Community services and resources for depressed women

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Abstract

The present study investigated the community services and resources available for depressed women in two rural counties of Nova Scotia. Employing asset mapping by means of a checklist, we surveyed 41 service providers in community agencies in these two counties regarding services and resources they viewed as available for a community project for depressed women. Analysis indicated that there were community and ancillary services that would be appropriate to meet the psychosocial and socioeconomic needs of depressed women. The respondents were also willing to offer their resources for such a cooperative network of community services. The findings suggest that there is a foundation for the establishment of more integrated community services in these rural counties to meet the needs of depressed women.

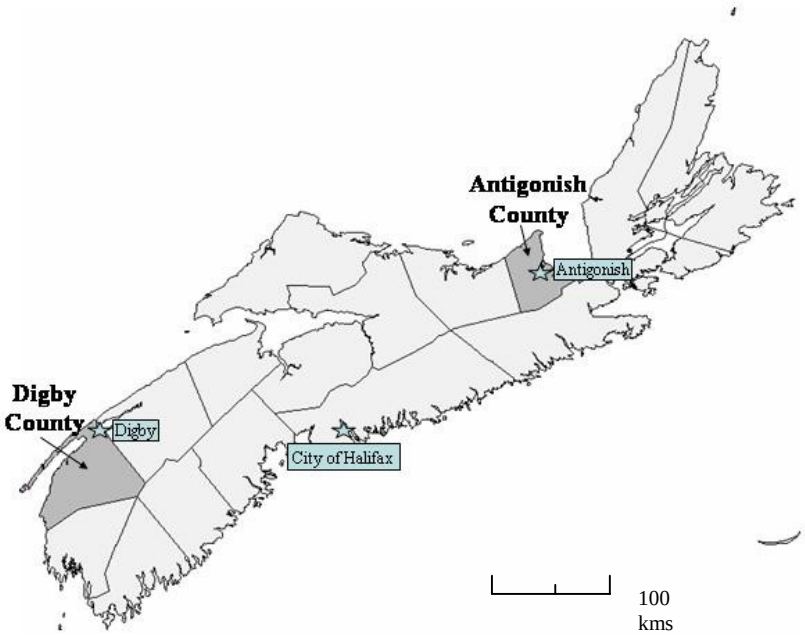
Keywords: community services, resources, availability, depression, women, rural

1.0 Introduction

Women are diagnosed at higher rates of depression than men (American Psychiatric Association, 1994; Brems, 1995). This finding includes the Atlantic region of Canada (Health Canada, 2002). Depression is the leading cause of disability among women worldwide (Mazure, Keita, & Blehar, 2002). Approximately one woman in five will experience an episode of major depression during her lifetime. Women are at least twice as likely as men to experience a major depressive episode within a lifetime and three times more likely than men to experience depression in response to stressful events. In view of such a serious situation it is important to explore ways in which communities can respond to this major health problem. The present study investigated the community services and resources that may be available to assist depressed women drawn from two rural counties of Nova Scotia.

Epidemiological studies show that the majority of individuals with symptoms of depression are not being reached by current mental health services (Blazer, Kessler, McGonagle, & Swartz, 1994). Barriers exist that prevent depressed women receiving the mental health assistance and services that they need (National Institute of Mental Health, 2000). Problems include shortage of available mental health services, difficulties of accessing them, and lack of affordability (Fox, Blank, Rovnyak, & Barnett, 2001). The stigma associated with mental health disorders also interferes with individuals' willingness to seek treatment (Corrigan, 2004; Mazure et al. 2002). Depressed women have also found the formal mental

health care system (e.g., physicians, psychiatrists) often difficult to use and not responsive to their needs (Gammell & Stoppard, 1999; Hughes & McCormack, 2000).



Rural populations are especially likely to face problems of access to mental health care. There are fewer specialty mental health professionals in rural communities (Merwin, Hinton, Dembling & Stern, 2003; Wagenfeld, Murray, Mohatt, & DeBruyn, 1994). Isolation in rural areas and lack of adequate resources place barriers to health care (Campbell, Gordon, & Chandler, 2002; Graveline, 1990; Scattolon, 1999; Logan, Stevenson, Evans, & Leukefeld, 2004). Individuals in rural areas are also reluctant to seek professional help for their mental and emotional problems, and if they see a physician, they are likely to present their problems in terms of physical ailments (Findlay & Sheehan, 2004).

