supporting behavior regarding volunteer engagement with the MWCC.

There is mixed evidence on the role that autonomy plays in volunteer engagement and commitment. Self-efficacy, a concept theorized by Joseph Bandura is the belief in oneself to be successful in carrying out a task (Wahome & Seed, 2024). Autonomous motivation posits that individuals act and engage because they inherently believe, understand, and endorse the activity with which they are willingly participating (Zaia, 2024). Often autonomous motivation is correlated with prolonged engagement and commitment to goals and performance and improved feelings of self-efficacy (Zaia, 2024). Importantly, according to the Basic Psychological Needs

Theory (BPNT), perceived autonomy, competence, and relatedness underpin an individual's motivation and directly contributes to their engagement (Hsieh & Chang, 2016, as cited in, Fernandes & Aires De Matos, 2023).

Prior to MWCC training, no data was collected from the facilitators on previous volunteer commitments or motivations for participation in the MWCC. Focus within both the pre and post survey was predominantly on what experience the volunteers had with the specific topic at hand, not their experience with volunteer commitments more generally. Questions were asked regarding engagement and experience with mental and physical wellness trainings such as “Have you ever participated in a mental health training?” and “Do you have any experience leading mental health or wellness events?” These questions, while helpful in gathering data on previous experience leading events, failed to capture information on facilitators' long-term commitment to volunteering. Additionally, no questions were specifically or indirectly asked to garner autonomous motivations for participating in the MWCC training. Notably, no questions in the pre survey started with the stem – “why”. However, many of the Likert-type scale questions did focus on self-efficacy regarding their beliefs and comfortability with the content. Moreover, there was only one Likert-type scale question that focused on their confidence to lead a MWCC conversation (“*At present, I am confident in my ability to lead a mental health and wellness event in my own community.*”). This question focused exclusively on confidence and not commitment or motivation. Digging deeper into the demographics that displayed the most confidence in leading a mental health and wellness event, the below table (table 11) plots both participant occupations as well as their responses to this item from pre-training to post-training for both cohorts.

Table 11. Likert Item 1

Occupation	Pre-survey Likert item 1	Post-survey Likert item 1	Change
Soldier and family readiness specialist	2	7	+5 (250%)*
Soldier and family readiness specialist w/MTARNG	3	10	+7 (230%)*
Health equity/outreach coordinator	4	10	+6 (150%)*
US Army HR	4	9	+5 (125%)*
Soldier and family readiness specialist	6	10	+4 (67%)
Lead soldier and family readiness specialist	5	8	+3 (60%)
Not listed	7	9	+2 (28%)
RN	5	6	+1 (20%)
Program assistant	8	9	+1 (12%)
Holistic health and wellness/fitness specialist/primary prevention	9	10	+1 (11%)
Director of community relations for Nonprofit	6	6	0 (0%)
4-H/FCBS agent	3	7	+4 (130%)*

Graduate student	5	9	+4 (80%)
Educator	6	10	+4 (67%)
Extension Associate	6	9	+3 (50%)
Professor of extension/District agent FCS	6	9	+3 (50%)
Farmer Hotline operator	7	9	+2 (29%)
Extension Agent	7	9	+2 (29%)
Behavioral Health specialist	7	9	+2 (29%)
Program Coordinator	7	8	+1 (14%)
Educator	8	9	+1 (13%)
Non-profit program director	9	10	+1 (11%)
MSU Extension/FCS Agent	8	8	0 (0%)
Professor/Extension health specialist	7	7	0 (0%)

* Denotes change of 100% $\geq$

Notably, we did not capture data on how long facilitators had been within their prospective field. The below table reveals that the Montana cohort started off with generally lower scores while the Regional cohort started off with higher scores for Likert item 1 (*“At present, I am confident in my ability to lead a mental health and wellness event in my own community”*). This highlights the importance of existing knowledge prior to the MWCC training and those that had occupations within the general field that the MWCC content covered were more likely to score higher from the outset. Importantly, as mentioned above, no questions were asked regarding community facilitators’ commitment and motivations which would have been valuable to capture what, if any, change occurred throughout the course of the training regarding these factors. More insight into previous professional experience and its role in volunteer engagement can be found below. Those with * had the highest percent change from pre to post training. Two soldier and family readiness specialists saw over a 200% improvement on scores from pre training survey to post training survey for item 1. As mentioned in the data and analysis section, all individuals scores improved or stayed the same.

When designing this curriculum and evaluation, the research team relied heavily on the transference of their own knowledge regarding the importance of mental health and physical wellness in rural communities to the volunteer facilitators. This conveyance in conjunction with a hands-off and autonomy promoting approach likely gave volunteers too loose of parameters and not enough structure or guidance. It was assumed that this knowledge sharing at the training would be sufficient to motivate volunteer engagement and commitment. Rather than capturing information on their motivations and long-term commitment to the MWCC facilitation, the evaluation was mostly focused on the volunteers’ knowledge, awareness, and confidence of the

topic at hand. It was perhaps optimistically assumed that the importance of the topic would be adequate to foster and promote initiative and drive continued volunteer commitment throughout the program. Going forward, the MWCC can leverage the SEM to understand the factors (both intrinsic and extrinsic) which make up each facilitators autonomy and agency and consider what role each of these factors might play in support or hinderance of autonomy for volunteers.

Self Determination Theory (SDT), Intrinsic

The significance of autonomy and agency in volunteer engagement is understood within a larger framework of understanding volunteer engagement and work ethic, which can be clarified by the Self Determination Theory (SDT). Because motivation is so critical to a successful volunteer program, the utilization of Self-Determination Theory (SDT) would have been helpful as a metric with which to capture and conceptualize motivation among the facilitators. The SDT plays a critical role when engaging volunteers because it examines the various motivations that inform human behavior (Deci & Ryan, 1980, as cited in, Fernandes & Aires De Matos, 2023). Moreover, the SDT separates motivation into two important categories, intrinsic motivation, and extrinsic motivation. When individuals are intrinsically motivated, they participate in activities they enjoy and find interesting (Bidee et al., 2013). Intrinsic motivations can be further understood through the utilization of the SEM in tandem with the SDT. Motivations, at the individual level of the SEM, are influenced and informed by personal characteristics such as one's beliefs, coping skills and tendencies, as well as existing leadership skills they might already possess.

