SECOND EDITION

Rural Social Work

Building and Sustaining Community Capacity

Edited by T. Laine Scales, Calvin L. Streeter, and H. Stephen Cooper

WILEY

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We dedicate this volume to our children,
April Scales, Brian and Aaron Streeter, and Hayden and Savannah Cooper.
May they forever be blessed by the strength and resilience
of their country neighbors and be inspired
to preserve the land and the life for generations to come.

Contents

Preface

T. Laine Scales, Calvin L. Streeter, and H. Stephen Cooper

Imagine you have just returned home from a brisk walk through the countryside on a warm and sunny summer day. You are hot, tired, and very thirsty. As you enter your home, you see a glass of cool, refreshing water sitting on the kitchen table. The glass is filled to the halfway mark. How do you see the glass? Is it half-full or is it half-empty?

If you are thirsty, you probably focus on the glass as half-full, and you are grateful that someone has left it for you to drink. If the water in the glass isn't enough to quench your thirst, however, you may focus on the glass as half-empty. In this case, whether you view the glass as half-full or half-empty probably doesn't matter, but how we answer the age-old question, "Is the glass half-empty or half-full?" may suggest how we perceive the world.

It has been said that perception is reality. What we believe to be true often takes over our thoughts so much that it really becomes true. When we view the glass as half-empty, we focus on the negative aspects of life, and we can become consumed with negativity and overcome with despair. But when we see the glass as half-full, we focus on the positive elements in our lives and the world around us.

John Kretzmann and John McKnight (1993), in their book, *Building Communities From the Inside Out*, challenged us to view the glass as half-full rather than half-empty. They contend that our focus on the half-empty glass leads us to see only the deficiencies and problems facing our communities. In rural areas this often means we see communities where few opportunities exist to retain young people, where we are too spread out to afford hard-surface roads, good Internet access, or cable television for everyone, where residents must leave town to acquire many goods and services, and where farms and local businesses are controlled by big corporations from afar.

By viewing the glass as half-full, we begin to see the depth of the human spirit and the richness of the creative potential that exist in rural communities. We see people who are talented and experienced in a variety of areas. We see strong social networks and

associations. We see that with rural services the lines are short, the hassles are few, and our business is easy to take care of. We see beautiful landscapes where we can easily enjoy nature. We see people getting things done that need to be done by using what is available. In other words, we see the capacity for strengths and assets rather than only problems and deficiencies.

As social workers, it is easy to become overwhelmed with a sense of despair because of the serious personal problems and societal conditions we are called upon to address. We see the child who has been verbally and physically abused. We witness the terrible toll that alcohol and drug abuse can take on a family. Daily we confront the reality of poverty, prejudice, and oppression in our society. Because our professional lives are wrapped up in the misery and trauma of the less advantaged in our community, it is no wonder that social workers are sometimes accused of seeing the glass as half-empty. For social workers in rural communities where resources are scarce, it may be even more difficult to view the glass as half-full.

A view that focuses on capacity, however, allows helping professionals to see people as citizens of the community, not just as clients. Every citizen has capacities that can be tapped to make life in the community better. Rural communities contain a wide range of assets and strengths, such as voluntary associations, close personal relationships among people, local institutions, histories and traditions, and land and property. Models of professional practice that focus on capacity-building can empower rural people to use their resources in innovative ways to create new assets. It can help them determine their own direction, set their own priorities, and leverage both internal and external resources in ways that make sense for their community.

Social work has a long tradition of practice focused on strengths and assets. For example, Dennis Saleebey and his colleagues at the University of Kansas School of Social Welfare have spent much of the last two decades developing, testing, and promoting a strengths perspective for social work practice (Saleebey, 2009). Drawing on the profession's commitment to building on people's strengths, rather than focusing on their deficiencies, problems, or disabilities, the strengths-based perspective provides an orientation to practice that seeks to uncover and reaffirm people's abilities, talents, survivor skills, and aspirations. It assumes that a clear and unyielding focus on the strengths found in individuals, families, neighborhoods, groups, and communities will increase the likelihood that people will reach the goals they set for themselves.

THREE STREAMS OF THOUGHT ON BUILDING CAPACITY FOR ASSETS AND STRENGTHS

In addition to the work at the University of Kansas, at least three significant streams of work during the last two decades have helped shift our focus from deficiencies to capacity. Although somewhat different in their approach, they share a common theme. All three embrace and celebrate the strengths and capacities of individuals and communities.

The first of these is the work of Kretzmann and McKnight (1993), mentioned previously. Their book, *Building Communities From the Inside Out*, provides a conceptual framework

for asset-based community development. In their book, Kretzmann and McKnight outline a set of tools for community practice that can be used to map assets and build capacities in our communities. At the heart of their model are relationships. From their perspective, asset mapping and capacity-building are about identifying resources and fostering relationships in the community.

In addition, Kretzmann and McKnight have established the Asset-Based Community Development (ABCD) Institute at Northwestern University to provide resources and technical support for people seeking to "build community from the inside out." Challenging the traditional approach to solving community problems, which focuses service providers and funding agencies on the needs and deficiencies of people and their communities, the ABCD Institute demonstrates that community assets are key building blocks in sustainable rural community revitalization efforts (Snow, 2001). These community assets include the skills of local residents, the power of local associations, the resources of public, private, and nonprofit institutions, and the physical and economic resources of local places. Central to their approach is the premise that every person has capacities, abilities, and gifts. The key is to identify and embrace those assets. To facilitate this process, the Institute has developed a Capacity Inventory, designed to identify the capacities of community members. The Institute now has more than 50 highly skilled practitioner/trainers who work with communities all across the country to promote asset-based community development.

A second stream of work focused on capacity-building is located at the Search Institute in Minneapolis, Minnesota. In an effort to identify the elements of an asset-based approach to healthy youth development, the Search Institute devised a framework of developmental assets for children and youth. This framework identified 40 critical factors for young people's growth and development.

The assets are divided into external and internal assets. The external assets focus on positive experiences that young people receive from the people and institutions in their lives and include a supportive environment, evidence that the community values youth and their contribution to community life, clearly stated boundaries and expectations, and opportunities for constructive use of time. However, a community's responsibility for its young people does not end with the provision of external assets. There needs to be a similar commitment to nurturing the internal qualities that guide choices and create a sense of centeredness, purpose, and focus. By developing these qualities, young people increase their capacities for learning, positive values to guide their choices, social competencies to build relationships, and a strong sense of their own power, purpose, worth, and promise.

When drawn together, the assets offer a set of benchmarks for positive child and adolescent development (Benson, 1997). The developmental assets framework clearly shows the important roles that families, schools, congregations, neighborhoods, youth organizations, and others in the community play in shaping young people's lives and increasing the community's capacity for positive growth.

The Search Institute's framework of developmental assets for children and youth has caught on all across the country, with asset-building initiatives flourishing in small towns and rural communities throughout the United States. For example, in Cape Girardeau, Missouri, the THRIVE Initiative is working to spread awareness of the 40 development assets and

encourage asset-building throughout the community. In Manchester, New Hampshire, Making It Happen is helping the community view all young people as "at promise," not "at risk," by promoting healthy choices and reducing risky behaviors while building developmental assets in children and youth. In Annandale, Minnesota, Youth First is a grassroots initiative to inspire and challenge the entire community to become asset-builders for youth in the community. In Georgetown, Texas, The Georgetown Project is devoted to the framework of developmental assets as a means to build a healthy community where all children and youth can grow into capable, caring, and resilient adults. And in countless other communities across the country, the developmental asset framework is providing the foundation for youth development initiatives that emphasize the positive contribution that children and youth make in the life of the community.

The work of Dr. Mike Sherraden and his colleagues in the Center for Social Development at the Brown School of Social Work at Washington University in St. Louis, Missouri, represents a third exciting area of work focused on the increasing capacity for economic well-being. With a focus on developing financial resources for poor families, Sherraden (1991) outlined his ideas about asset-based welfare policy in his seminal book titled *Assets and the Poor: A New American Welfare Policy*.

Challenging our traditional models of public assistance for low-income families, Sherraden proposed asset-building as an antipoverty strategy. He argues that existing consumption-based welfare policies make it impossible for people to get out of poverty, because they penalize families for accumulating personal economic assets. From his perspective, the way to move people out of poverty is to encourage them to increase their capacity to accumulate assets, which they can then leverage to purchase a home, capitalize a small business, or pay for an education for their children. The mechanism for doing this is something called individual development accounts (IDAs).

Sherraden and his colleagues led a national demonstration project on asset-building using IDAs called the American Dream Demonstration as the first large-scale test of the efficacy of IDAs as a route to economic independence for low-income Americans (Schreiner et al., 2001; Sherraden, 2002). Since then, IDA projects have emerged all across the United States and in many countries around the world. For example, the Community Action Partnership of Western Nebraska's IDA program called Assets Building Choices is designed to help low-income families and individuals achieve economic independence by building long-term assets. RAISE Texas supports asset-building efforts in underserved small cities and rural markets in Texas by increasing access to IDA programs and other financial mainstream products. The Rural California Asset Development Network provides supportive financial education, asset-specific training, and access to banking in poor, rural, and immigrant communities. The Food, Conservation and Energy Act of 2008 included provisions for the Beginning Farmer and Rancher Individual Development Account (BFRIDA), a program designed to help beginning farmers and ranchers of limited means build the capital necessary to expand their agricultural businesses through matched savings accounts. The Native American Asset-Building Initiative supports innovative asset-building projects that feature IDAs, financial education, and related services that enable low-income Native American people to improve their economic status and become economically self-sufficient.

EXPLORING ASSET BUILDING IN RURAL COMMUNITIES

We believe that practice models that keep us focused on the strengths, assets, and capacities of people are critical for social work practice in rural communities. That belief led us to create this resource for the classroom. It is designed to assist social work students and teachers as they integrate themes of capacity-building and social work practice in the rural context.

Because all three authors of this book are educators involved in the day-to-day challenge of integrating rural content into our courses with few current and classroom-friendly readings, we began to discuss with other educators what type of new resource would be useful. The ideal resource would be more than a mere collection of readings. It would be interesting and accessible for students at the BSW and MSW levels, and it would provide discussion questions and assignments to facilitate the study of the material.

We envisioned this book as a valuable educational resource on contemporary issues in rural social work practice and as a forum where scholars, students, and practitioners can share their current research and practice experience in rural communities. We reviewed other rural resources for social workers and found several ways in which we wanted this resource to be distinctive.

First, in contrast to other resources for students, these readings consistently integrate strengths, assets, and capacity-building themes, some of the newer, most talked-about theoretical foundations for social work. We have emphasized the depth of the human spirit and the richness of the creative potential that exists in rural communities. We introduce newer research tools, such as asset mapping, social network analysis, concept mapping, and geographic information systems (GIS). We also include practice models that hold special promise for rural social workers, such as wraparound and systems of care, evidence-based practice, community partnership models, and the role of faith-based organizations in rural communities. The readings highlight the tremendous resources that exist in rural communities and demonstrate ways to integrate them into contemporary social work practice.

We also address some of the most important practice issues facing rural social workers today, such as the challenges of working with stigmatized populations such as gay, lesbian, bisexual, and transgendered people; hospice and palliative care services; the homeless; immigration policy; and people living with HIV/AIDS. These and other contemporary practice and policy issues are very important to social workers, but they have not been addressed thoroughly in other resources on rural social work.

The intent of *Rural Social Work: Building and Sustaining Community Capacity* is to provide material for readers who are learning to use capacity-building frameworks and, at the same time, suggest ways for social workers to participate in sustaining rural communities. We expect that our readers will have a wide variety of experiences with rurality. Some of our readers may live and work in rural communities and may have read widely on rural social work. Many readers may live rural lifestyles, but perhaps they have not had an opportunity to reflect on their own cultures and how the rural environment impacts social work practice. Others may be destined for social work in urban areas, and they are preparing themselves to work with clients who have migrated to their city from rural areas. For all of these readers, our hope is that these articles, discussion questions, and assignments stimulate meaningful dialogue about how asset-building frameworks can enhance practice with rural populations.

GETTING THE MOST FROM THIS RESOURCE

Following this preface on asset-building perspectives and their application to community building in rural contexts, this book contains 21 chapters written by social work scholars, students, and practitioners. Each chapter includes three elements: (1) an article that integrates the themes of capacity-building and rural social work, (2) discussion questions that facilitate critical thinking around the chapter, and (3) suggested activities and assignments to provide opportunities for practical application of the concepts presented in the chapter.

The chapters are organized into five parts, with an organizing framework following curriculum areas often used by programs accredited by the Council on Social Work Education:

Part 1. Conceptual and Historical Foundations of Rural Social Welfare
Part 2. Human Behavior and Rural Environments
Part 3. Practice Issues in Rural Contexts
Part 4. Policy Issues Affecting Rural Populations
Part 5. Using Research to Evaluate Practice in Rural Settings

This framework for organizing will assist teachers who wish to integrate a few readings on rural issues into each course. Students may buy the book early in their program, and instructors may use this book to supplement other textbooks, which often carry an urban focus. The work will also be useful in introductory courses in both MSW and BSW programs, as it introduces new social work students to a variety of curriculum areas they will be studying and encourages students to consider these areas within a rural context. Finally, we expect the book will be particularly well suited for the growing number of specialized courses in rural social work.

Lead teachers have written brief introductions to each of the five parts that explore the connections between the readings and the curriculum area covered in that section. These veteran teachers and scholars have prepared students and instructors for the section of readings as if they were preparing their students for a new unit in their own classes. We intend for these introductory sections to invite readers to anticipate particular themes and connections as they work through the chapters.

The discussion questions and assignments are designed to provide maximum autonomy for student learners. We believe that students should be at the center of their own learning, so we designed the activities to be used with as little or as much guidance as the teacher believes his or her particular class will need. Teachers are encouraged to adapt these assignments as they wish and to create their own questions and assignments to fit their unique contexts.

No matter how students, teachers, and practitioners might choose to use this resource, we are confident that they will find good readings, discussion questions, and assignments to help them think about rural social work in new ways. We have learned a great deal from reading and editing the work of these well-informed and experienced contributors. We hope others' experiences with this resource will be equally enjoyable and stimulating.

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Many people have inspired, guided, and influenced our professional and personal development. We call those people capacity builders. I (Laine) would like to acknowledge my dad, Charlie Scales, who, along with my mom, provided my first learning about rural communities. Growing up in rural Kentucky and North Carolina, I watched (and helped) my parents as they tirelessly gave their time and energy in building natural helping networks to sustain our small communities. I am also indebted to Dr. Donoso Escobar, my teacher and friend, who first taught me that rurality is not just a matter of where we are located geographically, but also an important cultural study, and that social workers can (and need to) do this essential work.

I (Cal) was influenced by countless asset builders, many of whom didn't know they were influencing me, who have shaped who I am today. I would like to thank all those who have helped me along the way. In particular, I want to acknowledge my parents, Lloyd and Delores Streeter. My earliest memories of rural community life center around my parents' active participation in the life of their small farming community in central Nebraska. Working together with neighbors, sharing their dreams and aspirations, influencing one another's opinions, and supporting and encouraging one another during difficult times was a normal and natural part of their life. They were and continue to be asset builders for many people, young and old. I would also like to express my gratitude to my wife, Diane, and my children, Brian and Aaron, who remind me daily of the importance of family in our ongoing journey through life.

I (Steve) appreciate my parents, Hayden and Judith Cooper, who decided to raise my siblings and me in a rural community. The resulting experiences, as well as lessons about rural life taught by my grandparents, Lois Beeney and Jack Harrington, fostered a deep appreciation for life in a rural community. In fact, I went on to attend college in a rural community, where I have lived my entire adult life. I developed a passion for rural social work practice in that community, and I have witnessed the extraordinary capacity of rural communities to address the most difficult issues. Many people have contributed to my passion for and understanding of rural communities, including Linda Morales, Freddie Avant, Laine Scales, Barbara Nowak, David Cozadd, Cal Streeter, and Dennis Poole. Finally, I would like to express my deep gratitude for my wife, Angela, and our children, Hayden and Savannah, all of whom are constant reminders of the most important things in life.

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Amy Z. Boelk earned her MSSW from the University of Wisconsin–Madison and her PhD from the University of Texas, Austin. Presently, she is Associate Professor and Field Coordinator in the BSW program at the University of Wisconsin–Stevens Point. As a former hospice social worker, Dr. Boelk has a significant interest in end-of-life care. In addition to her work on end-of-life care in rural areas, she has published and presented on the topics of family conflict at the end of life and recovery from parental suicide. Forthcoming is a chapter in the first *Oxford Handbook of Oncology Social Work*.

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L. Neal Holly earned an MA in higher education administration from Appalachian State University, in Boone, North Carolina, and received his PhD in higher education administration from the College of William & Mary, in Williamsburg, Virginia. Currently, he is a Research and Policy Analyst for the West Virginia Higher Education Policy Commission. Neal's research has centered on low-income student postsecondary access and success. In particular, his work has focused on the impact of state-level education policies and initiatives on low-income enrollment, and college-going efforts in rural communities. He has co-authored two major reports on college access efforts in the state of Virginia, as well as contributed to peer-reviewed publications and presentations at the national level.

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PART ONE

Conceptual and Historical Foundations of Rural Social Welfare

Paul H. Stuart

Does rural social welfare differ from urban social welfare? And do social workers who practice in rural areas or with rural people experience a different reality than that which is encountered by other social workers? If so, what are the differences, both in policy and practice? Social work is often described as an urban profession, as the origins of the profession in the United States were found in the rapidly growing urban centers during the Progressive Era of the late 19th and early 20th centuries. However, much Progressive Era social work practice involved work with immigrants from rural Europe and migrants from rural America, who made up the populations that swelled turn-of-the-century cities. And social workers have been practicing in rural areas since at least World War I. The chapters in this section provide information on the rural roots of social welfare in the United States and some insights on what is special about social work practice with rural people. More importantly, they provide an orientation to rural social work and social welfare.

One answer to the question of what sets rural social work apart has been that rural areas—and by extension rural social welfare—can be distinguished from their urban counterparts by reference to what is lacking. Initially, the U.S. Census Bureau defined rural and urban areas by the number of people in the area. In the 1790 census, places of fewer than 2,500 people were designated as rural areas, whereas places with more than 2,500 were classified as urban. This classification continued to be used until 1991, when the Census Bureau developed a more nuanced definition. Smaller population was often associated with deficits. Thus, cities had relatively rich social welfare resources and were traditionally centers for innovation and experimentation, in contrast to rural areas, which had fewer resources and were often viewed as unchanging and set in their ways. Cities were also the locations of major social institutions, such as universities, hospitals, and religious institutions, whereas rural areas could be characterized by a lack of these amenities. Thus, much of the thinking about rural social work and social welfare emphasized the deficits that seemed to characterize rural communities.

If rural policy and practice is conceptualized from a deficit model, then the role of a social worker may be to make connections between people and the (often missing) services they need. Some rural social work practice is focused on community deficits and finding ways to work around those deficits. Such a view emphasizes what rural areas do not have, rather than the strengths of rural people and rural communities. In Chapter 1, "Down-Home Social Work: A Strengths-Based Model for Rural Practice," two social work educators, Michael R. Daley and Freddie L. Avant, state the case for a reconceptualization of rural social work practice. Instead of a focus on deficits, they argue in favor of a broader framework for rural social work practice—a generalist framework that takes into account both the person and the environment. *Rural* may be a concept that cannot be defined simply by population density or deficits in services, they suggest. Rather, a rural culture is something that people identify with, including some people who are currently living in standard metropolitan statistical areas (SMSAs), the most *urban* places, according to the current Census Bureau classification system.

