WHAT MAKES A CSP SUCCESSFUL?
STARTING A RURAL COMMUNITY SUPPORT PROGRAM
FOR PEOPLE WITH
SERIOUS AND PERSISTENT MENTAL ILLNESS
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**Introduction to Research Topic and Statement of the Problem**

Community support programs for adults with serious and persistent mental illness are designed to improve the ability of participants to live, work, plan, play, and maintain within their communities (Minnesota Statutes, 2002). Drawing on consumers’ strengths and goals, community support programs help consumers who have difficulty living independently to understand their symptoms, to learn coping, social, and independent living skills, and to provide hope for recovery.

Community support programs may intervene with neighbors, landlords, employers, and family members to ease the way for consumers to continue to live in their communities. As a result of community contacts and a variety of early interventions, community support programs/psychosocial rehabilitation programs are also able to meet another purpose - reducing costly and restrictive placements of participants (National Institute of Mental Health [NIMH], 2000a).

Starting a community support program in a rural community requires the knowledge that poverty, limited access to services, geographic isolation, cultural issues, and a higher incidence of disabling conditions impact mental health care (NIMH, 2000b). Starting a rural program also requires knowledge and understanding of the expectations of the community in which consumers live. If community expectations are not considered, the community may find it not in its best interest to adapt to members who have mental illness. The community may ignore the needs of people with mental illness and have little more than superficial contact with them. The community may also continue to stigmatize members who have disabling mental illness. If the community is not also treated as if it were a client, there is a risk of continued isolation of consumers,
long-term dependency on formal structures such as the community support program and discounting of the agency and its goals. The agency may lose the essential goal it was seeking for its consumers – support and integration within the community.

The focus of this research project is the identification of community factors in a rural area that affect acceptance and integration of consumers with mental illness and the community support program which serves them. This research provides a qualitative view of a rural community’s expectations of mental health services.

**Literature Review**

**Statistics and Background Information**

One in five individuals in the U.S. will have a diagnosable mental illness in a given year. Of this group, 13% will have a serious and persistent mental illness, a frequently disabling condition that includes such diagnoses as schizophrenia, bipolar disorder, major depression, and borderline personality disorder (NIMH, 2000a).

In 2000, rural areas with less than 2,500 people contain 21% of the U.S. population (Economic Research Service, n.d.). The prevalence of mental health disorders, disability, and substance abuse appears to be similar between urban and rural settings and sometimes more common in rural areas (National Rural Health Association [NRHA], 1999; NIMH, 2000b). Based on the national statistics listed in the previous paragraph, in an area with a population of 1,500 people, approximately 225 to 300 may have a diagnosable mental illness in a given year. Twenty-nine to thirty-nine of this number may have a serious and persistent mental illness (NIMH, 2000a).
Though mental health service for people with serious and persistent mental illness is a priority in public mental health, rural mental health needs and services have not been prominent in mental health policy (Newhill, 2003; APA, n.d.b; NIMH, 2000a). Research studies on mental health management issues and needs in rural areas are also limited (Wayman, 2000). Programs that have been established and are working well may also lack the measurements to show effectiveness (Anderson, 1997). It is only recently that rural mental health concerns are becoming a focus of study in the U.S (NIMH, 2000a).

**Evidence for Community-Based Care**

Research shows that certain models of service are effective in keeping people out of the hospital. Medications and community services drastically reduced hospital populations according to Witters, Venturelli, and Hanson’s (as cited in Husted, Wentler, & Bursell, 1994). Community support programs and psychosocial rehabilitation continue to reduce hospitalization rates and number of days in the hospital (Brekke, Long, Nesbitt, & Sobel, 1997; Husted et al., 1994; Canadian Mental Health Association, 2003; Maton & Salem, 1995; NIMH, 2000a; Beebe, 2002). Consumers who receive psychosocial rehabilitation, such as medications, employment help, social support and skills training, independent living skills, housing, leisure, and/or family support, tend to have shorter and reduced numbers of hospitalizations than those receiving traditional outpatient treatments (Dincin, Witheridge, Bell & Ryan as cited in NIMH, 2000a). Community based programs appear to have less effectiveness in reducing hospitalization rates for people with schizophrenia, but are still considered vital to their recovery (NIMH, 2000a; Husted, et al., 1994).
Secondly, a number of community-based rehabilitations and supports have shown importance for the general recovery of people with mental illness (NIMH, 2000a). Psycho-education for patients and family both reduce relapse rates and improve social functioning (Harvard Mental Health Letter, 2001). Intensive case management increases consumers’ connections to other mental health services, increases daily functioning, housing stability and independence, and reduces hospitalizations (Borland et al., and Mueser et al., as cited in NIMH, 2000a). Telephone interventions have also proven helpful as preventive care (Beebe, 2002).

It has been suggested that lower hospitalization rates also indirectly measure less concrete indicators such as self-esteem, sense of belonging, problem-solver identity, and confidence (Husted, et al., 2000). Furthermore, the social connections that are made in community support programs appear to aid improved functioning (Grusky et al., 1985). Training in social skills makes permanent changes in specific skills and is encouraged for overall functioning (Husted, Wentler, Allen, & Longhenry, 2000; Harvard Mental Health Letter, 2001; Canadian Mental Health Association, 2003; Brekke & Test, 1992). Physical health problems are also reduced following an increase in mental health treatment (Western Interstate Commission for Higher Education [WICHE], 2001).

**Rural and Urban Differences**

Urban and rural mental health needs are different from each other in significant ways (Wayman, 2000). Services and policies that are appropriate for urban mental health care do not always fit within a rural setting (Wayman, 2000; APA, n.d. a). Rural farm changes and the accompanying trauma is specific to rural settings (NIMH, 2000).
Personnel issues, including personnel shortages in mental health, are also different in rural settings (Wayman, 2000).

Some stressors in rural communities are not present in urban settings. Women, in particular, have a higher likelihood of a disability, poverty, poor health, depression, anxiety, chronic illness, infant and maternal mortality. Stressors for rural residents in general also include isolation, lack of education, disappearing economies such as farming, fewer social activities, and less access to mental health services, transportation, and housing (APA, n.d. a). Outcomes are worse in rural settings for people with schizophrenia or bipolar disorder, and are more difficult if substance abuse is also involved. Suicide rates are also higher for rural adults, youth, and people with depression (WICHE, 2001). People with schizophrenia also have fewer social and emotional contacts and are less satisfied in rural settings than in urban settings (Beebe, 2002).

On the positive side, rural settings have more structure, a greater sense of belonging, and greater familiarity with other people’s lives. Further, people who return to their rural community after hospitalization have lower re-hospitalization rates than those in urban settings, regardless of whether there are community mental health programs (Husted & Jorgens, as cited in Husted et al, 2000).

**Rural Mental Health Barriers**

There are a number of mental health barriers for people in rural communities. Rural residents face the problems of confidentiality and stigma, including the fear that the neighbors will discover that they had to rely on someone else for help (APA, n.d. a; NIMH, 2000a). Yet public acceptance is needed for successful moves from the hospital
to the community (Palmer, Redinius, & Tervo, 2000; Maypole, 1981). Cultural barriers and higher costs in rural settings also influence the use of mental health services (APA, n.d. a; NIMH, 2000b).

Though people in rural areas have generally positive views about mental health treatment itself, there is a lack of access to mental health services (Palmer et al., 2000; APA, n.d. a). Seventy-three percent of mental health personnel shortages are in rural areas (DeLeon, Wakefield, Shultz, Williams & VandanBos, as cited in Wayman, 2000). Seventy-five percent of rural areas are health professions shortage areas; Sixty percent of rural areas have been identified as mental health professional shortage areas (APA, n.d. a). Rural communities are also less likely to have inpatient psychiatric services available and advocacy is virtually non-existent (APA, n.d. a; NIMH, 2000a).

Primary physicians become the most common resource for mental health help, but are often poorly prepared to recognize psychosomatic symptoms and may not refer when needed (APA, n.d. a). Less than 20% of medications for mental illness in the U.S. are prescribed by physicians with mental health training (APA, n.d. b). Nearly half of the people who present to physicians for physical health reasons, but who also have signs of anxiety and depression, do not have their mental health symptoms identified (Zvolensky, Eifert, Larkin & Ludwig, 1999). Physicians also tend to provide less medical information in a shorter time to those who have lower socioeconomic or minority status (APA, n.d. a).

Another barrier experienced in rural areas is that it is often too far to go for mental health help and transportation is limited. Often long distances must be traveled, and access is only allowed to hospitals within a designated catchment area (APA, n.d. a; DeRue, Schlegel, & Yoder, 2002). Quality inpatient care may not be available near
friends and family (NIMH, 2000b). Disabilities can also make it more difficult to access services (APA, n.d. a).

Lack of awareness of mental health needs and resources is also a barrier. Some do not use mental health services because they have become accustomed to their condition and are not aware that there are alternatives (APA Report, n.d. a). Some recognize the benefits of using the mental health system, but do not feel medications are important (DeRue et al., 2002). Some perceive that services are less available than they are (WICHE, 2001). Many do not understand what mental illness is, what treatments are available, or what resources are in the community (APA, n.d. a; WICHE, 2001). As a result of not accessing services early, crisis services are used more frequently in rural areas (APA, n.d. a).

Cost is a barrier for some and not for others (DeRue et al., 2002). In rural areas, though insurance rates are comparable to urban rates, the total coverage is less (NIMH, 2000b). For many people, the inability to pay inhibits looking for help (APA, n.d. a).

Unknown outsiders trying to help are also a barrier to receiving services. People who are not known on a personal level are less trusted (APA, n.d. a). There is also a fear of being sent away where people cannot leave voluntarily (Australian Transcultural Mental Health Network, 2001).

**Rural Thinking and Help-Seeking Patterns**

Rural thinking and help-seeking patterns can also be important when developing a community support program. Rural residents place a high value on self-reliance and believe that problems should be handled privately (APA, n.d. a; Wayman, 2000). If help
is needed, rural residents turn to private sources – family, church, primary physician, or social services (NIMH, 2000a; Wayman, 2000; APA, n.d.a). The primary physician is used frequently due to the greater possibility for privacy. Fifty to seventy percent of rural patients describe physical symptoms that are representative of mental health issues (APA, n.d. b). Community based mental health programs are a good fit for this type of help-seeking behavior (Wayman, 2000).