Capturing data on the volunteer facilitators' intrinsic motivations would have been helpful in the application and intake process as well as within the pre and post survey. This would have

allowed for the MWCC team to capture baseline intrinsic motivations and track what, if any, changes occurred over the course of the training. Capturing this valuable data may have given the MWCC team greater insight into long term engagement from each volunteer. In the future, the MWCC might consider tailoring training to certain volunteer engagement motivations.

Skills-based Volunteering

Skills-based volunteering has become increasingly more common as it leverages the existing skills and experience of volunteers to meet the needs of the organization (Taproot Foundation, n.d.). As mentioned above, anyone was allowed to apply to go through the MWCC facilitator training, an intentional choice by the MWCC team. However, skills-based volunteering has been shown to garner volunteers who already have the necessary skills and expertise to successfully complete a volunteer task which can often lead to more impactful programmatic outcomes. One participant from the Montana cohort stated in an interview that they thought the curriculum might be best suited for individuals already in the mental health field or with extensive previous training (Personal communication). Anecdotally, this feedback is corroborated by much of the Likert and qualitative feedback data that we received within the survey. Those that had relevant work experience indicated so both through their Likert responses as well as qualitative feedback to the team.

In the context of the MWCC, the team could recruit from qualified candidates such as candidates that already have the skills necessary to execute the role of the MWCC facilitator. Or, the MWCC training could be amended to be more approachable to a wider variety of audiences.

Skills-based volunteering mobilizes at the individual level of the SEM as it focuses on specific skills and occupations possessed by volunteers that might improve their willingness,

availability, and competency as it relates to leading an MWCC conversation. Examples of professions that might already have background knowledge in some of the content of the MWCC as well as facilitator responsibilities would include mental health providers, educators, and healthcare professionals. Additionally, identifying facilitators that have experience leading groups, community organizing, leading volunteers, and facilitating conversations around mental health and wellness. It is also important to consider how socioeconomic status of individual facilitators might influence and play a role what extra time they might have to designate towards leading an MWCC conversation.

For many of the individuals participating in the Montana cohort, their professional experience did not directly correlate with the content, and they had far less exposure and experience leading a mental health and wellness event. In this case, the MWCC team should have better tailored the training to meet the volunteers where they were at. One strategy would be to disseminate the pre-survey weeks prior to the training, so that the MWCC team would have had ample time to tailor aspects of the training to their volunteer audience. The Regional cohort, however, had many facilitators who worked within the mental health and wellness space, often with master's or PhD degrees. Many of the facilitators within the Regional cohort also demonstrated higher level of comfortability with the content on the pre-survey than the Montana cohort.

Relationships

The three factors areas that will be explored within the relationship sphere of the SEM are: 1) extrinsic motivation and its role in the self-determination theory, 2) recruitment and objectives, and 3) content delivery.

Self Determination Theory (SDT), Extrinsic

The importance of intrinsic motivating factors as it relates to the SEM were discussed above. But, it is important to note the significance of extrinsic motivating factors and the role they play at the relational level of the SEM. Extrinsic motivation refers to engagement that results in an extrinsic gain to the individual outside the specific duties of the task (Bidee et al., 2013). Not only were intrinsic motivations not measured during the intake process or on the MWCC evaluation survey, but no extrinsic motivating factors were offered, such as positive feedback, monetary compensation for their time (Regional cohort facilitators were offered \$1,000 to help ‘host’ a conversation), or cohort connectivity opportunities such as opportunities for facilitators to connect and collaborate with their peers. In a study conducted by Finkelstein 2009, they looked at the role that intrinsic and extrinsic motivating factors had on volunteerism, results from this study were not statistically significant and indicated that these two motivating factors be viewed as ‘orthogonal traits’, or rather tangential to one another (Finkelstien, 2009). Interestingly, money can decrease intrinsic motivation, but positive feedback does not (Deci, 1971, as cited by, Finkelstien, 2009). Incorporating more opportunities for positive feedback to community facilitators would be simple to implement going forward.

Additionally, continually engaging volunteers and elevating their sense of competence and relatedness to create organizational trust among the facilitators as a group as well as their connection to the MWCC mission would have been helpful and acted as an extrinsic motivating factor. Because the MWCC research team was intentionally prioritizing a hands-off approach to managing volunteers -assuming this was the best way to empower their volunteers- they offered minimal social networking opportunities for connection among the facilitators outside the trainings. Offering formal and informal ways for the facilitators to stay in touch with one another

and collaborate might have elevated their sense of competence and improved their motivation and subsequent investment in the MWCC overall. Lastly, offering subsequent check ins with facilitators after the training might have afforded opportunities for the facilitators to discuss topics of confusion and volunteer requirements with the MWCC team. To better understand what motivates each unique facilitator, it is important to understand how they connect with one another and the benefit and importance of how extrinsic feedback can positively impact social cohesion among facilitator peers within the SEM.

Recruitment and Objectives

Recruitment for the MWCC occurred through social media post (see appendix A), email listservs, and flyers. Those that reached out to be a part of the Montana cohort were not formally interviewed and all that applied were accepted, there was no formalized screening protocol. The only requirement was that all applicants must be 18 years or older, a Montana resident, committed to two days of training, and committed to hosting a local conversation in their local community within six months of the training. All these recruitment factors were achieved by each volunteer except for the latter regarding hosting a local community conversation. However, as discussed, this aspect of the curriculum delivery is crucial for ensuring the long-term success of the MWCC.