In rural cultures people relate to each other in informal or personalized ways. Primary family and friendship groups are often more important than formal resources, such as agencies and other official sources of information and assistance. Social workers need to be aware of this attitude, whether they work in rural areas or in urban communities, as rural people migrate to cities, where some are in need of services. How can social workers be aware of the culture of their clients? Daley and Avant provide some clues, but because rural people self-identify as rural, the best strategy is to ask them.

The importance of informal relations in rural cultures is illustrated in Chapter 2, "Rural Is Real: History of the National Rural Social Work Caucus and the NASW Professional Policy Statement on Rural Social Work." In this chapter, rural social work practitioner Samuel A. Hickman provides a description and history of the Rural Social Work Caucus. Founded in the 1970s, the caucus, now known as the National Rural Social Work Caucus, represents the interests of rural social work practitioners and social work educators who focus on rural practice. The caucus has encouraged attention to rural issues by the National Association of Social Workers, the Council on Social Work Education, and other organizations, and was responsible for the 1981, 2002, and 2011 Professional Policy Statements on Rural Social Work, which were adopted by the National Association of Social Workers Delegate Assembly. The caucus is less formally organized than many other professional organizations, but it gets a lot done, as Hickman shows.

The history of social welfare policy in the United States reflects the nation's varying attitude toward rural areas. In Chapter 3, "Social Welfare and Rural People: From the Colonial Era to the Present," I, Paul Stuart (chapter author), trace the development of social welfare in the United States as the nation evolved from a predominantly rural and agricultural country to a modern urban and industrialized nation. The locus for social welfare activity and innovation shifted from the local community to the state and eventually to the nation, while the view of rural areas shifted as well. Initially viewed as ideal democratic communities, rural areas were increasingly seen as backward and isolated during the 20th century. Along with rapid urban development, a deficit view of rural communities came to dominate discussions.

Rural and frontier areas were stimulated by the enactment of the "Western measures" of the 1862 Congress. The Homestead Act, the Land Grant College Act, the Department of

Agriculture Act, and the Pacific Railroad Act represented major social investments that transferred assets in the form of land, education, research, and transportation to frontier settlers and rural residents in general. Corresponding asset-building measures may be needed to revitalize rural communities in the 21st century.

As Americans came to view rural areas as backward, another function of rural communities suggested itself. Urban problems—or urban people who had problems—could be moved to rural areas, where they could be "out of sight, out of mind." Mental hospitals, prisons, and other institutions were located in rural areas, far away from population centers. From the "orphan trains" of the late 19th and early 20th centuries to the New Deal Civilian Conservation Corps and Great Society Job Corps programs of the mid-20th century, Americans have endeavored to relocate urban people with problems to rural areas. In part, this reflected a belief in the restorative powers of rural environments, but it also reflected a desire to remove problems far away from an increasingly urban society.

In Chapter 4, "Out of Sight, Out of Mind: Rural Social Work and African American Women at Efland Home for Girls, 1920–1938," Tanya Brice describes a rural residential facility for African American girls established by the North Carolina Federation of Colored Women, an organization composed of middle-class African American women who engaged in a variety of works designed to "lift up" African American people in the early 20th century. The Efland Home for Girls provided a way to remove girls who were viewed as having problems from their environment to a rural refuge, where they could be cared for and prepared for adult life. In this case, which was not unusual, particularly in Southern states where African American people had access to few services, Brice shows that the Efland Home served both to remove girls from problematic environments and provide them with education and vocational training. But isolating these "wayward" girls far from familiar environments served another function—that of removing them from their home communities so they could be "out of sight, out of mind."

These four chapters provide an introduction and orientation to rural social welfare and rural social work practice. They represent a variety of points of view, yet they still do not provide every possible way of looking at rural social work. They do provide a basis on which you can begin your exploration of social work and social welfare in rural communities.

CHAPTER 1

Down-Home Social Work

A Strengths-Based Model for Rural Practice

Michael R. Daley and Freddie L. Avant

Historically, social work developed from urban roots and paid relatively little attention to the issues and concerns related to rural populations (Daley & Avant 2004b; Ginsberg, 2011; NASW, 2012). Interest in rural social work appears to have originated around the early years of the 20th century and initially focused on community-based issues involving the need for better infrastructure in areas, such as promoting the development of electricity, education, and health care (Galen & Alexander, 2011; Martinez-Brawley, 1980). Given these origins, it is not surprising that rural social work developed a strong emphasis on community-based practice that focused on addressing a shortage of community resources, which continues to the present (Barker, 2003; Ginsberg, 1998; Martinez-Brawley, 1990; Southern Regional Education Board, 1998; York, Denton, & Moran, 1998). Thus, the typical portrayal of rural social work practice is that it is an activity occurring in areas of low population density, and that the problems of rural people stem from the physical environment or geographic location wherein resources are sparse.

Although this perspective has been helpful in directing attention to the service needs of long-neglected rural communities and the people who live in them, it has been somewhat limiting in advancing both the practice and educational development of knowledge and skills of rural social workers. Specifically, the development of literature regarding social work with rural individuals, families, groups, and organizations has lagged far behind that of macro practice for addressing organizations and communities.

Rural social work is and should be viewed more broadly than community-based work. Rural social work at a fundamental level is work with rural people as well as practice in and with rural communities (Daley & Avant, 2004a; Ginsberg, 2011). This perspective suggests the use of both the person-in-environment and the multisystem focus that is so critical for social work practice. In the past, by concentrating on the rural community aspects of practice, we tended to overlook the interaction between the rural environment and other systems that influence behavior. Indeed, the cultural or lifestyle issues relating to rural people in terms of individual, family, group, and organizational systems translate into behavior that may be as

important as the community environment in understanding the problems of and in shaping social work practice in this context (Daley & Avant, 2004b).

The purpose of this chapter is to present a broad-based model for rural social work practice that addresses a comprehensive strengths-based approach to effective work with rural people in this important arena of practice. The chapter will explore traditional views of rural communities and rural social work. Additionally, it will address ways in which these traditional definitions can be broadened to enhance the understanding of rural social work. Within this context, a model for rural social work will be presented, along with implications for this expanded model for social work practice and education.

DEFINING RURAL

Rurality, or the presence of rural characteristics, is clearly the context for rural social work, just as mental health, health care, families and children, education, and corrections provide the context for other fields of social work practice. It is often unclear what elements differentiate the rural from nonrural as a context for social work practice. In part, this lack of clarity has arisen because of multiple definitions of rurality that currently exist. Thus, the term *rural* is not consistently used by everyone. The traditional way in which rurality is defined is based both on geography and population density. This method is defined by the Census Bureau and has many attractive features. The Census definitions are widely used, and they are appealing because they are absolute in that they unambiguously and clearly classify a region as either rural or nonrural, and all except the most recent definition of rurality classify rural as part of a rural–urban dichotomy.

Perhaps the most traditional definition of rurality is that used by the U.S. Census Bureau prior to 1991. By this definition, a rural community was one with a population of fewer than 2,500 people living in either incorporated or unincorporated areas. Communities of 2,500 or larger were classified as urban. This was a long-standing definition dating from the period when the country was primarily rural, and it became somewhat outdated with the growth of the country's population.

In 1991, a more functional definition for rurality was developed by the U.S. Census Bureau. This definition moved away from the dichotomous rural–urban approach and viewed communities on a rural–urban continuum. *Metropolitan* and *nonmetropolitan* became preferred terms as opposed to *rural* and *urban*. Metropolitan communities were those that had a central city population of 50,000 or more. Metropolitan statistical areas (MSAs) were communities formed by the core city and the county in which the central city was located. Nonmetropolitan or rural communities consisted of everything lying outside of the MSAs (Davenport & Davenport, 1995; Ginsberg, 1998; Olaveson, Conway, & Shaver, 2004).

Changes for the year 2000 census shifted the rural and urban definitions once again (U.S. Census Bureau, 2000). Under these criteria, there are new classifications for urbanized areas (UAs) and urban clusters (UCs). UAs consist of a densely settled core of census block groups along with surrounding census blocks that encompass a population of at least 50,000 people. UCs consist of a densely settled core of census blocks along with adjacent densely settled

census blocks that have a population of at least 2,500 but fewer than 50,000 people. Using this method, rural populations are classified as those not residing in either UAs or UCs. The latter definition is helpful in that it moves away from the rural–urban dichotomy by adding a classification of the UC that corresponds to small- to medium-sized communities.

Further complexity is added when other methods of rural–urban classification are considered. For example, some classification models use population density, commuting patterns, the economy, and "open country" as identifiers of rurality (Olaveson et al., 2004). These complexities of defining rurality can be bewildering for the practicing social worker.

What can be concluded from all of these definitions is that the rural population of the United States is considerable, although clearly a minority. Ginsberg (2011) indicates that the rural population in the United States is between one-fifth and one-fourth of the total population, or 60 million to 75 million people. This substantial population needs the services that social workers deliver.

The percentage of the population that is rural is not uniform nationwide and varies considerably by state and by region. In some states, such as North Dakota, the majority of the population lives in rural areas. High concentrations of rural people are also found in the West and South regions of the United States. Even states with large metropolitan populations have substantial numbers of rural people within their boundaries (Daley & Avant, 2004b).

RURALITY AND SOCIAL WORK PRACTICE

What is a social worker to make of this complexity, and how does it help in identifying a rural context for practice? The practical fact is that social workers are neither demographers nor economists, and many of these approaches to rurality cloud rather than clarify the issue. Generally, social workers are more concerned with addressing the needs of clients and addressing social ills than in classifying societal structure. And nowhere in these methods of classifying rurality does it effectively address the individual, family, or group that self identifies as "country folk," or rural. There is often an implicit assumption that rurality lies within the community and not within the person.

However, as social workers we can often attest that rural characteristics and behaviors remain strong with people even after they move to the city. People may continue to identify themselves as country or rural and refer to their customs, institutions, and means of interacting with others as "down-home." There may be some wisdom in the old saying, "You can take the girl (or boy) out of the country, but you can't take the country out of the girl (or boy)."

Rural sociologists have long viewed rurality as rural environment structure composed of occupations, ecology, and sociocultural elements (Daley, 2010). All of these structures in some way translate into behaviors that may be the concerns of social workers, particularly when these behaviors result in problems in living and adapting to the environment.

Traditionally, this has led us to approach rurality by attempting to identify the salient characteristics that define rural social work where the focus has been on community characteristics, such as lack of transportation; nondiversified economies; poor housing, education, and health care; poverty; shortage of professionals; and lack of services. In the

past few years, additional concerns about rural communities have emerged that include decaying infrastructures, withdrawal of essential services, and a weak communications infrastructure for cellular phones and broadband connections. Although these are all important problems in rural America, they are all deficits. Too little attention has been focused on the community assets and strengths that may be used in addressing these problems and in building a positive perspective from which rural social workers could practice.

There are clearly some differences between rural and urban communities, from a social work perspective, but this tends to ignore major differences that exist between other important systems that influence social problems, rural behaviors, and the responses to them. In other words, definitions of rurality that focus primarily on population or community characteristics lead us to an environmental perspective with community-based interventions, whereas a person-in-environment perspective may lead us to develop smaller system interventions that fit within the environmental context.

It is much more likely that sociobehavioral-based definitions of rurality would be beneficial for the practice of social work. As Daley and Avant (2004a, 2004b) indicate, "Rural practice is social work both in and with rural communities, and it is also social work with rural people." Ginsberg (2005) also supports the idea that we should examine human behavior and problems in the rural environment from a person-in-environment perspective and consider the social problems of rural populations as stemming from both the physical environment and from a sociocultural or rural lifestyle perspective. Honestly, stereotypes of rural people and communities as simple and pure were never accurate, and both life and relationships in a rural community are often every bit as complex as those of their urban counterparts.

So what is the most practical approach to identifying rurality in the practice arena? To begin, one should avoid the trap of thinking of a rural–urban dichotomy. As Daley (2010) states, neither purely rural nor purely urban communities exist, and they are more accurately categorized as lying somewhere along a continuum, with elements of each. Then Daley and Pierce (2011) and Ginsberg (2005) suggest that using cultural and behavioral norms of the people as well as community characteristics are the most effective means of practicing social work with rural people and communities. Daley and Pierce (2011) add that in social work practice, cultural and behavioral factors should be of primary concern, and the use of population figures should be secondary. They go on to identify some important considerations in determining rurality, including "Do the residents of a community think of themselves as rural and possess rural attributes and behaviors?" and if the answers to these questions are yes, then the people are probably rural.

This kind of approach moves us away from the idea of a rural–urban dichotomy and helps us to develop a broad-based framework for rural practice that is behaviorally based. Rural and urban practice share many elements, and making an either-or distinction is not all that useful for practice purposes. The key point is that rural communities are not all alike, and this is also the case with urban communities. It is perhaps easiest to point out the differences between communities in the extremes, say between a city of 1 million and a small town of 800. But where does this leave us when assessing the differences between a city of 55,000 and a town of 30,000? The differences there are not so clear.

Given all of this information, how might we view rurality in a different light that is more productive in building a framework for rural social work practice? At this point, it is appropriate to consider a multisystem model that incorporates cultural or lifestyle perspectives for social work practice with rural communities.

A MULTISYSTEM MODEL FOR DOWN-HOME (RURAL) SOCIAL WORK

Although traditional definitions of rurality provide a starting point for formulating a framework for rural social work practice, these definitions often do not reflect the complexity of working with both rural people and communities. In order to address this complexity, a broader multidimensional framework is needed. This more comprehensive framework does not negate the existing definitions of rurality as underlying principles of rural practice. Rather, the model would build on existing definitions, broadening and enriching them, and increasing their relevance for social work with rural people. The model can consider not only the characteristics of the community, but also the interactions among systems in the community, utilizing a strengths-based perspective. Existing models tend to identify the rural context through census-based definitions, but they do not provide rural social workers with consistent approaches for analyzing the interactions that occur among social systems in the rural environment.

This leads us to consider a somewhat different framework for rural social work practice than has been traditionally used. This model of practice is one in which economics, population density, and geography still play a part, but are not entirely sufficient. Rather, it proceeds from a multisystems person-in-environment and systems-based perspective. The interactions among these systems are crucial for reflecting the complexity of rural people and communities and understanding the origin of problems so that intervention strategies can be developed. We should understand that the interactions and transactions exchanges among these systems are based on principles of social exchange, and these exchanges are key to understanding how to work effectively with rural people and in rural communities. We know that in rural communities, the nature of social exchange tends to be informal or personal, as opposed to the formal exchanges and relationships that exist in urban communities.

These informal relationships are, in fact, strengths, because they represent affirmative coping skills in rural communities where formal agencies and services often either do not exist or are difficult to access. The model also incorporates the strengths perspective to identify existing coping skills and community-based assets while still maintaining a problem-solving approach. This too differs from traditional rural social work models that tend to focus on what personal deficits exist or community resources are missing.

To address all of these issues, the authors suggest using the model presented in Figure 1.1. This model is based on three principles. The first is the multisystems, or generalist, approach to effectively adapt to the needs of rural people and the rural community and to address social problems in the appropriate environmental context. The second principle is that of analyzing social exchange among systems to assess and design appropriate interventions. This addresses the point made in the rural literature that social interactions in rural communities often take a slightly different form than is commonly seen in the urban environment. The

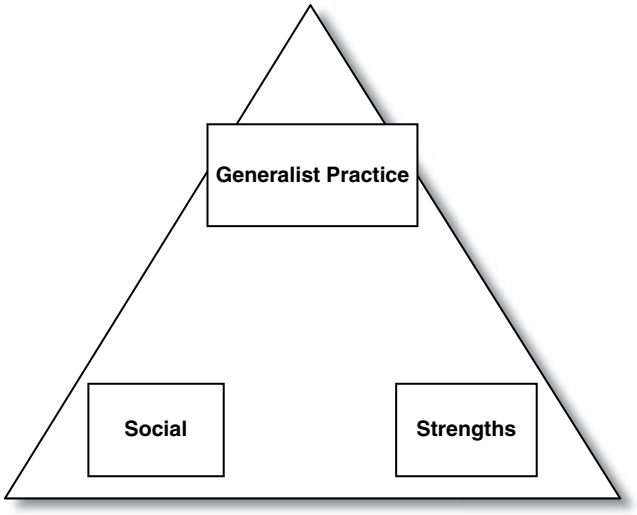

Figure 1.1 Model for rural social work.

third and final principle is that of using a strengths- or assets-based perspective. Too often we identify what rural communities lack and spend too little time looking for the strengths of individuals and community assets that could assist us in effective practice.

RATIONALE FOR THE DOWN-HOME MODEL OF RURAL SOCIAL WORK

Although many themes related to rural practice have emerged over the years, two consistent themes in the literature assist in building a multisystem practice model. The first is the concept of generalist practice. Several authors have identified generalist practice as the best-suited and the primary method for rural social work (Daley, 2010; Daley & Avant, 2004a, 2004b; Daley & Pierce, 2011; Ginsberg, 1998, 2005; Locke & Winship, 2005; Lohmann, 2005; NASW, 2009; Southern Regional Education Board, 1998). In fact, the discussion of generalist practice is so common today that this method is almost unchallenged as *the* method for rural social work (Daley & Pierce, 2011).

Generalist practice is by definition a multisystem approach to practice that uses a wide range of interventions. Generalist practice is based on a systems framework utilizing both larger and smaller systems to assess problems and implement interventions for change. Thus, generalist practice addresses individuals, families, and groups, as well as organizations and communities (Kirst-Ashman & Hull, 2006). The community system is important but not necessarily the primary concern for the social worker. Rather, generalist practice emphasizes the person-in-environment approach and gives appropriate attention to all relevant factors.

The generalist method of social work is broad enough to encompass the unique elements of the rural community in terms of their influence on client behaviors. This method assists

with comprehensive social work assessments and interventions and is flexible enough to allow for specific interventions, resource development, and referral where appropriate. The multisystem approach of generalist practice permits a strong focus on direct rural practice while maintaining an appropriate balance with underlying community-based social and cultural factors that shape behavior in rural environments. In other words, the generalist method permits a more balanced person-in-environment equation than the traditional community-focused approach.

A second key theme in the literature helps explain the types of social interactions in the rural community. These social exchanges are key components of the generalist method in assessing client and community problems and in designing appropriate interventions.

Daley and Pierce (2011), Ginsberg (2011), Martinez-Brawley (2000), and Burkemper (2005) have pointed out that the theoretical concepts of *Gemeinschaft* and *Gesellschaft* are useful in explaining important differences between social interactions for people in rural and urban communities. *Gemeinschaft* communities are those closely identified with small towns and rural areas, and human relationships are personal, lasting, and based on where a person stands in society. Thus, social relationships are clear and based on who a person is rather than what he or she has done. *Gemeinschaft* communities tend to be relatively homogeneous, and the church and family are strong sources of norms and values. In contrast, *Gesellschaft* is more closely identified with urban communities in which social interactions based on impersonal and contractual relationships are more typical.

The constructs of *Gemeinschaft* and *Gesellschaft* give us the ability to frame social, political, and economic transactions in communities according to the nature of the social exchanges. Using these concepts of social exchange facilitates a comprehensive analysis of the interactions among members of a rural community across all systems. This frees the rural practitioner from approaches that focus primarily on community characteristics such as population density, size, or geography. Because social work practitioners are primarily concerned with the nature of social relationships, both functional and problematic, these theoretical constructs help us identify important factors to consider in developing a framework for rural social work (Collins, 1988).

