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Community Input and Rural Mental Health Planning
Listening to the Voices of Rural Manitobans: Using Community Input to Inform Mental Health Planning at the Regional Level

Author: Karen Grace Dyck, & Melissa Tiessen

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Listening to the Voices of Rural Manitobans: Using Community Input to Inform Mental Health Planning at the Regional Level

Karen Grace Dyck
University of Manitoba
Winnipeg, Manitoba, Canada
dyckkg@cc.umanitoba.ca

Melissa Tiessen
Canadian Psychological Association
Ottawa, Ontario, Canada
melissatiessen@yahoo.ca

Abstract

Clients of mental health services in rural and northern areas of Canada encounter a myriad of challenges in accessing high quality services. These challenges include stigma and confidentiality concerns, limited resources, transportation barriers, and heightened rates of professional turnover. Fortunately there are some promising and innovative approaches (e.g., computer-based treatment, internet discussion groups, group-based programming, telehealth, telephone counseling, stepped care, collaborative mental health care) that may prove useful at addressing some of these challenges. Nonetheless, these resources must be accessed by clients in order to be effective. The current study used mail-out surveys to gather information from over 1600 residents in two large rural Manitoba health regions regarding their preferences for (1) accessing mental health information (e.g., searching the internet, reading books, accessing information from various professionals) and (2) treatment delivery options (e.g., group-based services, internet discussion groups, computer-based treatment, telephone counseling), as well as (3) perceived barriers (e.g., stigma, confidentiality, transportation) and facilitators to accessing treatment. These data are presented within the context of informing regional mental health policy with respect to such issues as allocation of mental health funding, adoption of an effective mental health resource development plan, and adoption of an effective mode of mental health care.

Keywords: mental health services, regional mental health policy, accessing mental health information, treatment delivery options

1.0 Introduction

Studies of particular sub-groups of rural and northern (r&n) Canadians reveal a high degree of variability in mental health disorders and risk factors across communities. For example, despair, depression and psychological distress are becoming increasingly common for women in rural Canada (Leipert, 2002). Masley and colleagues (2000) reported a greater frequency of depression and insomnia among rural women, while men were more likely to report being highly stressed. Young rural Canadians, especially young men, are at a greater risk of completed suicide than urban males (Canadian Institute of Health Information, 2006).

Rural and northern Canadians face a variety of contextual barriers to accessing appropriate mental health services. These include limited availability of appropriate services, stigma, lack of anonymity, lack of information, travel costs, and a preference for self-reliance (Boydell et al., 2006; Kirby & Keon, 2006; Leipert, 2002; Ryan-Nicholls & Haggarty, 2007; Ryan-Nicholls, Racher, & Robinson, 2003). Additional barriers include ineffective communication between service providers and clients/families and insufficient mental health client involvement in resource development (Boydell et al., 2006; Ryan-Nicholls et al., 2007; Ryan-Nicholls et al., 2003). These latter findings clearly highlight the importance of client input into the development of mental health services. Given these barriers, it is not surprising that r&n Canadians have typically been found less likely than their urban counterparts to access mental health services (Wang, 2004).

Mental health services delivered over the internet and/or telephone and self-directed treatment options have been found effective in addressing various mental health issues (Brannen et al., 2006; Manitoba Farm and Rural Stress Line, 2005; Vincent, Walker, & Katz, 2007) and may effectively address barriers for r&n residents such as self-reliance, stigma, anonymity, and travel costs. However, such programs are not without disadvantages. In particular, internet usage is much lower in r&n Canada (McKeown, Noce, & Czerny, 2007) and strong health literacy skills are required to successfully partake in self-directed interventions. "In-home" approaches like these also do little to foster support networks. If made available within the context of a broader mental health service delivery model (e.g., stepped care, collaborative care) that includes locally available services, these technological advances do have the potential to address many of the barriers to accessing effective mental health services in r&n Canada. In order for any model to be truly successful, however, residents must be open to the types of services available.