Facilitator cohorts participated in the MWCC training with different objectives that were conveyed from the beginning of the recruitment process. Beginning with the Montana cohort, a request for participation was sent out by Dr. Alison Brenan and all that applied were accepted into the training. After their training, the Montana facilitators were asked to return to their community and lead an MWCC event within six months of their training. Despite this initial

request, it has been difficult to get in touch with the Montana cohort. Not only has communication been limited in general, but there has also been no coordinated or scheduled MWCC events administered by this cohort at this time as of April 2024. There have been two email communications sent out in the immediate months after the training to the Montana facilitators with minimal response. The first email sent out was after the July training on July 24th and the second was sent out August 25th. Responses to the July email included enthusiasm for the content from a few of the facilitators but no follow up regarding any local MWCC conversations. The August email received even fewer responses. A call for phone interviews was also sent out to four individuals within the Montana cohort at the beginning of March and only one individual responded.

The second facilitator training in December was administered to representatives throughout the state and territory of the Western Region with the request that facilitators return to their respective locales and administer their own facilitator trainings and/or host their own MWCC conversations. It was also asked that they be the state lead for the MWCC and assess whether local adaptations need to be made. All facilitators were aware of this prior to the beginning of training. If individuals from this cohort chose to, they could collaborate with Lori Mayr to modify the design of the card deck to be culturally relevant and appropriate to their state/territory as well as incorporate local resources specific to their region, instead of utilizing the existing Montana resources provided in the original MWCC deck and facilitator guide

Going forward, data suggests that recruitment efforts with the MWCC could involve garnering information on volunteer motivations, volunteer commitment histories, as well as a comprehensive overview of the MWCC objectives. Each of these factors could be addressed

prior to admittance into the MWCC facilitator training by ensuring that facilitators are admitted who are motivated, committed, and understand the overall objectives. The recruitment stage would be ideal time to evaluate the motivations that might be drawing the volunteers to apply to work with the MWCC as well as capture information about the feasibility of volunteers hosting local conversations within six months.

The recruitment stage also offers the MWCC team valuable time to consider the group dynamics of volunteers admitted into the MWCC training. During the recruitment stage, the MWCC team can consider how facilitators might interact with one another and the content based on their shared experiences, occupations, interests, and motivations. By leveraging the SEM, the MWCC team can focus on capturing this invaluable information and then consider how they might group or encourage collaboration before and after the training across these shared interests, improving facilitator to facilitator relationships and encouraging cohesion within the group. The MWCC team could also offer ways for facilitators to connect with one another prior to the training by starting an email thread, or chat-based group to encourage conversation before, during, and after the training. This chat tool could be utilized after the training to encourage cross collaboration among the facilitators and give them a quick and easy way to share updates, ask questions of the team, and connect with one another.

Further explanation must be given to the prospective volunteers on what is required from them as volunteers and if they are willing to commit to leading MWCC conversations within their community in a timely manner. It is important to note that because this was the pilot year of the MWCC, the team was not overly particular regarding who was admitted into the cohort and maintained enthusiasm for all that showed interest in the MWCC. Additionally, interest in the

MWCC was far more important this first pilot year than specific volunteer commitments. The MWCC team was focused more on promoting the pedagogy within the MSU community and beyond. This focus was certainly achieved given the immense and continued interest in the MWCC curriculum. Going forward, data suggests that either creating a rubric of ideal desired volunteer skills that could act as a rubric in the recruitment and interview stage or tailoring training content would be helpful. The recruitment stage also is an excellent time to advise the volunteers on what the volunteer commitment looks like, instead of when they have already been admitted. For long term retention and engagement, prioritizing communication with prospective community facilitators is essential to securing consistently engaged volunteers.

Content Delivery

Lastly, the format of the MWCC trainings likely had an impact on volunteer engagement as well. Particularly with the first facilitator cohort in July, there was some confusion on the overall objectives of the trainings and what the facilitator deliverable was supposed to be. Research suggests that the fact that MHFA was offered during the same training period seemed to confuse some facilitators as to whether the objective was to obtain a certificate in MHFA with the MWCC curriculum acting more as an adage - the opposite was supposed to occur. The intention of offering MHFA in the same training was as a supportive tool to the MWCC curriculum. The research team thought this was necessary as an adage to the curriculum to help facilitators feel more comfortable with the content and the potential conversations that might arise at their local MWCC conversation(s). In an interview with one participant from the Montana cohort, they explained that the MHFA component was their biggest takeaway from the training, and that it felt most applicable to their occupation and life. That same participant stated that they did not feel

comfortable leading an MWCC conversation with just one training on the content and believed follow-ups and supplemental trainings would have been helpful to improve comfortability with the MWCC material. Additionally, questions related to MHFA were also on the post-survey; anecdotal evidence suggests questions might want to be framed to exclusively focus on the MWCC content. Additionally, per feedback from the surveys, facilitators indicated that they would have appreciated more time to collaborate and connect with their facilitator peers throughout the training. By removing the MHFA component that would free up nearly eight hours of training time that could be allocated towards MWCC content, cross collaboration from facilitator to facilitator, and increased opportunities for knowledge and resource sharing among the facilitators and MWCC staff.

Data suggests that future MWCC facilitator events should separate the MHFA training and MWCC training. The evidence suggests that the MHFA be offered virtually prior to arrival at the MWCC training to delineate the two and convey that the MHFA is a prerequisite and complimentary material to the MWCC. This content seemed to lead to a lack of coordination and inconsistent volunteer buy in, either expressed or observed. It is likely that the facilitators from the Montana cohort were not completely aware of their responsibility once the training ended. A simple solution to these inconsistencies in interpretation of roles would have been to offer ample time for follow-up questions and check-ins both with the MWCC team and among their peers.