A substantial proportion of women seeking treatment for their physical ailments from their family physicians (Ivey, Scheffler, & Zazzali, 1998) or in community health centers in rural areas (Hauenstein & Boyd 1994; Sears, Danda, & Evans, 1999; Van Hook, 1996) show symptoms of depression. However, only a minority may even discuss their emotional problems with these health care providers because of concerns with stigmatization or confidentiality. In rural areas, stigma regarding emotional problems, and cultural attitudes, such as an emphasis on self-reliance, reduce the use of mental health services (American Psychological Association, 2002; Barry, Doherty, Hope, Sixsmith, & Kelleher, 2000; Farrell & McKinnon, 2003; Raingruber, 2002). Most life problems in rural areas are dealt with informally, without consulting professional help (D'Augelli & Vallance, 1981).

A second main issue has to do with the appropriateness and effectiveness of the services for women with depression. Socioeconomic problems and environmental

stresses are important contributors to the onset of depression in women (Boyce et al. 1998; Brems, 1995; McGrath, Keita, Strickland, & Russo, 1990; Stoppard, 1989). Such problems however, are not the main targets of mental health care. Among these environmental factors are work overload due to multiple roles and responsibilities, abuse, social inequalities, and economic problems (Mazure et al., 2002; Mirowsky, 1996; Nolen-Hoeksema, Larson, & Grayson, 1999; Piechowski, 1992; Rosenfield, 1999). Geographic and social isolation, unemployment, poverty, substandard housing, and farming hazards contribute to the development of depression in women in rural areas (American Psychological Association, 2002; Carruth & Logan, 2002; Graveline, 1990; Hauenstein, 2003; Scattolon, 1999). Traditional mental health services are often seen as not very effective to deal with these needs and problems (Graveline, 1990; Hughes & McCormack, 2000). Conversely, environmental supports and resources can provide protection for women, or reduce the severity or duration of depressive episodes. For example, strong social networks, including regular church attendance and visiting with friends, are associated with lower levels of depression among women (Hertsgaard & Light, 1984).

More efficient utilization of community resources and services would decrease barriers to treatment and increase support for depressed women. With regard to barriers to treatment, Raingruber (2002) recommended that more use of community-centered and in-home services would reduce stigma, normalize treatment, and enhance care available for individuals with depression. More use of natural helpers, those inclined to volunteer within their communities, can also be useful towards this end. Such volunteers have access to all segments of the community and promote the use of their services (Bergstrom, 1982; Heyman, 1982). Mental health consumers who act as staff in mental health programs can also help to reduce the stigma that commonly occurs in clinical practice (Dixon, Hackman, & Lehman, 1997).

The coordinated use of community resources and services would also help to increase the effectiveness of preventive and treatment programs for depressed women (American Psychological Association, 2002; Mazure et al., 2002). Existing community groups can organize themselves to promote and reach common health goals (Israel, 1985). Increasing cooperation and integration among community and human services has been proposed as a way to improve service delivery in rural areas (Linzmayer, 2003). There is also a need for programs in which the mental health care consumer can remain integrated in the community (Alvarez & Nicemboim, 1998; Bruce, Smith, Miranda, Hoagwood, & Wells, 2002). Community groups, including informal care networks, can provide ancillary services, needed resources, and alternative sources of mental health care and assistance (Fox, Merwin, & Blank, 1995). Nonprofessionals within rural communities, such as clergy, lay healers, and family members are highly accessible and can assist in providing informal counseling and other forms of help (Hauenstein, 2003; Stone, 1998). The use of such community resources would increase treatment effectiveness. They are cost effective and individuals respond positively to them (Gerrard, 2000).

Without awareness and knowledge of their assets and interests, communities are not likely to undertake the task of coordinating their resources for cooperative programs. Evaluating the existence of potential community resources is a critical first step towards coordinating and organizing community networks for health

promotion (D'Augelli & Vallance, 1981; Israel, 1985). Asset mapping is both a philosophy and a technique to evaluate the skills, resources, and commitments of individual citizens, associations, and local institutions for community and capacity building activities (Kretzmann, 1995; Kretzmann & McKnight, 1993). It allows communities, organizations, and groups to identify their interests, hidden resources, and their interconnections to attain social, economic, or performance goals. Asset mapping also lends itself to a more positive and strength-based approach to capacity building compared to needs assessments that are more focused on identifying deficiencies in the community (Kretzmann & McKnight, 1993). All too often, using a needs assessment approach alone, communities are left with an extensive 'wish list' that in practice is difficult to achieve and leaves frustration rather than motivation. In contrast, strength-based programs can leave decision-making in the hands of individuals with mental and emotional problems and support them to acquire the skills and capacities to deal with their problems (Burchard, Atkins, & Burchard, 1996; Malysiak, 1997). Therefore, the asset mapping of the services and resources of a community can be used to evaluate a community's strengths, potential, and capacity for health.