Although the aforementioned studies offer some insight into the mental health needs of r&n Canadians, they offer little guidance to mental health planning and policy at a regional level. Rural and northern communities in Canada are highly diverse and local residents must be consulted in order to develop meaningful and useful services. The purpose of the present study was to gather information regarding the mental health needs of adults living in two large rural Manitoba health regions, the Interlake and South Eastman regions. The data were gathered within the context of informing regional mental health policy with respect to such issues as allocation of mental health funding, adoption of an effective mental health resource development plan, and adoption of an effective mode of mental health care. Regional data of this nature had not been gathered prior to this study. Furthermore, health care organizations tend not to routinely gather community-level input when planning new services – yet this is key information to access if organizations wish to offer services which are truly client centered.

2.0 Regional Backdrop

The Interlake region, with a population of 78,815 (Manitoba Government, 2010a) lies north and west of Winnipeg between Lake Winnipeg and Lake Manitoba. The region is approximately 33,675 square km (Statistics Canada, 2007), with a population density of 2.3 people per square km. The South Eastman region lies south east of Winnipeg, extending to the Ontario border in the east and the United States border in the south. This region's population of 68,383 (Manitoba Government, 2010b) is distributed across approximately 9,961 square km

(Statistics Canada, 2007), resulting in a population density of 6.9 people per square km. Both the Interlake and South Eastman regions include a number of smaller and larger towns as well as one city with a more substantial population base (9,784 and 18,926 respectively; Manitoba Government, 2010a, 2010b).

However, the regions also differ in some important ways. Approximately 22% of Interlake residents identify themselves as Aboriginal, compared with only 9% in South Eastman (Statistics Canada, 2007). Nineteen percent of South Eastman residents report speaking a language other than English in their home, compared to less than 5% of Interlake residents (Statistics Canada, 2007). Anecdotally, the South Eastman region is also perceived by many Manitobans as a region where churches play a strong role in the community. This perception has statistical support as 70% of young families in that region report regular church attendance (South Eastman Health, n.d.).

Residents of the Interlake and South Eastman regions have access to free mental health services through self-help organizations (e.g., Anxiety Disorders Association of Manitoba, Mood Disorders Association of Manitoba, Manitoba Schizophrenia Society) as well as through the local health region's Community Mental Health Program. As such, residents have access to a variety of services including, but not limited to, individual and group based paraprofessional services, individual counseling (typically offered by psychiatric nurses and/or social workers), and psychological and psychiatric consultation. These services are available in various communities throughout the regions and can be accessed with or without a referral.

3.0 Method

The Mental Health Needs Survey (MHNS) is a paper and pencil questionnaire developed by the authors in conjunction with input from local mental health providers and self-help organizations. The MHNS contains questions regarding adults' preferences for (1) accessing mental health information and (2) treatment delivery options as well as (3) perceived barriers and facilitators to accessing treatment. Based on regional feedback, two related but region-specific versions of this survey were created (Interlake version included six pages of questions; South Eastman version included three pages). Given the breadth of information obtained, the current paper will focus primarily on data from questions asked in both regions.

The MHNS was sent out as unaddressed ad mail to a stratified random sample (based on proportional community representation) of 5,000 rural households in each of the two rural health regions of Manitoba. The mail out package included a description of the study (including contact information if anyone should wish additional information about the study or require assistance completing the survey), a business reply envelope, and a copy of the MHNS. In the South Eastman region, a French version of the survey was printed on the reverse side of the English version, and instructions were also included regarding how to access a German version of the survey if desired (no such request was received). Additionally in the South Eastman region the mail out package included a pamphlet providing information on how to access mental health services in the region.

Potential participants were instructed to have the adult of the household complete the survey. If there was more than one adult living in the home on a full-time basis participants were asked to decide which adult was best suited to complete the survey. Participation in the study was completely voluntary. In order to ensure

anonymity and confidentiality, adults who chose to complete the survey were instructed not to put any identifying information on the survey. In both regions notices were placed in the local newspaper both prior to and following the distribution of the MHNS, and within the South Eastman region notices were also posted on two community websites throughout the survey period. These notices were used to alert residents to the upcoming survey and to serve as a reminder to complete the survey.