The concept of *Gemeinschaft* is particularly useful in this regard for rural social work. *Gemeinschaft* communities are those in which family, place, and friendships are key elements. *Gemeinschaft* communities promote a collectivist and personal orientation in their members, as opposed to the purpose-driven, individualistic, and impersonal orientation found in *Gesellschaft* communities (Appelrouth & Edles, 2007). Thus, the relationships with one's family, connection with the land or locality, and social relationships define who a person is and are important to understanding behavior in small towns and rural communities. Small towns and rural communities may also be characterized as traditional, as opposed to rational-legal, in their authority structure (Martinez-Brawley, 2000).

It is important for a model for rural social work practice to incorporate both the concepts of multisystems or generalist practice and the concept of the general nature of relationships as defined by *Gemeinshaft* and *Gesellschaft*, because both are important to understanding the nature of human relationships and problems. In addition, it is also important to incorporate the concept of social exchange to help shape practice.

The nature of social relationships and exchanges between persons and systems make social work practice in rural settings somewhat different than practice in urban settings, so understanding the nature of these exchanges is critical. Social exchange theory from social psychology helps us to understand the rural behavior in the environmental context that is so important to social work practice. *Gemeinschaft* and *Gesellschaft* concepts reflect the prevailing environment in any community that shapes the nature of the social exchanges (Daley, 2010).

Social exchange theory is based on a central premise: that the exchange of social and material resources is a fundamental form of human interaction. The social exchange is based on the idea that relationships among people are centered on the perception that certain positive outcomes may ensue as a result of the relationships. The strongest relationships are likely to be established with those from whom the benefit or potential is likely to be greatest. Social exchange theory deals with both the ties that bind people together and the effects of interactions among people (Collins, 1988).

From a social work perspective, social exchange in rural communities may be seen as a positive form of adaptation to the environment. As many authors have suggested, social welfare needs may not be easily met in a rural area for several reasons. First, income to meet basic needs may be limited. Additionally, formal helping resources such as social agencies may be scarce or nonexistent, and finally, helping professionals may not be readily available (Daley & Avant, 1999; Ginsberg, 1998; NASW, 2012).

Therefore, instead of relying heavily on the formal social welfare system that may not prove adequate, rural people are more likely to find help by establishing interpersonal relationships that may offer them help in meeting their social welfare needs. By using personal relationships to substitute for a formal social welfare system, individuals are, in effect, creating an informal service system that is more likely to meet their needs (Daley & Avant, 2004b). In addition, because of the personal nature of relationships in rural communities, relationships based on exchange may extend beyond interactions with individuals to connect them with family, groups, organizations, and the community.

For example, social exchange in a rural context begins with a focus on "who the person is" as opposed to what the person's accomplishments might be or what formal position he or she holds. The social exchange focus is not limited to person-to-person interactions, but affects exchanges with other systems such as families, groups, organizations, and the community. For example, people may choose to trade with the drugstore where they know the pharmacist to get personalized service, rather than patronize the discount store that offers the cheapest price. Thus, the personalized nature of relationships is a key element in explaining and changing behavior in rural communities and small towns, and it is critical for social workers to understand these relationships.

The concepts of using a multisystem generalist model of practice and the focus on social relationships and mutual exchange as central concepts in rural social work logically lead us from a deficit to a strengths-based perspective for practice. Generalist practice generally includes a strengths perspective, and many of the social exchange relationships for rural people reflect their strengths and use of assets (Daley & Avant, 2004b). As Saleebey (2006) states, in the strengths perspective

> the person or family in front of you and the community around you possess assets, resources, wisdom, and knowledge that, at the outset you probably know nothing about. First *and* foremost, the strengths perspective is about discerning those resources, and respecting them and the potential they may have for reversing misfortune, countering illness, easing pain, and reaching goals. (p. 16)

This is, in fact, what the authors suggest using in a rural context, because social workers and others frequently look at the rural environment and rural practice in terms of simply what is missing or deficient. In the rural environment, social relationships and exchanges and other informal helping networks are valuable assets to assist coping with the day-to-day challenges of living and problem solving in a rural environment.

Although many authors have noted the deficits of rural communities, such as high poverty rates, inadequate housing, inadequate health care, scarcity of resources and professionals, socioeconomic underdevelopment, and physical distance from services and transportation, many strengths of rural areas go unnoticed. These strengths include a sense of community, connection to the land, intimacy among community residents, orientations toward self-sufficiency, an ability to develop natural helping networks, and an abundance of personal space.

One might say that what we have is really a question of looking at whether the glass is half-empty or half-full. We can look at rural practice as occurring in a context where many important things like transportation, health care, formal services, and social service professionals are in short supply, or we can look at the positive adaptive behaviors that rural people use to develop informal resources to meet their needs. Clearly, the former is a deficit-based perspective, whereas the latter is strengths-based. By using the strengths-based perspective, social workers are more likely to identify the problem-solving abilities routinely used by rural people and operate in a culturally competent context. Furthermore, by using a strengths approach, it is less likely that rural people needing help will be viewed as either backward or lacking in coping skills.

Rural practice is, above all, social work with rural people that incorporates the social environment (Ginsberg, 2005). It is because rural social work is work with rural people that the concepts of informality and social exchange are so crucial to practice.

IMPLICATIONS FOR RURAL SOCIAL WORK

In recent years, it has become clear that the generalist model of social work is the best-suited practice approach in rural communities (Brown, 1980; Daley, 2010; Daley & Avant, 1999, 2004a, 2004b; Daley & Pierce, 2011; Davenport & Davenport, 1998; Ginsberg 1998, 2005; Riebschleger, 2007; Southern Regional Education Board, 1998; Waltman, 2011; York et al., 1998). The generalist method is most appropriate because rural social workers must be multiskilled to fill in where needed (Ginsberg, 2005) and are necessarily generalists as opposed to specialists. This point of view is widely accepted, but a significant amount of literature suggests that rural practice should be primarily community oriented.

The framework identified in this chapter embraces the multisystems generalist model of practice. This is appropriate because the rural social worker must work with multiple social

systems ranging from individuals to communities in order to be effective. Applying the generalist method involves assessment and intervention centered on social exchanges and behaviors that occur among social systems, and applying both person-in-environment and strengths perspectives to the professional helping process. Thus, the model of rural social work practice identified in this chapter uses the concepts of generalist practice (multisystem), social exchange, and the strengths perspective as key elements.

This does not mean to suggest that social workers in rural areas do not have or need advanced or specialized skills in working with these systems. Rural social workers, because of the nature of their communities, have to deal with a broad spectrum of social problems and issues. Often they may be the only resource to deal with a problem, and they therefore need an ability to work with all systems and with other professionals. Consequently, there is a strong need for rural social workers to be flexible and adaptable. However, rural communities do face the same types of problems as their urban counterparts, so there is a clear need for advanced skills in working with the more complex and difficult problems related to these systems.

Rural social work is social work with rural people, typically occurring within a rural context. Rural people are traditional people in that they cling to traditional values and norms of behavior. In a rural community, these values and norms serve a positive function that helps to maintain social order. Understanding and using these community-based norms and values and how they work can help identify significant strengths and assets that can be employed in the helping process. Obviously not all rural communities have the same traditions, values, and norms, and it is important for the social worker to become competent in those that are part of a specific community. Rural Arkansas may be very different from rural Wyoming in many ways, and it is important for the social worker to understand how they differ.

Because personal (informal) relationships are very important to living and coping in small towns and rural communities, maintenance of some kind of social order is essential for individual and community survival. Friends, relatives, clergy, the beautician, or even the mail carrier are relied on much more extensively for information than are formal resources such as agencies. Rural populations also rely heavily on the use of natural helping networks such as family, church, and friends to resolve problems. The visibility of individuals in rural communities often leads to reluctance to seek help from formal agencies, in order to keep the community from knowing their business. Seeking help through family, friends, and church may be no more private, but this approach is generally considered more acceptable in the community.

To outsiders, the rural way of coping may seem strange, conservative, and resistant to change. It may also appear that outsiders are not trusted and that diversity and change are not tolerated. These appearances can easily be interpreted as deficits or some form of social pathology infecting the rural community. Rather, these are strengths for the rural community, because they provide mechanisms for community survival by defining expectations for behavior in the community.

Unfortunately, when rural people move to an urban environment, the use of the personalized (informal) coping mechanisms that they have learned may not be as functional, and problems may develop. All too often, social workers in urban environments are surprised to find themselves working with rural individuals, families, and even communities inside of a

metropolitan area. These are populations with whom urban-educated and urban-oriented social workers are ill prepared to deal (Daley & Avant, 2004b; NASW, 2009). Urban social workers "have difficulty applying their knowledge to rural practice and must adapt their practice model significantly to do a credible job in rural areas" (NASW, 1997, p. 293). Similarly, urban social workers are not well-prepared to assist clients from rural areas who have moved to the city.

In order to work effectively with rural people in any setting, it is important for social workers to understand the cultural context in which they were socialized, because this socialization has a profound effect on behavior. Social workers must be sensitive to the cultural differences that characterize rural communities and be ready to question many of the myths and stereotypes about rurality that exist (Southern Regional Education Board, 1998).

Rurality has its own, often invisible, culture that must be considered as part of any effective work with this population. Culture in this sense represents "the customs, habits, skills, technology, arts, values, ideology, science, and religious and political behavior of a group of people in a specific time period" (Barker, 2003, p. 105). Rural people are socialized into a culture that may have somewhat different values, norms, beliefs, and even language than our own, all of which help them adapt to their environment. As social workers we must be culturally sensitive to these issues in order to work effectively with rural people.

Unfortunately, educational preparation for working with rural people and communities is often not as strong as it could be, and the profession has the responsibility of preparing social workers for rural practice (Daley & Avant, 1999, 2004b; Daley & Pierce, 2011; NASW, 2009). Locke (1991), in a review of five studies of educational preparation for social work practice, concluded that schools of social work needed to better prepare social workers for practice in small towns and rural areas. Weber (1980) indicates that the commitment of social work to rural communities is not adequate. In addition, she suggests that the attention to rural issues in most social work educational programs is superficial (Weber, 1980).

We should aspire to prepare rural social workers as "well-trained, creative professionals who can work in relative isolation with limited additional resources" (Barker, 2003). However, in order to do so, we must address rural issues and content in a stronger and more meaningful way. It is hoped that by looking at some of the basic premises that have provided the foundation for rural social work, we have built on these concepts, expanded on them, and developed a useful model for rural social work. Using this model, social workers can adapt their practice to the down-home needs of the rural community and respond in a more culturally sensitive and effective way.

Discussion Questions

1. List at least 10 characteristics that you would associate with rural living. Then list at least 10 characteristics that you would associate with urban life. Compare and contrast the rural and urban characteristics you have identified in terms of the following: positive or negative, progressive or conservative, and strengths or weaknesses. Based on your comparison, which environment seems more appealing and why?
2. What are the strengths of rural communities? Identify at least five strengths and how these assets might be of use in social work practice.

3. The concepts of *Gemeinschaft* and *Gesellschaft* are used to describe and explain behaviors in different communities. Identify five specific behaviors that define each concept. Then explain how any two of these behaviors might make a difference in either assessing problem behavior or in shaping social work interventions.

Classroom Activities and Assignments

1. Identify rural perspectives on lifestyle using either music or literature. Read either two pieces of literature or listen to 12 songs dealing primarily with rural life. Identify the major themes and how they would affect a rural person's approach to problem solving.
2. Visit a rural community and identify at least 10 ways in which life in this community is different than in your home community. What are some of the differences in language, values, and norms that you can identify?
3. Write a paragraph or two explaining how rural people and communities are portrayed in the media. Do these portrayals cast rural people and communities in a positive or a negative light?

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CHAPTER 2

Rural Is Real

History of the National Rural Social Work Caucus and the NASW Professional Policy Statement on Rural Social Work

Samuel A. Hickman

In the mid-1970s, social work practitioners and educators serving rural areas formed a loose organization that continues to this day. Known as the Rural Social Work Caucus, its members are joined by a common interest in and appreciation for rural cultures and people, and a desire to use and enhance social work skills to support and improve them. Caucus members coined the phrase "Rural Is Real" to impress on their social work colleagues across the nation that rural life and rural social work practice are thriving in the vast areas located beyond urban and suburban centers, and to raise awareness that urban sprawl and similar influences can threaten to homogenize or overcome desirable aspects of rural culture.

More than 19% of the U.S. population classified as rural resides on approximately 83% of the country's landmass (U.S. Census Bureau, 2012). This is down from 21% in 2010. Still, tens of millions of people live in small communities, remote areas, on reservations, and in narrow valleys not far from town. They are separated by time and distance but strongly connected by family, culture, history, common struggles, and a sense of place. Rural people and families share the same hopes and dreams as their urban and suburban neighbors: They want the opportunity to build a life, raise a family, engage in meaningful work, and retire in comfort. However, the smaller population and economic base that is common to rural areas can limit the availability and quality of public and private services, and the opportunities that come with them. Limitations include the availability of good paying jobs, adequate health care and social services, access to enrichment programs and services such as libraries and cultural activities, and the quality of public services such as transportation, infrastructure, and education. For the professional social worker, several questions may immediately spring to mind, including how to provide reliable services to a widespread population. How do we assess varying needs from community to community? Who is available to help advocate, raise money, or provide professional and volunteer services? And where should we begin?

Rural social work practice is rewarding and satisfying (Stoesen, 2002). Human relationships tend to be more genuine among rural people (Martinez-Brawley, 2000). The potential is

great for a small group of committed individuals to create something of lasting impact or meaningful change (Yevuta, 1999). Practice experiences can be richly varied and stimulating, often requiring the deft application of both direct services and macro-level skills to adequately address issues and concerns that arise and to determine how the professional social worker assesses, collaborates, and finds solutions to the real-life needs of people and communities. The term *multitasking* certainly applies here.

In social work, the term *generalist* is often mentioned as the desired and necessary preparation for practice in rural areas. The term should not be confused with *generic*, implying a smattering of rudimentary skills (Ginsberg, 2005). Effective rural practitioners must command a wide variety of social work skills and interventions (Carlton-LaNey, Edwards, & Reid, 1999). Their work may require them to combine multiple aspects of direct practice, advocacy, needs assessment, and research, with an understanding of human behavior, social systems, and interactions.

In particular, managing confidentiality issues and professional–client relationships in rural areas requires a highly tuned understanding of the *NASW Code of Ethics*. The experiences and advocacy efforts of rural practitioners significantly informed the dual-relationships provisions of the current *Code* in recognition of the conditions faced in small towns and rural areas.

Although the challenges of rural practice are real, professional social workers possess values and skills uniquely suited to assessing human needs, delivering effective services, and building mechanisms and organizations that enhance or improve rural communities and the lives of rural people and families. In return, social workers can be inspired by and benefit from the personal and professional rewards of serving truly authentic people and communities.

A nostalgic notion portrays rural America as a pristine, sedate, and unchanging landscape (Carlton-LaNey et al., 1999). In reality, rural communities are dynamic and rapidly changing. They can differ more widely from each other than from urban areas. A play on the common phrase "If you've see one, you've see them all" says it well: "If you've seen one rural community, you've seen one rural community" (Miller, Farmer, & Clark, 1994).

Although many rural communities are economically diverse, prosperous, and thriving, rural areas of the South, Southwest, and Appalachian Mountains have the highest rates of unemployment in the United States (USDA, 2012). A 2011 project sponsored by the Rural Policy Research Institute created a way to identify counties at risk because of their lack of and/or dependence on human services program supports (Heflin & Miller, 2011). The study identified 313 counties as particularly distressed in terms of their ability to adequately address their residents' needs across the life span.

Immigration is dramatically changing the cultural mixture of remote and rural areas and small cities and towns, bringing the United States face-to-face with the rest of the world (Stoesen, 2002). Suburban sprawl has claimed what was once rural farmland, bringing new, often more affluent or upwardly mobile residents with differing expectations and values as they move to escape the cities and suburbs. Sometimes property taxes are increased to the point that it becomes difficult for less-affluent rural landowners to keep their land. Vast tracts of rural lands or mineral rights are owned or controlled by government, corporations that extract natural resources and minerals, and large agribusiness interests. Outside ownership of land can restrict the ability of rural residents to influence state and local laws, policies, and

ordinances (which also determine property values, tax rates, and land-use policies) in ways that support local development initiatives.

THE RURAL SOCIAL WORK CAUCUS AND THE NATIONAL INSTITUTE ON SOCIAL WORK AND HUMAN SERVICES IN RURAL AREAS

The Rural Social Work Caucus was formed in the mid-1970s to focus attention on and encourage scholarly study of social and professional issues unique to rural social work practice, rural people, and rural communities. Although relatively few in number, committed Caucus members have made a significant impact on professional social work education and practice, social policy development, and the activities of professional associations.

The primary vehicle for encouraging scholarship and collaboration among rural social workers is the annual National Institute on Social Work and Human Services in Rural Areas. Each year since 1976, rural social workers have gathered in various locales in the United States to experience this unique, three-day professional conference (National Rural Social Work Caucus, 2012). Rural practitioners and educators alike present papers, share practice wisdom, describe innovations, and network with one another. They listen to speakers who discuss topics of timely local, regional, national, and even international interest. The annual business meeting of the Rural Social Work Caucus also takes place at the conference.

The annual institute cultivates an inclusive and supportive environment. Social work students, new practitioners, and junior faculty combine and converse as equals with more seasoned educators and practitioners. Organized and informal outings, tours, concerts, and cultural immersion activities are sometimes the most powerful memories of a particular institute, leading to recollections such as, "I remember we had to get out and push the bus out of the mud at the county fair," or "which was the real Appalachia . . . the living farm museum or the young musicians continuing the old-time music tradition?" After the day's scheduled events, social workers continue with impromptu discussions, music, and singing. A theme song written by caucus members declares, "words like change [and] community are drifting through the trees," and "as long as people feel at home . . . this travelin' rural road show will pop up again somewhere" (Winship & Hickman, 1992).

As much a homecoming as a professional conference, the annual Institute on Social Work and Human Services in Rural Areas attracts a variety of participants, including stalwart annual attendees (and often their families) and social workers from the host area (Stoesen, 2002). Invariably, a few new attendees "get hooked," promising to return next year and the year after, adding to the ranks. Participants are invited to sing along with the Caucus theme song. Attendees are "sworn in" through a brief, only partially tongue-in-cheek ceremony and designated as members of the National Rural Social Work Caucus. The "traveling quilt," a high-quality patchwork quilt incorporating the t-shirt logo designs of previous institutes, is passed to next year's host.

The Caucus exerts minimal control over the planning of the Institute as the host. Generally, an accredited social work program bears the financial risk. As one frequent attendee put it, "I always thought it was a bigger challenge to try to be different—to hold the Institute in places that were hard to get to; to include stories, humor, music, and traditions of

the populations in the area; to include families of the participants in all the events so that they were cross-generational" (Lennox, 2002).

Social work educators and students at the University of Wisconsin and the University of Tennessee, Knoxville, were instrumental in establishing the Caucus and the annual Institute, with the first Institute held in Knoxville in 1976. Subsequent Institutes have attracted social work educators, students, and practitioners from every geographic region of the country. Interprofessional collaborations between agricultural extension services and organizations such as the Rural Mental Health Association and the Rural Health Association have sometimes occurred. When held near international borders, social workers from neighboring countries are invited to participate. Use of the Internet to publicize the Institute has resulted in participation by social workers from Australia, Canada, Israel, and Korea.