The present study employed an asset mapping technique to survey community services and resources that may be available for a proposed cooperative and integrated network of community resources and ancillary services for depressed women in two rural counties of Nova Scotia. The coordinated use of such community services and resources would help to address some of the identified problems of depressed women. We made the following predictions: 1) the sampled community-based organizations would have services and resources appropriate for the psychosocial and socioeconomic needs and stresses of depressed rural women; and 2) these community groups and service providers would be willing to offer their services for a coordinated and integrated program to assist women with depression.

2.0 Method

2.1 Participants

Community workers and volunteers, who provided services to residents of two rural counties of Nova Scotia, were interviewed. The counties meet the designation of "rural" in terms of the demographic, economic, and life style characteristics of the population (Thorngren, 2003). Digby County is the most western region of Nova Scotia situated on the Bay of Fundy, with a 2001 census population of 19,548. The largest municipality in the county is the Town of Digby with a population of 2,111. Antigonish County is in the eastern part of Nova Scotia situated on the Northumberland Strait across form Prince Edward Island and adjacent to Cape Breton Island, with a 2001 census population of 19,578. The largest municipality in the county is the Town of Antigonish with a population of 4,754. Agriculture, forestry, fishing, and tourism are important economic activities in the two counties and nearby regions. Higher education is also an important part of the economy in Antigonish County with St. Frances Xavier University, a primarily undergraduate institution, located in the Town of Antigonish.

A total of 41 community service providers (32 women and 9 men) were interviewed. There were 21 participants (18 women and 3 men) from 18 nonprofit and volunteer organizations providing services to residents of Antigonish County.

Although most agencies were in the Town of Antigonish, 3 participants were from agencies 65 kilometers to the west in New Glasgow in Pictou County and two participants were from agencies 70 kilometers to the south-east in Guysborough, Guysborough County (see Location Map of Serviced Counties). There were 20 participants (14 women and 6 men) from 16 nonprofit and volunteer organizations providing services to residents of Digby County. Although most agencies were in the Town of Digby, some participants were from agencies to the south-west in small towns like Church Point and Saulnierville and as far as Meteghan 65 kilometers away.

All regions included paraprofessionals and volunteers who were affiliated with community organizations including women's centers, education and job training programs, women's shelters, food banks, churches, and support groups. There were 27 support or volunteer workers, 5 respondents were counselors or therapists, 4 were affiliated with health positions (2 nurses, 1 acupuncturist, and 1 dietician), 3 were religious practitioners, 1 was a researcher at an agency, and 1 was a social worker. Eleven of the above listed respondents were program coordinators or directors in administrative positions in their agencies. Therefore, most of the participants in the sample were community-based service providers rather mental health professionals. The length of service of the participants in their present positions ranged from 2 months to 20 years, with an overall average of 6.32 years across both counties.

2.2 Measures

An asset mapping survey of community resources was developed for this study to be completed by the service providers in individual interviews. It was modeled on capacity inventories used in asset mapping to evaluate the skills, resources, and commitments of individual citizens, associations, and local institutions for community building activities (Kretzmann, 1995; Kretzmann, McKnight, Dobrowolski, & Puntenney, 2005; McKnight & Kretzmann, 1996). The survey was in the form of a checklist of services and resources currently available in the agency or volunteer organization that were seen by the workers as potentially available and that may be appropriate for a community project to organize services for depressed women. The identified depression was defined in terms of the types of depressed women these service providers were likely to have encountered, "stable, long-term, or chronic depression, depressive symptoms, or sadness that are the result of aspects of women's lives." The list of services and resources was developed based on the types of resources and services that may be applicable to assist women with depression, as identified in the research literature. The service provider was asked, "Please check off any services or resources that your group has that you think would be appropriate for a community project for depressed women." The survey contained a list of 30 community services or resources and allowed for additional comments. Definitions were made available to the participants that described each of the services and resources listed. The checklist was completed by the participants in face-to-face interviews and the responses reflect their perceptions of the availability of the listed services for a cooperative community project.