4.0 Results

Descriptive statistics were calculated in order to enable exploration of region specific patterns and trends relative to residents' responses to survey questions. Percentages were rounded to the nearest whole number. Higher level statistical analyses and regional comparisons, although potentially interesting, are not reported as they were not deemed relevant for the purposes of this investigation.

4.1 Respondents

Response rates for the surveys were similar for both regions; 16% (n = 792) for the Interlake and 18% (n = 910) for the South Eastman region. Although these response rates were lower than anticipated in both regions, it is interesting to note the similarity despite varying survey lengths between both regions. Consequently, it is highly likely that respondents largely included individuals with strong opinions, and those residents without an opinion on the issues may have tended not to respond. In both regions, the distributions of respondents indicate a slight over-representation of residents from the smaller, more geographically isolated communities. The authors view this as a positive aspect of the data, as these individuals are often under-represented in health care planning.

Comparing respondents' demographics with regional census data for residents 15 years and older, it is clear that we have an over-representation of women, as well as middle age and older adults, adults who are not in the labor force, and adults with a higher level of education (see Table 1). Aboriginal residents were underrepresented in the Interlake region (comparable data were not gathered in the South Eastman survey). As such, the current findings must be viewed within this context.

Table 1. *Demographics of Respondents (Census Data in Parentheses)*

	Interlake (n = 792)	South Eastman (n = 910)
Gender		
Female	68% (50%)	81% (50%)
Male	32% (50%)	18% (50%)
Age		
18 – 24[a]	1% (16%)	3% (20%)
25 – 34	4% (12%)	14% (16%)
35 – 44	11% (18%)	17% (19%)
45 – 54	29% (20%)	23% (18%)
55 – 64	27% (16%)	23% (13%)
65 – 74	20% (10%)	14% (8%)
75 – 84	6% (6%)	5% (5%)
> 84	1% (2%)	1% (2%)
Self-Identity[b]		
Aboriginal	7% (22%)	--
Non-Aboriginal	84% (78%)	--
Language spoken at home[b]		
English	89% (96%)	81% (78%)
French	<1% (<1%)	11% (8%)
Other[c]	1% (4%)	4% (11%)
Marital status		
Single	7% (21%)	5% (23%)
Married/living as married	66% (62%)	85% (66%)
Separated	1% (3%)	1% (2%)
Divorced	4% (6%)	4% (4%)
Widow	8% (7%)	3% (5%)
Education		
Some high school[d]	13% (34%)	11% (37%)
High school	27% (25%)	31% (27%)
College/tech/voc/trade	34% (28%)	30% (24%)
University	19% (13%)	24% (12%)
Employment status[e]		
Employed (part or full time)	41% (62%)	53% (70%)
Unemployed	1% (4%)	1% (2.3%)
Not in the labor force[f]	51% (34%)	39% (28%)
Other	3%	1%

Note. Due to rounding and missing data, percentages may not equal 100%. Census data (Statistics Canada, 2007) is for residents 15 years of age and older, unless otherwise indicated. -- is used to indicate instances where data were not obtained in that particular region. [a]Census data is based on age category of 15 – 24 years. [b]Census data reflects all residents (not just 15 years and older). [c]Census data includes individuals reporting more than one language as well as individuals reporting a language other than French or English. Survey data includes only those who reported a language other than French or English. [d]Census data reflects individuals reporting no certificate, diploma, or degree. [e]Census data reflects employment status the week prior to Census day (May 16, 2006), whereas survey data reflects respondents status over the majority of the past year. [f]This category includes homemakers, students, retired workers, and individuals who could not work due to long-term illness or disability. Census data also includes seasonal workers in an "off" season who were not looking for work in this category.

4.2 Mental Health Concerns

Consistent with previous literature regarding lifetime prevalence rates of mental illness (Health Canada, 2002), 21% of Interlake and 20% of South Eastman respondents reported having concerns about their own mental health at some point in their lifetime. A much greater percentage of Interlake respondents reported having concerns only about another person's mental health (53% versus 28%). In contrast, a much greater percentage of South Eastman respondents reported having concerns about their own and another person's mental health (27% versus 2%). Twenty-four percent and 20% of Interlake and South Eastman respondents, respectively, reported not ever having a concern about their own or another person's mental health.