ACTIVITIES OF THE NATIONAL RURAL SOCIAL WORK CAUCUS

A meeting of the National Rural Social Work Caucus can be an interesting and refreshing affair. It is often proudly referred to as an *organization by rumor*. Caucus members share a profound common interest in rural people and rural social work, as well as for preserving the strengths and assets of rural people and communities in a constantly changing world. They quickly pool their experiences, knowledge, and resources to identify the best ways to have a positive impact on rural communities and rural social work practice.

All Institute participants are welcome at Caucus meetings, and those present are considered equal voting members. A scant leadership structure of elected officers facilitates the agenda to get things started. The Caucus receives reports from committees on future institutes, publications, professional policy, practice policy, and scholarly research. The group acknowledges its connections to related organizations, such as the Council on Social Work Education and National Association of Social Workers.

A summary of the 2012 meeting provides an example. A president, two vice presidents, and a secretary were elected and, as is optimal, the officers had ties to both the social work education and practice communities. A host for the 2014 institute was approved (the 2013 host had previously been approved), and there were reports on the Caucus's robust online professional journal, *Contemporary Rural Social Work*, as well as on the website (www.RuralSocialWork.org), listserv, bibliography, and the successful adoption by the 2011 NASW Delegate Assembly of the *Social Work in Rural Areas* updated professional policy statement.

Additional caucus networking opportunities are often featured on the agendas of the Annual Program Meeting (APM) and Baccalaureate Program Directors (BPD) meetings of the Council on Social Work Education (CSWE), and at National Association of Social Workers (NASW) national and state conferences. The Caucus has twice participated as a member of the Social Work Congress, has a memorandum of understanding with the National Association of Social Workers indicating support of mutual goals, and maintains a collaborative relationship with organizations such as the Rural Policy Research Institute (www.RUPRI.org).

The most contentious Caucus meetings have occurred over the question of whether to establish a more formal structure for leadership and decision making. Regional

representatives have sometimes been identified to facilitate input from different areas of the country, but this has been the exception rather than the rule. The tradition of an *organization by rumor* prevails, because it holds certain advantages. Minimal hierarchy encourages participation. It can adapt to change quickly and be opportunistic in its approach to involvement and intervention. Although the National Rural Social Work Caucus represents the interests of a significant number of practitioners and educators, actual membership size is a "moving target" because there is no formal membership application. A small organization can cultivate a much larger footprint when key committed members are determined to utilize their knowledge and connections to further the cause, generating the illusion of influence beyond that of the actual power base, enhancing the potential for effectiveness. Caucus members have always been encouraged to use the name of the caucus to enhance activities that support rural policies and people. What is perhaps most significant about this practice is the members' self-restraint, professionalism, and commitment to rural causes that have prevented abuses of the privilege.

Another important Caucus function has been to advance the professional development and academic careers of its members. A significant group of social work educators has supported one another through the completion of their doctoral degrees. Their dissertations have often focused on rural social work and how best to prepare students for rural practice. Many of the students have become deans and senior faculty, whose research on rural social work is well-respected.

ACHIEVEMENTS OF THE NATIONAL RURAL SOCIAL WORK CAUCUS

Despite its minimal organization, the Rural Social Work Caucus has achieved a great deal. It has successfully fostered the annual Institute every year since 1976. It shepherded a national professional policy statement on the rural social work practice and education through its initial 1990 approval and two subsequent revisions. Its print journal, *Human Services in the Rural Environment* (HSITRE), has given way to the online journal, *Contemporary Rural Social Work*, which continues to contribute to the body of scholarly writing and provide an important publishing outlet for rural social work educators and practitioners. Its website features a bibliography of rural social work writings that is continually updated. The Caucus maintains a memorandum of understanding with the National Association of Social Workers to cooperate on shared goals and projects. Members of the Caucus have been invited to participate in two national Social Work Congresses. Its members have evoked the name of the Caucus to support sound social policies to benefit rural people and practice.

In the mid-1970s, Caucus members supported the National Association of Social Workers' move to a statewide chapter system from the previous metropolitan-based structure. This provided a home chapter for NASW members living in less-populated areas, offering opportunities to be more active in professional and policy advocacy. It also placed NASW in a better position to influence the decisions of federal and state legislators. Caucus members supported the creation of a special chapter development fund within NASW to support the operating costs of NASW state chapters with fewer than 1,000 members. At present, more than one-half of NASW chapters are in this category. These strategies have

helped make NASW more effective in changing social and health care policies, and have increased the influence and effectiveness of the social work profession. In addition, Caucus members crafted the original professional policy statement on Social Work in Rural Areas approved by the 1990 NASW Delegate Assembly and published in *Social Work Speaks*.

A GENERALIST APPROACH

The educational model for rural social work practice has come to be known as a generalist approach, arguably having its greatest impact at the Master of Social Work (MSW) level of social work education. Practice specialization had been a major trend in the profession, led by urban and suburban institutions preparing MSW candidates for private and specialty practice settings. Rural social work educators and practitioners helped the profession evolve in its understanding more accurately and appealingly underscore of the term *advanced generalist*, which requires broad knowledge and application of diverse theories, models, and methods.

The NASW professional policy statement on Rural Social Work submitted to the 2011 NASW Delegate Assembly argues that the rural generalist needs well-developed practice skills and thorough knowledge of the *NASW Code of Ethics* to be most effective. Why? Rural communities typically have fewer resources and services available. This requires the social worker to use a variety of practice skills to best serve the population. For example, clients may experience conditions for which no appropriate referral resources are available locally. In order to respond to such needs, the rural social worker may find it necessary to advocate for the development of a new service or program.

Life in a small town or rural area offers frequent challenges in maintaining client confidentiality and distinct client–practitioner relationships. A thorough understanding of the dual or multiple relationships provisions of the *NASW Code of Ethics* is necessary. Dual or multiple relationships are those that potentially place the professional in conflict with the client's best interests, or that put the professional in a position of power or control over the client. These provisions are sometimes misinterpreted to mean that such relationships should always be avoided. In actuality, the social worker must evaluate whether the relationship could have a harmful effect on the client. Dual relationships can be more difficult to avoid in rural practice. For example, the social worker may have to decide whether to shop at a store where a client works. Urban areas may offer several shopping alternatives, thereby solving the problem. Rural areas typically have fewer options.

INCLUDING RURAL SOCIAL WORK IN EDUCATIONAL CURRICULA

The professional policy statement on Rural Social Work approved by the 2011 NASW Delegate Assembly encourages all social work educational programs—whether rural, suburban, or urban—to offer instruction on the unique characteristics of social work practice with rural populations. This is encouraged as an issue of cultural competence in social work that mandates social workers to work effectively with individuals, families, groups, and communities of different cultural backgrounds, norms, and influences.

There are two additional reasons for including rural issues content in the social work education curricula. Rural people have a long history of relocating to urban and suburban centers for gainful employment. Close-knit rural groups have sometimes gathered in distinct neighborhoods or ghettos, where assimilation into their new culture is slow. At other times they have scattered to the winds, as it were, cut off entirely from their social support systems. In any case, the urban and suburban social worker with knowledge of rural cultures is better equipped to work effectively with displaced rural people.

Also, rural and inner-city people have reasons to work together to meet local needs. Congressional redistricting caused by population shifts to suburban areas in 2010 reduced the number of seats in Congress in urban and rural areas of the Northeast, Midwest, and upper Midwest (Bloch, Ericson, & Quealy, 2010). Both rural and urban areas tend to experience similar challenges, such as a lack of adequate health care and community services and the lack of a tax base sufficient to meet local needs. Public schools, libraries, and other infrastructure projects suffer as a result. Job opportunities and economic growth become more limited. Social workers can be instrumental in creating new coalitions among rural and urban people, groups, and communities to facilitate a congressional voting block to redefine how Congress reacts to both rural and inner-city problems.

A BRIEF HISTORY OF THE RURAL SOCIAL WORK PROFESSIONAL POLICY STATEMENT

Members of the National Rural Social Work Caucus have developed and advocated for professional policies that improve the social work profession's awareness of and support for rural issues, and that define elements of preparation for rural practice. These improvements have been achieved through participation in two professional organizations, the National Association of Social Workers (NASW) and the Council on Social Work Education (CSWE). NASW is the largest professional membership organization for social workers, while CSWE reviews, accredits, and sets standards for Bachelor of Social Work (BSW) and Master of Social Work (MSW) social work educational programs at colleges and universities.

NASW uses the member-driven democratic process to identify, analyze, and approve professional and social policy statements. Chapter representatives are elected to participate in the Delegate Assembly held every three years. Delegates consider, amend, and vote on the statements in much the same way a legislative body deliberates over a bill that is to become law. The decisions of the Delegate Assembly are binding on the association and its state chapters. The finalized professional and social policy statements are published by NASW in *Social Work Speaks* and widely disseminated. They influence the public image of the social work profession and also guide our messaging to the public and the nation about a wide variety of social, health, and public issues ranging from adoption to welfare reform. Professional policy statements provide direction to social work practitioners and educators on a wide range of practice issues. For example, there are statements to guide social workers working with special client groups, such as the elderly, children and families, and indigenous populations.

At the 1981 NASW Delegate Assembly, Caucus members created a vision and applied their energies to the achievement of a specific goal: adoption of the first professional policy

statement on *Social Work in Rural Areas*. The Caucus drafted and presented a statement to the Delegate Assembly for consideration. Observing how the Delegate Assembly operated, Caucus members quickly developed a plan to use the structure to support the statement's adoption. As the time neared to take comments on the proposed statement, Caucus members positioned supporters at several microphones in the hall to ensure that favorable comments were heard repeatedly and the statement was adopted. Primarily an educational tool for urban and suburban social workers, the 1981 professional policy statement encouraged NASW to advocate for rural human services issues, such as health care, diversity, poverty, and the environment in its legislative and social policy agenda efforts.

THE 2002 AND 2011 RURAL SOCIAL WORK PROFESSIONAL POLICY STATEMENTS[1]

The professional policy statement adopted by the 1981 NASW Delegate Assembly endured for 18 years. At the 1999 NASW Delegate Assembly, it was recommended for elimination as outdated and in need of revision. The statement's elimination from *Social Work Speaks* served as a call to action for Caucus members. The Caucus mounted an immediate effort to draft a revised statement.

In a meeting at the University of Texas during the 2001 Institute, Caucus members formed a working group to draft a new professional policy statement and submit it for consideration at the 2002 NASW Delegate Assembly. The new statement differed from its predecessor in that it concentrated on professional social worker roles and functions in rural practice, as well as the need to include rural practice issues in all social work education programs. In addition, it addressed unique ethical practice issues, cultural competency, and the need to use strengths-based approaches that consider a community's capacity and potential when working with rural populations.

The 2011 update continued the themes of the 2002 revisions. Both revised statements have made a case for viewing generalist social work practice in rural areas as requiring a combination of highly developed skills and applications, rather than as a grouping of core competencies. Regarding dual or multiple relationships, as addressed in the *NASW Code of Ethics*, the authors of the revised statements noted that because of special difficulties in managing client contacts and relationships in rural areas, an advanced understanding of the Code was required for effective rural practice. Education and practice competence for multicultural awareness, now commonly referred to as developing cultural competency, was also addressed. Finally, the statements from 2002 and 2011 encouraged taking a strengths- or asset-based approach to rural social work. In this approach, social workers identify and build on the natural assets and capacities of people and systems to help them achieve positive changes or outcomes. Focusing on assets requires that the social worker be highly observant and acutely aware of the unique cultural norms and values of rural people, their culture, and their social institutions.

[1] The Rural Social Work professional policy statement adopted by the 2011 NASW Delegate Assembly is included in Appendix A.

Discussion Questions

1. The Rural Social Work Caucus encourages the belief that rural practice differs from urban practice, and that all students of social work should be taught skills that help prepare them to work effectively with rural people. Discuss whether you agree that there are differences between rural and urban social work practice. Support your argument with examples of similarities or differences.
2. Ethical standard 1.06(c) of the *NASW Code of Ethics* describes dual or multiple relationships as occurring "when social workers relate to clients in more than one relationship, whether professional, social, or business." It is assumed that avoiding dual or multiple relationships is more challenging in rural areas. Discuss whether you agree with this assumption. Provide at least two reasons to support your argument.
3. The Rural Social Work Caucus is sometimes called an *organization by rumor*. Discuss the advantages and disadvantages of this type of organization.

Classroom Activities and Assignments

1. List two ways you would change the social work education curriculum to better prepare yourself for rural practice. Elaborate by adding at least two sentences of explanation for each item. Why would the changes you propose improve your effectiveness in working with rural people?
2. Imagine you are a rural social worker who helps place abused or neglected children into the homes of qualified foster parents. Describe a hypothetical dual or multiple relationship in which you could find yourself with a client or clients. How would you go about setting clear, appropriate, and culturally sensitive boundaries to manage the situation effectively?

Internet Resources

- Association of Social Work Boards: www.ASWB.org
- Council on Social Work Education: www.CSWE.org
- National Association of Social Workers: www.socialworkers.org
- Rural Policy Research Institute: www.RUPRI.org
- Rural Social Work Caucus: www.ruralsocialwork.org

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CHAPTER 3

Social Welfare and Rural People

From the Colonial Era to the Present

Paul H. Stuart

The United States was an agricultural nation before the 20th century; most people lived in rural areas. Consequently, most social welfare services were delivered in rural areas, and the nation's social welfare system reflected its rural social structure. The history of rural social welfare is, in part, a story of the transfer of the location and control of social welfare services from rural areas to metropolitan areas. During the 19th and 20th centuries, the proportion of Americans living in urban areas increased steadily. State governments and the federal government provided an increasing range of social services. More important, the states and the federal government funded and regulated many of the services delivered at the local level.

A parallel history involves the social development of rural areas. Abundant land and its rapid development characterized North America from the time of the European invasions of the 16th and 17th centuries until the early 20th century. Frederick Jackson Turner (1893), the most prominent American historian of the early 20th century, concluded that "the existence of an area of free land, its continuous recession, and the advance of American settlement westward, explain American development" (p. 1). The land had been taken from Native American groups, sometimes by purchase but often as a result of warfare, deceptive dealings, or simple dispossession. The Constitution gave the federal government plenary power to deal with the Indian tribes; thus, lands alienated from Indian ownership became part of the public domain. Congress followed a social investment strategy during the 19th century, characterized by human and social capital investments and the development of individual and community assets (Midgley, 1999). The strategy rested on a liberal land policy, which resulted in the rapid development of the West. That liberal strategy, some have suggested, provides a model for the developing world in the 21st century (deSoto, 2000).

Thus, two themes were important in the interaction of social welfare services and rural people. The financing and control of social services shifted as the population shifted from rural to urban areas, in a process that some social scientists have called modernization. In his examination of the real-life execution of Gary Gilmore, the novelist Norman Mailer referred to "Eastern" (or urban) and "Western" (or rural) voices to capture this transition (Mailer, 1979). Rural areas lost control of social welfare service delivery during the 19th and

20th centuries. At the same time, the economic and communal development of rural areas was an objective of national policy. Development implied the transfer of assets to prospective settlers and investment by the state or federal government in education, transportation, and community development. Thus, asset-building and social investment to meet the needs of emigrating native-born white and immigrant families dominated American social policy before 1900, often to the detriment of indigenous populations.

COLONIAL PERIOD

The British colonies in North America faced chronic labor shortages. Colonial landowners depended on the involuntary labor of slaves, convict laborers, and indentured servants. Land policy in many of the British North American colonies, however, was liberal. The availability of land on terms that made landowning feasible for ordinary people made British North America "the best poor man's country"—at least for Europeans—during the 18th century (Lemon, 1972). Thus, access to assets and asset accumulation explained much about the appeal of America even before independence.

Attempts to enslave Native Americans met with frustration, and colonial authorities turned to a variety of types of bound labor to counteract chronic labor shortages during the 17th and 18th centuries. "Bound" laborers were obligated to work for a master, either for a term of years or for life, in the case of African slaves. In addition to slaves, bound laborers included convict laborers, paupers from the streets of English cities, and indentured workers from the British Isles and the continent of Europe, who worked for a term of years to repay the cost of their passage from Europe to North America. Bound workers provided the labor that cut the trees, planted the crops, loaded the ships, and performed a variety of other jobs in the New World.

Competition for laborers with other European colonies around the world induced the colonial elite to create incentives to European settlement, including religious toleration and ready access to land (Baseler, 1998). Contracts for indentured service in the middle colonies often provided for land ownership at the conclusion of the period of indentured service. The prospect of land ownership provided a major incentive for prospective immigrants. According to a student of colonial era migration,

> Throughout the eighteenth century . . . European emigrants could choose from a variety of destinations for future settlement—America was far from the only choice. When prospects at home looked dim, the "pull" factors for selecting a particular destination tended to mirror the problems they sought to escape. Land, employment, and trading opportunities were strong lures, for they promised a decent living for colonists and their families. (Wokeck, 1999, p. 224)

Religious freedom, coupled with a land policy that made it relatively easy for recent immigrants to acquire land, created a powerful magnet for immigration. In a study of the social and economic structure of the colonies, Jackson Turner Main (1965) found four typical phases in development in the Northern colonies: a frontier phase, followed by subsistence

farming, commercial farming, and urbanization. Land was easy to obtain in the frontier stage: "Land prices . . . were low enough so that poor men could become farmers almost at once . . . [and] better land, which was of course more valuable, could always be obtained on credit" (p. 9). The Southern colonies were more varied, and the institution of slavery contributed to greater inequalities in wealth. However, in subsistence farming regions there was substantial equality. "Southerners had a disorderly way of settling without a land title," and many subsistence farmers evaded land taxes (p. 48).

A locality's level of development affected its social welfare programs. Following English practice, local rather than provincial governments provided the social and institutional services that existed. The Elizabethan Poor Law made poor relief a local responsibility. Colonial towns and counties devised programs for the poor and deviant that were appropriate for their level of social and economic development. In many rural areas, poor-relief arrangements were informal. Often, local authorities used households to deliver services by boarding the dependent poor (Guest, 1989).

Main (1965) found few differences in wealth or status during the frontier phase. Before the development of such institutions as poorhouses, jails, and hospitals, rural township or county authorities handled problems of poverty, frailty, and deviant behavior informally. Masters were responsible for providing care or discipline to their slaves or indentured servants. As a region moved from subsistence farming to commercial farming and towns began to develop, local governments developed some services in order to provide for more efficient handling of the increasing numbers of the poor that accompanied economic development. Poorhouses, jails, and, in some cases, schools and hospitals, operated by town or county governments, opened as a region entered its commercial farming or urban phase.

EARLY NATIONAL PERIOD

After the American Revolution, Congress invested in internal improvements and followed a liberal land policy that promoted settlement (Young, 1969). A land-rich and cash-poor federal government used public land sales to finance a variety of public projects, which were subsumed under the summary appellation "internal improvements" (Larson, 2001). These included transportation—roads and canals and later railroads—and schools, including common schools and state universities. Even before the Constitution, the Continental Congress laid out plans for developing the territory West of the Allegheny Mountains. The Land Ordinance of 1785 provided for surveying the public domain into six-mile-square townships. One square-mile section in each township was to be reserved for the support of the common schools. The Northwest Ordinance of 1787 provided for the organization of territories and their eventual progression to statehood, as did a similar ordinance enacted in 1790 for the territory South of the Ohio River. States admitted to the union after 1800 received grants of land to support state universities and other state services.