Gender issues can also be part of rural thinking, including threats to masculinity if seeking help, and women sacrificing their own needs for work and family. Delaying help until things are unbearable is also common for both genders (ATMHN, 2001).

**Tailoring Services to Rural Patterns**

Mental health services must be tailored to rural community needs and help-seeking patterns. Increased acceptance and trust can be gained if local resources are used to educate the community. Respected members of the community who have mental illness can be a powerful source for changing viewpoints. Using the churches as educational centers for mental illness can provide credibility to the message. Support groups in which community residents share their experiences can educate others also. People with mental illness who have improved and are now visibly better provide hope and motivation to others to try as well (ATMHN, 2001). Collaborating with educated people, technical schools, or community colleges can also be a way to educate the community and provide contact with medical help (APA, n.d.a). Publicizing the benefits of the new services, including the economic and social effects, can also increase acceptance (Maypole, 1981).
Increasing the number of existing community members who can identify early warning signs and intervene is another way to tailor services to local needs. Building relationships with and training other professionals in the community who do not usually have a direct mental health role is one way to do this. The veterinarian, the banker, the real estate broker, the minister, and the physician may see rural residents when they are not doing well and can suggest getting help or refer as needed (Wayman, 2000; WICHE, 2001). Building on and training people in informal community connections is another method of early intervention (NIMH, 2000). Speaking with a quilting group, duck hunters’ association, or with indigenous healers can result in greater support and understanding within the community.

Tailoring services to local needs may mean adapting urban methods to rural situations. In some rural areas, only psychologists are available for mental health treatment, and the community may benefit from law changes to allow prescriptive privileges for psychologists (APA, n.d. b). It is also important to reduce the stress on local providers who must cope with dual roles, lack of privacy, and 24 hour availability. Setting up community helpers, a crisis line, or computer connections with other providers can relieve this stress (Wayman, 2000).

Adapting to the local culture is another way to tailor services to local needs (APA, n.d. b). Developing drop-in centers where people can stop in to talk often fits a rural viewpoint. One third of all drop-in centers are in rural areas. Drop-in centers can provide choices, social support, individualized service, role models, and group empowerment (Mowbray, Robinson, & Holter, 2002). Providers must be willing to focus on a rural client’s way of viewing the world rather than a professional one (NIMH, 2000a).
Providers must also be aware that silence, especially from women, may mean disagreement with what is being planned, rather than giving a negative answer (DeRue, Schlegel, & Yoder, 2002).

Finally, tailoring services to local needs should involve combining mental and physical health care as a best practice (NIMH, 2000a). Overall health care costs can be reduced if behavioral health needs are covered promptly (Zvolensky et al., 1999). The public health model has worked well in rural areas for many years (APA, n.d. a).

**Concerns of People with Mental Illness**

Concerns of people with mental illness in communities must also be considered when starting a community support program. Large barriers exist in rural communities for people with schizophrenia (Beebe, 2002). Some of these barriers have already been noted and affect any member of the rural community, such as lack of awareness of need, confidentiality, and limited mental health services.

Living in the community is different from long-term hospitalization and presents new and different problems for people with schizophrenia (Beebe, 2002). These can include lack of structure if not working, developing an internal versus external locus of control, and more complicated decision making when living in the community. This change can be overwhelming, especially if the mental illness is also not completely under control. Further, the adjustment to community living can add its own stress, especially for those who have been away for a long time. A comprehensive system of services must be available to ensure full functioning in the community (Schulberg, 1979).
People with mental illness are concerned about not being accepted in their communities, especially by churches, which promise support to their membership. It is especially disheartening for people with mental illness when leaders in the church deny the illness or continue to spread misinformation about mental health issues. People with mental illness also wish that church leaders would provide more support in general (DeRue, 2002). People who attend church may be more favorable, however, to such projects as establishing a group home (Maypole, 1981).

Feeling supported makes a difference in overall mental health. The emotional level of social relationships is important to people with mental illness. Situations that are hostile, overinvolved emotionally or critical can result in relapse (Beebe, 2002). One study found community dissatisfaction to be the strongest predictor of depressive symptoms (APA, n.d. a). Other studies have found social support to be important to maintaining in the community and to overall quality of life (Bengtsson-Tops & Hansson, 2001). Having a social group can also provide a reference point for what is acceptable behavior (Baker, Jodrey, & Intagliata, 1992). Family support is also important to people with mental illness, both in coping with problems and in being a part of a social group (Beebe, 2002; Bengtsson-Tops & Hansson, 2001).

A community support program must provide for the special needs of males with schizophrenia, who often have fewer social supports and lower relationship quality than women with schizophrenia. Frequent hospitalization reduces functioning, skills, and social networks; men use hospitals more often than women do in part because they may not seek help until the illness is severe (Baker et al., 1992; Beebe, 2002). This can become a circular problem, as more severe symptoms are related to a limited social
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network, and a limited social network results in greater hospitalizations. Further, each contact with people with schizophrenia needs to be meaningful, as their network is smaller and has fewer reciprocal contacts (Beebe, 2002). The oldest consumers had the least social support and the younger consumers had the most social support, but felt it was not enough (Baker et al., 1992).

The ability to give back to the community is also important to people with mental illness, but often lacking. Three-fourths of people with mental illness in board and care facilities in one study lacked opportunities to provide social support to others (Parks and Pilisuk as cited in Baker et al., 1992). This lack of opportunity may be related to mental illness symptoms, such as negative affect, that result in fewer social contacts from others (Baker et al., 1992). People with schizophrenia may also experience less flexibility in thinking, slower reaction times, lower alertness, increased memory problems, and lower levels of social functioning that may affect the number and quality of relationships (Angell & Test, 2002).

Living in the community also presents medication problems, including side-effects and running out of medications, that can be devastating for overall mental health (Beebe, 2002). These situations may not occur in a hospital setting where constant monitoring exists. The development of a community support program must take into account the medication needs of consumers and promptly assist people with mental illness to get help for side effects and to get refills on medications. This is especially important since pharmacies may not be open on evenings or weekends or holidays. Dissatisfaction with medications can also result in going off medications. Younger men are especially likely to do this. Often it is related to side-effect problems and lack of
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It is vital in developing a community support program to focus on trust-building early in the relationship – including honesty, respect, choices, and advocating for consumer concerns – as well as urging prompt action for medication issues and mental illness symptoms. This is especially important since an increase in symptoms of mental illness is associated with loss of reciprocal friendships, a lowered relationship satisfaction, and increased loneliness (Angell & Test, 2002).

People with mental illness may also have concerns about the services they are receiving, and may not be satisfied with the programming or care they have been given. Often this is related to not knowing others in the programming and/or being uncomfortable with others they are expected to be with (Beebe, 2002). It is especially vital to keep this in mind, including developing a relationship prior to group activities, and accompanying the individual to the activities so they know someone. It can also mean being alert to personality differences and trying to match people in mutual activities so that the event is positive for all. It can also mean asking for feedback after meetings so that there can be immediate corrections in the services provided.

Having a safe, low stress, and friendly place to live is also important to people with mental illness. Conflicts in living arrangements can create unnecessary environmental stress (Beebe, 2002). Further, people who live alone without on-site social supports report a higher rate of social isolation (Angell & Test, 2002). A community support program may consider matching consumers as roommates for housing needs, finding housing in apartment settings, or encouraging social connections outside of the home such as clubs or organizations.
Being involved in work is also important to mental health and can increase the size of social networks (Warner, Huxley, & Berg, 1999; Angell & Test, 2002; Bengtsson-Tops & Hansson, 2001). Many consumers are unhappy with their economic situation and would like to work (Baker et al., 1992). Satisfactory employment can result in lowered use of community support programs/clubhouses (Warner et al., 1999). The job must also be carefully matched to the consumer, as a mismatch can actually add to poor social functioning and lack of integration into the community. If supervisors are over-critical, the job involves high speed and/or high stress, or co-workers are not supportive, the job can add additional stress (Warner et al., 1999; Beebe, 2002).

**Community Expectations and Acceptance**

When developing a community support program, it is also important to consider the community expectations and what makes a community willing to accept or reject people with mental illness. Sometimes a community has limited knowledge that results in misinterpretation of the behaviors of a person with mental illness. This can include myths about what treatments work, how homes for people with mental illness affect property values, and other negative thinking about mental illness (ATMHN, 2001; Arens, 1993; Maypole, 1981).

Community members may also misattribute causes to the behaviors they see and urge members to take actions that may not be helpful to improved mental health. This can range from comments that “It’s all in your head – just get a job and get over it”, to attributing behaviors to physical illnesses. It can include viewing the behaviors as “the work of the devil” or other spiritual causes. It can be considered a family problem and
kept hidden or ignored by the community (ATMHN, 2001). An important part of developing a community support program should include education to the community on a variety of topics related to mental illness to reduce neighborhood fears and increase openness to people with mental illness.

Secondly, behaviors make an impression on the community. Some community groups are less accepting of behaviors. For example, older persons tend to be less favorable toward people with mental illness who have obvious unusual behaviors. People who attend church tend to be more favorable, as are renters and liberals (Maypole, 1981). Mental illness is one of the least accepted disabilities by health practitioners. Acceptance of people with disabilities is more likely by high school students rather than junior high students and acceptance is more likely by female rather than male students. Smaller communities tend to view persons with disabilities as different from other people in the community, including being less capable, unhappy, depressed, and hypersensitive (Palmer et al., 2000).

Socially inappropriate behaviors make acceptance even less likely. These appear to range from behaviors that are tolerated at first, but become bothersome over time, to behaviors that in and of themselves are not tolerated. Behaviors that can be tolerated for awhile, but then become a burden include needing help with everything to noise disruptions at night to not maintaining an adequate diet. It can also include problems with personal hygiene and not managing finances well. Failure of a loved one to do household chores also increases complaints by family members (Gubman, Tessler, & Willis, 1987).
Behaviors that are not tolerated include physical violence, wandering/loitering, trouble with the law, suicidal threats, incontinence, inappropriate sexual behavior, not taking medications, or property destruction. Temper tantrums, bizarre behavior, and failure to socialize appear to be the hardest for communities to cope with (Palmer et al., 2000; Gubman et al., 1987).