4.3 Forms of Help Accessed During One's Lifetime

In the Interlake region, respondents were asked to distinguish between the forms of help accessed to help them cope with their own versus another's mental health concerns. As shown in Table 2, respondents from both regions identified books as their primary means of coping. A much larger percentage of Interlake respondents reported accessing group services to assist them in coping with either their own/another person's mental health concern (25% versus 12%). A number of respondents from both regions reported using individual counseling, medication, and websites to assist with mental health concerns.

Table 2. *Forms of Help Used During One's Lifetim*e

	Interlake		South Eastman
Help used	Self	Other	Self/Other
Book	25%	25%	43%
Individual counseling	21%	14%	38%
Medication	20%	13%	34%
Website	17%	21%	38%
Presentation	8%	12%	16%
Telephone counseling	3%	5%	10%
Group	25%[a]		12%
Internet discussion group	1%	2%	2%

Note. [a]This question did not ask respondents to distinguish if they accessed group services to help with their own or someone else's mental health concern.

4.4 Likelihood of Accessing Various Supports and Resources

All respondents were asked to indicate how likely they would be to access various supports if they became concerned about a serious mental health issue. As shown in Table 3, residents in both regions identified their spouse, family physician, and a close friend as the individuals whose advice they would be most apt to seek. Respondents from both regions also appeared equally open to speaking to a service provider with personal experience with mental illness, or one with a degree/diploma in a mental health field. A larger percentage of South Eastman residents reported being very likely to talk to a religious advisor (19% versus 6%).

Table 3. *Likelihood of Talking to Various Supports*

	Interlake					South Eastman		
	Not at all		Somewhat		Very	Not at all		Very
Support	1	2	3	4	5	1	2	3
Spouse/partner	7%	2%	14%	9%	39%	6%	21%	60%
Family doctor	6%	7%	21%	15%	35%	8%	39%	48%
Friend	11%	9%	26%	12%	21%	17%	43%	29%
Sibling	17%	9%	19%	9%	14%	23%	40%	21%
MH degree/diploma	13%	8%	23%	17%	17%	26%	40%	21%
MH personal experience	13%	12%	20%	15%	14%	17%	48%	21%
Religious advisor	31%	7%	16%	7%	6%	30%	33%	19%
Parents	18%	4%	9%	6%	7%	24%	23%	13%
Phone help line	30%	14%	17%	6%	7%	50%	28%	6%

Note. Due to missing data, percentages may not equal 100%. M.H. = mental health.

With respect to specific mental health resources, respondents from both regions appeared more likely to access medication, one-on-one counseling, and books as means of dealing with their mental health issues (see Table 4). Websites were also identified by South Eastman respondents as a resource they would be likely to access (unfortunately this question could not be reliably interpreted in the Interlake survey due to a printing error). In contrast, respondents from both regions appeared considerably less likely to access computer-based treatments, internet discussion groups, in-person groups, and telephone counseling.

Table 4. *Likelihood of Accessing Various Mental Health Resources*

	Interlake					South Eastman		
	Not at all		Somewhat		Very	Not at all		Very
Resource	1	2	3	4	5	1	2	3
Medication								
Psychiatrist	27%	10%	17%	18%	21%	24%	40%	30%
Family Doctor	22%	6%	22%	19%	26%	14%	41%	42%
Counseling								
One-on-one	21%	6%	22%	19%	26%	22%	47%	26%
Telephone	43%	17%	19%	9%	3%	46%	37%	9%
One-on-one religious	--	--	--	--	--	42%	32%	19%
Group Education								
Meeting								
2 hour meeting	51%	16%	16%	5%	3%	--	--	--
1 x (20-30 people)	52%	17%	14%	6%	3%	--	--	--
2-4 x (20-30 people)	50%	16%	16%	8%	2%	--	--	--
8-12 x (4-8 people)								
6 hour meeting	55%	16%	13%	4%	3%	--	--	--
1 x (20-30 people)	--	--	--	--	--	58%	30%	5%