2.3 Procedure

The goal was to interview all the agencies or organizations in the particular rural county that could potentially provide ancillary services or community resources to

assist depressed women. Physicians, mental health clinics, family and children's services and other profession-based agencies were not the focus of the study and were not included in the samples. Only one agency that was approached refused to participate. Participants were located from telephone and community directories or from suggestions made by previous respondents. Each participant was initially contacted by telephone and informed of the study and those interested were interviewed at their offices or volunteer centers. After obtaining informed consent and assured confidentiality, the respondents completed the surveys. In Antigonish County two participants were interviewed by telephone and for two others the surveys were dropped off at their place of work and the completed surveys were later collected. The participants were debriefed verbally and with a handout describing the purpose of the research.

2.4 Design and Analysis

The survey results from Antigonish and Digby counties were examined with relation to the first prediction. The resources and services checked off in the survey were tabulated and totalled for the samples and then divided by the number of participating organizations to calculate the percentage of organizations that offer each type of service within the community. The percentages were used to determine which services or resources were abundant or scarce in the given county as well as to compare the availability of different services.

We also predicted that community groups would be willing to offer their services in a proactive program for depressed women. In order to test this prediction, responses to this question were examined, "How interested, willing, or committed are you or your group to participate in a proactive or preventative community project to assist depressed women and to offer relevant services which you identified?" Responses to this question were coded under the three categories "interested", "not interested", or "conditional." The last category meant an expressed willingness to offer the services under certain conditions (e.g., if additional funds were available for such a project). The frequencies of the responses in the three categories were statistically compared using a chi-square test.

3.0 Results

The first analysis examined the prediction that there would be services and resources available in these agencies appropriate for the psychosocial and socioeconomic needs and stresses faced by depressed rural women. Table 1 presents the total number and percentage of services offered by organizations that were seen as available and appropriate for depressed women, arranged in order of their frequency. The percentages are rounded to the nearest whole number. While the most frequently offered services varied between the two counties, they mostly corresponded to services with a psychosocial or socioeconomic focus. Across the two regions, the most frequently offered services were social support (68%), volunteer opportunities (65%), workshops and seminars (62%), transportation (50%), and mental health services and counselling (50%). In Antigonish County the most frequently offered services were social support (55%), clothing (55%), volunteer opportunities (50%), workshops and seminars (50%), transportation (50%), and food (50%). In Digby County the most frequently offered services were social support (81%), volunteer opportunities (81%), workshops and

seminars (75%), mental health services and counselling (62%), transportation (50%), and services that enhance physical health (50%). The least frequently offered service in both Antigonish and Digby was day care (0% and 6% respectively). Overall, these findings indicate that these counties have services and resources that cater to the psychosocial and socioeconomic needs of depressed women and which could potentially complement or supplement existing mental health services.

Table 1: The Number and Percentage of Organizations that Offer the Surveyed Services

Service/Resource	Antigonish County		Digby County		Average	
	Total	%	Total	%	Grand Total	%
Social Support	10	55	13	81	23	68
Volunteer Opportunities	9	50	13	81	22	65
Workshops/Seminars	9	50	12	75	21	62
Transportation	9	50	8	50	17	50
Mental Health Services/Counselling	7	39	10	62	17	50
Safety/Security Services	7	39	7	44	14	41
Budgeting/Financial Planning	7	39	6	37	13	38
Housing/Shelter	8	44	5	31	13	38
Services that Enhance Physical Health	5	28	8	50	13	38
Clothing	10	55	2	12	12	35
Food	9	50	3	19	12	35
Crisis Planning/Intervention	6	33	6	37	12	35
Suicide Intervention/Hotline Support	6	33	5	31	11	32
Child Resource Support/Parental Skills	7	39	3	19	10	29
Social and Family Services	4	22	6	37	10	29
Education/Job Training	5	28	4	25	9	26
Training/Access to Computer Technology	4	22	5	31	9	26
Home Care/Support	5	28	4	25	9	26
Employment/Job Opportunities	4	22	4	25	8	23
Physical/Medical Health Services	3	17	5	31	8	23
Child Care	4	22	4	25	8	23
Recreation Services/Subsidized Programs	3	17	5	31	8	23
Domestic Products/Furniture	5	28	2	12	7	21
Home Improvement/Renovations	4	22	3	19	7	21
Women's Shelter	3	17	4	25	7	21
Nursing Care	2	11	4	25	6	18
Social Assistance	4	22	2	12	6	18
Marriage Counselling	3	17	3	19	6	18
Religious Services	3	17	3	19	6	18
Day Care	*0*	*0*	1	6	1	3