Even providers trained in mental health sometimes struggle with tolerance of some behaviors. A national survey of social workers found the following situations challenging: people who did not show for appointments, who were decompensating, showing manipulative behaviors, and not taking responsibility. They also struggled with people who had constant disruptions, abused substances, threatened, or had slow progress (Newhill, 2003). Communities were able to tolerate some behaviors such as minor bad habits or deficits in academic skills (Palmer et al., 2000).

Successful community integration of people with mental illness is dependent upon positive community attitudes about people with disabilities (Palmer et al., 2000). Seeing improvements in the behaviors of a person with mental illness can result in an attitude change and greater tolerance and understanding (ATMHN, 2001). Socializing by the family member with mental illness decreases complaints by family, as do planned activities during the day and recreational activities at home (Gubman et al., 1987). However, mere exposure to people with mental illness does not change community attitudes (Palmer et al., 2000).
Empowering the Community

Developing a community support program also means developing a community. Organizational characteristics, including belief system, role structure, support system, and leadership, may be used to empower both people with mental illness and members of the community (Maton & Salem, 1995). Focusing on strengths, relationship and personal growth, helping the group improve, and having a turn at the various roles can lead to empowerment (Maton & Salem, 1995). Developing reciprocal relationships, keeping all informed, having leaders who are committed to the cause, and welcoming of a wide range of people can also empower a community (Mowbray et al., 2002; Maton & Salem, 1995). Since community support programs and rural areas tend to encourage social contact, a positive sense of belonging, and roles for each member, the stage is already set for an empowering rural community support program (Husted et al., 2000).

Significance to Social Work

Findings from this research will guide the next stage of development for a community support program in a rural community in Minnesota. The expectations stated by the community and people with mental illness will form the future goals and plans for the program. Changes, including localizing staff and services, will be made to adapt to these expectations as needed.

Findings from this research may also guide others as they seek to improve programs for people with mental illness, especially in rural areas. They may take more notice of community concerns, or build in additional empowering characteristics into
their programs. The fit between community support programs, consumers, and communities may be enhanced.

State policy makers may use this information to set certain requirements for community support programs, such as identification of community concerns, or design of programs that increase community involvement. This research may also challenge existing traditional theory that only people with mental illness are expected to change (i.e. “social adjustment” or “community adjustment”) to be part of the community.

**Research Questions**

The research questions are:

1) What are the mental health issues in this community?

2) What indicates to people in this community that a program is working?

3) How do clients with serious mental illness and other community members differ in their views about mental health issues and program indicators?

4) How do responses differ based on length of time in the community or gender of the interviewee?

**METHODS**

**Sample/Population**

The non-probability sample for this research consisted of thirty-four transcripts that were in the possession of a newly established rural community support program
within a resort community of about 4,000 people in north central Minnesota. Of the thirty-four respondents, twenty-four were female and ten were male. Five were identified consumers and twenty-nine were other community members and professionals. Fourteen had been in the community for twelve years or less, and fourteen had been in the community for thirteen or more years. Six did not identify a length of time in the community.

The transcripts were of interviews conducted by the community support program between November, 2002 and February 2003. The interviews were conducted in accordance with agency program policy as part of a data-gathering effort to start the program. It included key informants who lived or worked within the rural area where the program was planning to provide services. All interviewees had experience with mental illness, either personally or professionally.

Of the transcript records, twenty-nine were interviews with professionals who lived and/or worked in the community. These people were selected by asking informants about mental health issues and what other resources were currently available in the community, then seeking out the head person at each of the agencies noted. Key respondents were from county court and social services, churches, hospital and clinic, rape/assault crisis service, disability employment service, home health, in-home counseling, law enforcement, private therapy, a group home, and the school system.

A number of these professionals also had personal experience with mental illness – their own or a family member’s- but the community support program did not obtain this
information until months after the interviews were completed. The interviews, therefore, reflect their professional/community viewpoint only.

The community support program also conducted interviews with clients/consumers within two weeks of the start of service. The first ten consumers in the program were scheduled to answer questions about mental health issues in the community and their own needs in the program. These questions were asked for the program’s internal planning for rural needs from a client perspective. Records of five of these interviews were obtained. The community support program reports that the remaining consumers either did not show for appointments, had immediate needs that took precedence, or chose not to participate. Names were connected with neither the consumer nor the professional data obtained for this research.

**Research Design**

This was a qualitative research study. It involved secondary data analysis of open-ended, face-to-face interviews. It was a cross-sectional study in that there was only one interview per person and there were not follow-up interviews. Transcripts from the rural community support program interviews were analyzed for themes and responses related to the research questions listed above. An interview guide was used for the original questions. In addition to the qualitative analysis, general themes were compared with years in the community and gender. Individuals were the unit of analysis.

**Operational Definitions/Data Collection**

The original interview guide used by the rural community support program included the following questions (see Appendix A for full interview schedule): 1) How
long have you lived or worked in this community? 2) In your view, what are the mental health issues of people in this community? 3) What resources are currently available in this community? 4) In your view, what do people with serious mental illness need from a community support program? 5) (After a brief description of the community support program) What will indicate to you that progress is being made with consumers in a community support program? or for consumers: What will indicate to you that the community is becoming more accepting of people with serious mental illness? The gender of the interviewee and the number of years they had been involved in the community were also documented. In some cases, this latter item was not included.

“Mental health issue” is defined as disturbances in thought, mood, or behavior that are associated with distress or impaired functioning. “Consumer” is a person who uses mental health services.

“Community” includes people who live or work within the rural county and who are not consumers of program services. The approximately 4,000 people in this northern Minnesota county benefit economically from multiple resorts, fishing, and winter sports, as well as a pharmaceutical company and a hospital/clinic.

“Serious mental illness” is defined as schizophrenia, bipolar disorder, major depression, borderline personality disorder, or other diagnosis in which there are moderate to severe problems in functioning in at least three areas of life.

“Community support program” or “CSP” is a state-funded program, mandated by statute, and established to encourage support, prevention, and recovery within the community for people with serious and persistent mental illness (NIMH, 2000a). Community support programs were designed so that people with serious mental illness
could “work in a regular or supported work environment, handle basic activities of daily living, participate in leisure time activities, set goals and plans, obtain and maintain appropriate living arrangements, and reduce the need for intensive, costly, or restrictive placements.” (Minnesota Statutes 245.4712, 2002).

**Data Analysis**

Secondary data analysis of qualitative data from face-to-face interviews done prior to the start of the community support program was used. Using cut and paste, the transcripts of these interviews were organized based on length of time in the community, gender of the respondent, and whether the respondent was a consumer or another community member. After making some adjustments for confidentiality, both for consumers with unique disabilities and for other community members whose positions may be obvious by their comments, the data was reviewed for similarities and differences among the categories listed above. The frequency of responses in each category was noted, as were the types of general mental health issues evident in this community. Ways in which community members differed in response from others in the community who had mental illness was also noted, as were indicators that the program was working.

**RESULTS**

The data was explored for mental health issues, indicators that the program was working, differences and similarities in opinion between consumers and other community members, and differences and similarities based on years in the community or gender of the respondent.
What Are the Mental Health Issues in This Community?

Thirty-two of the respondents—five consumers and twenty-seven other community members—responded to this question. Identified community mental health issues fell into four categories: (1) Resources needed, (2) Mental-related problems, (3) Passive rejection, and (4) Provider disconnection.

1) Resources needed

Twenty-six people commented on resources needed in the community. These included one-to-one help, more professionals, family skills and support groups.

Fifteen respondents identified local, trusted, in-home help as a resource lacking in the community. These included persistent, private, and consistent workers. These ideas are noted in the following comments:

“The ideal is to have someone from the community. Anonymity is ok, but it needs to be local, trusted.”

“There is lack of in-home help. My work crosses over into this sometimes, teaching housekeeping, personal skills, changing sheets, or how to clean out the refrigerator.”
Thirteen people mentioned more professionals as a needed resource. This included clinically trained personnel, such as a psychiatrist, and removing barriers in getting people to hospitals, as noted below:

“We need a psychiatrist and a psychologist who are free and that there would be no stigma.”

“The nearest hospital for holds is two hours away. There are also no on-call staff or advocacy through ______________.”

Nine respondents identified family skills and other support groups needed in the community:

“There are groups to teach cooking, but not anything for mental health or support of families and partners. We also need a support group for losses and someone trained to do it. There are also no groups for singles in the middle ages.”

“We need a support group for people with the same mental illness problems and similarities.”

“The community needs education about how parents should be. Child protection teams make guidelines, but parents don’t know.”

2) Mental-Related Problems

Twenty-two respondents identified serious mental illness/ suicides, chemical dependency, and an independent, male-dominated mind-set as mental-related problems that affected the community. Some respondents answered in several categories.
Nineteen people mentioned serious mental illness and suicide, with depression as the most common illness.

“Depression is the biggest problem. In a rural environment, it seems people learn ways not to be happy. Some have ongoing depression and the recent natural catastrophe magnified it.”

“We have people with mental health needs on all ends of the county. I know five people with serious mental illness, some of whom have been in the hospital often. We don’t see much of other types of mental illness – usually just the most severe.”

Some respondents did not believe there were serious mental health issues, as noted below:

“I’ve been here six months and during that time no one has been identified with serious and persistent mental illness, not even much depression, anxiety, or alcohol abuse.”

“There is not much need. Maybe people are doing a good job?”

Thirteen respondents mentioned chemical dependency issues. Responses were usually multiple sentences and emphatic. They detailed a community where alcohol was an ingrained aspect of the community, where members enabled youth and adult drinking, and where there had been severe trauma related to alcohol. The following quote illustrates this:

“People work hard and play really hard – snowmobiles and four wheelers go better with a beer. It's a way of life. Work is also available here, so there is lower unemployment. So there are lots of parties. There are suicide and grief issues, tragic deaths that are alcohol-related. There were nine or ten funerals of
Seven people mentioned a **self-sufficient, male-dominated mindset**. This was listed as a mental health issue because it often led to isolation, abuse and depression. It is described below:

“Buck up-keep your mouth shut is the mindset around here. Some men don’t have respect for women. They just look to them for cooking and cleaning.”

“The attitude toward women is pathetic. Traditional males see women as property. They are isolated.”