One-time, large group	--	--	--	--	--	59%	29%	5%
Series, large group	--	--	--	--	--	46%	38%	8%
Series, small group								
Other								
Book	26%	10%	28%	11%	19%	19%	45%	29%
Website	--	--	--	--	--	23%	34%	37%
Computer-based	62%	15%	10%	3%	2%	74%	15%	2%
treatment	61%	10%	12%	4%	5%	78%	10%	3%
Internet discussion								
group								

Note. Due to missing data, percentages may not equal 100%. – is used to indicate instances where data were not obtained in that particular region.

4.5 Barriers and Facilitators to Seeking Help

As shown in Table 5, respondents in both regions identified wanting to manage the problem on their own and thinking the problem is not bad enough to seek help as the two primary barriers to accessing assistance for mental health concerns. Concerns about cost and about what others might think were also endorsed by a large number of respondents. In the South Eastman region a considerable percentage of respondents also identified not knowing where to access help and wait lists being too long as additional barriers. Although transportation issues are often thought of as a significant barrier to help seeking behavior, this did not appear to be the case for respondents in the present surveys.

Table 5. *Barriers to Seeking Mental Health Services*

Barrier	Interlake	South Eastman
Prefer to handle problems on own	55%	68%
Problem is not bad enough to get help	48%	68%
Concerns about cost	35%	48%
Concern about what others might think	28%	46%
Concern others might find out	23%	34%
Do not know where to go to get help	17%	30%
Other responsibilities to tend to	16%	--
Wait list too long for services	15%	30%
Type of help unavailable	15%	17%
Transportation	9%	--
Transportation/child care	--	15%
Think treatment won't help	6%	13%
Think nothing will help	4%	10%
Service not in my language	1%	2%
Concerns it might label me	--	38%
Concerns info might not be kept private	--	30%

Note. – is used to indicate instances where data were not obtained in that particular region.

As reported in Table 6, factors such as being able to call the service provider directly, being able to access the service in their community, knowing the provider

has a relevant degree/diploma, and having had previous positive contact with the provider were commonly identified facilitators for help seeking behavior. A noticeably larger percentage of South Eastman respondents identified having personal information about the provider, and the provider being active in the community as facilitators for help seeking behavior. Forty percent of South Eastman respondents also reported they would be more likely to seek help if the provider shared their religious beliefs. In contrast, a large percentage of respondents from both regions identified having to access the service outside their community and having previous negative contact with the provider as factors that would reduce their likelihood of help seeking behavior.

Table 6. *Factors Influencing the Likelihood of Seeking Help*

	Interlake			South Eastman		
Factor	Less likely	Neither	More likely	Less likely	Neither	More likely
Able to call provider directly	4%	25%	65%	8%	23%	53%
Provider has mental health education	3%	29%	62%	5%	18%	66%
Provider works in community	12%	27%	57%	15%	19%	57%
Positive contact with provider	6%	33%	54%	6%	17%	64%
Service in general health centre	13%	38%	43%	12%	30%	46%
Provider has personal experience	10%	46%	38%	8%	34%	46%
Provider lives in region/community	14%	45%	34%	30%	32%	26%
Needing to be referred by medical	31%	30%	34%	--	--	--
Able to get referral from medical	--	--	--	11%	14%	67%
Service in community mental health	23%	44%	25%	32%	32%	21%
Have personal information about	13%	64%	16%	11%	45%	30%
Provider active in community	20%	55%	16%	14%	42%	30%
Provider not live in	27%	50%	15%	22%	35%	28%
Provider works outside community	44%	33%	15%	44%	25%	16%
Negative contact with provider	53%	34%	5%	60%	22%	2%
Provider shares my religious beliefs	--	--	--	5%	43%	40%

Note. Due to missing data, percentages may not equal 100%. Tx= treatment. – is used to indicate instances where data were not obtained in that particular region.