The second hypothesis predicted that the community agencies would be willing to offer their services in a coordinated community approach to assist women with depression. The responses to the question with regard to their willingness to participate in such a program were analyzed. Across the two counties, the majority of respondents (82%) were willing to offer their resources, while 5% were unwilling, and the remaining 13% indicated that their involvement would be conditional. A *chi-square* analysis of the frequencies of these three types of responses indicated that these differences were significant with $\chi^2(2, N = 39) = 42.00$, $p < 0.001$. Again, the overall results were corroborated by analyses in each of the two regions. In Antigonish, 74% of respondents were willing, 5% unwilling, and 21% offered conditional support, with $\chi^2(2, N = 19) = 14.63$, $p < 0.01$. In Digby, 90% of respondents were willing, 5% unwilling, and 5% offered conditional support, with $\chi^2(2, N = 20) = 28.90$, $p < 0.001$.

4.0 DISCUSSION

4.1 Main Findings

As predicted, the asset mapping survey found that there were services and resources offered by community agencies to address the social and material needs of depressed women in these two rural counties. Overall, the majority of services available in these agencies catered to the social, economic, and sustenance needs of women. Although the most frequently offered resources varied by county, the most prominent were typically community-focused, with social support, educational, and volunteer opportunities heading the list. Services for other material needs, such as transportation to address the problem of isolation in rural communities, were also represented. These findings are promising because they indicate that the resources available in these communities are consistent with the environmental factors recognized as contributing to the development of depression in women (Brems, 1995; Mazure et al., 2002; Mirowsky, 1996; Rosenfield, 1999; Stoppard, 1989). Mental health services/counselling, however, was ranked high, with an average of 50% of organizations offering it across the two counties. It is likely that various forms of counselling services are offered in these community agencies, with some following a traditional mental health model of treatment, at least to some extent.

The present analysis did not evaluate the quality and the level of the services offered or whether they are adequate to meet the needs of rural women, as we did not conduct needs assessments in these counties. However, there is suggestive evidence that relevant resources and services are available to meet the needs of depressed women in these counties. Hughes and McCormack (2000) noted the importance of matching depressed women's needs with appropriate strategies and resources required to cope with their everyday problems. Our results suggest that these agencies could potentially offer services, if properly coordinated, that would cater to many of the social and sustenance needs of depressed women in the community that may not be met under the present conditions.

The prediction that these agencies would be willing to offer their services to depressed women was also strongly supported. Our results suggested that the service providers already have the motivation to participate in community programs to assist depressed women. Most respondents indicated that they were willing to share resources at their disposal for depressed women, and the only

exceptions were due to lack of additional resources to allocate to such new programs. It has been noted that the mental health services available in rural areas are often not adequate to meet the needs of depressed women (Logan et al., 2004). Our findings indicate, however, that there is interest to change this situation and to participate in a cooperative network offering ancillary and supportive services that could complement existing mental health care for depressed women.

5.0 Community Implications

Members of rural communities often prefer to seek informal assistance and support for their mental and emotional problems (Barry et al., 2000). Natural helpers and other members of the community can provide assistance that complement those provided by traditional mental health care providers. They have been shown to be capable of providing effective interventions for emotional problems (Berman & Norton, 1985; Hattie, Sharpley, & Rogers, 1984). Among the many advantages of making more use of such exiting natural helpers and community resources are their effectiveness in reaching members of the community who are in distress but who would not likely seek and make use of exiting mental health services because of the various problems of stigma and access already discussed.

Raingruber (2002) noted that the separation of health and community services contributes to stigma concerning depression, and as such presents a major treatment barrier to those in need. More cooperation and integration among human services has been proposed as a way to improve health care delivery in rural areas and to make it more cost effective (Fox et al., 1995; Linzmeyer, 2003). Even more importantly, however, further efforts should be made to break down the existing attitudinal barriers among community workers and health service providers and to explore ways in which they can cooperate to capitalize on their latent resources to meet the needs of depressed women.