The format of the MWCC trainings can have significant impacts at the relational level of the SEM. If facilitators were allowed more time to collaborate with their peers this could improve cohesion and trust among the group, competency through collaboration, social support, facilitate knowledge and skill sharing among the facilitators, and empower and encourage facilitators.

Each of these factors would improve the dynamic among the group by increasing and expanding social networks and relationships among the facilitators, leading to improved facilitator buy in with the MWCC curriculum and program itself.

Community

More research is needed to better understand how the MWCC can leverage the community sphere of the SEM to support the volunteer facilitators through the process of leading MWCC conversations. Although this investigation was out of the scope of this research project, there could be both community-level barriers that these facilitators are faced with as well as community supports that could be leveraged to turn these MWCC conversations into a reality. The MWCC could consider organizing volunteer facilitators by community or region to encourage resource sharing and cross collaboration among peers. Again, more research is needed on this specific aspect.

Society

More research is needed to understand how the MWCC can leverage the societal sphere of the SEM to improve the volunteer facilitator role and increase opportunities for facilitators to lead MWCC conversations. This sphere was not a specific focus area for this research project but going forward the MWCC could consider utilizing part of the training for a share out regarding existing community organizations doing health trainings as well as identify infrastructure already in place that might be helpful to facilitators hosting an MWCC conversation. The MWCC training could also allocate time to discuss existing policies at the local, state, or national level

that might be relevant or a helpful resource to the facilitators in hosting their own MWCC conversations.

CONCLUSION

In conclusion, this thesis examined the effectiveness of the MWCC training and shed light on the efficacy of this new, community-based, volunteer-led mental health and wellness pedagogy. This thesis examined two questions: 1) *Did the MWCC facilitator trainings impact the volunteer facilitators confidence, awareness, and knowledge of mental health and wellness topics as well as confidence leading a MWCC conversation?*, and 2) *Are there external factors that could be impacting the successful facilitation of MWCC conversations, and if so, how can the SEM be utilized to understand these factors?* Through a comprehensive examination of the training process and its outcomes, this study aimed to determine whether the MWCC adequately prepares and supports community facilitators to conduct their own MWCC conversations.

The MWCC training and pilot year has overall been a success. As demand for the card deck and facilitator guidebook expands to new audiences, amendments to content and design to fit the needs of a growing audience remain a priority for the MWCC team. This thesis also reveals that the MWCC content itself is widely well received but that volunteer engagement must remain a priority focus going forward to ensure longevity, replicability, and to guarantee that community conversations are taking place that utilize the MWCC curriculum.

This evaluation addresses the need for a few minor amendments to be made going forward to improve volunteer engagement from community facilitators. These amendments are all achievable and require no specific changes to the MWCC curriculum itself. Focusing on the following factors will improve volunteer engagement from community facilitators: 1) understanding importance of agency and autonomy in volunteering, 2) leveraging self-determination theory as it relates to volunteer motivation, 3) improving volunteer recruitment

strategies, 4) considering the value of skills-based volunteering in community facilitator selection, and 5) prioritizing the importance of content delivery within the MWCC training.

This thesis also examined the importance of defining rural if it is indeed a significant factor in intervention design. Given the numerous definitions of rural, it is critical to give this significant thought and consider the nuance of the rural context in which it will be utilized. Though rural communities remain the focus and degree of rurality is an important component of the MWCC and training, the curriculum could be applicable to any community defined as rural, under any definition. Because of this, specifying the MWCC content and delivery within a particular definition of rural is not critical at this juncture. Long-term, if the program continues to expand, and if it is to remain decidedly rural based, choosing a specific definition would be important for funding and expansion efforts if this is a direction the program chooses to go.

When thinking about why the MWCC, a healthcare pedagogy is effective, evidence suggests that community-based programming situated within the Social Ecological Model provides a framework to understand its effectiveness. In the context of the MWCC, the emphasis on creating a curriculum that is community based and volunteer led highlights the significance of the integration of broader socio-environmental factors across mental health and wellness prevention. The MWCC, and community-based healthcare more broadly, considers that individual health behaviors are directly influenced by the social and community contexts in which these behaviors occur. The MWCC addresses aspects of the SEM in numerous ways by focusing on the individual and relationship level of the SEM. The MWCC training and content; 1) increases knowledge, attitudes, and beliefs at the individual level of the facilitators, 2)

provides opportunities for increased social support networks through facilitated conversation, connection with peers and staff.

These SEM factors, in coordination with the MWCC community facilitators, increases connection within communities and improves access to preventative wellness and mental health information. Community-based programs are highly effective in improving the connectivity within the community, leveraging existing knowledge and resources and fostering ownership and empowerment among all facilitators. Importantly, since the MWCC is a community-based program and inherently strengths based, drawing on what communities have rather than do not have is important. Through the utilization of existing resources, this pedagogy can drive positive change.

Going forward, the MWCC team can utilize examples of successful community-based programs and consider implementing some of their design strategies, such as the *Atmiyata* or AzCHOW program. Both programs were deemed widely successful by both facilitators and communities alike and their designs corroborate some of the above strategies and findings for improved volunteer engagement. Especially as it relates to the *Atmiyata* program, the research team focused heavily on the volunteer “experience”. The *Atmiyata* team prioritized that volunteers not only felt prepared for their specific duties but that there were ample opportunities to gain further instruction and feedback from both the *Atmiyata* team and their peers. Additionally, the program included a rigorous and comprehensive volunteer training with clear deliverables and objectives to their volunteers; there was no ambiguity regarding their responsibilities and overall function. This undoubtedly played a significant role in the long-term impact of the *Atmiyata* program and could be applied to the MWCC in the future.

Similar insight can be gleaned from the AzCHOW program which also showcases important strategies for volunteer engagement as well as effective training recruitment techniques that could be mirrored within the MWCC. Some of the strategies implemented by the AzCHOW program that would be adaptable to the MWCC include: 1) recruiting volunteers from health fairs and community events (which demonstrates an existing involvement and/or interest in community and health), and 2) providing supplemental trainings so volunteers can stay abreast on skills acquired. Each of these community-based and volunteer-led health programs prioritize engagement and integration of the volunteers not only among one another but to their community as well. These programs reinforce the additional findings within this thesis validating the important techniques and frameworks required to retain quality engaged volunteers.