5.0 Discussion

Data from the current surveys indicate respondents from both the Interlake and South Eastman regions (regardless of whether or not they reported having a concern about their own or another person's mental health) are most likely to seek advice from their spouse, family physician, or a close friend if they were to become concerned about a serious mental health issue. Respondents from both regions also appeared more likely to seek out medication, individual counseling, and books as means of coping with mental health concerns and less likely to access computer-based treatment, internet discussion groups, in-person group education meetings, and telephone counseling. These findings likely reflect, at least in part, the types of resources that have been most readily available within the regions and, consequently, the resources that are most familiar to residents in these regions.

These findings suggest that successful integration of the newer self-directed technologically supported services (e.g., computer based treatment, telephone supported services) would likely require an initial knowledge translation step, whereby information regarding these less familiar resources is made available to the general public. Ideally this would include information such as documented efficacy, advantages and disadvantages of such services, and perhaps a demonstration where those in attendance have an opportunity to briefly view or try out the service. Depending upon their familiarity with these services, a similar step may also be necessary with local health care providers.

The majority of respondents in both regions indicated that a spouse or friend would be the person they would be most likely to speak to in the event of facing mental health difficulties and a large portion of respondents reported having concerns about another person's mental health at some point in their lives. Traditionally, the mental health system is designed only to support the individual at risk, yet clearly their loved ones require support as well, and often may be in the challenging position of providing the sole mental health support to an individual in need. Programs such as Mental Health First Aid (http://www.mentalhealthfirstaid.ca) are currently offered to help people develop the requisite understanding and skills to better manage mental health difficulties faced by a family member, a friend or colleague, as well as themselves. Furthermore, many self-help organizations, such as the Manitoba Schizophrenia Society, offer programming and supports specifically for family members. Our data support ongoing efforts to offer and expand upon services and supports that target the needs of individuals' natural support systems.

The current data also speak to the importance of region-specific planning. For example, in the South Eastman region as compared to the Interlake, respondents indicated a stronger preference for religious-based mental health supports. This finding fits with the cultural context of the South Eastman region, which includes a high proportion of individuals who place much value on the role of religion in their lives. Consequently, it would be inappropriate and potentially ineffective to develop enhanced mental health programming in this region without regard for collaborations with members of the religious/spiritual community.

Finally, consideration of identified barriers and facilitators to help seeking behavior is also essential for program planning. Data from the current surveys suggest respondents from both regions may delay or refrain from accessing services due to their desire to manage the problem on their own, thinking the problem is not bad enough to seek help, worrying about what others might think, and concerns about costs. In contrast, being able to call the service provider directly, being able to access services in their community, knowing the provider has a relevant degree/diploma, and having had previous positive contact with the provider were commonly identified facilitators for help seeking behavior. These findings highlight the importance of ensuring residents have accurate information regarding the actual cost of various mental health services, the confidential nature of these services, and the location of services. Given the reported likelihood of respondents speaking to their family doctor regarding a mental health concern, it appears equally important that family doctors are well informed about local mental health resources, as well as reputable books and websites to which they could direct their patients. Respondents' desire to manage the problem on their own, worry about what others might think, and the desire to access services in their

home community offer additional support for the integration of more self-directed services that could be accessed either in their home or in their home community. These findings also highlight the need for strategies aimed at reducing stigma and informing the general public about mental health and mental illness and appropriate help seeking behavior.

Data from the current surveys offer the largest community input to date regarding mental health programming at a regional level. However, this data is clearly not without its limitations. The most obvious limitation of the current study is the low response rate and the impact this has on the regional generalizability of these findings. Comparing respondents' demographics with regional census data for residents 15 years and older, it is clear that we have an over-representation of women, as well as middle age and older adults, adults not in the labor force, and adults with a higher level of education. Furthermore, Aboriginal residents were under-represented in the Interlake survey. As such, the current findings must be viewed within this context.

Future efforts should focus on identifying strategies for accessing input from groups that were less represented by the current survey findings. In addition, the importance of input from local service providers must not be overlooked and should be actively sought.

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