Bergstrom (1982) had proposed that programs built around already existing resources would be cost-efficient, reduce stigma, and help community members to become more empowered to deal with their emotional problems. In our study we have found that these rural communities have appropriate resources and the desire to respond to the needs of depressed women that are often not being met by traditional mental health services. In addition, there are already informal referral networks among these community groups, so that a transition to a more community-centered and proactive network of services would be a logical and useful step. In this way, our findings are promising with regard to the development of comprehensive programs for depressed women that currently are not being offered in these rural communities.

5.1 Limitations

Although the present analysis consisted of the compilation of data from two counties and adjacent areas, the scarcity of resources in rural areas limited the sample size drawn from each region. Furthermore, the sample may have been subject to volunteer bias that could have influenced the results. By design, the study limited sampling mainly to community, social, and volunteer services because the purpose of the study was to assess community-focused services and resources that may be available in the future for coordinated efforts to assist and support depressed women. Therefore, some of the results are as one would expect given the kinds of agencies that were surveyed. Also, the participants were

affiliated with organizations that are intended to assist the community, and as such, they may have been motivated to present their groups' assets in a favourable light. Especially in face-to-face interviews, where anonymity is reduced, it is possible that participants somewhat emphasized their assets and downplayed their shortcomings. We also recognize that we did not evaluate whether depressed women were aware of the services available to them in these counties or how frequently they made use of them. These could be important goals for future community needs assessments in these localities.

We do not believe, however, that the above limitations had a deciding effect on the main aspects of the results. There are several reasons for our view. First, we were able to include most of the relevant agencies in our surveys so that the results reflect the status of community services in these counties. We continued to solicit new community contacts until we could, and we emphasized our commitment and obligation to protect the respondents' confidentiality and identity. The participants were also given ample freedom and opportunity to state their views. In addition, the respondents selected had considerable experience in their positions so that their responses were based on good knowledge. Finally, the similarity in the findings across the two counties also supports the validity of the results. Therefore, in spite of possible biases, we believe that the present findings provide a reliable and valid profile of the possible community resources available for a coordinated community project in these two rural counties of Atlantic Canada. Further studies, however, will need to be conducted to explore the quality and adequacy of these community resources before actual coordination and integration can be undertaken.

6.0 Conclusions

Evaluation of their assets and interests can assist communities to undertake the challenging task of coordinating their resources for cooperative programs. The present findings have provided some of the preliminary information required to undertake such projects in two rural counties of Atlantic Canada. The findings indicate that there are potential community resources and ancillary services available for cooperative community-centered programs appropriate to meet the psychosocial and socioeconomic needs of depressed rural women. The agencies were also willing to offer their resources for the establishment of such a cooperative network of community services.

In conclusion, based on the assessed resources and the attitudes of service providers there appears to be a foundation for future endeavours to integrate community services in these rural counties to meet the needs of depressed women. A valuable lesson to be drawn from our findings is that even in relatively deprived areas, the main problem may not be the lack of appropriate services and resources. Instead, an effective way to extend and improve services may be to increase coordination and cooperation among existing services and resources along with the use of a proactive intervention focus that could reach more depressed women in the community.

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8.0 References

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author. American Psychological Association. (2002). *The behavioral health care needs of rural women.* Available at: http://www.apa.org/rural/ruralwomen.pdf

Alvarez, H. F., & Nicemboim, E. (1998). Prevention of mental disorders: Steps toward community interventions. *Journal of Community Psychology, 26*, 205-217.

Barry, M. M., Doherty, A., Hope, A., Sixsmith, J., & Kelleher, C. C. (2000). A community needs assessment for rural mental health promotion. *Health Education Research: Theory and Practice, 15*, 293-304.

Bergstrom, D. A. (1982). Collaborating with natural helpers for delivery of rural mental health services. *Journal of Rural Community Psychology, 3*, 5-26.

Berman, J. S., & Norton, N. C. (1985). Does professional training make a therapist more effective? *Psychological Bulletin, 98*, 401-407.

Blazer, D. G., Kessler, R. C., McGonagle, K. A., & Swartz, M. S. (1994). The prevalence and distribution of major depression in a national community sample: The National Comorbidity Survey. *American Journal of Psychiatry, 151*, 979-986.