As the new nation moved westward, American pioneers created new social institutions on the frontier that were similar to those with which they were familiar. Thus, American frontier society and institutions resembled those found in the East (Berkhofer, 1964). The four phases of frontier society identified by Main (1965)—frontier, subsistence agriculture,

commercial agriculture, and, in some cases, urbanization—were to be repeated, with variations, as the new nation expanded westward.

During the first half of the 19th century, Congress repeatedly liberalized land policies to make it easier for individuals to acquire and work the land. A liberal land policy was based on a Jeffersonian ideal that emphasized the superiority of the yeoman farmer and the benefits of the family farm. Although land sales provided a major revenue source for the federal government, the pressure for liberal terms for land ownership proved irresistible. A series of land laws made land more accessible to ordinary people. In 1841, Congress enacted the Preemption Act, providing that squatters on the public land could claim their land after 14 months of residence. Payment of as little as $1.25 per acre secured their title. The Graduation Act of 1854 reduced the price per acre for land that had been unsold for a period of time. Land that had been on the market for a decade sold for $1 per acre. After 15 years, the price dropped to 75 cents per acre, after 20 years, to 50 cents per acre, and so on. Land that remained unsold for 30 years sold for $12\frac{1}{2}$ cents per acre (Hibbard, 1924).

In other laws, Congress provided free land for soldiers who fought in the Revolutionary War, the War of 1812, and the Mexican War. Because the benefit was often provided in scrip that could be exchanged for land, many veterans sold the scrip to speculators, who held the land for increased prices. These veterans' measures began a tradition of generous and selective benefits for veterans that continued with the Civil War Pensions and reflected a preference in American social policy for selective program entitlements (Jensen, 2003).

A more liberal land policy, often combined with provisions for internal improvements, facilitated the settlement and development of the Middle West. Between 1800 and the 1850s, settlers poured into the Ohio and Mississippi River valleys, the Great Lakes, and the old Southwest, the present states of Alabama and Mississippi (Clark & Guice, 1996). Substantial federal investment supported this expansion. The federal government purchased land from American Indians, fought wars against them, and ultimately removed them from lands that were soon to be occupied by white settlers. The system of frontier military outposts often provided the first markets for western farmers (Prucha, 1967). Appropriations for internal improvements supported the construction of roads, canals, and eventually railroads to facilitate the movement of settlers westward and the transportation of crops to market.

Towns and counties continued to provide basic social welfare services—namely, support for the dependent and mentally ill, increasingly in small institutions such as almshouses and poor farms. However, the campaigns of Dorothea Dix and others for expanded state services, usually institutional care, for specific categories of poor people—the mentally ill, the blind and the deaf, the developmentally disabled, children, and criminals—increased the power and prominence of state governments in the provision of social welfare services. As social welfare provision became more specialized, more of these programs targeted persons with identifiable physical, emotional, cognitive, or moral impairments, and states began to expand their social welfare activities. Although county and town services continued to be important as a first line of defense for the "undifferentiated poor," some state leaders argued the superiority of state services as opposed to the backward, often corrupt town or county services. Reformers charged that county officials awarded contracts to supporters and engaged in patronage, rewarding supporters and relatives with jobs. The theme of local government incompetence and corruption would become increasingly important after the Civil War.

THE CIVIL WAR AND AFTER

A half-century of agitation for a more liberal land policy culminated in the successful passage of four "Western measures"—the Homestead Act, the Morrill Land Grant College Act, the Department of Agriculture Act, and the Pacific Railroad Act—by the first Civil War Congress in 1862. The Republican Party had pledged to support two of the measures—the Homestead Act and the Pacific Railroad Act—in its 1860 platform, and President Lincoln had endorsed the other two during the 1860 campaign. Eastern Congressmen who were concerned about problems of soil exhaustion in their states promoted land-grant colleges and the agriculture department. The four measures determined the subsequent development of the Western United States to a much larger extent than anyone anticipated in 1862.

Between 1863 and 1912, the federal government distributed more than 239 million acres of free land to homesteaders (although settlers claimed final title to only 150 million acres). The states received nearly 100 million acres in land grants for agricultural and mechanical colleges, and railroad companies received nearly 350 million acres. The four Western measures were the culmination of an increasingly liberal land policy and embodied a social investment approach to the development of the Western United States (Midgley, 1999). The federal government distributed assets in the form of land to settlers and invested in research, education, and a transportation infrastructure through direct appropriations and land grants to states and railroads. Some have criticized the inconsistency of Congress in opening some lands to free settlement while granting other lands to be sold to support internal improvements (Gates, 1936). However, the four laws, as modified by subsequent legislation, were to provide the basic structure for the development of the Western United States (Bogue, 1969; White, 1991).

Congress created the Department of Agriculture "to acquire and to diffuse among the people of the United States useful information on subjects connected with agriculture . . . and to procure, propagate, and distribute among the people new and valuable seeds and plants" (Department of Agriculture Organic Act, 1862, p. 387). The department was to become a large agricultural research agency where new farming techniques, seeds, and fertilizers could be developed and tested. Initially, the agency's chief, the Commissioner of Agriculture, was not a member of the President's cabinet, but Congress raised the agency to cabinet status in 1889. However, scientific research lagged until President McKinley appointed James "Tama Jim" Wilson as Secretary of Agriculture in 1897. A graduate of Grinnell College and a former professor of agriculture at Iowa State College, Wilson remained in office until 1913, serving three presidents: McKinley, Roosevelt, and Taft. During his tenure, he expanded the department's scientific research, including experiment stations and laboratories, and its extension work.

Initially, land-grant colleges were intended to provide agricultural instruction to future farmers and the children of farmers. In some states, farmers objected to the fact that many faculty members preferred a traditional liberal arts curriculum. They feared that this preference would impede the goal of teaching "such branches of learning as are related to agriculture and the mechanic arts" (Cumo, 1998; Douglass, 1992). However, the lasting contribution of the land-grant colleges was their introduction of "useful knowledge" into the higher education curriculum, to accompany the classical studies (Geiger, 1998). At some of

the agricultural colleges, faculty began to provide information to farmers in brief institutes held in rural areas of the states, and faculty members at many of the colleges began to conduct agricultural research. In 1887, Congress passed the Hatch Act, to "aid in acquiring and diffusing among the people of the United States useful and practical information on subjects connected with agriculture, and to promote scientific investigation and experiment respecting the principles and applications of agricultural science" (p. 440). The Hatch Act provided funding to support agricultural experiment stations operated by the agricultural colleges (Kerr, 1981).

In 1890, a second Morrill Act authorized an annual cash appropriation (initially from the proceeds of land sales) to support the agricultural colleges. This infusion of cash "contributed to the rapid development of land-grant colleges . . . [most of which] received a total of $48,000 within 12 to 18 months" (R. L. Williams, 1998, p. 76). The second Morrill Act also authorized payments to separate institutions for African Americans in states that maintained segregated educational systems; the funds were to be "equitably divided" between White and African American institutions (Morrill Act, 1890, p. 418). Thus, Congress provided for "separate but equal" institutions six years before the *Plessy v. Ferguson* Supreme Court decision of 1896. The second Morrill Act resulted in the creation of the "1890 schools," historically African American institutions whose missions were similar to the White land-grant institutions. The Department of Agriculture failed to enforce the requirement that funds be "equitably divided," and the 1890 institutions continue to struggle with inadequate appropriations (Schuck, 1972; F. Williams, 1998).

The Homestead Act succeeded in distributing large amounts of land to settlers, who could claim 160 acres of free land upon payment of a small filing fee. Full ownership would be granted if the settler improved the land and lived on it for five years. The act extended homesteading to unmarried women and widows, to African Americans, to Native Americans who abandoned tribal membership, and to immigrants who declared an intention to become citizens. By 1897, more than 525,000 farms totaling more than 67 million acres had been created as a result of the act, making it the most significant asset distribution program in American history (Gates, 1968). Although the half million farms were home to more than 2 million people, the American population had increased by more than 32 million people during the same period (White, 1991), with the largest increases in urban areas.

Railroads were a necessary part of development in the late 19th century. The railroads carried the settlers west and delivered the farmers' agricultural products to market. The United States provided land grants to encourage railroads to construct lines, creating the Union Pacific Railroad in the Pacific Railroad Act of 1862. During the late 19th century, the federal government distributed much more land to railroads, either directly or through state grants for internal improvements, than it gave to settlers under the Homestead Act. Railroad corporations received more than 223 million acres of land, although they had to forfeit 35 million acres because of delays in completing the lines (White, 1991).

States began to centralize social welfare and correctional services during the late 19th century. Following Massachusetts's lead in 1863, many states created boards of charities and correction to organize state institutions on a businesslike basis. State social welfare provision expanded as state boards examined outcomes of institutionalization. Specialized mental health services, correctional services, and a variety of other institutional services were

provided under state auspice, rather than by towns or counties. Services administered by state governments were believed to be less patronage-ridden and corrupt than local services. The widely imitated New York State Care Act of 1890 gave the state responsibility for providing care to all of the insane poor (Dowbiggin, 1992; Trattner, 1999). In some states, commissioners visited township and county institutions and recommended improvements in local programs. Wisconsin went even further, mandating that counties provide care for chronically mentally ill residents in county institutions (Ebert & Trattner, 1990).

THE PROGRESSIVE ERA

By the 20th century, the United States had become an urban nation. Urban population, which had been only 25% of the total in 1880, increased to 40% in 1900 and to 50% of the population in 1920 (see Table 3.1). Even with increased urbanization, the years between 1901 and 1913 represented the heyday of homesteading, as an average of 78,000 persons per year claimed homesteads, compared to 37,000 per year between 1863 and 1900 (Nugent, 1999). Despite agricultural expansion, rural areas began to be seen as problem areas. In comparison to cities, rural areas had fewer specialized services and less economic opportunity. Following European precedent, in 1908 President Theodore Roosevelt organized a Country Life Commission. The Commission celebrated rural life but criticized the "self-defeating individualism of the farmers themselves" (Rodgers, 1998, p. 334). It called for the development of cooperative enterprises and focused attention on the problems of farm wives and the difficulty of keeping children on the farm. The commission resulted in the Country Life Movement, a national effort to reform the rural family and the rural community. The new discipline of rural sociology arose to describe rural family and community life (Martinez-Brawley, 1981; Rodgers, 1998).

Although social reformers focused primarily on urban problems, they had discordant ideas about rural life. Two distinctly different themes characterized thinking about rural communities in the early 20th century. For many, the rural community provided the image of ideal community life. In this view, strong bonds of friendship and even stronger family relationships resulted in an ethic of mutual assistance that softened the difficulties of rural life. These reformers viewed rural life as the solution to urban social problems: Introducing

Table 3.1 Percentage of Urban U.S. Population, 1800–1920

Year	Percentage Urban
1800	6.1%
1830	8.8%
1860	19.8%
1880	26.3%
1900	40.2%
1920	51.4%

Source: Bureau of the Census (1975), Series A 57–72.

mutual support and self-reliance, they believed, would help resolve urban social ills (Mills, 1943). The "orphan train" movement, which placed New York City "street urchins" on Midwestern farms between 1853 and the eve of the Great Depression, provided an example of this view of rural life (Holt, 1992).

Other social reformers viewed rural communities as problem areas. More poverty-stricken and backward than urban areas, excessively individualistic, and lacking adequate remedial services, rural areas were themselves "in crisis." In the eyes of these social reformers, rural communities, especially in the South, were viewed as a significant social problem (Sealander, 1997). For some, presumed rural backwardness was an inherent part of the nature of rural communities. Others believed that urban development had resulted in the deflection of rural resources to cities.

Although reformers could cite evidence for both contradictory impressions of rural community life, neither view described the reality of life in the rural United States. One view idealized the rural community, whereas the other was too pejorative. Yet the varying ideas about rural communities had implications for how and when reformers got involved in providing services in rural areas. Were rural areas models for the cities? Had they been underdeveloped as a result of urbanization? Or were their problems the result of inherent rural backwardness and a lack of resources?

Some reformers wanted to make farms more efficient. They reasoned that the decline in rural population resulted from inefficiencies of the family farm. This group of reformers promoted farm demonstrations and agricultural extension programs. In addition, they believed that improved health and education services would help eradicate both disease and ignorance from the countryside. Philanthropic foundations, including the Rosenwald Fund and the Rockefeller Foundation, supported the extension of education and health services to rural populations, especially to underserved rural African Americans in the Southeast.

By the first decade of the 20th century, the federal government was heavily involved in agriculture, mostly through federal-state programs (Hamilton, 1990). In 1906, Congress enacted the Adams Act, which increased federal funding for agricultural experiment stations and required that they engage in "original research" (Rosenberg, 1964). The Smith-Lever Act of 1914 authorized appropriations to support agricultural extension work carried out by the land-grant colleges. States that had segregated land-grant colleges established by the second Morrill Act were free to allocate extension services as they saw fit between the White and African American institutions. The result was to perpetuate segregated and unequal services, as southern states created dual and unequal extension services for African American and White farmers (Schuck, 1972).

A major agenda of the progressive era was the expansion of state regulation and state social welfare services. Social workers campaigned for the children's code, a codification and expansion of state laws that included mothers' pensions and juvenile courts, as well as child labor restrictions and compulsory school attendance laws, and other state social welfare measures (Clopper, 1921). However, the reforms were often limited to urban areas. For example, Missouri's mothers' pension law, the first in the nation, applied only to St. Louis and Kansas City when it was enacted in 1911. State social welfare legislation had the potential to influence rural areas by establishing standards for children and families, but often

it was only potential. Problems of funding, inadequate resources, and rural resistance frustrated reform efforts in rural America.

WORLD WARS, PROSPERITY, DEPRESSION, AND PROSPERITY AGAIN

The farm population peaked at 32.5 million in 1916 and then began a decline that continued through the 20th century. Mechanization, farm tenancy problems, drought, and expanding opportunities in the cities took their toll even before the agricultural depression of the 1920s that preceded the Great Depression of the 1930s. New homestead filings peaked in 1913; during the 1920s, homesteading dwindled. In 1934, the Taylor Grazing Act closed most of the public domain to homesteading (Nugent, 1999).

During World War I, the American Red Cross organized the Home Service, a national social service program. Red Cross workers attempted to link servicemen, many of whom were away from home for the first time, with their families on the home front (Black, 1991). For the first time, social workers attempted to organize services in rural areas as well as in cities. Several social workers who were to be associated with rural services in the 1920s and 1930s, notably Josephine C. Brown, began their professional careers in the program (Davenport & Davenport, 1984; Martinez-Brawley, 1981).

Drought and agricultural depression in the 1920s accelerated the move to the cities that began during World War I. The war ended large-scale immigration as the buildup of wartime industry created new demands for workers. Immigration legislation in 1924 severely limited immigration from Eastern and Southern Europe, creating new industrial employment opportunities for domestic migrants who had been displaced by the agricultural depression or were fleeing rural poverty. Rural states in the Great Plains lost population as homesteaders abandoned their claims and sought wage work. African Americans and poor Whites left the South, moving to Eastern and Midwestern cities in search of economic opportunity.

For social workers, public welfare seemed to have come of age during the 1920s. As one social work executive put it, they had witnessed a "transition from charities and correction to public welfare" beginning in 1910 (Kelso, 1923, p. 21). In 1929, social work educator Porter Lee declared that social work, once "a Cause . . . a movement directed toward the elimination of an [e]ntrenched evil," had become "a Function of well-organized community life" (p. 3). The children's code movement succeeded in state after state, and state child welfare laws extended social services into even the most isolated rural areas. States from Alabama to Minnesota established county child welfare boards to enforce child labor and school attendance laws, to establish juvenile courts and juvenile probation services, and to provide support to dependent children (Burson, 2001; Hodson, 1921).

During the Great Depression of the 1930s, rural areas, which were already hit hard by the agricultural depression of the 1920s, suffered even more than the cities. New Deal planners addressed rural problems. A Division of Rural Rehabilitation within the Federal Emergency Relief Administration encouraged community gardens and other self-help measures, while the Agricultural Adjustment Administration sought to support the prices of agricultural products. New Deal power-generating projects, including the Tennessee Valley Authority,

Boulder Dam, and projects on the Missouri and Columbia Rivers, provided electric power to rural Americans organized by the Rural Electrification Administration (Schlesinger, 1958). The Social Security Act of 1935 addressed rural problems in two ways. First, the law established three public assistance programs—Old Age Assistance, Aid to Dependent Children, and Aid to the Blind—and required states to provide these programs to persons living in all political subdivisions of the state, not merely in urban areas. The Act also established several social service and health programs, such as Child Welfare, Maternal and Child Health, and Crippled Children's Services. Congress required states to target children living in rural areas when planning services provided under these programs.

World War II resulted in a resumption of large-scale migration from rural areas to cities, as the defense buildup created a demand for workers who had previously been excluded from the industrial labor force—women and rural people, including African Americans, Whites, Hispanics, and Native Americans. After the war, the GI Bill provided opportunities for vocational and higher education to veterans from rural as well as urban backgrounds, providing many with entry to the middle class. The homeownership provisions of the GI Bill, combined with the improvement of road systems, facilitated the development of suburbs surrounding central cities. The postwar arms race with the Soviet Union provided continuing employment for defense workers, including many returning veterans. Postwar prosperity fueled an industrial expansion that stimulated continued urban growth.

Rural areas seemed less isolated as an interstate highway system replaced the railroad as the major linkage between farmers and markets and between the countryside and cities in general. The Hill-Burton Act of 1946 stimulated the construction of hospitals in rural areas, increasing the availability of health services. Advances in communication, radio and more important television, seemingly reduced the isolation of rural areas even while replacing homemade recreation with mass entertainment. By the end of the 20th century, the computer and the World Wide Web brought information and entertainment to rural schools, libraries, and homes. Advances in marketing, such as the franchise fast-food restaurant and the retail super center, made a wider range of products available to rural people even as they threatened to homogenize rural life.

RECENT DEVELOPMENTS

By the 20th century's end, rural areas had higher rates of poverty than urban areas, and the nation experienced "a rural crisis of severe proportions" during the 1980s that continued into the next decade (Martinez-Brawley, 1988). The highest concentration of poor Americans was found in rural areas in the Southeast and the Southwest, notably the Southeastern "Black belt," the Appalachian mountain region, the Rio Grande Valley and the Texas Gulf Coast, and the Southwest's Native American reservations. Rural poverty was often exacerbated by an absence of jobs for all seeking employment, a lack of high-paying jobs, inadequate health and social services, and inferior schools (Flynt, 1996).

Contemporary observers, like those of the Progressive Era, noted a relative lack of general resources and inadequate and inaccessible community agencies in rural communities. Consolidation of social service agencies left many rural people without nearby services.

Others noted a tendency for urban areas to drain resources from rural areas. The result for social service providers included large caseloads and insufficient staff and resources (Ray and Murty, 1990). For example, in a survey of 61 rural child welfare workers, Ray & Murty (1988) found that more than 80% of all clinicians surveyed perceived a lack of trained counselors or resources to deal with the problem of child sexual abuse. Only 48% of those providing services thought child sexual abuse victims were receiving good services. The rating of problems by agency staffs showed a pattern of staff shortages, lack of resources, and increasing caseloads among all three types of rural agencies. Other problems included poor interagency coordination, lack of community support, and problems stemming from societal denial of sexual abuse (p. 1).