### 3) Passive Rejection

Twenty respondents identified as a mental health issue the community’s tendency to passively reject people with mental illness. They noted that the community limited its learning about, its sensitivity to, and its recognition of people with mental illness.

Eleven respondents noted that the community **limited its knowledge about mental illness**. This included lack of questions about the illness, passive dependence on TV for impressions, action without adequate knowledge on the part of some professionals, and lack of knowledge about personal mental hygiene skills.
“I wish my family would ask questions. It is easier to answer a question, than to start the conversation with an explanation. No matter how dumb it seems, people could ask, “What’s it like?” When I moved back to this area after my break, no one asked me how I was. They asked my family instead.”

“There is a stigma, a stereotype. I’m not treated badly, not shunned. But with all the TV or cop shows, people think that everyone with mental illness sees things or kills people. With mental illness, they shut up and assume you are wacko.”

“Education in the schools is needed. Kids need to know mental hygiene – this is not yet an accepted health area.”

The community also was not sensitive to the needs of people with mental illness, as eight people observed:

“There is non-acceptance of the differences. The community doesn’t understand grooming problems or body odor.”

“People on the outside just observe and make assumptions. If there is a diagnosis, people are scared. They say, “If that had been my kid, I would have beat him more,” or “If he worked hard enough, he wouldn’t feel lousy.”

The community also limited its recognition/support of people with mental illness, as seven people noted. Some examples are below:

“There is support if they are not really sick.”

“Loneliness is a big issue. People hang out at restaurants for a place to talk with people. People will talk with them, but they are not friends with them.”
4) Provider Disconnection

Fourteen respondents identified provider disconnection problems. These included lack of education/knowledge among providers, and relationship/communication barriers between agencies.

**Lack of education/awareness** among providers was a problem identified by nine people. The following comments were from providers who identified their needs.

“We are interested in reporting child protection needs. Who do we report to?”

“We would like to be invited to a seminar on how to deal with people with mental illness.”

Eight respondents described **lack of referral and other communication barriers between agencies**, as follows:

“We don’t know someone is in the hospital until the state regional treatment center calls. We don’t know which local doctor signs the (72-hour mental health) hold.”

“The system is fragmented.”

Table 1 summarizes the mental health issues identified by this community. It describes the results by the number of respondents per each category. Note the high number of
respondents who identified mental health resources needed in the community and who identified serious mental illness in the community. There were 32 total respondents.

Table 1.

Identified Mental Health Issues by Number of Respondents

<table>
<thead>
<tr>
<th>Mental Health Issues</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Resources Needed</strong></td>
<td>Total 26</td>
</tr>
<tr>
<td>Trusted, in-home help</td>
<td>15</td>
</tr>
<tr>
<td>Professionals</td>
<td>13</td>
</tr>
<tr>
<td>Family/group supports</td>
<td>9</td>
</tr>
<tr>
<td><strong>Mental-Related Problems</strong></td>
<td>Total 22</td>
</tr>
<tr>
<td>Serious mental illness/suicide</td>
<td>19</td>
</tr>
<tr>
<td>Chemical dependency</td>
<td>13</td>
</tr>
<tr>
<td>Independent mind-set</td>
<td>7</td>
</tr>
<tr>
<td><strong>Passive Rejection</strong></td>
<td>Total 20</td>
</tr>
<tr>
<td>Limited learning</td>
<td>11</td>
</tr>
<tr>
<td>Limited sensitivity</td>
<td>8</td>
</tr>
<tr>
<td>Limited recognition</td>
<td>7</td>
</tr>
<tr>
<td><strong>Provider Disconnection</strong></td>
<td>Total 14</td>
</tr>
<tr>
<td>Lack of awareness among providers</td>
<td>9</td>
</tr>
<tr>
<td>Lack of communication between agencies</td>
<td>8</td>
</tr>
</tbody>
</table>

*Note. Many respondents answered in more than one category. Some survey respondents did not answer this question at all.*
What Indicates To People in This Community That A Program Is Working?

The community provided indicators of a successful program that fell into three categories. These included positive publicity, changes in coping skills and reduction in service intensity. Twenty-four total respondents provided indicators.

1) Positive Publicity

Sixteen people responded with indicators of positive publicity. Responses covered community awareness of the program, provider comfort with referral, and consumer acceptance.

Nine respondents noted that provider comfort with referral would indicate the program was working.

“The clergy will make referrals. The program will get physicians on board – ask about mental health issues and meet with nurses to connect. Physicians make a token referral and then are still referring. There is damage control- people are told what has changed to help.”

“I’ll be able to bounce things off the CSP.”

Eight respondents identified community awareness as an indicator that the program was working.
“I’ll see something in the paper about it. There will be an update newsletter with information.”

“No one will ever ask for services because they will know where to go.”

Three respondents identified consumer acceptance of services as an indicator that the program was working.

“People will feel free to attend the activities. The activities will be matched to the personalities. So if there are social isolates, you won’t just offer dancing.”

“There is feedback from consumers. I will be aware of services available without an individual meeting.”

2) Coping Skill Changes

Coping skill changes were an indicator noted by sixteen respondents. These included skills learned, as well as visible changes in consumers.

Thirteen people identified specific skills learned/taught as an indicator of program success.

“I’m not working and would like to be. I will feel better about myself. I will do activities that I like. I will not panic so much. I’ll be physically fit and be able to lose weight.”
“Consumer skills will be used, whether it is crafting, computers, or speaking. There will be someone to check in every other day to see that the person is taking medications and that there is heat. Money management skills will be taught and there will be credit improvement. People will get help with daily structure, prioritizing and managing time. They will have leisure activities and help finding better housing.”

**Visible changes** were identified by six respondents as an indicator of the program’s success.

“Other people will say hi and not avert their eyes.”

“We will see a change in environment and dress.”

“There will be an attitude change so that the client wants to work on being well.”

3) **Service Intensity Decreased**

Eleven people identified a decrease in the intensity of services as an indicator of program success. Seven respondents noted a **workload decrease in other agencies** as a decrease in service intensity.

“Social workers will have less contact for things that are not case management and there will be less drop-in at social services for socialization.”

“The clinic will not be as busy.”
Six respondents noted that **less intensive care**, including fewer hospitalizations, would indicate that the program was working.

“There will be no commitments! What a boon for the community!”

“We will be able to bring back four to five people who are at the hospital to live in the community.”

Table 2 summarizes the indicators that a community support program is working. It describes the results by number of respondents per each category. The reader should notice the importance to this community that the program has positive publicity, changes

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive Publicity</td>
<td>Total 16</td>
</tr>
<tr>
<td>Provider referrals</td>
<td>9</td>
</tr>
<tr>
<td>Community awareness</td>
<td>8</td>
</tr>
<tr>
<td>Consumer acceptance</td>
<td>3</td>
</tr>
<tr>
<td>Coping Skill Changes</td>
<td>Total 16</td>
</tr>
<tr>
<td>Skills learned/taught</td>
<td>13</td>
</tr>
<tr>
<td>Visible changes in consumer</td>
<td>6</td>
</tr>
<tr>
<td>Service Intensity Decreased</td>
<td>Total 11</td>
</tr>
<tr>
<td>In local agencies</td>
<td>7</td>
</tr>
<tr>
<td>Fewer hospitalizations</td>
<td>6</td>
</tr>
</tbody>
</table>

*Note.* Respondents chose more than one category. Some respondents did not answer this question at all.
WHAT MAKES A CSP SUCCESSFUL?

in coping skills in their members, and a workload change in other agencies. Readers should also notice that the emphasis made by this community is on provider and community improvement and comfort, and less on consumer satisfaction/changes. There were 24 total respondents.

**How Do People With Identified Serious Mental Illness and Other Community Members Differ in Their Views about Mental Health Issues and Program Indicators?**

People with identified serious mental illness differed from other community members by the focus of their concerns. Only five consumers made responses. Twenty-seven responses came from other community members.

1) **General Themes**

Consumers focused on their personal experiences in their comments. Consumers told how experiences affected their own lives, spoke in the first or second person, and discussed personal feelings.

“We need somewhere to go. I’m bored on my days off from work.”

“When I needed social contact I went to the bar. You can’t have depression and want to be out with people. It’s easier in the big events, like 4th of July, because you get lost in the crowd.”
Other community members provided comments that were removed from their personal lives. They told how experiences affected their work or the community, they spoke in the 3rd person, only spoke in the first person in relation to employment, and did not discuss personal feelings.

“We’ve been busting keg parties and seeing a difference. Except the city allows the 4th of July keg party and kids see this.”

“Services have changed over the past five years for people with mental illness. People pushed for change.”

Consumers’ focus also differed from other community members through owning their challenges when they were unhappy with a situation. Consumers readily identified their needs, weaknesses, or desires. For example,

“I wish my family would ask questions. It is easier (for me) to answer a question, than to start the conversation with an explanation. No matter how dumb it seems, people could ask, “What’s it like?”

“I want my husband and I to be on the same page to care for our child.”

Other community members’ focus was on others’ challenges when they were unhappy with a situation.

“The seniors are stubborn. They won’t take what is offered.”

“Parents provide alcohol to their kids.”
Only one non-consumer respondent used the first person when identifying lack of knowledge,

“I don’t know of groups who work with perpetrators.”

Others referred to the need for more knowledge, but in the 3rd person. For example,

“There are bad parents with children and we don’t know how to reach the resources. We don’t know who to call, so we call the intake worker.”

 Consumers’ focus was on speaking about their illness:

“My dad doesn’t understand mental illness. He finds it embarrassing. You want your parents to be proud of you, not look down on you. My father says I shouldn’t tell people- that I won’t ever get a job in this town if I do tell. I talk about it anyway.”

“People look at my face and can tell. They know something is different and wrong, but they don’t know what is wrong. And they don’t ask.”

Other community members focused on privacy instead:

“Buck up- keep your mouth shut is the mindset around here.”

“It is hard to trust that people will not find out that somebody takes medications.”
“People are benefiting from outreach services, but you will need to come to them.”

2) Mental Health Issues

Consumers and other community members differed in the magnitude of their responses about mental health issues, such as lack of resources. Community members identified many resources for a variety of needs within a small community.

“There are many outdoor activities that people with mental illness and others can get involved in – tagging fish, harvesting balsam bows, a club for duck hunters, picking pine cones for extra money.”