The MWCC shows promise as a conversation pedagogy that can reduce the burdens and barriers associated with mental health and wellness care in rural America. With renewed focus on increasing volunteer engagement and improved training delivery design, as well as content tailored to specific volunteer characteristics and skills, the MWCC is certain to be a valuable tool to address this growing crisis in America.

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APPENDICES

APPENDIX A

RECRUITMENT SOCIAL MEDIA POST



MSU Extension

May 21 at 8:00 PM · 🌐



Do you live in rural Montana? Are you passionate about promoting wellness, including mental wellness?

MSU Extension seeks adult volunteers to bring the Mental Wellness Conversations Project and Mental Health First Aid to rural Montana communities. Volunteers will complete a two-day training (July 11-12) in Bozeman. Travel, lodging, meals, and materials are covered.

For more information and to apply to be a volunteer:
<http://ow.ly/420450NCAfc>



Become a mental wellness advocate in your community

Training in Mental Health First Aid and Mental Wellness Conversation Project

When: July 11-12, 2023

Where: Bozeman
 Lodging, travel, meals, and materials are covered

Learn more:
<http://ow.ly/42o450NCAfc>



APPENDIX B

IRB QUALIFIER JULY (MONTANA) COHORT

Welcome to the Mental Wellness Conversation Curriculum Training!

You are being asked to participate in a larger research study which aims to learn about the various stressors that rural community members face and the preferred ways of managing stress. You will take two surveys throughout your training over the next few days. The first survey will be taken on the evening of July 10th and the second survey will be administered in our final session on July 12th, prior to your departure. Each survey will take you approximately 15 minutes, participation is voluntary, and you may elect to stop participating in this survey any time.

This study is considered to be minimal risk of harm. Minimal risk of harm means that your participation in this survey is similar to what you might encounter in daily activities. There is a chance you may experience minor discomfort as some of these questions might get you thinking about stress and mental health overall. Overall, we hope to learn more about how this unique delivery modality works within rural communities. The information collected from this survey will directly inform future outreach and research design.

Your survey information and results will be kept confidential and only available and utilized by the research team. Your personal information will not be personally identifiable in any reports or publications that may result from this survey. Proceeding with this survey indicates your consent to participate.

If you have any questions, concerns, or complaints about this survey, you may contact Katharine Sutphen at Katharine.sutphen@student.montana.edu. You may also contact MSU IRB at irb@montana.edu.

APPENDIX C

IRB QUALIFIER DECEMBER (REGIONAL) COHORT

Welcome to the Mental Wellness Conversation Curriculum Training!

December 3-6, 2023

You are being asked to participate in research evaluating the impact of the Mental Wellness Conversation Curriculum (MWCC). You will have the opportunity to take two surveys throughout your training over the next few days. The first survey will be taken on the evening of December 3rd and the second survey will be administered during lunch on December 5th. Each survey will take you approximately 15 minutes, participation is voluntary, and you may elect to stop participating in this survey any time.

This study is considered to be minimal risk of harm. Minimal risk of harm means that your participation in this survey is similar to what you might encounter in daily activities. There is a chance you may experience minor discomfort as some of these questions might get you thinking about stress and mental health. Overall, we hope to learn more about how this unique delivery modality works within rural communities. The information collected from this survey will directly inform future outreach and research design.

Your survey information and results will be kept confidential and only available and utilized by the research team. Your personal information will not be personally identifiable in any reports or publications that may result from this survey. Proceeding with this survey indicates your consent to participate.

If you have any questions, concerns, or complaints about this survey, you may contact Katharine Sutphen at Katharine.sutphen@student.montana.edu. You may also contact MSU

IRB at irb@montana.edu.

APPENDIX D

JULY (MONTANA) COHORT PRE-SURVEY

1. What is your age range?
 - ☐ 18-30
 - ☐ 31-45
 - ☐ 46-64
 - ☐ Above 65
2. What gender do you identify as?
 - ☐ Male
 - ☐ Female
 - ☐ Trans-gender
 - ☐ Non-binary
 - ☐ Prefer not to answer.
 - ☐ Not listed, please identify _____.
3. Please choose one option that best describes your ethnic background.
 - ☐ Asian or Pacific Islander
 - ☐ Black or African American
 - ☐ Hispanic or Latino
 - ☐ Native American or Alaskan Native
 - ☐ White or Caucasian
 - ☐ Multiracial or Biracial
 - ☐ A race/ethnicity not listed here, please identify _____.
4. Please select your highest level of educational attainment.
 - ☐ Master's or higher degree
 - ☐ Bachelor's
 - ☐ Associates
 - ☐ High school/GED
 - ☐ Less than high school
5. What is your occupation? _____
6. Have you ever participated in a mental health training?
 - ☐ Yes
 - ☐ No
 - ☐ If yes, please give a brief description of the training

7. Do you have any experience leading mental health or wellness events?
 - ☐ Yes
 - ☐ No
 If yes, please describe.

-
-
8. What skills/knowledge do you hope to gain during the MWCC training?
-
-
-
-
-

Please answer the following questions on a Likert scale from 1 to 10, from **strongly disagree (1)** to **strongly agree (10)**.

1. At present, I am confident in my ability to lead a mental health and wellness event in my own community.

1 2 3 4 5 6 7 8 9 10

2. At present, I am aware of existing mental health and wellness resources in my community.

1 2 3 4 5 6 7 8 9 10

3. At present, I am aware of how to utilize existing mental health and wellness resources in my community.

1 2 3 4 5 6 7 8 9 10

4. At present, I am confident in my ability to make recommendations and referrals to individuals regarding available resources.