Privatization compounded the problems of rural social welfare. Reimbursement systems often favored urban service providers. Egan and Kadushin (1997) found that "the prospective payment system [used to reimburse health care providers] . . . differentially reimburses rural facilities at lower rates than urban facilities," resulting in severe cost constraints (p. 1). Rural communities also had relatively fewer after-care resources than urban areas. Rural areas could also be characterized by the presence of certain resources that are not easily available in urban areas. Rural practitioners made use of natural helping networks, including extended kinship systems, lodges, and churches (Patterson, Memmot, & German, 1995; Sundet & Mermelstein, 1984). Distinctive cultural aspects of rural areas were also relevant to rural practitioners. Jones (1981) found that "social workers in rural midwestern areas such as Iowa must consider distinctive characteristics of the poor in those areas to help clients within the framework of family and community." These important characteristics included

> the presence of father in family, residence in small towns with a single industry, presence of high numbers of female elderly, community skepticism of social welfare programs and denial of poverty conditions, independence and rugged individualism as societal values, distant or nonexistent social services, intolerance of difference, predominance of primary or kin relationships, lack of anonymity, less mobility, [and] more stigmatization. (Jones, 1981)

Jones (1981) also emphasized the importance of a "generalist, autonomous, and self-directed" social worker who "needs to be creative in developing resources, and must provide a very personal type of service." Religion was important in many rural communities. Johnson (1997) found that "spirituality and religion are very important components in the rural community, providing strength, support, and simultaneous integration for the individual to the collective population."

Despite the relative prosperity of the 1990s, many rural areas lagged behind or even deteriorated economically vis-à-vis metropolitan areas (Wimberley & Morris, 1997). Although some rural areas became popular vacation and retirement centers, not all rural residents benefited from this demographic change. The influx of "new residents" sometimes caused the dislocation of less-affluent rural residents. Other areas have continued to lose population, as the continuing mechanization of agriculture results in demands for fewer workers, and alternative ways of earning a living have been slow to emerge. Although federal programs from the New Deal to the 1980s had expanded the supply of health and social

services in rural areas, privatization and mergers and consolidations of private and semi-public social service providers threatened to drain rural areas of available services.

By the start of the 21st century, the transfer of the location and control of social welfare services from rural areas to metropolitan areas seemed complete. Ironically, the devolution of social welfare services to states and private entities seemed to accelerate this trend rather than reversing it. Block grants, including the Temporary Assistance to Needy Families (TANF) Block Grant of 1996, shifted power from the federal government to the states, but states have not generally empowered local governments in rural or urban areas. Privatization has often meant consolidation, as private and semi-private contractors sought to maximize economies of scale.

As the proportion of Americans living in urban areas has increased, nostalgia about rural areas has grown. Much of the appeal of suburban and exurban areas derives from this nostalgia but ignores the challenges faced by many rural Americans. Yet a contemporary equivalent of the "Western measures" of 1862 to develop rural communities has not as yet been developed. Such a social investment approach would combine asset building and job creation with investments in education, research, and transportation. Developing such an approach may be the key to revitalizing rural communities in the 21st century.

Discussion Questions

1. Local governments controlled and financed social welfare services during the Colonial and Early National periods of American history. The growing importance and wealth of urban areas resulted in a shift of financing and control from local governments to state and federal governments. As Norman Mailer might say, Eastern voices became more prominent than Western voices. Is it possible to envision another scenario, one in which rural areas maintained control of social welfare services? Would the results have been beneficial for rural communities and for the consumers of social welfare services? Why or why not?
2. Rural areas presented a dilemma for social reformers during the Progressive Era—one that is not unfamiliar today. On the one hand, rural areas provided a model of the good society, cooperation, strong family ties, and community integration. On the other hand, rural areas were viewed as corrupt and patronage-ridden, characterized by a paucity of services and an abundance of social problems. In the bleakest view, urban growth had drained the best and the brightest members of rural society, leaving a residue of unproductive people and intractable problems. Which view or combination of views about rural society is the most accurate? What are the implications of the varying views for crafting solutions to social problems in rural areas?
3. Recent years have seen the devolution of power from the federal government to the states, as Congress has "returned" authority for many decisions about social welfare services to the states (often reducing federal budget commitments in exchange for greater flexibility). However, states have not in turn devolved power and authority to local governments. Would such devolution be desirable or not? What would the consequences be for rural communities and for the consumers of social welfare services? Why?

4. A contemporary equivalent of the "Western measures" of 1862 may be required to revitalize rural communities in the 21st century. Such a social investment approach would combine asset building with investments in education, research, and transportation. How might such an approach be developed today?

Classroom Activities and Assignments

1. Investigate the patterns of early land acquisition in your area. When was the county or region first occupied or organized by European Americans? How did the first occupiers of the land secure title to their lands after the region was organized as a colony, territory, state, or reservation? What assistance did early residents receive? Was the distribution of wealth relatively equal or unequal? Sources for your investigation might include published local and state histories, the local or state historical society, a local public library, and the university archives (if it collects information on local history).
2. Describe one aspect of late-19th-century social investment in rural areas. Take either homesteading, collegiate education in agriculture, agricultural extension services, agricultural research, or investment in transportation and show how and to what extent the activity contributed to the development of rural communities and the welfare of rural people. What lessons does the experience provide for contemporary efforts to revitalize rural communities? Sources for your investigation might include contemporary reports of relevant government agencies, accounts of beneficiaries of the programs, other contemporary comment, and academic research that attempts to assess the contribution of the program.
3. Today's "new federalism" represents an attempt to "return" authority for decision making about social welfare services to the states and local communities, where it was originally lodged (at least in common belief). Investigate the implications for rural areas of the devolution of power from the federal government to the states using at least two of the following websites:
   - Assessing the New Federalism (The Urban Institute): www.urban.org/Content/Research/NewFederalism/AboutANF/AboutANF.htm
   - Association for Community Organization and Social Administration: www.acosa.org
   - Influencing State Policy: www.statepolicy.org
   - National Rural Social Work Caucus: www.ruralsocialwork.org

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CHAPTER 4

Out of Sight, Out of Mind

Rural Social Work and African American Women at Efland Home for Girls, 1920–1938

Tanya Smith Brice

Asset-building activities have long been used in an effort to alleviate poverty among communities of people. Asset-building activities typically include acquiring savings and retirement accounts and home ownership, as a means to secure stability over a generation or more. Sherradan and Gilbert (1991) posit that the building of assets, or resources, is more effective than income building in antipoverty efforts. Social capital, a key component of asset-building interventions, consists of the resources developed by relationships of trust and cooperation among people (Warren, Thompson, & Saegert, 2001). These include all of the potential resources in a community, such as financial resources, talents and skills of individuals, the capacity of organizations, political connections, and buildings and facilities (Page-Adams & Sherraden, 1997). Asset-building activities have received a great deal of scholarly attention since the 1990s, but these activities have historical antecedents.

Women have played a major role in asset building through volunteerism. Middle- and upper-class women historically have been instrumental in the development of asset-building activities through the development of programs such as child welfare institutions and acculturation activities for new immigrants. For instance, the Charity Organization Society was one of the earliest social work organizations in the United States. This largely urban organization relied heavily on middle-class women, who volunteered to "bring middle class values into an immoral environment" (Gittell & Shtob, 1980, p. s68). Although these women focused on White, native and non-native, populations, African American women focused primarily on asset-building activities in African American communities. These women mobilized resources and organizations from within the African American community to address the needs of the poorest of that community.

African American women, through organized women's groups, mobilized churches, social groups, business leaders, and other philanthropists to support efforts to improve the lives of the most vulnerable community members. The National Association of Colored Women (NACW), founded in 1896, was the most prominent of these organized women's

groups. Representing middle- and upper-class African American women in 40 states, the NACW was a reflection of the national trend of clubwomen's groups that developed in response to growing social welfare concerns (Salem, 1994). The NACW exemplified the theme of social uplift through their motto "Lifting as We Climb." It was critical to African American clubwomen that the circumstances of their lower-class sisters be improved in order to improve the circumstances of the race as a whole.

Progressive Era clubwomen were concerned that racism would impact the need for social services and the quality of those services. As a result, clubwomen developed a national reform network to demonstrate the ability of African American women to effectively meet their community's growing and complicated needs. This resulted in a private social welfare system for African Americans that included orphanages, old-age homes, kindergartens, homes for working girls, homes for wayward girls, as well as other programs (Hodges, 2001; Lerner, 1974; Salem, 1994).

The ultimate goal of the African American clubwomen's movement was to rise above the social and political injustices of the time by achieving social, spiritual, and political uplift by developing valuable assets, that is, their own social welfare institutions (Billingsley & Giovannoni, 1972; Cook, 2001; Lerner, 1974). Clubwomen were instrumental in creating a social order through their meticulous attention to education, benevolence, and social graces (Cook, 2001; Gilmore, 1994; Hodges, 2001; Salem, 1994). This chapter focuses on the asset-building activities of African American women in a rural North Carolina community.

FEMALE DELINQUENCY

The Progressive Era is characterized by Victorian standards of morality (Carlson, 1992; Morantz, 1974; Peterson, 1984), which placed women under particular scrutiny. Any outward display of sexuality could result in a young woman being deemed delinquent. Women were considered the standard bearers of morality and were figuratively placed on a "pedestal of true womanhood." Immoral behaviors displayed by men and children were often viewed as a result of the woman's inadequacies.

These attitudes negatively impacted African American women. African American women, who were often characterized as "morally obtuse," "openly licentious," and as having "no immorality in doing what nature prompts" (Gutman, 1976), were often held responsible for the negative stereotypes of the race. It was widely believed that there was "no room on the pedestal for the southern Black lady. Nor could she join her White sisters in the prison of 'true womanhood'" (Hines, 1989). To further illustrate the relationship between womanhood and race, a journalist wrote the following in the March 17, 1904, issue of the *Independent*, a popular Northern and liberal periodical of this era:

> Degeneracy is apt to show most in the weaker individuals of any race; so Negro women evidence more nearly the popular idea of total depravity than the men do. They are so nearly lacking in virtue that the color of a Negro woman's skin is generally taken (and quite correctly) as a guarantee of her immorality. . . . And they are evidently the chief instruments of the degradation of the men of their race. . . . I

> sometimes read of a virtuous Negro woman, hear of them, but the idea is absolutely inconceivable to me. . . . I cannot imagine such a creation as a virtuous [B]lack woman. (Anonymous, 1904; Scott, 1990)

This sentiment is typical of the characterization of African American womanhood. This is the context for the work in which African American clubwomen engaged in rural social work practice through the Efland Home. There were homes established all across the United States, particularly in the Northeast and Midwest, for young girls who were considered sexually delinquent, or "wayward," but rarely did any of these homes accept African American girls (Abrams & Curran, 2000; Brenzel, 1975; Peebles-Wilkins, 1995; Sedlak, 1982). Furthermore, Folks (1902) found in his study of the state of care for vulnerable children that there were no homes for these young girls in the South. Consequently, young African American girls adjudicated as delinquent by these societal standards and public policies were subject to the harsh penitentiary system, particularly those young girls in the South.

GIRL-SAVING EFFORTS

The North Carolina Federation of Colored Women (NCFCW), an affiliate of the NACW, was founded in 1909. This organization was instrumental in developing programs and services for African American girls, through the founding of the North Carolina Industrial Home for Colored Girls, also known as Efland Home. Through program development and service provision, these women demonstrated their ability to clearly identify problems that affected the African American community.

In North Carolina, there was no state institution for African American girls who had been adjudicated as delinquent until 1943. However, North Carolina's juvenile courts handled approximately 192 cases annually, involving African American girls, between 1919 and 1939. These girls were placed on probation or returned to their communities "without benefit of any form of vocational training and rehabilitation" (Bost, n.d.). For those infractions labeled as serious crimes, other than moral crimes, African American girls were sent to adult penitentiaries. A North Carolina juvenile and domestic relations court judge expressed frustration with this lack of services to African American girls, saying:

> In my work as Judge of Domestic Relations Court which includes juvenile jurisdiction, my hands are completely tied in dealing with delinquent Negro girls and the absence of any institution, I am convinced [this] encourages delinquency. (North Carolina Board of Public Welfare-Institutions and Corrections, 1920)

The county superintendents of public welfare also expressed frustration with the lack of placement options for African American girls. In an undated note, a representative of county superintendents wrote that there is a:

> . . . consensus of opinion of superintendents of public welfare that something should be done for Negro girls. Superintendents of Public Welfare in North Carolina have to deal with delinquent boys and girls of both races. They always want to be fair

> to all and feel very much handicapped when we reach the end of our row in using local resources. If Negroes, who want professional training, are entitled to provisions for such training in state supported colleges surely the less fortunate Negro girls who needs [sic] training to prevent their continuing a life of delinquency, is entitled to some consideration. (North Carolina Board of Public Welfare-Institutions and Corrections, 1920)

Although these public welfare employees could clearly see the extreme need and the service gaps, little formal action was taken. African American clubwomen were moved to establish programs to meet the needs and to fill the gaps. In 1911, Dr. Charlotte Hawkins Brown, prominent clubwoman and president of the NCFCW, began a campaign to establish a home for these girls (Beasley, 1919; Moore, 1919). The NCFCW purchased 147 acres of land in Efland, North Carolina, for the purpose of building a facility to house delinquent African American girls. Efland is a rural, unincorporated town between Durham and Greensboro, North Carolina.[1]

Efland Home began accepting African American girls as "inmates" in October 1925. The stated purpose of Efland Home was "to save the young Negro girl who is on the verge of wasting her life." Efland Home served as a mechanism by which "to give her a second chance." The underlying mission of Efland Home was to "save Negro womanhood and we shall hope to surround these girls with the spirit of Jesus whose memorable words were 'Go in peace and sin no more'" (North Carolina Industrial Home for Colored Girls, 1925). Efland Home was governed by a board of trustees made of 7 to 13 prominent clubwomen from around the state of North Carolina (Brice, 2012).

Efland Home accepted African American girls under the age of 16 on referral from the North Carolina Board of Public Welfare (NCBPW) and the county juvenile courts. In addition to the NCBPW and the county juvenile court, Efland Home's board and the local community also participated in the admission process. The NCBPW identified a potential candidate for Efland Home and would make a written presentation of the candidate to the home's board of trustees. Potential candidates were those who were identified as problems in the community, and who generally exhibited immoral characteristics. Consequently, many of these girls were put out of their homes, with no placement alternatives. The board's admissions subcommittee would determine if the candidate was suitable for Efland Home. If she was considered suitable, the NCBPW would petition the juvenile courts for commitment orders to Efland Home. Upon admission, the young girl was paroled to the custody of Efland Home (Benton, 1931).

The board of trustees planned for Efland Home to train young girls to provide domestic services in the state's various institutions. African Americans were expected, and often legally relegated, to provide domestic and agricultural labor in the South. The training provided at Efland Home was intended to be consistent with the social mores of the times. There was a need for African Americans to provide domestic services such as cleaning, cooking, and serving, as the state established racially segregated facilities for its African American citizens, such as the NC Orthopedic Hospital, Gastonia; the NC Sanatorium for the Treatment of

[1] Efland, NC, is approximately 18 miles west of Durham, NC, and 37 miles east of Greensboro, NC.

Tuberculosis, Montrose; and the State Hospital at Goldsboro. In the organizational plan, the board wrote the following:

> The school should be made a center for the scientific re-training and education of juvenile delinquents and in considering the expansion of the industrial school program, potential opportunities for practical training in institutional service should not be lost sight of. Eventually this School should be used as a training center for institutional workers. (North Carolina Board of Public Welfare-Institutions and Corrections, 1920)

This specialized training further strengthened the need for such a home for African American girls, as well as demonstrated the benefits of such a home to the state. The founders of Efland Home identified academic training as an asset. The goal of Efland Home was to "enable the inmate to prepare themselves for efficient service in obtaining a livlihood [sic]" (Efland Home Charter, 1925). To ensure that these young girls could obtain a livelihood, Efland Home provided a curriculum with elementary school courses and industrial courses. The girls received 261 days of instruction annually. The academic instruction took place in the morning hours, and the industrial instruction took place in the afternoons. Many individuals, organizations, and local Historically Black Colleges and Universities (HBCUs) were instrumental in providing consultation to Efland Home, particularly in curriculum development. The impressive list included the following: Nathan Newbold, the state's first director of the Division of Negro Education, Department of Public Instruction, Raleigh; Miss Margaret Edwards, a teacher in Raleigh; C. K. Hudson, State College, Raleigh; North Carolina A&T, Greensboro; and Teachers College, Winston-Salem. These supporters were also instrumental in the training of teachers to work at the home.

Like many early training schools located in rural areas, Efland Home had a working farm. The inmates were expected to participate in all aspects of growing and preparing food. For instance, in 1928, the inmates consumed 580 gallons of "fresh cow's milk," having produced 478 gallons at the home's dairy. Of the 149 acres of land purchased for Efland Home, the inmates cultivated 10 acres, producing vegetables and fruit for sustenance. The inmates also prepared and canned vegetables and fruit for future consumption. According to a 1929 report from Chairwoman Bickett, Efland Home was able to:

> . . . raise much of the provisions, and vegetables and fruit are put up by the girls at the Home. They have two cows, a mule, 100 chickens, 4 hogs and two pigs. 24 fruit trees have recently been planted out. The girls help with the farm work with the assistance of their foreman. The girls pick cotton, and do other things under strict supervision and in this way earn a large part of their wardrobe. (Bickett, 1929)

The Progressive Era's recreation movement was an effort to provide organized recreational activities to children as an effort to prevent juvenile delinquency (Cavallo, 1981; Rosoff, 1999). As influenced by this movement, Efland Home provided recreation activities for its inmates. These activities included swing ball, croquet, jumping rope, basketball, as well as other games. Recreation activities were provided under the direct supervision of the teacher or matron.

Religious instruction was also a fundamental aspect of the life at Efland Home. The young girls were required to attend church services every Sunday afternoon at the home, to participate in morning and evening prayers, and to attend weekly prayer meetings.

Because Efland Home was not a state-supported institution, it relied heavily on charitable donations to meet operational needs. The board maintained meticulous financial records of expenses and income to the home. To meet its $6,000 annual operational budget (Pearson, 1929, 1931), Efland Home received support from social clubs, Sunday school groups, fraternities and sororities, as well as from individuals from African American communities across the state (Pearson, 1926, 1927, 1928). The NCFCW, and its White counterpart, the North Carolina Federation of Women's Clubs (NCFWC), also provided ongoing financial support. Furthermore, the staff and board members were frequent donors. Donations ranged from $1 to $100, and the average donation was about $25. Efland Home also required that each county pay $5 per month for each inmate sent to the home (Futtrell, 1934; Johnson, 1925; Taylor, 1934). Although the smaller counties had difficulty meeting these financial demands, the larger counties made consistent payments (Futtrell, 1934; Taylor, 1934).

These financial donations were supplemented by in-kind donations, such as the donation of farm animals, dishes and utensils, maintenance services, and clothes for the inmates (Pearson, 1926, 1927, 1928). Members of the African American community often lobbied Whites for in-kind donations to the home, although the requests were only granted after verification from White state officials. The following letter from a social worker at Duke University to Lily N. Mitchell, director of Public Welfare, demonstrates this exchange:

> One of our colored orderlies has asked me to help him get some clothes and other things for the children in the Efland Home run by "Mr." and "Mrs." Pearson. Do you know about this place and if they are worthy? If so, I think I can assist him in the work as he is very much interested and wants to do something for the children. He says there are eleven there, ages five to thirteen. (Hobgood, 1934)

This letter exemplified the diverse endorsement from the African American community for the maintenance of the home. It also exemplifies the level of support sometimes provided by Whites. Even with these valiant efforts, Efland Home continued to struggle with meeting its operational budget. The home was forced to close its doors in 1939 due to these financial deficiencies.