“There are numerous clubs and organizations – quilting, women’s groups, men’s groups, AA, humane society, snowmobile club, community education, county extension office, tae kwon do, historical society, chamber events.”

In contrast, consumers identified few resources. The resources identified were directly related to services they used and focused almost entirely on mental health and related needs. For example,

“It is really good to have the mental health column in the paper.”

“There is a therapist in town I used, to learn how to get my post-traumatic stress disorder under control.”
Consumers frequently identified **resources that were needed to assist families or individuals.**

“I’d like to see a family support group.”

“I need things to do like cooking, social activities, baking cookies, dinners or parties.”

Though other community members also identified these needs, they frequently identified **resources that were professional-level** also.

“We seek biofeedback as a resource.”

“We need a call back from a psychiatrist within four to six hours.”

Community members spoke extensively about **community-wide issues**, including chemical dependency, elderly depression, independence/male domination, and community mental illness.

“We serve 750 people. About 20% have issues with alcohol.”

“Many elderly are depressed. The cost of living has increased. Their family is gone. They are lonely. They don’t have money.”

“There needs to be someone for abuse issues. Five to ten percent of the people we work with experience abuse.”
Consumers’ only references to community wide issues were in relation to their own illness.

“I want to stay sober.”

“My child quit school so he could check on me to see if I’m ok.”

Consumers and community members also differed regarding behaviors that ignore others. Though both groups agreed that the community was less sensitive to people with serious mental illness, and gave less recognition to them, they diverged when talking about learning patterns in the community. Consumers concentrated on lack of questions and dependence on stereotypes that resulted in behaviors that ignored others.

“When I moved back to this area after my break, no one asked me how I was. They asked my family instead. With mental illness, they shut up and assume you are wacko.”

“They treat you differently. If you have a brain tumor, they do a benefit dinner for you and your family. I was in the hospital for a time. They gave no support to my immediate family. People don’t pass an envelope for you at work for financial help, like they do for other health conditions. I could have used the help. People just don’t talk about it.”

Other community members concentrated on professionals who took action without adequate knowledge.
“____________ needs to learn to be more sensitive. Some are wonderful.”

“____________ give medications without a thorough assessment. It’s like they experiment.”

Consumers did not speak about provider disconnection problems, whereas other community providers spoke of needed education among providers and communication barriers between agencies. For example,

“They aren’t referring to my practice – might not know I’m here.”

“It would be helpful for churches to have resource information.”

2) Indicators

Consumers and other community members differed somewhat about indicators that the program was working. Both identified positive publicity within the community and among consumers as an indicator that the program was working; other community members also identified provider comfort level as an indicator that the program was working. Consumers made no mention of this indicator.

“There is an open door for providers.”

“The program will be approachable.”
Other community members went on to note that a **workload decrease** in other agencies and **reduced hospitalizations** would indicate program success. Consumers did not mention either of these indicators.

“The sheriff’s job will be easier.”

“There will be fewer emergency room visits.”

Consumers and community members diverged on the topic of coping skills. Consumers worded their indicators to reveal **improvements that satisfied them internally**.

“I can go uptown without being afraid.”

“I’ll have more interest in keeping the house up.”

Consumers also identified **visible changes in the community’s reaction** as an indicator that the program was working.

“The community will treat me like everyone else who is having a medical problem. They’ll give support to my family and to me. They’ll raise money to help me when I am sick. They’ll talk about it.”

“The _________ will listen to me and recognize when I am trying to do what they ask.”
Other community members, however, focused on **visible changes in consumers** as an indicator that the program was working. For example,

“There will be less difference between people with mental illness and others.”

“I will see it working. Clients I work with will improve and they will not be making trouble.”

Table 3 summarizes the differences in response between people with identified mental illness and other community members. It describes how they differ through general themes, views on mental health issues, and indicators that the program is working. The reader should notice the frank openness, roadblocks to health, internal assessment, and need for community acceptance of those with identified mental illness. The reader should also notice the personal distance and emphasis on privacy, focus on professional concerns and community resources and needs, and the expectation of visible changes in consumers. Five consumers and twenty-seven other community members’ responses are described here.
Table 3

Differences In Response between People with Identified Mental Illness and Other Community Members

<table>
<thead>
<tr>
<th>People With Identified Mental Illness</th>
<th>Other Community Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>General themes</td>
<td></td>
</tr>
<tr>
<td>Personal experiences</td>
<td>Non-personal experiences</td>
</tr>
<tr>
<td>Ownership of challenges</td>
<td>Non-ownership of challenges</td>
</tr>
<tr>
<td>Speak about mental illness</td>
<td>Privacy about mental illness</td>
</tr>
<tr>
<td>Mental health issues</td>
<td></td>
</tr>
<tr>
<td>Few resources noted</td>
<td>Numerous resources noted</td>
</tr>
<tr>
<td>Resources for families/ individuals</td>
<td>Professional resources</td>
</tr>
<tr>
<td>Individual needs</td>
<td>Community-wide needs</td>
</tr>
<tr>
<td>Stereotypes/lack of others’ questions</td>
<td>Lack of professional skills</td>
</tr>
<tr>
<td>No provider disconnection</td>
<td>Barriers/Agency education</td>
</tr>
<tr>
<td>Indicators</td>
<td></td>
</tr>
<tr>
<td>Program publicity</td>
<td>Plus provider referral</td>
</tr>
<tr>
<td>Internal satisfaction</td>
<td>Visible consumer changes</td>
</tr>
<tr>
<td>Visible community changes</td>
<td>Visible consumer changes</td>
</tr>
<tr>
<td>No service changes noted</td>
<td>Service reductions</td>
</tr>
</tbody>
</table>

How Do Responses Differ Based On Length Of Time In The Community?

Of 28 people who stated how long they had been in the community, the mean length of time in the community was 14.52 years. Lengths of time ranged from 6 months to 46
years. Consumers as a group lived in the area longer than other community members had. The mean length in the community for consumers was 24.8 years. The 23 other community members who stated a length of time in the community were present for a mean length of 13.5 years. Thirteen of the 23 community members (57%) had been in the community for 12 years or less. Ten of those thirteen had been in the community for five years or less. The roles of these respondents were throughout the community.

Twenty-three people who stated their length of time in the community commented on the need for resources. Those who had been in the community for 13 or more years saw a need for increased professional help. For example,

“We need a psychiatrist for the kids in school.”

“We need to maintain care after the crisis is over for kids and adults.”

Those who had been in the community for one to twelve years saw a need for more outreach and community health skills/services for the general population.

“Anger management skills need to be taught.”

“Family support is needed, but it is difficult to start. People are afraid to be seen coming out to it.”
Fourteen people who stated their length of time in the community commented on mental-related problems. Ten of these people identified chemical dependency as a problem in the community.

“CD is the biggest problem- there are so many places to drink.”

“People don’t see alcohol as a drug up here. Both alcohol and drugs are used for self-medicating. Family alcohol use is an issue, but people have been so private about it. There is more talking now. There were nine or ten funerals of people age 23 or under in the next county during the first few years here.”

Those who had been in the community for less than 12 years either did not speak of chemical dependency or did not speak of it as much as those people did who had been in the community longer. Some denied it altogether:

“In six months, no one has been identified as SPMI, not even much depression or anxiety or much alcohol abuse.”

“There is not much need. Maybe people are doing a good job?”

Fifteen people who gave their length of stay in the community also identified serious mental illness and suicide as mental health issues. Seven of the fifteen people had been in the area for more than 12 years and focused on past suicides, schizophrenia, and bipolar disorder.

“Twenty years ago, there were mental illness problems. There were more suicides back then. Unemployment was greater, so people had more time and less
money. Now unemployment is less, so people are busier. There are more services now, too.”

The remaining eight who had been in the area for twelve years or less spoke of depression, especially in the elderly. They did not speak of other serious mental illnesses.

“Many elderly are depressed. The cost of living has increased. Their family is gone. They are lonely. They don’t have money.”

Six people who stated a length of time in the community identified self-sufficiency as a mental health issue. Those who had been in the community for 12 years or less stated this idea more frequently.

“This is a proud community. They don’t need anything.”

“The seniors are stubborn. They won’t take what is offered.”

Sixteen people who identified a length of time in the community discussed passive rejection.

“There is support if they are not really sick.”

“There are a lot of places that don’t accept people, don’t give them tasks that are important to the organization, don’t call them by name, don’t recognize their skills.”
Nine of the sixteen people noted that the community ignored mental illness through limiting their learning. The majority of these respondents had been in the community for 12 years or less.

“The community needs a better understanding of mental illness. When there are disruptions, they need knowledge of why it happens.”

“People on the outside just observe and make assumptions.”

Five people identified lack of recognition of people with mental illness as part of passive rejection. Three of the five were in the community for more than 12 years.

“When I moved back to this area after my break, no one asked me how I was. They asked my family instead.”

“Loneliness is a big issue. People will hang out at restaurants for a place to talk with people. People will talk with them, but they are not friends with them.”

Eight respondents commented on the limited sensitivity of community members toward people with mental illness. Those who had been in the community for 12 years or less raised this subject more frequently.

“People look at my face and can tell. They know something is different and wrong, but don’t know what is wrong. With mental illness, they shut up and assume you are wacko.”
“The community doesn’t understand grooming problems or body odor.”

Ten respondents noted provider disconnection. Of this group, seven people who stated their length of time in the community discussed education/knowledge among providers. This topic was referred to most by those who had been in the community for more than 12 years.

“It would be helpful to have resource information.”

“How are crisis response services handled?” (From a provider)

When asked about indicators that the program was working, 16 people responded that positive publicity would indicate success.

“Physician’s perceptions will be positive.”

“I will hear what is going on by word of mouth and that people in the congregation are using the services.”

Four people commented on positive publicity with consumers. Three of the four had been in the community for more than 13 years.

“The program will be respectful to consumers and will see it pay off.”
“People will look forward to going to it.”

Eleven people who stated a length of time in the community mentioned **coping skills learned/taught** as an indicator of the program’s success. Nine of the eleven had been in the community for longer than 13 years.

“They will learn how to manage time and how to prioritize.”

“We need independent living skills, housing, and other basics.”

Fourteen people who stated a length of time in the community noted that **visible changes in consumers** would be evidence that the program was working. Eight of these respondents had been in the community for more than 12 years.