Boyce, P., Harris, M., Silove, D., Morgan, A., Wilhelm, K., Hadzi-Pavlovic, D. (1998). Psychosocial factors associated with depression: A study of socially disadvantaged women with young children. *Journal of Nervous & Mental Disease, 186*, 3-11.

Brems, C. (1995). Women and depression: A comprehensive analysis. In E. E. Beckham & W. R. Leber (Eds.), *Handbook of depression* (2nd ed., pp. 539-566). New York, NY: Guilford Press.

Bruce, M. L., Smith, W., Miranda, J., Hoagwood, K., & Wells, K. B. (2002). Community-based interventions. *Mental Health Services Research, 4*, 205-214.

Burchard, J. D., Atkins, M., & Burchard, S. N. (1996). Wraparound services. In J. W. Jacobson & J. A. Mulick (Eds.). *Manual of diagnosis and professional practice in mental retardation* (pp. 403-411). Washington, DC: American Psychological Association.

Campbell, C. D., Gordon, M. C., Chandler, A. A. (2002). Wide open spaces: Meeting mental health needs in underserved rural areas. *Journal of Psychology and Christianity, 21*, 325-332.

Carruth, A. K., & Logan, C. A. (2002). Depressive symptoms in farm women: Effects of health status and farming lifestyle characteristics, behaviors, and beliefs. *Journal of Community Health, 27*, 213-228.

Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist, 59*, 614-625.

D'Augelli, A. R., & Vallance, T. R. (1981). The helping community: Promoting mental health in rural areas through informal helping. *Journal of Rural Community Psychology, 2,* 1-9.

Dixon, L., Hackman, A., & Lehman, A. (1997). Consumers as staff in assertive community treatment programs. *Administration and Policy in Mental Health, 25*, 199-208.

Farrell, S. P., & McKinnon, C. R. (2003). Technology and rural mental health. *Archives of Psychiatric Nursing, 17*, 20-26.

Findlay, R. A., & Sheehan, M. C. (2004). Utilization of mental health services in rural and remote communities. *Journal of Rural Community Psychology, E7, No. 1.*

Fox, J. C., Blank, M., Rovnyak, V. G., & Barnett, R. Y. (2001). Barriers to help seeking for mental disorders in a rural impoverished population. *Community Mental Health Journal, 37*, 421-436.

Fox, J., Merwin, E., & Blank, M. (1995). De facto mental health services in the rural south. *Journal of Health Care for the Poor and Underserved, 6*, 434-468.

Gammell, D. J., & Stoppard, J. M. (1999). Women's experiences of treatment of depression: Medicalization or empowerment? *Canadian Psychology, 40*, 112-128.

Gerrard, N. (2000). An application of a community psychology approach to dealing with farm stress. *Canadian Journal of Community Mental Health, 19,* 89-100.

Graveline, M. J. (1990). Threats to rural women's well-being: A group response. In V. Dhruvarajan (Ed.), *Women and well-being* (pp. 169-179). Montreal and Kingston: McGill-Queen's University Press.

Hattie, J. A., Sharpley, C. F., & Rogers, H. J. (1984). Comparative effectiveness of professional and paraprofessional helpers. *Psychological Bulletin, 95*, 534-541.

Hauenstein, E. J. (2003). No comfort in the rural south: Women living depressed. *Archives of Psychiatric Nursing, 17*, 3-11.

Hauenstein, E. J., & Boyd, M. R. (1994). Depressive symptoms in young women of the Piedmont: Prevalence in rural women. *Women & Health, 21*, 105-123.

Health Canada. (2002). *A report on mental illnesses in Canada*. Ottawa: Author.

Hertsgaard, D., & Light, H. K. (1984). Anxiety, depression, and hostility in rural women. *Psychological Reports, 55*, 673-674.

Heyman, S. R. (1982). Capitalizing on unique assets of rural areas for community interventions. *Journal of Rural Community Psychology, 3*, 35-48.

Hughes, J., & McCormack, C. (2000). *The stories of women living with depression: Their coping strategies and resources* (Report). Halifax, NS: Maritime Centre of Excellence for Women's Health.

Israel, B. A. (1985). Social networks and social support: Implications for natural helper and community level interventions. *Health Education Quarterly, 12*, 65-80.

Ivey, S. L., Scheffler, R., & Zazzali, J. L. (1998). Supply dynamics of the mental health workforce: Implications for health policy. *Milbank Quarterly, 76*, 25-58.