1 2 3 4 5 6 7 8 9 10

5. At present, I can identify and name some positive coping skills.

1 2 3 4 5 6 7 8 9 10

6. At present, I can identify and name some negative coping skills.

1 2 3 4 5 6 7 8 9 10

7. At present, I understand the connection between mental wellness and physical wellness.

1 2 3 4 5 6 7 8 9 10

8. At present, I am aware of strategies that promote mental wellness.

1 2 3 4 5 6 7 8 9 10

APPENDIX E

JULY (MONTANA) COHORT POST-SURVEY

Please answer the following questions on a Likert scale from 1 to 10, from **strongly disagree (1)** to **strongly agree (10)**.

9. At present, I am confident in my ability to lead a mental health and wellness event in my own community.

1 2 3 4 5 6 7 8 9 10

10. At present, I am aware of existing mental health and wellness resources in my community.

1 2 3 4 5 6 7 8 9 10

11. At present, I am aware of how to utilize existing mental health and wellness resources in my community.

1 2 3 4 5 6 7 8 9 10

12. At present, I am confident in my ability to make recommendations and referrals to individuals regarding available resources.

1 2 3 4 5 6 7 8 9 10

13. At present, I can identify and name some positive coping skills.

1 2 3 4 5 6 7 8 9 10

14. At present, I can identify and name some negative coping skills.

1 2 3 4 5 6 7 8 9 10

15. At present, I understand the connection between mental wellness and physical wellness.

1 2 3 4 5 6 7 8 9 10

16. At present, I am aware of strategies that promote mental wellness.

1 2 3 4 5 6 7 8 9 10

1. After taking Mental Health First Aid my biggest takeaway is...

2. After participating in the MWCC training, my biggest takeaway is...

3. What was the most useful/helpful skill you learned at the MWCC training?

4. Do you feel this training set you up to lead a successful MWCC in your own community?
Why or why not?

5. What skill, if any, do you need more training on?

6. What feedback do you have for the team regarding the structure of the MWCC training?

APPENDIX F

DECEMBER (REGIONAL) COHORT PRE-SURVEY

1. What is your age? _____.
2. What gender do you identify as?
 - Male
 - Female
 - Transgender
 - Nonbinary
 - Prefer not to answer.
 - Not listed, please identify_____.
3. Please choose one option that best describes your ethnic background.
 - Asian or Pacific Islander
 - Black or African American
 - Hispanic or Latino
 - Native American or Alaskan Native
 - White or Caucasian
 - Multiracial or Biracial
 - A race/ethnicity not listed here, please identify _____.
4. Please select your highest level of educational attainment.
 - Doctoral/Terminal degree
 - Master's degree
 - Bachelor's degree
 - Associate's degree
 - High school/GED
 - Less than high school
5. What is your occupation?

6. What is your organization/affiliation?

7. Have you ever participated in a mental health training?
 - Yes
 - No
 - If yes, please give a brief description of the training(s)

8. Do you have any experience leading mental health or wellness programs?
 - Yes
 - No

If yes, please describe.

9. What skills/knowledge do you hope to gain during the MWCC training?

Please answer the following questions on a Likert scale from 1 to 10, from **strongly disagree (1)** to **strongly agree (10)**.

1. At present, I am confident in my ability to lead a mental health and wellness event in my own community.

1 2 3 4 5 6 7 8 9 10

2. At present, I am aware of existing mental health and wellness resources in my community.

1 2 3 4 5 6 7 8 9 10

3. At present, I am aware of how to utilize existing mental health and wellness resources in my community.

1 2 3 4 5 6 7 8 9 10

4. At present, I am confident in my ability to make recommendations or referrals to individuals regarding available resources.

1 2 3 4 5 6 7 8 9 10

5. At present, I can identify and name multiple positive coping skills.

1 2 3 4 5 6 7 8 9 10

6. At present, I can identify and name multiple negative coping skills.

1 2 3 4 5 6 7 8 9 10

7. At present, I understand the connection between mental wellness and physical wellness.

1 2 3 4 5 6 7 8 9 10

8. At present, I am aware of strategies that foster mental wellness.

1 2 3 4 5 6 7 8 9 10

APPENDIX G

DECEMBER (REGIONAL) COHORT POST SURVEY

1. At present, I am confident in my ability to lead a mental health and wellness event in my own community.

1 2 3 4 5 6 7 8 9 10

2. At present, I am aware of existing mental health and wellness resources in my community.

1 2 3 4 5 6 7 8 9 10

3. At present, I am aware of how to utilize existing mental health and wellness resources in my community.

1 2 3 4 5 6 7 8 9 10

4. At present, I am confident in my ability to make recommendations or referrals to individuals regarding available resources.

1 2 3 4 5 6 7 8 9 10

5. At present, I can identify and name multiple positive coping skills.

1 2 3 4 5 6 7 8 9 10

6. At present, I can identify and name multiple negative coping skills.

1 2 3 4 5 6 7 8 9 10

7. At present, I understand the connection between mental wellness and physical wellness.

1 2 3 4 5 6 7 8 9 10

8. At present, I am aware of strategies that foster mental wellness.

1 2 3 4 5 6 7 8 9 10

1. After participating in the MWCC training, my biggest takeaway is...

2. What was the most useful/helpful skill you learned at the MWCC training?

3. Do you feel this training set you up to lead a successful MWCC event/conversation/program in your own community? Why or why not?