“I will see it working.”

“People will be compliant with their medications.”

**Service intensity decreases** were also noted as an indicator that the program working. Eight people noted **less use of services in other agencies**. Five of the eight had been in the community for more than 12 years.

“There will be less drinking and drug problems.”
“Social workers will have less contact for things that are not case management. Less drop-in at social services for socialization, because they will get it at the CSP.”

Three people who stated length of time in the community indicated that **less intensive care needed** would be evidence of the program working. Two had been in the community for less than 12 years.

“People will stay out of the hospital.”

“There will be fewer emergency room visits.”

Table 4 summarizes the differences in response based on length of time in the community. It describes how those who have lived in the community for 1-12 years differ in response from those who have lived in the community for 13 or more years. The reader should notice that those who had been in the community for one to twelve years appear to be more focused on community health and more common or accepted mental illnesses. Those who have been in the community for more than 12 years focused more on professionals and consumers with serious and persistent mental illness. Twenty-eight people stated a length of time in the community and the mean length of time in the community was 14.52 years.
### Table 4.
Differences In Response Based on Length of Time in the Community

<table>
<thead>
<tr>
<th></th>
<th>Short-term (n=14)</th>
<th>Long-term (n=14)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(1-12 years)</td>
<td>(13+ years)</td>
</tr>
<tr>
<td>Resources needed</td>
<td>- outreach</td>
<td>- more professionals</td>
</tr>
<tr>
<td></td>
<td>- community health skills</td>
<td></td>
</tr>
<tr>
<td>Mental health concerns</td>
<td>- depression</td>
<td>- chemical dependency</td>
</tr>
<tr>
<td></td>
<td>- elderly depression</td>
<td>- schizophrenia, bipolar</td>
</tr>
<tr>
<td></td>
<td>- self-sufficiency</td>
<td>- suicides</td>
</tr>
<tr>
<td>Passive rejection</td>
<td>- lack of learning</td>
<td>- non-recognition</td>
</tr>
<tr>
<td></td>
<td>- insensitive</td>
<td></td>
</tr>
<tr>
<td>Provider disconnection</td>
<td></td>
<td>-services/scope</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Indicators**

<table>
<thead>
<tr>
<th>Positive publicity</th>
<th>Positive publicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>-community awareness</td>
<td>-consumer satisfaction</td>
</tr>
<tr>
<td></td>
<td>Coping skills changes</td>
</tr>
<tr>
<td></td>
<td>-specific skills learned</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service reduction</th>
<th>Service reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>-less intensive</td>
<td>-less use of other agencies</td>
</tr>
</tbody>
</table>

*Note: Six respondents did not provide a length of time in the community.*
How Do Responses Differ Based On The Gender Of The Interviewee?

Of the 34 responses about both mental health issues and indicators, 24 were female (71%) and 10 were male (29%). It is assumed that if gender does not influence the responses, the following issues and indicators should fall approximately within these percentages. If, however, there are seven or more percentage points away from this norm, it is assumed that gender may have some influence.

Twenty-six people commented on resources needed in the community. Of this group, 19 were female (73%) and 7 were male (27%). Fifteen of the twenty-six people commented on the need for consistent, one-to-one help as a needed resource. Of this group, 10 were female (67%) and 5 were male (33%). Nine people commented on family skills and supports as a needed resource. Of this group, 6 were female (67%) and 3 were male (33%).

Thirteen people commented on more professionals as a needed resource. Of this group, 8 were female (62%) and 5 were male (38%). This response may be influenced by gender, with a 9% increase in males identifying a need for more professionals:

“We need a psychiatrist and a psychologist who are free and that there would be no stigma.”

“Adequate psychological care is needed.”
Twenty-two people commented on **mental-related problems** in the community. Of this group, 13 were female (59%) and 9 were male (41%). This response also may be influenced by gender, with at least a twelve percent change in all of the following categories. Nineteen people commented on **serious mental illness/suicide issues** in the community. Of this group, 10 were female (53%) and 9 were male (47%). The number of males responding increased by eighteen percent. Some of the comments from male respondents included:

“There are one to two people with schizophrenia, some with bipolar.”

“Twenty years ago, there were mental illness problems. There were more suicides back then. Unemployment was greater so people had more time and less money. Now unemployment is less, so people are busier. There are more services now too.”

Thirteen people commented on the **chemical dependency issues** in the community. Of this group, 7 were female (54%) and 6 were male (46%). Again the number of males who responded increased, this time by seventeen percent. Some of their comments included:

“There are ball diamonds at the school that don’t allow alcohol. They are building new diamonds across town where people can use alcohol.”

“There is some pressure on city police not to DUI.”
Seven people commented on the issue of unhealthy self-sufficiency in the community. Of this group, 3 were female (43%) and 4 were male (57%). In this category, males actually exceeded females in the percent of responses. There was a twenty-eight percent increase for males responding:

“They have a mindset of independence. They take care of themselves. They need lots of prodding.”

“There are more independent minded people here.”

Twenty people commented on passive rejection within the community towards people with mental illness. Seventeen respondents were female (85%) and 3 were male (15%). Eleven of the twenty people noted that the community limited their knowledge and as a result, ignored people with mental illness. Of this group, 10 were female (91%) and 1 was male (9%). Females had a 20% increase in responses for this topic:

“People on the outside just observe and make assumptions. If there is a diagnosis, then people are scared. They say, “If that had been my kid, I’d have beat them more and then they would be better and if they worked hard enough, they wouldn’t feel lousy.”

“The community needs a better understanding of mental illness. When there are disruptions, they knowledge of why it happens.”

Eight people commented on the lack of sensitivity toward people with mental illness. Of this group, 6 were female (75%) and 2 were male (25%). This category more closely matched the overall percentage of male and female and did not appear to be influenced
by gender. Seven people commented on the ignoring behavior of **limiting recognition of people** with mental illness. Of this group, 6 were female (86%) and 1 was male (14%). This category showed a fifteen percent increase in females responding and may be influenced by gender:

> “Loneliness is a big issue. People will hang out at restaurants for a place to talk with people. People will talk with them, but they are not friends with them.”

> “They treat you differently. If you have a brain tumor, they do a benefit dinner for you and your family. I was in the hospital for a long time. They gave no support to my immediate family.”

Fourteen people commented on the issue of **provider disconnection**. Eight were female (57%) and 6 were male (43%). Nine people commented on lack of **provider knowledge of services and scope of practice** as an aspect of provider disconnection. Of this group, three were female (33%) and 6 were male (67%). This category had a thirty-eight percent increase in the number of males responding, suggesting that this topic may be influenced by gender:

> “I don’t know of groups that work with perpetrators.”

> “It would be helpful to have resource information.”

Eight people commented on **communications between agencies**. Of this group, six were female (75%) and 2 were male (25%). These percentages were not very different from the overall percentages.
Of indicators that the program was working, sixteen people commented on the importance of **positive publicity**. Of this group, 11 were female (69%) and 5 were male (31%).

Under the positive publicity indicator, nine people mentioned **providers’ comfort level with referral** as an indicator of positive publicity. Of this group, 7 were female (78%) and 2 were male (22%). Females had a seven-percent higher number of responses in this category. This topic may be influenced by gender:

> “Physicians make token referrals and then are still referring.”

> “There will be positive feedback at the local advisory council.”

Eight people mentioned **community awareness** as an indicator. Of this group, 6 were female (75%) and 2 were male (25%). This percentage was not much different than the norm listed earlier. Three people mentioned **consumer satisfaction** as an indicator of positive publicity. Of this group, one was female (33%) and 2 were male (67%). In this category, males had a thirty-eight percent increase in responses. However, the actual numbers were very small. This topic may be tentatively considered as influenced by gender:

> “Being respectful and seeing it pay off with your clients will be an indicator that the program is working.”
“People will feel free to go to your program.”

Sixteen people noted that overall coping skill changes indicated that the program was working. Of this group, 13 were female (81%) and 3 were male (19%). This is a ten-percent increase over the usual number of female responses, so gender may have an impact in this category.

“People need to learn how to manage time, prioritize, and improve their daily structure and patterns.”

“It would be great to teach wellness, exercise, proper eating, losing weight, and sleep less.”

Thirteen people commented that if consumers learned specific skills for coping, this would indicate that the program was working. Of this group, 10 were female (77%) and three were male (23%), not a significant change. Six people noted that visible changes in the consumer’s coping skills would indicate that the program was working. Of this group, 4 were female (67%) and 2 were male (33%). These percentages were not dramatically different than the overall percentages either.

Eleven people indicated that the program was working if the intensity of other services dropped. Of this group, 7 were female (64%) and 4 were male (36%). This was a seven percent increase from the standard for males and may show a gender difference.
“There will be a reduction in at-risk kids.” (CSP serves adults)

“There will be changes in spouse abuse cycles.” (This is not a specific focus of CSP)

Seven people mentioned that if consumers used less service from other agencies, this would indicate that the program was working. Of this group, 5 were female (71%) and 2 were male (29%). Six people mentioned that less intense services, including fewer hospitalizations would indicate that the program was working. Of this group, four were female (67%) and two were male (33%). Neither of these was much different from the norm listed earlier.