Kretzmann, J. P. (1995, September/October). Building communities from the inside out. *Shelterforce Online*. Available at: http://www.nhi.org/online/issues/83/buildcomm.html

Kretzmann, J. P., & McKnight, J. L. (1993). *Building communities from the inside out: A path toward finding and mobilizing a community's assets*. Evanston, IL: Northwestern University, Institute for Policy Research.

Kretzmann, J. P., McKnight, J. L., Dobrowolski, S., & Puntenney, D. (2005). *Discovering community power: A guide to mobilizing local assets and your organization's capacity*. Evanston, IL: Northwestern University, School of Education and Social Policy, Asset-Based Community Development Institute.

Linzmayer, C. (2003). Integrated human services in rural areas: A social work approach. *Rural Social Work, 8*, 25-37.

Logan, T. K., Stevenson, E., Evans, L., & Leukefeld, C. (2004). Rural and urban women's perceptions of barriers to health, mental health, and criminal justice services: Implications for victim services. *Violence and Victims, 19*, 37-62.

Malysiak, R. (1997). Exploring the theory and paradigm base for wraparound. *Journal of Child and Family Studies, 6*, 399-408.

Mazure, C. M., Keita, G. P., & Blehar, M. C. (2002). *Summit on women and depression: Proceedings and recommendations*. Washington, DC: American Psychological Association. Available at: http://www.apa.org/pi/wpo/women&depression.pdf

McGrath, E., Keita, G. P., Strickland, B. R., & Russo, N. F. (1990). *Women and depression: Risk factors and treatment issues: Final report of the American Psychological Association's National Task Force on Women and Depression.* Washington, DC: American Psychological Association.

McKnight, J. L., & Kretzmann, J. P. (1996). *Mapping community capacity* (rev. ed.). Evanston, IL: Northwestern University, Institute for Policy Research.

Merwin, E., Hinton, I., Dembling, B., & Stern, S. (2003). Shortages of rural mental health professionals. *Archives of Psychiatric Nursing, 17*, 42-51.

Mirowsky, J. (1996). Age and the gender gap in depression. *Journal of Health and Social Behavior, 37*, 362-380.

National Institute of Mental Health. (2000). *Depression: What every woman should know*. (NIH Publication No. 00-4779). Washington, DC: Author.

Nolen-Hoeksema, S., Larson, J., & Grayson, C. (1999). Explaining the gender differences in depressive symptoms. *Journal of Personality and Social Psychology, 77*, 1061-1072.

Piechowski, L. D., (1992). Mental health and women's multiple roles. *Families in Society: The Journal of Contemporary Human Services, 73*, 131-139.

Raingruber, B. (2002). Client and provider perspectives regarding the stigma of and nonstigmatizing interventions for depression. *Archives of Psychiatric Nursing, 16*, 201-207.

Rosenfield, S. (1999). Gender and mental health: Do women have more psychopathology, men more, or both the same (and why)? In A. Horowitz & T. Scheid (Eds.). *A handbook for the study of mental health: Social contexts, theories, and systems* (pp. 348-360). New York, NY: Cambridge.

Scattolon, Y. (1999). *Perceptions of depression and coping with depressive experiences among rural women in New Brunswick*. Unpublished doctoral dissertation. University of New Brunswick.

Sears, S. F., Danda, C. E., & Evans, G. D. (1999). PRIME-MD and rural primary care: Detecting depression in a low-income rural population. *Professional Psychology: Research and Practice, 30*, 357-360.

Stone, H. W. (1998). Summoning hope in those who are depressed. *Pastoral Psychology, 46*, 431-445.

Stoppard, J. M. (1989). An evaluation of the adequacy of cognitive/behavioural theories for understanding depression in women. *Canadian Psychology, 30*, 39-47.

Thorngren, J.M. (2003). Rural mental health: A qualitative inquiry. *Journal of Rural Community Psychology, Vol. E6, No. 2.*

Van Hook, M. P. (1996). Challenges to identifying and treating women with depression in rural primary care. *Social Work in Health Care, 23*, 73-92.

Wagenfeld, M. O., Murray, J. D., Mohatt, D. F., & DeBruyn, J. C. (Eds.). (1994). *Mental health and rural America: An overview and annotated bibliography 1978-1993.* Washington, DC: U.S. Government Printing Office.