4. What skill, if any, do you need more training on?

5. What feedback do you have for the MWCC team regarding the structure of the MWCC training?

6. What feedback do you have for the MWCC team regarding the training content?

7. My organization has capacity to implement MWCC into our organization.

- Yes
- No
- Unsure

APPENDIX H

QUALITATIVE RESPONSES, PRE-SURVEY

Have you ever participated in a mental health training? If yes, please describe.
Montana
Assist
YMFA
Suicide prevention trainings, stress management trainings, sparx trainings, aces, hope wraps, which all include mental health awareness mental health first aid
Annual assist/CARE training with military
Normal Army training about signs and issues. Nothing very formal
MHFA both adult and youth
Regional
I participated in the mental health training during the October 2022 NAE4-HYDP conference in Madison Wisconsin
Mental health first aid, QPR, rural resilience, counseling on access to legal means (CALM)
Mental health first aid for youth, YAM, QPR, My MHFA was training I received as a high school teacher
I took a suicide prevention (awareness) training at our state conference this year
C-SSRS
Mental health first aid 1 day training in Spokane Washington in March 2023
I am trained as a counselor; I have also attended numerous trainings throughout my career
QPR, MHFA

Do you have experience leading mental health or wellness events? If yes, please describe.
Montana
Support events for deployed soldiers families
Stepping On
Certified health and fitness director, certified wellness and health coach, certified health promotions specialist, certified trainer, fitness instructor, yoga instructor, injury prevention
MHFA instructor
Regional
I am a fitness and wellness instructor for the past 20 years
Wellness, diabetes prevention program, chronic diseases self-management, diabetes, strong people
Limited experience leading YAM and QPR because I received my initial training in the past 6 months
Limited stress management
In working towards becoming a registered horticultural therapist and I conduct wellness programming for youth
I have been running a program that offers mental wellness workshop for people working in agriculture for 2 years
I was the lead for a mental health program called family empowerment with two other people under me

MHFA, QPR
QPR in Spanish/English, group discussions and activities, case management + referral (warm hand off)

What skills/knowledge do you hope to gain during the MWCC training?
Montana
How to talk to people regarding mental health issues
Hoping to gain knowledge on putting on successful mental health educational events
A better understanding
Understanding the resources available for my community
I just want to know more and find out if there's more I can do to help. There are not enough resources and what resources there are, there is not enough awareness of them.
Overall reinforcement of information/awareness of tools
Networking on available mental health resources around Montana and its rural areas
How to better assist veterans in my unit/community. Also to assist those at my church
How to better facilitate a conversation with members of agriculture community especially if they are not at a mental health event
Regional
Proper mental health training planning skills

I hope to learn or hone my skills to help identify and better observe signs of those who may be experiencing low mental health, how to assist them with resources and how to better communicate with those who may need assistance
Mental health first aid for youth, YAM, QPR, My MHFA was training I received as a high school teacher
Understanding of program, mission “”, ability to bring program to my community
Refresh my skills essentially, including ALGEE, explore impact of early intervention/early signs of mental health decline
More techniques to facilitate conversation with folks who are hesitant to discuss mental health. I would like to be able to create a space that allows participants to step away from their stigmas related to mental health
Develop the skills to provide training to arability clients in NM
Learning about mental health resources specifically for farmers in rural areas
I hope to learn more about how to use and spread mental wellness in my community.
How to engage people in mh + w training that leads to behavior change. How to train community members to have mh+w conversation w/others in their community
A good refresher and chance to learn new things. I haven't had the chance to while being siloed in the past job for the past 4 years. I didn't get to attend new trainings.
Non-judgmental listening, recognizing symptoms of mental health distress, conversational skills, coping skills
Collaboration, outreach ideas, modifying the MWCC for other locations and populations

I hope to learn how to utilize MWCC and how and if it can be used as a training, conversation, or how it works. Also learning how this researched info can be adapted for Spanish speakers and limited literacy

APPENDIX I

QUALITATIVE RESPONSES, POST-SURVEY

After participating in the MWCC training, my biggest takeaway is...
Montana
The cards are a brain child – awesome!
I am now more comfortable helping others
Self care education
All the resources that are available in Montana
How much fun it could be to share this info
How many resources I was[nt] aware of for Montana
There are so many great skills, practices, and resources that we can utilize to help others and ourselves
The amazing cards and resources
The importance of making a self-care plan
It can be simple or complex, in the end knowing where to go is important
Identifying the 4 A's of managing stressors
Regional
Easy recommendations for daily tasks to foster positive mental health habits
There's a wealth of resources available for me to refer to and provide for others; as well there's a supportive community of colleagues and educators to work together for the wellness of all
Informal mental/emotional health informal education/discussion is useful and desirable
That mental health wellness parties are effective and imperative

Just do something! Be willing to engage people in conversations about MH. Be aware of resources to connect people to if they want them.
This is another tool/curriculum that can be used in community based educational delivery
Making connections with people interested in implementing similar mental health work in the western US
Using physical health as an entry point into mental health and overall wellness
Mental wellness looks different for all of us, there are many practices that can help one experience better mental wellness in their life
The knowledge of how to use the card activity
Great resource to use to start a conversation on mental health with our farmers at our BBQ bootcamp
POPC!!
Non-classroom style education is still research based, content and application can be flexed in many ways and can lead to more meaningful community connection

What was the most useful/helpful skill you learned at the MWCC training?
Montana
I need more sleep ☺
How to approach someone that is having problems
Different aspects of each component of self care
Proper communication with someone in need and getting them resources

I'm not sure
Easier to engage people into talking about sensitive topics
Recognizing the different stages of imminent mental health crisis
The creative ways to use the cards and training
ALGEE
How to de conflict situations
The 4 A's of managing stressors
Regional
The contacts! Breathing exercises
Staying updated on language to use or not to use in sensitive conversations
The ability to put it all together through this one vehicle is a compelling way
The 4 A's of stress [and] how to use self-assessment to support the conversation around stress
I've been teaching/delivering this type of program for 10 years. What I most like are the variety of resources that are easily accessed
Learning the correct language and approach for intervening in a mental health situation as a first aid trainee
Introducing space for those wellness conversations in informal ways
I was reintroduced to the mindful practice of a body scan and 4-7-8 breathing
Using the cards
Different ways to instigate a health and positive conversation on mental health
Integration of physical and mental wellness