Table 5 summarizes the differences in response based on how males and females answered the questions about mental health issues and program indicators. The reader should notice that females appeared more likely to mention the impact of passive rejection on mental health, including lack of community knowledge or recognition of people with mental illness. Males appeared more likely to mention specific mental-related concerns including serious mental illness/suicide, chemical dependency, and unhealthy self-sufficiency that impacted overall community health. They also mentioned lack of provider knowledge about other services or the scope of appropriate service. The reader should also notice that provider referral and coping skill changes might also have been indicators to females that the program was working. Consumer satisfaction and a decrease in service intensity may have been indicators to males that the program was working. Thirty-four people responded, of which 71% were female and 29% were male.
Table 5.
Differences In Response Based on Gender

<table>
<thead>
<tr>
<th>Mental Health Issues</th>
<th>More Frequently Identified by Females</th>
<th>More Frequently Identified by Males</th>
</tr>
</thead>
<tbody>
<tr>
<td>Passive rejection</td>
<td></td>
<td>Resources needed</td>
</tr>
<tr>
<td>- knowledge</td>
<td></td>
<td>-professionals</td>
</tr>
<tr>
<td>- recognition</td>
<td></td>
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<tr>
<td>Mental-related concerns</td>
<td></td>
<td>Provider disconnection</td>
</tr>
<tr>
<td>-mental illness/suicide</td>
<td></td>
<td>-services/scope knowledge</td>
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<tr>
<td>-chemical dependency</td>
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<tr>
<td>-self-sufficiency</td>
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</tbody>
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Indicators That Program is Working

| Positive publicity                       | Positive publicity                   |
| -provider referral                       | -consumer satisfaction               |
| Coping skill changes                     | Service intensity decrease           |
DISCUSSION

Interpretation of Results/Implications for Practice

Mental Health Issues in the Community

This research reflects the current literature on rural mental health issues. Rural areas struggle with adequate mental health resources, depression and suicide, and an attitude of privacy and independence that limits help-seeking behavior (WICHE, 2001; Wayman, 2000; APA, n.d.a). This community also struggles with these problems. People in rural areas are often friendly toward their members who have mental illness, but are not always sensitive to or knowledgeable of consumer needs and skills (DeRue, 2000; Arens, 1993; ATMHN, 2001). This community also struggles with this issue. Finally, rural providers often lack knowledge about mental illness and available resources that would be helpful to consumers (APA, n.d.a). The community in this research study also struggles with this problem.

Some of the results appear to be unique to this community, however. The community identified the top mental health issue as the need for more resources. This response was especially interesting, because this community already has multiple resources. These include AA and Al-Anon, 4-H, Rotary, domestic violence center, sewing and quilting clubs, marriage care classes, and the humane society. It also includes multiple children’s programs, community events such as a community-wide Christmas dinner, dances on Fridays, open skating, multiple outdoor clubs and events, church activities, psychologists, a community fitness center, and trips for seniors through the
senior center, to name a few. The community also appeared interested in working cohesively. Some respondents expressed concern about agency relations, with several describing agencies that did not work well together.

Despite the multiple choices, the community identified “more mental health resources” as a need. It appears that community members had already been thinking about mental health issues prior to the study and pinpointed the gaps in services. This was borne out by the records of community-wide strategic planning in which mental health became one of four main issues to work on over the next few years.

Secondly, this community appears to be a forward thinking group active in planning their future. Responses identified real gaps in services, including supports for people with serious mental illness, advanced providers such as psychologists and psychiatrists, and family supports and skills training. Concerns about elderly depression, and suicide/ recklessness/chemical dependency among youth also were borne out by emergency room records and the history of the area. Issues such as chemical dependency had obviously been a severe problem in the past, based on people’s comments, but people who were new to the area were not seeing the same severity. This, along with reductions in DWI’s, could be taken as evidence that progress had already been made in the community’s mental health efforts, prior to the establishment of a community support program.

This community also voiced, on its own, the need for greater sensitivity to people with mental illness. This appeared to be a recent, but broad-based community interest. This may be a result of breaking through many years of denial with a change in administration in key agencies. The community also seemed to be quite knowledgeable
about mental illness. Those who were interviewed did not confuse mental illness with mental retardation, Alzheimer’s, or other conditions that are sometimes confused with mental illness. This may be due to a number of factors, including many respondents with a bachelor’s degree or higher, many respondents who had moved out of the area and returned with life experience, and recent educational efforts in the community, including a weekly column on mental illness. A community support program could utilize this current openness and energy to further the acceptance of people with mental illness (Maton & Salem, 1995).

**Indicators of a Successful Community Support Program**

The indicators described by respondents to show that the program was working were also very interesting. “Provider comfort with referral” may have been a priority due to problems in the past with providers who made others feel uncomfortable through poor boundaries, aggression, or inconsistent behavior. “Community awareness” may have been listed as an indicator, because even with the multiple resources, even providers were not aware of what was available. Based on these indicators, a community support program would do well to concentrate on developing positive relationships with as many people as possible, so that word of mouth is always or almost always positive. This could best be accomplished by getting to know key people within the community – doctors, social services, school personnel, church leaders, government leaders- and helping them meet their goals within the context of mental health (APA, n.d.a). Interestingly, “consumer acceptance” did not include a large number of respondents. Perhaps providers
were thinking from a provider perspective, or perhaps it was assumed that if the community accepted the program, consumers would be included in that number.

Besides positive publicity, teaching coping skills was also a top indicator that the program was working. Teaching coping skills was noted more often than having visible coping skills, giving the appearance that teaching was more important than the results. It is possible that under “teaching” people also assumed there would be visible changes. On the other hand, it may imply that the community needs to see the program in action, even if they don’t see the results within individual people. Again, the community support program needs to publicize its work (ATMHN, 2001). During a presentation at an agency, for example, it may be helpful to note how consumers are taught to stay on a budget, or how they are taught to make friends. The skills training component, whether it is assertiveness skills, nutrition, or self-esteem building needs to a strong part of the program and regularly talked about.

The other main indicator that the program was working – less weight on other agencies – probably is more a measure of what other agencies are experiencing than of the program itself. It appears that other agencies are feeling burdened with problems and people whose needs do not fit within their range of expertise or duties, and they would like someone to fill the gap (Newhill, 2003). It was also interesting that so many people expected one new program to make such dramatic changes that the result would be fewer people in the hospital. This is evidence of the optimism of this community, and also the high level of quality the community is expecting. The community support program needs to be alert to ways to prevent crisis situations (skills training) that will prevent future extreme behaviors and result in fewer people in the hospital and better publicity for the
agency (Palmer et al., 2000; Gubman et al., 1987). Every instance of hospitalization should be used as a learning tool by the community support program to identify ways to limit instances in the future.

**Differences and Similarities in Consumers’ and Other Community Members’ Responses**

The following are tentative descriptions of differences, with the understanding that the small sample size may skew actual differences. Consumers’ concerns tended to reflect their personal challenges, feelings, and thoughts. Consumers seemed to be vocal about their personal lives, while other community members seemed generally not to be vocal about their personal lives. A community support program may benefit from remembering this by providing opportunities for consumers to talk about their concerns – alone, with each other, and later with other community members (Bengtsson-Tops & Hansson, 2001).

Consumers described few resources in their community, so another aspect of the community support program may be to educate consumers about their town. Consumers also sought help for their families. A community support program may help meet this need either through family groups, consumer activities where family could attend, or working with key community leaders to develop family supports (Beebe, 2002; Bengtsson-Tops & Hansson, 2001). The community support program may also work with community leaders to help reduce stigma and encourage people to ask questions – two problems that consumers noted in their community.
Consumers did not report any concerns with professionals—neither knowledge problems, nor conduct problems, nor relationship problems between agencies. Consumers as a group may just be positive people, they may be grateful for any service they can use, or they may be involved enough in their personal lives to be unaware of provider issues. All of these possible explanations point to one thing, however. Consumers appear to be at the mercy of the services they receive. Community support programs should consider this in their planning, so that services are provided with respect, with dignity, with understanding, with tolerance, and with empowerment. Each contact should have meaning for the consumer (Beebe, 2002).

Other community members rarely spoke about personal mental health issues, yet they were very interested in the health of their community. One explanation is that since they were approached based on their role in the community, that they responded from that role. Some respondents who had mental illness did not speak of it during the interview, but it was learned many months later that they had a mental illness. Another explanation is that community members are used to hiding any mental health concerns and transferring their energies to helping others handle theirs. With this explanation, consumers become the voice and the behaviors of mental illness, thus allowing others with less severe mental health issues to hide, ignore, or at least not count themselves in the category of people with mental illness.

This does not mean that community members are uncaring. On the contrary, they care very much as is clear in this community where they are working hard on community wide issues, including resolving barriers between agencies, and having providers who are knowledgeable and ethical. But providers unwittingly become the stigmatizing voice of
the community, advocating privacy (client confidentiality is required in the mental health profession), including privacy about their own mental health. To providers’ credit, it is a very difficult balance between personal and professional, especially in a small town and so providers may opt for the “safe” way of not speaking at all about it. A community support program must take into account this community need and provide a confidential, safe, nonjudgmental face to the public. But it also must point out similarities between people with severe mental illness and people in general, so that gradually community members see that, in the fashion of the toy store chain, “people with mental illness R us”. Community support services also must help consumers see that they can be a valued part of the community and help them find ways to be valued (Parks and Pilisuk as cited in Baker et al., 1992).

Consumers made no mention of provider needs – comfort level, workload decrease, reduced hospitalization, or barriers between agencies. Other community members, however, mentioned these areas frequently. With this in mind, a community support program may wish to develop and maintain on ongoing dialogue with community professionals to ensure that their expectations are also being met (Mowbray et al., 2002; Maton & Salem, 1995). For example, if consumers are hanging around social services, the community support program can involve consumers in activities in the community support program to help relieve the load on social services. The community support program needs to be known in the community as an agency that will work to solve problems in collaboration with other agencies. This involves being a member of various organizations and helping where possible.
Consumers also tended to differ from other community members in their responses by seeking changes in themselves that were internally satisfying, and seeking changes from other community members that would show more acceptance of people with mental illness. Other community members sought just the opposite – visible changes in consumers (ATMHN, 2001). Interestingly, community members made no mention of their own behaviors. A community support program would need to seek out what is personally satisfying for each consumer and work with them on those goals, while also helping them make visible changes in a non-obvious way. According to the literature, acceptance may come if consumers have fewer disruptive behaviors (Palmer et al., 2000). For example, if a consumer speaks loudly, and has a personal goal to have a job in a local business, the community support program may assist that consumer with reducing volume to increase the likelihood of getting a job. As the volume comes down, this may be noticed by others as the consumers shops for groceries, goes to the post office, and so on. When the consumer’s voice is lower, he or she may apply for a job and perhaps obtain one. Having a job means fitting in a little more, and the community may begin to notice that the person no longer stands out as they once did (Angell & Test, 2002).