EFLAND HOME AS AN ASSET

Efland Home was an asset-building institution. African American girls who were considered delinquent were perceived as undesirable by policy makers, public welfare workers, and their community. The issues of these young girls were largely ignored. By the time Efland Home was established in 1925, North Carolina had already invested in meeting the needs of delinquent boys of both races and White girls. There were no plans to establish a facility for African American girls, although the court system was inundated with cases involving this population (North Carolina Board of Public Welfare-Institutions and Corrections, 1920).

Dr. Charlotte Hawkins Brown and the women of the NCFCW addressed the needs of delinquent African American girls in the state of North Carolina by establishing Efland Home. These women used their talents to provide resources for their target population. The women of NCFCW were educated women who were teachers, musicians, lawyers, and entrepreneurs (Brice, 2007). They were leaders in their churches and communities. These women used their social capital to encourage community members to make financial and in-kind donations, as well as to donate their specialized skills to the efforts at Efland Home. These community members ranged from the leaders at North Carolina Mutual Insurance Company, the only African American–owned insurance company in the country, to university presidents, to laborers. In addition, they used their social capital to engage state-level policy makers in ongoing discourse about the needs of this population.

Middle-Class Values as an Asset

Delinquency among African American girls was largely seen as sexual delinquency. The contraction of sexually transmitted diseases, particularly syphilis, was seen as evidence of sexual delinquency. Sexual delinquency was commonly viewed as a lower-class phenomenon (Brice, 2005; DuBois, 1913; Hazen, 1937). This is evident in an observation by Dr. Henry Hazen, a Howard University College of Medicine professor who wrote,

> There are absolutely no records of any real value regarding the prevalence of syphilis among the Negro teachers, professional men, business men, or students. However from a long experience with this class the author knows of very few instances. (Hazen, 1937, p. 13)

Dr. Hazen was a prominent African American physician who specialized in the study of sexually transmitted diseases among African American populations. In addition, Dr. Hazen was also a prominent member of the upper-class African American community, and the views he expressed were commonly expressed among the upper classes about the lower classes. In addition to sharing these views, the women of NCFCW saw delinquency among African American girls as a reflection of all African American women. In a call to the middle- to upper-class African American women of North Carolina, Dr. Charlotte Hawkins Brown penned the following letter in the *Asheville Daily News* (Brown-Moses, 1923):

> There is no better opportunity given to our women for self-expression than through this medium which strikes at the very roots of a great social evil, namely, the wasting of the womanhood of the race, through neglect to take the initiative in providing some means of saving the girl in her teens who is without a vision and the easy prey of evil seekers.

Brown exemplifies the sentiment that building the assets in delinquent young girls builds assets among all African American women and the entire African American community. Consequently, these women created opportunities to model middle-class values for the Efland Home girls, as a means to prevent further delinquency.

Job Training as an Asset

The Efland Home curriculum focused on developing work ethics that would result in each young girl having domestic skills to maintain a middle-class home. They were given the opportunity to develop skills that would enable them to seek gainful employment, as well as to maintain a morally respectable lifestyle. These skills were instrumental in reducing recidivism rates among these girls, further decreasing the inclination to engage in future delinquent behaviors.

Efland Home provided a respite to the families of these troubled girls. Whereas, before Efland Home, delinquent girls were often returned to the community with no treatment, or sent to the harsh penitentiary system, this home provided services that equipped the girls with necessary life skills. So, while many of these girls did not return to their home of origin, these skills provided a peace of mind to the families that their daughters, sisters, nieces, and so on would be able to live a moral and wholesome lifestyle (Brown, 1930; Johnson, 1921; North Carolina Industrial Home for Colored Girls, 1925, 1931). In a 1931 Efland Home brochure, this process is described as "knowledge with efficiency is what will aid in transforming the idle mind into a fertile field for the production of healthy, happy, clean thinking." The brochure further claims that most of the girls paroled from the home "are able to earn a living and to become useful members of their communities" (North Carolina Industrial Home for Colored Girls, 1931).

Spirituality as an Asset

The women of NCFCW were confident that a spiritual foundation would serve as a preventative tool for further delinquency or victimization (Brice, 2012). African American clubwomen were motivated by their religious convictions to engage in these efforts. Mary Church Terrell, the first national president of the NACW, wrote,

> But in connection with such work, let us not neglect, let us not forget, the children, remembering that when we love and protect the little ones, we follow in the footsteps of Him, who when He wished to paint the most beautiful picture of Beulah land it is possible for the human mind to conceive, pointed to the children and said—"Of such is the kingdom of heaven." (Terrell, 1900, p. 343)

The women of NCFCW relied on their spirituality, and they sought to develop that same spirituality in the young girls of Efland Home.

CONCLUSION

Approximately 308 young girls were served by Efland Home throughout its tenure. The efforts of African American women sent a powerful message to the citizens of North Carolina that so-called delinquent African American girls were worthy of saving. The women of NCFCW engaged in asset-building activities, such as instilling middle-class values, providing job training, and promoting spirituality among the young girls of Efland Home. In addition,

they encouraged support from their rural community, which at the same time built assets at the community level. As a result, the administration of the home boasted of a low recidivism rate, stating that ". . . girls sent to the school have shown a great improvement and those who have left are employed and making good" (Bickett, 1929). Furthermore, it was reported that "many were giving satisfactory service in a number of homes" (North Carolina Industrial Home for Colored Girls, 1939). These asset-building activities were instrumental to providing young African American girls in rural North Carolina, who had been deemed sexually delinquent by the courts, a second chance to lead a productive and meaningful life.

Discussion Questions

1. The title of this book chapter is "Out of Sight, Out of Mind." This phrase implies that an undesirable population is easily dismissed as unimportant if that population is not in direct view. Identify three populations named in this chapter that were considered to be "out of sight, out of mind." To whom were these populations "out of sight"? Provide evidence to support your responses.
2. The Progressive Era was an era of social reform and progressive social action. The professionalization of social work occurred during this era. In what ways does Efland Home for Girls represent a Progressive Era institution? Provide evidence to support your response.
3. Compare and contrast Progressive Era social welfare institutions developed by White women reformers and African American reformers. Identify specific names of four reformers and their social welfare institution. In what region of the country were these institutions located? Who were their target populations? What kinds of services were offered? Were these asset-building institutions? Provide evidence to support your responses.
4. Women have historically played a significant role in the development of social services. Social work textbooks concentrate on the work of White women reformers, such as Jane Addams, Mary Richmond, and Sophonisba Breckenridge. Very little is written in social work textbooks about African American women reformers, such as Charlotte Hawkins Brown, Ida B. Wells-Barnett, or Janie Porter Barrett. What impact does this exclusion have on social workers' understanding of assets in the African American community?

Classroom Activities and Assignments

1. Identify a contemporary population that is a recipient of the "out of sight, out of mind" attitude. Research contemporary clubwomen's organizations to determine if these organizations are engaged in services that address the needs of your identified population. Are these asset-building activities? Identify those activities. What level of support does the community provide to the efforts of contemporary clubwomen?

   Contemporary Clubwomen's Organizations
   National Association of Colored Women's Clubs: www.nacwc.org
   General Federation of Women's Clubs: www.gfwc.org
   The Links, Incorporated: www.linksinc.org

The Association of Junior Leagues International, Incorporated: www.ajli.org
Jack and Jill of America, Incorporated: www.Jackandjillinc.org

2. Interview an elderly African American person in a rural area about social services that were available prior to 1950, when segregation was still normative. Some examples might be orphanages, hospitals, maternity homes, and nursing homes. Were these services provided privately, like in the case of Efland Home? Do you see evidence of neighbors helping neighbors and extended family, reducing the need for formal services? What community assets do you identify through your interview?

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PART TWO

Human Behavior and Rural Environments

Freddie L. Avant

Rural social work practice is built on the assumption that social workers will use theory to guide their practice. It is a well-known hallmark that in order to be an effective social worker, one must use a body of knowledge that is organized into a consistent framework of theory. Thus, an important professional skill is the application of theory to practice. A good social worker should ask the question: "In what ways does the application of theory enhance the practice of social work?" Theory provides a lens through which a practitioner can obtain a better perspective and understanding of a practice situation. If we can understand a situation better, then we are more likely to find the best solution. In fact, theories also help social workers predict and understand the effects of and responses to interventions. As a result, it is imperative that social workers understand theories associated with human behavior and social environments.

It is especially critical for social workers working in rural environments or with people with rural lifestyles to understand how to apply knowledge and skills in a rural context. The effectiveness of a social worker's efforts to address rural issues depends on a solid understanding of theories that explain human behavior in the rural environment. Unfortunately, social workers are often unprepared to work in rural environments and base their practice on urban bias or a misrepresentation of the reality of rural life. In addition, many social services personnel in rural areas often are not professional social workers. Consequently, rural social workers and social services personnel face significant challenges in attempting to assist rural people and environments to meet their needs.

A rural social worker's knowledge base should include theories related to asset or capacity building, especially because this approach provides increased opportunities for achieving and sustaining change. An asset-building approach in rural social work assumes that people are most likely to grow and develop when their strengths, rather than their problems, receive recognition and support. In being an effective rural social work practitioner, we have to ask: "To what extent have our foundational assessment and intervention strategies incorporated the knowledge and skill related to human behavior and the rural environment?" Also, in what ways might our language, our assumptions, and our

conventional knowledge-building approaches be limiting our ability to perceive connections among rural people, rural environments, and the world we inhabit? This part of the book attempts to address these important questions and concludes that it is time (or past time) for social work to move beyond our conventional deficit model in rural social work practice and to move toward a new paradigm and a new understanding of rural people and environments that includes an asset-building and strength-based approach.

Chapter 5 by Alleman and Holly and Chapter 9 by Openshaw support this change by reflecting rural communities' abilities to adapt to change and the strengths they possess to achieve positive outcomes. They show the importance of rural communities working together to improve opportunities for the younger generation. These chapters capture the essence of trust and relationship building that creates successful outcomes for those living in rural communities, especially the children.

Chapters 6 through 8, by Avant, Villalobos, and Russell, respectively, discuss three distinct population groups in rural areas of the United States. These chapters focus on how African Americans, Latinos, and gay, lesbian, bisexual, and transgendered persons possess distinctive attitudes, beliefs, experiences, and behaviors, with each group developing its own set of assets. More specifically, these chapters describe the lifestyles of these groups and some of the challenges faced while living in rural environments and the often-overlooked strengths that they possess. The authors present compelling information on each population and various practice principles to consider when working with these populations in rural areas. Furthermore, the authors challenge us to push past facile notions of practice with these populations to realize the importance of multicultural thinking in social work practice in rural communities and with people with rural lifestyles.

The chapters in this section are intriguing and extremely valuable to becoming a more effective rural social work practitioner. As you read these chapters and complete the discussion questions and assignments, the richness and relevance of this information to understanding human behavior in the rural environment will become obvious. The authors offer compelling arguments for identifying and building assets exhibited by individuals and their environments and the relationship between the two. You will be motivated and encouraged to explore becoming more engaged in understanding and expanding your knowledge and skills in working with rural communities and especially with people with rural lifestyles in all settings.

CHAPTER 5

Accomplishing the Four Essential Tasks for Higher Education Access

The Role of Natural Helping Networks in Rural Virginia

Nathan F. Alleman and L. Neal Holly

Social workers play an important role in the life of rural communities across the United States, though some aspects of this role require knowledge of systems and processes that may be outside the areas of formal education for generalists. One of those areas, highlighted in this chapter, is access to postsecondary education for low-income rural students. Professional responsibilities allow and require social workers to serve in a wide range of capacities, from micro-level family interventions to macro-level policy advising on local governance issues. The accumulated relationships formed among individuals, families, community organizations, and local government officials place social workers in a unique position, not only to rally human and financial resources on behalf of those in need, but also to recognize and encourage local expertise, helping networks, and resource development, including financial, human, and educational. Access to postsecondary education[1] is one of the areas where social workers' personal educational experiences, along with their knowledge of other social support resources (family services, mental and physical health services, and others), position them to positively contribute to rural students' aspirations and planning for further education. However, the processes by which rural communities can promote students' preparation for and entry into postsecondary education are not typically aspects of generalist or advanced generalist social work education. Toward that end, in this chapter we explain a framework of college access elements and describe ways that rural communities use formal and informal systems and processes to promote educational attainment, based on examples from six small rural school districts in Virginia.

[1]In this chapter we use the terms *higher education*, *postsecondary education*, and *college* interchangeably. By these terms we mean any post–high school credit-bearing formal education that leads to a degree. This intentionally broad definition includes technical education, associate's degrees, and traditional bachelor's degrees.

MAKING SENSE OF SOCIAL NETWORKS

In recent years, educational researchers and practitioners have adopted social capital theory to explain the effects of family and community networks in the college-going process. Social capital theory emerged from Pierre Bourdieu's work on social reproduction, which stressed the importance of cultural awareness and social cue perception imbedded throughout levels of social class. *Social capital* refers to the interpersonal obligations that are influenced by a particular station in society (Winkle-Wagner, 2010). Social capital, in Bourdieu's (1977) original formulation, is often misunderstood and defined as a simple social network, which is incorrect. Social capital is discreet and requires a specific set of cultural knowledge. Although the college-going process is complicated and populated by esoteric information that is typically most familiar to high socioeconomic status families, developing outreach programs and other forms of assistance that replicate this social capital could take several generations. Stakeholders who are interested in developing college-access opportunities in rural communities often discuss developing social capital as a way to develop community support. However, what they really intend is to utilize preexisting natural helping networks.

Introduction to Natural Helping Networks

Social work professionals interact with natural social networks every day through their exchanges with community leaders, volunteers, families, and nearly anyone who has a permanent presence in a rural community. "Social networks are referred to as 'natural' when they are formed spontaneously without the involvement of professionals" (Li, Edwards, & Morrow-Howell, 2004). Particularly in rural areas, where structured public and nonprofit service agencies may have a minimal presence, social bonds and networks of bonds that develop from physical proximity, kinship ties, exchange relationships, and other informal interaction patterns are often very important to local residents (Collins & Pancoast, 1976; Pyles & Lewis, 2007; Waller & Patterson, 2002). Lewis and Greene (2007) argue that within these organically occurring social networks are "natural helpers" found at many levels and filling a variety of social roles. Such networks are not social only, but represent a vital source of support and resources.

In this chapter we focus on a subset of natural social networks known as *natural helping networks*, or informal connections developed through proximity relationships and personal referrals through which physical and social needs are met (Gitterman & Germain, 2008). These networks often supplement or even supplant formal services systems and structures. In the small rural communities we studied, natural helping networks were not only a point of pride for many participants, but given the dearth of formal agencies and systems, they were often indispensible elements of survival for rural residents. However, rural helping networks have both pros and cons. Because of their size and the nature of rural relationships, the helping network is able to respond quickly to immediate needs. However, natural helping networks may be limited in their ability to access technical information, such as steps or strategies necessary for higher education access. In addition, these networks sometimes exclude new residents or members of particular social, economic, or racial and ethnic groups.

In the following sections we will introduce the four essential college-going tasks using data from six small rural school districts in Virginia, demonstrating the role of formal agreements and informal helping networks that promote and facilitate postsecondary access within these communities.

About Rurality in Virginia

Although demography and geography vary substantially, rural areas in Virginia share a set of challenges with many other rural areas in the United States. In particular, changes in net migration, the decline of major local businesses and industries, consolidation of agriculture production and natural resource gathering, and persistent poverty both challenge and reinforce the importance of traditional rural patterns of life (Virginia Rural Center, 2010). In Virginia, rural citizens experience higher unemployment rates (9.1% compared to 6.1%) and poverty rates (12% compared to 9.1%) and, on average, earn less than those in metropolitan areas (U.S. Department of Agriculture Fact Sheet, 2011). Although these statistics seem to reflect poorly on rural conditions, opportunities for resource gathering, subsistence farming, and participation in an informal exchange economy, coupled with a lower cost of living, allow many rural residents to maintain a comfortable standard of living by utilizing opportunities that are not available in metropolitan areas.

Educational attainment, access, and resource statistics suggest that the issues facing the rural education process parallel and may be related to the issues facing many rural economies. Rural adults in Virginia have lower percentages of high school degree or equivalent completions (77.7%) than urban dwellers (86.4%)[2] and are less than half as likely to have a bachelor's degree (16%) than their urban Virginia counterparts (37%) (Virginia Rural Center, 2010). Rural students graduate from high school at rates (73.2%) well behind the average on-time state rate (86.6%) (Strange, Johnson, Showalter, & Klein, 2012; Virginia Department of Education, 2011).

Coupled with unemployment, poverty, and other indicators, Virginia's rural students face immense challenges, yet are often identified as a key component in the future success of their rural home areas (see the Rural Virginia Prosperity Commission report, 2001, and the Virginia Rural Center, 2010, update). Nevertheless, some rural residents view formal education with suspicion, concerned that the education process inculcates students with values and ambitions that alienate them from their rural upbringing, resulting in their departure to pursue college and career (Corbett, 2007). In our case study of six small rural, high-poverty school districts in Virginia,[3] we focused on community-level resources and factors that influenced the academic success and postsecondary aspirations of local students. The most successful of the districts not only had developed a shared vision between educators and community members for the value of educational attainment, but they also developed the

[2]Based on 2006–2008 estimates, as cited in the Virginia Rural Center, Rural Virginia Prosperity Commission Data Update 2010.

[3]This study was conducted on behalf of the State Council of Higher Education for Virginia with funding from the federal College Access Challenge Grant Program. The conclusions and opinions expressed here do not necessarily reflect those of either entity.

students' own capacities and college-going resources through a blend of formal and informal (or natural) supports.

UNDERSTANDING COLLEGE ACCESS: FOUR ESSENTIAL TASKS

Many residents of our six case study communities, whether they were affiliated with business, public, or nonprofit entities, promoted educational attainment and success through a complex combination of formal and informal roles and relationships, which we will explore in more depth following this section. The particular services, activities, and behaviors engaged in by rural community members can be matched with one or more of four essential tasks required for postsecondary access: qualification, graduation, application, and aspiration/imagination (Cabrera & La Nasa, 2001). In the following discussion, we briefly describe the contents and imperative of each of these four essential elements and identify community stakeholder activities that promoted their accomplishment in our case study school districts.

Qualification

Qualification means that students must take and succeed in sufficiently rigorous high school courses. Many students and their families fail to appreciate, or fail to appreciate soon enough, the importance of a challenging academic course of study to college preparation and qualification (Gladieux & Swail, 1999). Community stakeholders supported students' mastery of the selection and completion process through at least three approaches. First, at the most basic level, in-school academic efforts were buttressed through donations of supplies, materials, and financial resources. In some cases, this aid was as simple as pencil-and-paper provisions; in others, local civic organizations (often community education foundations) set up instructional mini-grants from which teachers could make requests for equipment and other curricular needs. However, school administrators also described unofficial lists of community members they knew to call who were willing to anonymously give money for school trips, basic equipment, clothing, and other essential supplies as needs arose. Although this sort of support may seem superfluous to the selection and completion of challenging coursework, in terms of Maslow's (1943) hierarchy of needs,[4] assuring that basic material needs were filled is an important prerequisite to confronting more difficult academic tasks.

Second, students' academic qualification was promoted by residents, who offered tutoring within and outside of the school setting. Businesses, religious groups, public agencies, nonprofit organizations, and unaffiliated individuals sponsored or facilitated these opportunities, often targeting at-risk students. In many cases, students' preexisting familiarity with sponsoring individuals (for example, through church attendance) made academic help acceptable to them.