Content is relevant to many different backgrounds because as humans we need connection
--

Do you feel that this training set you up to lead a successful MWCC in your own community? Why or why not?
Montana
Yes-detailed explanation helped
It's a great start, would be confident to give an overview not an in-depth training
Yes – if I have the audience
Yes, gave great tools to utilize
Yes, I just feel more knowledgeable
Yes. I have more confident in addressing mental health topics
Yes I am grateful for the workbooks, because I have a hard time remembering things and I can refer to them to refresh my memory
Yes-very extensive, detailed and physically addresses all areas towards mental health treatments
Yes – great pace – I would break into segments for community presentation
Yes. It gave me the tools to assist and tailor to my group
Yes, ability to share ideas with each other
Regional
Yes, still need ideas of how to use the cards with producers

Yes, the training set me up successfully to know the content, how one may implement the information with various audiences and allowed networking with other professionals for future collaborations and on support
Yes – modeling and engagement and enthusiasm of instructors!
Yes. The training was thorough in all reports. I feel like I Understand the research, rationale, execution, and nuances
Yes. What I do first will be a work in progress and that is okay. Facilitating a space to allow conversation to happen is the good
I'm confident in delivering this type of program. I need more time exploring the curriculum and see how best it fits in my program of work.
Yes. The curriculum is very easy to use and understand without a major background in the human sciences
Yes! Brainstorming ways to implement this tool in our community after this training was particularly helpful
Yes the extended training allowed time for dialogue and opportunity to engage the material in a manner that allowed learning confidence in comprehension
Yes, it was thorough in the training
Yes because its structure for an informal workshop which is what our community wants and interested in
Yes
Yes because it is so versatile

What skill, if any, do you need more training on?
Montana
n/a
Just a repetition of training and more research on my part
n/a
Talking training on mental health first aid for kids
I'm not sure
Not sure but will know more as we get into the presentation
I cannot think of one. I feel like I just need time to practice applying the skills and that is something that can only be done through practical application and experience
n/a
n/a
Can't think of one for now
Let me think
Regional
Application of the cards
Nothing comes to mind immediately
Ideas for effective approaches in using the cards
Can't think of any other than staying abreast of how folks employ it in creative ways + settings
How to play card games!
n/a

How to utilize the curriculum in a way that is specific to the populations that I serve
I'm curious to look a bit more into how I might alter the kings for my community
I would like to help people integrate new mental wellness practices. I need more training on how to help someone create behavior change
Not sure yet
Other resources and tools on promoting positive conversation on mental health
Adapting the desk to specific state or population resources
I need to become more familiar with how people typically use cards to offer different options of use

What feedback do you have for the team regarding the structure of the MWCC training?
Montana
Fantastic idea and superb job presenting
I thought it went well, maybe a few more breaks to walk around
Loved it! Love the process one of my biggest passions – something I've been working on for 3 years
n/a
I think the training was spot on
Great job!

I really enjoyed the training and got a lot out of it. It would be nice to have many more of these trainings available throughout the state
n/a
This is a great program and very inspiring/encouraging to see all the various organizations willing to participate and support
It was good. I understand that the mental health aid training could be broken up into two days. You would still get all the data but not as many glazed eyes. Thanks
Great training, great concept to assist rural MT w/health and well being
Regional
Great!
Well done! Great structure and format – a nice balance of listening and engaging w/other participants and including some movement
Loved the combination of MHFA with community conversations. I would have liked a slightly deeper dive into facilitation of the discussions
This venue was fantastic. The presentation was intuitive, and you obviously know your stuff! Maybe a little bit more free time to practice self-care a bit more would have loved to squeeze in a workout or two (although I could have gotten up earlier to do so!)
This was a great format to convert a broad range of topics in a short amount of time
I think the team did an excellent job. There were a variety of activities to keep participants engaged. Good job!
Everyone was wonderful, approachable, and knowledgeable. I hope we can work together in the future! <3 <3

I'm not sure if we'll maybe do it later today but it could be cool to try actually playing a game with the cards to get a sense of what its like and how you might fit the conversations in there
I appreciate the dialogue questions w/neighbor. I would have appreciated if the room arrangement shifted, and we had different neighbors to discuss questions and notes (?) with. I would have also enjoyed more time for people to share what programs they had been a part of that that they thought were successful
It was good. I liked having it broken down into two days.
Great resource! Thank you for providing an opportunity for our community to learn and gain skills to help with their mental health
Excellent awareness of self-care needs
Training was great, loved the back and forth between trainers. I have trainees talk about the cards with them or instead of just the questions.

What feedback do you have for the team regarding the training content?
Regional
N/A
Seems that the “ace” through “king” categories cover all the major areas of mental wellness, yet leave room for people to add on broader topics in
Really enjoyed it – I liked the many Montana resources and thought that the manual was done really well – complete, up to date, etc
The tactical portion of handling cards was very gratifying
n/a
I thought the pace was appropriate and I liked how the information was chunked and presented
Oops. See #5. I like the structure of the training.
The content is great and extensive. Nice job!
Great job! You guys have created and provided a resource that will tremendously help our community in addressing our mental health
More ideas of card games that would integrate with the MWCC
More illustrations to help leader remember content when they have not seen it in awhile and to make it feel less dense when it is first picked up.

*Question was only asked on the December cohort survey

APPENDIX J

INTERVIEW QUESTIONS

1. Reflecting on the MWCC training that you participated in, what high level feedback do you have for the MWCC team?
2. Do you feel like the MWCC training prepared you to lead an event in your own community? Why or why not?
3. What barriers might exist within your community that might make it challenging to lead an MWCC event?
4. Do you feel like your previous professional and personal experience made the MWCC content more approachable? Why or why not?
5. Positionality can often play a critical role in community acceptance of novel interventions. Do you agree or disagree, why/why not? What role do you think your positionality might play in the delivery of future MWCC event(s)?