Consumers and other community members had similarities in their responses also, including identifying a need for relationship skill development, spotting the impact of alcohol-based activities on the community, and the need for the community to be more sensitive to mental illness. They also appeared to agree that visible changes of some kind were important, and that positive community reaction to the program was needed.
**Differences Based on Length of Time in the Community**

The response differences based on length of time in the community were also interesting. Consumers had lived in the area nearly twice as long on average than other community members. One might speculate that it is more difficult for them to leave (APA, n.d.a). Consumers who responded either did not own a car or had an unreliable car. In some cases, consumers came home to family when they got sick – and stayed. It may be said that consumers have a long-term interest in how their community changes. A community support program could keep this in mind and alert consumers to local government and community changes, as well as teaching advocacy skills, so that consumers can speak up about concerns. Since consumers in this research were vocal about their illness, they may use their talents to educate the public about appropriate changes that will affect them.

Another unique item about this town is the influx of new, educated people. In an era where small communities are getting smaller, and people with education are moving away, this town is somewhat of an anomaly. More than half of those who stated time in the community had been there for less than 12 years. Within this group, three-fourths of them had been in the town for less than 5 years.

For those respondents who had been in the community for one to twelve years, teaching more mental health skills to community members tended to be a priority. For those who had been in the community for 12 to 46 years, obtaining more professional help tended to be a priority. Though personal ages were not asked, younger adults generally made up those who had been in the community a short time and older adults made up the category of those who had been in the community a long time. There
appears to be a shift from turning to people who are in authority, such as professionals to
whom people go for help, to having all individuals with skills who turn to themselves or
each other for assistance. A community support program may do well to keep the ages of
their constituents – consumers and providers- and length of time in the community in
mind. Referrals to people in authority may be more appropriate for middle-aged persons
and older, and teaching of direct skills in a group or individually may be more
appropriate for people younger than middle age. Also in this community, chemical
dependency issues were on the minds of people who had been in the community for more
than five years, while those who had been in town for less than five years reported fewer
community chemical dependency problems. A community support program may want to
be sure to ask about chemical use, while realizing that for many consumers it may be part
of their past and is now not an issue.

Respondents who had been in the community for eight years or less mentioned
elderly depression. It may be that these respondents held job roles where they interacted
with elderly or that they had moved back to the area and now had elderly relatives to care
for. A community support program might assist in this area by involving consumers in
activities with elders, such as cribbage at the senior center, to encourage additional
support for both groups.

Respondents who had been in the community for twelve or more years identified
serious mental illness as an issue. There may have been people in the community prior to
that time who were seriously ill and were now in facilities in other parts of the state. The
newer anti-psychotic medications came into existence in the early 1990’s, so people who
did not respond well to the older anti-psychotic medications would have been struggling
prior to twelve years ago. For a small community with limited medical help, an uncontrolled illness would be remembered for a long time (Palmer et al., 2000). In fact, learning coping skills was most strongly emphasized by those who had been in the community the longest, as well as emphasizing visible changes and less use of other services. This may very likely be related to memories of a time when people had an uncontrolled illness. A community support program can acknowledge and listen to the history people lived through prior to medications and can continue to urge people to get help now for illnesses that are currently very treatable.

Respondents who had been in the area for less than twenty years identified unhealthy self-sufficiency as a mental health issue. This has also been identified in the literature regarding rural communities (APA, n.d. a; Wayman, 2000). It is interesting that people newer to the area speak of this, but those who have lived in the community a long time do not speak of it. A community support program may need to allow for more resistance to help from people who have been in the community a long time, than from those who are new to the area. A community support program may need to use more informal networks to involve and assist those who have been in the area a long time.

Those who had been in the community for a mean length of 10 years wanted to see fewer people hospitalized. For this age group, it is actually possible for this to happen. Those who had been in the community for many years would have lived during a time when this was not possible. It takes time to change one’s thinking. A community support program could provide hope to those who have been in the community a long time through statistics, personal success stories, and repeating this information over time (Maton & Salem, 1995).
Similarities between the short-term group and the long-term group included a strong identification of more resources needed, a clear understanding of mental illness as a separate category from other conditions, and passive rejection as a community phenomenon. Other similarities between the short-term group and the long-term group included identification of positive publicity as an indicator of success and some type of service reduction as an indicator of success.

**Gender Differences and Similarities**

Gender divisions also created some interesting responses. Males tended more frequently to see a need for more professionals. Since professionals have traditionally been male, this may be an effort to have more people whose style they are familiar with in the community. Another possibility is that males may see a gap in services that could be filled by professionals, where females may not see that same gap. Males also identified more mental-related problems in the community, including serious mental illness/suicide, chemical dependency issues, and unhealthy self-sufficiency. Many of the males in the study were in contact with people with these issues because of the types of jobs they held. A community support program may need to consult with male-dominated professions to find out if the program is reaching the needs mentioned here.

Females, on the other hand, focused on behaviors by community members that passively reject people with mental illness. Where the males sought to bring in help (professionals), many of the females tended to seek to change the people who were already present in the community. Because of the nature of their jobs, females may be in a unique position to see the impact of passive rejection.
Females especially emphasized the ways people limited their learning about mental illness. Whether it was knowledge of mental illness or resources for mental health issues, females were concerned with the need for people to increase their education about mental illness. A community support program might keep this in mind and make a special effort to involve females – consumers or providers – in its efforts to educate the public. This may include asking what they think might work, as well as joining groups that are already working on these issues.

Recognition and support of people with mental illness also were important to females. Benefit dinners and helping people with loneliness were two of the positives that females mentioned. A community support program could look for additional ways to recognize the skills and assets of people with mental illness, such as sending birthday or get well cards, providing a small gift for people who meet goals, or helping them assist someone in the community where they can be recognized.

Males noted more frequently that education among providers was needed. Many of the male respondents were uncertain of available resources. It might be that this was not an issue for females because they were already communicating and/or educating themselves. Another possibility may be that with the independent, male-dominated mindset, males might not feel comfortable seeking out information and possibly looking weak (ATMHN, 2001). A community support program may benefit from going to males, meeting individually, and providing verbal and written information to them. As with males with schizophrenia, it may be that an extra effort is needed to assist males in being knowledgeable in their community.
Females noted more frequently the importance of coping skills. One possible explanation for why this was important to females is that they also saw the problems involved with being ignored. They may believe that increased skills will help people with mental illness be noticed in a positive way. A community support program needs to acknowledge this and publicize the skills it teaches.

Males, on the other hand, emphasized consumer satisfaction more frequently. One possible explanation is that due to job roles, males may have a greater opportunity to hear consumer concerns and complaints. A community support program needs to keep this in mind and ensure ways to find out if consumers are happy (Beebe, 2002).

Similarities between males and females included expectations for more resources that provide consistent, one-to-one help and family skills and supports. They also noted communication barriers between agencies. Positive publicity, including community awareness, and visible changes in the consumer along with awareness of skills taught were also reported by both genders as indicators of success. Both genders also identified a specific decrease in other local agencies’ workloads and fewer hospitalizations as indicators of success.

**Limitations of the Study**

There are a number of limitations to this study. Only five consumers’ input was part of the data collected, compared to twenty-nine responses from other community members. Consumer comments cannot be generalized because of the small number of respondents. Further, differences between any of the small groups may not be significant because of the limited sample size.
Secondly, none of the other community members identified themselves as consumers; however, several of them self-identified after the program had started. Thus some of their comments may be influenced by their perceptions as a consumer.

Third, this data may not be relevant to other rural communities due to the community’s unique nature. This particular community has had waves of new people entering its system, where many rural communities are seeing an exit of new people. It also seems to be an educated community, and active in developing its infrastructure.

Fourth, due to the need for confidentiality some data was generalized so that even the residents would not recognize each other. In doing so, some of the richness of this data was lost.

Fifth, in the course of reporting, some data had to be left out. Though care was taken to provide a balanced view, some data may have been omitted that was relevant to key aspects of the research topic. Also along these lines, data had to be classified. Some data may have been misclassified based on misinterpretation of the respondents’ words. This could change the percentages in the tables and potentially the results.

Sixth, this researcher was an employee of the agency when the program initially started. This may have created some bias, as the researcher wanted to see the program be successful. Also, someone not already known to the community did the initial research, and there was only one interview and no follow up, so the community did not have time to build trust with the researcher. The presence of a researcher not well known to community members may have resulted in modified opinions. Community members may have attempted to maintain their best image with the researcher. This appears to be the case, since no one mentioned personal mental health issues and it is now known that
several did have personal mental health issues either with themselves or a family member.

There was corroboration between sources, however. The research done here was compared to a Local Advisory Council survey completed approximately six months after this research. The results were similar.

Seventh, the original questions were asked for the purposes of program development, not as a research project. Answers may have been provided in a different way if respondents were answering for a research project.

Eighth, there may be interactions between characteristics of respondents that influence the differences. For example, the majority of consumers were also long-term residents, so may over-influence the responses of long-term residents.

Finally, the writer doing secondary analysis is from a town classified as micropolitan (not metropolitan) and not rural (Economic Research Service, n.d.). The interpretations of respondents’ actions may have been interpreted in light of this classification, rather than from a rural perspective.

**Recommendations for Future Research**

Researchers may wish to explore the following areas to further expand social work knowledge. First, doing a study in which the number of consumers equals the number of other community members would yield more accurate information about consumers’ thoughts. Second, studying on a larger scale the effect of gender on the perception of resources needed would provide more accurate information about this topic. Third, because this community has so many resources, it may be interesting to study the correlation between the number of community resources and the level of stigma in the
community or the number of visits to emergency room, jail, or chemical dependency treatment.

It may also be interesting to study the personality style differences between consumers and other community members, especially as it relates to privacy needs, openness, and internal/external focus. Family needs could also be explored further to find out what supports consumers thought would most help their families. A researcher could also study the effect of positive program publicity on consumer’s level of satisfaction with integration into the community. A study could be done on the effect of specific programs for males on the level of hospitalization. Finally, a study could be done on the effect of the length of time in the community on perceptions of mental health issues in the community.
APPENDIX A – INTERVIEW SCHEDULE

This interview schedule was the original used to gather data as the first part of establishing a community support program.

1) How long have you lived or worked in this community?

2) In your view, what are the mental health issues of people in this community?

3) What resources are currently available in this community?

4) In your view, what do people with serious mental illness need from a community support program?

(After a brief description of the community support program) “A community support program serves people with serious and persistent mental illness by providing support and ways to live with their illness within the community.”

5) What will indicate to you that progress is being made with consumers in a community support program? or for consumers: What will indicate to you that the community is becoming more accepting of people with serious mental illness?
REFERENCES