[4]Maslow's theory assumes that the fundamental human needs of shelter, food, and others must be met before higher-order needs, such as a sense of accomplishment, can be fulfilled.

Third, community stakeholders, usually through local nonprofit or public agencies, designed supplementary learning experiences that built students' self-efficacy and skills applicable to future academic and career contexts. In one community, an arts center that specialized in traditional musical styles partnered with the local school system to give low-income students the opportunity to learn an instrument. The schools agreed to bus students to the center for group lessons that were provided at no charge. The director of the center, whose family had lived in the area for generations, described the self-confidence that students from traditionally marginalized groups gained from mastering an instrument and playing in front of their peers. Particularly for low-income students, this new skill set offered a new source of self-esteem and connected them to a larger world of music and performance.

Graduation

On-time *graduation* greatly increases the likelihood that a student will apply for college (Cabrera & La Nasa, 2001). Graduation is a deceptively simple metric, however: Virginia issues multiple diplomas—nine in all—not all of which qualify a high school graduate for attendance at an in-state, four-year institution because of less rigorous math, science, and language course requirements (Virginia Department of Education, 2011). As a result, the graduation step toward postsecondary education has two elements that received the attention of community stakeholders. First, direct encouragement and peer influence to complete high school is a task undertaken through informal relationships and via targeted activities. Most often, completion of these tasks is promoted by parents, family members, and teachers, but often also by religious groups, community agencies (such as 4-H), college access organizations (such as federal TRIO programs or the state-administered Career Coach program), and occasionally by initiatives spearheaded by businesses. These multiple points of contact reinforce the value of high school graduation and establish community norms of academic completion and planning. As one school superintendent commented, "I think it's important that the student sees that the whole community supports the mission of the school, and it's not just the school's mission, it's the community's mission."

Second, given the well-documented misalignment between many of Virginia's high school diplomas and the rigorous coursework that has been shown to improve the likelihood of college completion, students (especially prospective first-generation college students) benefit from course advising to plan out a four-year high school strategy that will best facilitate postsecondary matriculation, financing, and an active support system that is necessary to persist to completion. Clearly, teachers and parents have the most central role in this area. However, in our six case districts, community individuals and groups also participated in these tasks. Although federal TRIO programs are the most familiar college-access providers, regional or state-based access organizations that focus on financial aid information, application assistance, academic and career counseling, and other student needs make up nearly one-third of all college-access provider organizations in the Commonwealth. All six case study communities benefited from one or more of these organizations, which, in many cases, worked directly in schools to supplement the work of school administrators, guidance counselors, and teachers.

Some researchers have criticized organizations like this for inserting education professions into rural areas and attempting to impose programs that were developed for

metropolitan areas (Corbett, 2007). In some cases, this critique is accurate, but we also observed many instances where these nonprofit organizations, such as the Career Coach program, hired retired educators and other long-time community members who were already embedded in local social and helping networks, equipping them with specialized college-going information, resources, and perspective that they then translated into in-school programs and targeted (though often informal) conversations with students. In addition, public agencies and other nonprofit groups frequently ran programs that emphasized high academic standards and provided academic accountability that promoted high school completion. Districts with the highest matriculation rates often held career and college-going events, such as career fairs, which required planning and participation by a variety of community businesses and other organizations.

Application

The attainment and type of high school degree earned is shaped by the prior element qualification and represents a necessary, though not sufficient, criterion for the third element, *application*. Particularly for first-generation college students, understanding and completing all of the requisite forms for admission and financial aid can be a daunting process (Avery, Fairbanks, & Zeckerhauser, 2003). In their analysis, Cabrera and La Nasa (2001) note that the successful completion of each step greatly increases the likelihood of success in the next, though parental encouragement and socioeconomic status impact the percentage of students who do not capitalize on their high school achievements by pursuing postsecondary entry.

The first two critical tasks, qualification and graduation, are clearly the focus of K–12 educational systems and are often areas where parents, families, and social networks are able to provide encouragement and support as well. The step from high school to postsecondary education requires knowledge of systems and processes (or the drive to discover them), such as application timelines, aid forms, and testing requirements, which may be in short supply from families or social networks without first-hand higher education experience. School counselors and teachers are frequently an important source of information about college selection and entry, particularly for low-income students (Griffin, Hutchins, & Meece, 2011). However, school personnel may also find that mandated testing requirements and reporting obligations crowd out flexible time (Powell, Higgins, Aran, & Freed, 2009) that had been used for advising and college preparation and information events and activities, such as college visits or recruitment sessions. Although several of the schools in this study had adopted daily schedules that created flexible remediation and college information blocks, school counselors in particular discussed how testing requirements and staffing cuts reduced the time available for college and career advising.

Discussion with community members showed the many ways that membership in subcommunities connected students from underrepresented groups with trusted individuals who had, because of other roles, information or connections to this knowledge. In two districts with substantial Spanish-speaking populations, we were directed to native Spanish speakers whose English language skills and interest in promoting the educational success of the local immigrant population made them central figures within the community, despite their own modest educational and career attainment: one held a manufacturing job, and the other

was part of a family who owned a Mexican restaurant. Neither individual had a college degree. Spanish-speaking parents and their English-speaking children who were considering college came to these central figures for assistance in understanding application and financial aid documents, or to serve as an intermediary with school and agency personnel. In some instances, when the knowledge of these intermediaries was exceeded, they connected the students and families to others in the community with more specific knowledge. However, in other situations, the limitations of their knowledge created an impasse for those they were trying to assist. Similarly, a woman whose church shared its building with a Spanish-language congregation used her prior career as an educator to voluntarily provide tutoring and advising, including help with college forms, for both Spanish- and English-speaking students.

Aspiration

The fourth factor, *aspiration/imagination* (the internalized desire to excel academically and the ability to imagine the future status of being a college student), implied by the Cabrera and La Nasa (2001) study and others, pervades and undergirds each of the three critical tasks. According to Cabrera and La Nasa, aspiration actually emerges from the pursuit of the first three elements as students and their families begin to plan for the future financially and strategically, and develop an idea of what it will be like to become a college student. Without third-party intervention, aspiration is subject to the same Matthew Effect[5] as many other aspects of education: On the whole, students from wealthy and educated families are encouraged by their parents to consider college from a young age, are influenced by parents and peers, who model values and behavior associated with college graduates, are more likely to have conversations about college-going with peers, and are inculcated into a socialization process for college that includes increased academic focus and intensified information gathering. However, first-generation and underrepresented student groups also leverage trail-blazing peers, relatives, and community acquaintances to "scale down" (Attanasi, 1989) the college experience in ways that make it seem manageable and attainable (Choy, 2001).

Community members and groups encouraged academic and career aspirations through three general practices in the six case study districts. First, by providing positive influences through individual relationships and through organizations that valued and celebrated academic accomplishments. This assistance was often undertaken by civic organizations, social clubs, and religious groups, who formally recognized high school graduates, celebrated specific academic accomplishments, and encouraged future planning. These groups also developed formal and informal systems of peer modeling, demonstrating positive academic behaviors for younger students and encouraging them to consider college and career options that required advanced training.

Second, local residents modeled pro-educational attitudes and behaviors, in some cases in conjunction with formal programs, such as a career day where professionals talked to

[5]This phrase, referencing the Biblical parable of the talents found in the gospel of Matthew, has been adopted by social scientists to reference situations in which those who have an abundance of resources get more, and those with very few resources have those taken from them.

students not only about their jobs but also about the kind of focus and preparation required to achieve their current vocation. Because these programs made use of local professionals who were often already known to the students, they also contributed a sense that despite the rural and isolated setting, *you can make it from here—and come back*. In one school, the guidance counselor polled students on careers of interest and then invited community members in, to great effect:

> So they come in and say, "It's really great to be a doctor but this is how many years of college it took, and this is how dedicated I had to be even in high school." . . . "These are some classes that you might want to take in high school," you know, don't take the easy road. Or "These are some clubs that might be of interest to you," or "It's really important for you to be involved in things outside of the school, volunteerism and that kind of thing, because we all know those are things colleges and universities look at. It's not just your GPA anymore." So those kinds of things I think, too, are helpful to kids because they're seeing it's not too early to start volunteering when you're at the middle school.

These presentations were not limited to traditional high-status roles (doctors, lawyers, and the like), but also included those engaged in trades requiring technical education.

Third, community members and organizations encouraged academic motivation by providing experiences that exposed students to the arts, physical sciences, higher-order thinking, and to diverse cultural ideas and practices that inspired them to imagine their own potential. This exposure occurred within rural communities through environmental science field work, historical interpretation and reenactment at nearby venues, and higher education coursework at local community colleges in some cases. Educators and nonprofit employees commented on the impact that positive educational experiences that utilize resources of the local region have on students, which researchers elsewhere have found as well (Combs & Bailey, 1992). In several of the districts, both schools and other community partners developed programs in conjunction with nearby state parks to provide hands-on lessons in field biology, conservation, wildlife management, and a range of other interest areas. One public agency leader, who runs a program where students are able to visit a park at night and use a high-powered telescope, described how these experiences benefit students who sometimes struggle to find their place in traditional educational settings:

> And these are the kids that, I mean they're great kids, but they are the ones that have such a hard time academically kind of sitting there and listening. So . . . we were in the gym and I looked and there was about four or five of them sliding on their backs on the gym floor. But those same kids, when you get them outside in the woods . . . something happens to them there that doesn't happen in a structured kind of environment, which is kind of cool.

In other situations, tours to metropolitan areas, colleges and universities, or specific cultural events were funded, staffed, or guided by local organizations and favorably impressed students precisely because they took place in unfamiliar locales. Academic

aspirations were certainly inspired for some students within the traditional education system and context. For others, and particularly those whose experiences in formal settings had at times been negative, the combined impact of targeted encouragement from respected adults and positive learning experiences that inspired wonder, curiosity, and engagement represented an initial step toward developing the necessary intrinsic motivation needed to succeed in higher education.

NATURAL HELPING NETWORKS AND SCHOOL–COMMUNITY PARTNERSHIPS

The preceding discussion of four essential tasks serves as a backdrop against which we can understand the complex intersection of formal and informal community roles that can contribute to student achievement and success. As previously described, natural helping networks arise from social connections based on proximity, referrals, and frequent interaction. An obvious example in our study of these networks in action was the bilingual Latino community members to whom many fellow immigrants turned for information, advice, and, at times, economic assistance. These natural helping networks offer a diverse assortment of possible benefits, generally identifiable in four support categories: (1) through *instrumental support* individuals access goods and services; (2) through *emotional support* they receive nurturance, empathy, and encouragement; (3) through *informational support* persons hear advice and feedback and learn details of processes; and (4) through *appraisal support* participants gather self-evaluation information (Gitterman & Germain, 2008).

The four categories of support found in natural helping networks are important, both to illuminate the functions of informal connections generally and to provide detail about the ways in which these networks contribute to rural students' academic preparation, aspirations, and success. Figure 5.1 highlights the intersection of Gitterman and Germain's (2008) four natural helping network functions with Cabrera and La Nasa's (2001) four essential tasks. Although the descriptions provided in Figure 5.1 are not comprehensive, they are instructive about the type and range of possible positive college-going influences natural helping networks provide, demonstrating convergence of the types of support potentially gained from natural networks that address the particular needs of each stage in the process of building academic and logistical preparedness for postsecondary education. We do not intend to suggest by this chart that student needs are completely met through these networks; as we will argue, formal systems are also important for postsecondary preparation. Nevertheless, natural networks represent an important and easily overlooked resource for low-income and aspiring first-generation college students.

The Role of Formal Partnerships

Students in these rural areas also benefited from a variety of formal organizations, groups, and enterprises, including local businesses, churches, nonprofit college-access organizations,

	Qualification	Graduation	Application	Aspiration
Instrumental Support	School supplies, tutoring, transportation to scholastic and extracurricular events	School supplies, tutoring	Small monetary gifts/loans for college applications	Transportation to college visits, monetary gifts and loans for college supplies, fees, tuition, etc.
Emotional Support	Encouragement to complete difficult courses; empathy for struggles	Encouragement to complete high school, advice and empathy during difficult academic and social experiences	Empathy during process of evaluating options, encouragement to complete this step	Nurturing abilities and interests, direct and indirect encouragement to consider higher education
Informational Support	Advice on course selection	Discussing future options and importance of graduation	Help with forms, finding financial aid, selecting a school, etc.	Helping connect student interests to career options and paths
Appraisal Support	Feedback on abilities and courses that may offer a good match	Input on progress toward graduation and assessment of time use, skill development, etc.	Feedback on timelines and due dates for forms and applications; aiding in college choice decisions	Helping students develop enthusiasm for future educational and vocational options through pointed feedback

Data drawn from Cabrera & La Nasa, 2001 (rows), and four types of support offered by natural helping networks from Gitterman & Germain, 2008 (columns).

Figure 5.1 Intersection of four essential college-going tasks.

local, state, and federally funded social services and pro-educational agencies, as well as civic and special-interest groups, such as gardening clubs, veterans' organizations, historical societies, and many others. Although a smaller percentage of these organizations' primary purpose was pro-educational (exceptions included locally initiated community education foundations, public and nonprofit college-access organizations, and a variety of other organizations and agencies such as 4-H), many others promoted educational attainment and aspirations through a wide variety of services and activities. These initiatives included scholarship funds, writing contests, tutoring, funding and logistical support for college trips, job fairs, internships, job shadowing experiences, career advising, reading programs, arts initiatives, and many other offerings that, however incrementally, advance the worth and importance of education and help young people begin to imagine college as part of an attainable future. In some cases, these organizations were part of formal agreements with

schools for a particular function or resource delivery, commonly known as a *school–community partnership* (Sanders, 2006). However, in many cases, the genesis of support came from educators or local citizens who felt passionately about improving educational access for local residents and recognized a way that resources within their purview could be mobilized for that purpose. In our study the example of the community arts organization reflects this process well: The director, a long-time resident and close friend with several school administrators, used informal channels to gently pressure school leaders to provide busing to the arts center for low-income students. Although this is a cursory summary of formal pro-educational roles, it is important for social workers in rural areas to recognize the many groups—in type and number—that in some way support and promote educational attainment, even in small rural areas with few apparent resources.

The Intersection of Formal and Informal Community Roles

Identifying the types of resources available locally and the roles that community members play within them will allow social workers and other helping professionals to interpret and utilize the complex intersection of these constituent parts. Both formal school–community partnerships and informal natural helping networks offer vital and often locally based resources from which students can draw as they develop their academic, social, and instrumental capacities and determine their future educational and career plans. In fact, scholars suggest that a blending of formal and informal services can enhance person–environment fit, promote self-efficacy, and support pro-social behavior (Greene, 2005; Whittaker, 1983). Greene (2005) emphasizes that natural networks "seem to work best when undergirded by the support of basic formal services" (p. 234). Yet he and others (Libertoff, 1980) caution that these relationships are delicate and should not simply be appropriated to meet the goals of formal groups.

Previous research has demonstrated effective case examples of natural helping networks that have been further enabled through targeted training, information, and access to a variety of mental and physical health and support resources (Collins & Pancoast, 1976; Lewis & Greene, 2007; Libertoff, 1980). Our case analysis was focused on rural educational success, but typically researchers emphasize the importance of school and parental factors to the exclusion of community factors (Herzog & Pittman, 1995; Stockard & Mayberry, 1992). Although we do not contest the importance of these central elements, we also found that many community persons were highly involved in advancing the educational achievement of local students from one of three positions (Figure 5.2): natural helping network roles only, blended roles, or formal roles only. Many of those in natural helping network roles, such as the aforementioned bilingual Latino residents, were not in formal groups or organizations, or

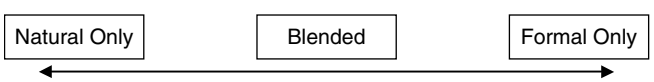

Figure 5.2 Types of educational helping roles observed in case study districts.

their group membership was not a significant aspect of their helping behavior in relation to educational issues. At the other end of the continuum, those in formal organizational roles often were aligned with regional, state, or federal programs that gave them a particular mission or purpose in a community. However, some of them did not live in the community they served, and their only ties to it were through their professional assignments. These exterior affiliations, sometimes referred to as bridging networks, linked the rural communities to educational opportunities, such as community college partnerships or federal TRIO program access.

The third category, blended roles, was a prominent feature of high-achieving rural school districts in our study. Because the four essential tasks, each require specialized knowledge of educational and financial processes, forms, and expectations (such as completing the federal FAFSA form), we observed many cases where local individuals already nested in helping networks sought information and even formal roles that gave them access to this specialized educational knowledge. For example, in several communities, retired educators were hired by the community college Career Coaches program to work with local high school students to talk about future plans, career options, and the steps necessary for postsecondary preparation. The insider knowledge of these community members gave them legitimacy and trust that would otherwise have taken years to earn. Their affiliation with the Career Coaches program gave them access to knowledge about scholarships and other aid programs, information about technical training necessary for nearby career opportunities, and the flexibility to develop programs and interventions that best fit the needs of local residents. Other examples of blended roles included long-time resident business owners who initiated local community education foundations to provide scholarships to local residents and mini-grants to teachers, and members of religious groups who used their influence and church resources to provide tutoring and mentoring opportunities.

CONCLUSION

Although access to postsecondary education for students from middle- and upper-income families is often a clear expectation supported throughout childhood, for many low-income, first-generation, and underrepresented individuals in rural areas, these pathways and processes are largely unknown and require information, preparation, and the development of a vision of becoming a college student. Rather than focusing on the necessary skills, preparation, and knowledge as a deficit situation, our example of six small rural school districts in Virginia highlights how, at the community level, a shared vision for the importance of educational success has empowered adults and students to utilize both natural social networks and formal systems and organizations to equip students for future success. Certainly, the difficulties inherent in the circumstances of some students create ongoing challenges in all four essential tasks. Yet many of these communities had or were developing an internal locus of self-determination from their ability to mobilize different types of networks and resources toward pro-educational ends. For example, Timothy, the director of a community college extension center in one of the districts, argued that the focus of the

community must be on maximizing local resources and believing that the solution is primarily internal: "We can't always depend on somebody to come here. We've got to build the capacity of people from within."

Discussion Questions

1. From your own college-going process, what did you find the most challenging? What persons or experiences were the most helpful as you began to imagine your future as a college student?
2. Low-income and potential first-generation students are often skeptical about postsecondary education. How would you approach this issue with a family that is already dealing with a host of other socioeconomic challenges?
3. What are the positive and negative aspects associated with social work professionals becoming involved in other issues in the community, particularly those, like education, that have professionals already working to address them?
4. From this introduction, what do you need to know or to learn that will prepare you to encounter postsecondary access issues in rural high-poverty areas?

Classroom Activities And Assignments

Using the following case study, work in small groups to respond to the questions:

You are a social worker in a rural community far from a metropolitan center. Recently, the local furniture factory closed, laying off hundreds of employees. Not only is the closing a challenge for those who have lost their jobs, but also for students at the local high school who had hoped to work at the factory after graduation. This turn of events is a particular problem for some low-income students who have not considered postsecondary education as an option for them. With so many other immediate issues arising from the closing, many local leaders have not considered the plight of those young people still in school. The local school superintendent has asked you to assist with improving college-going efforts in the area, especially among those who are interested in promoting educational attainment, but have no formal training in this area.

1. When considering the Cabrera and La Nasa framework, what can your social services office do to help promote college access as a response to local events?
2. Through your office, what external resources can you coordinate to help with access needs?
3. Beyond professional connections and resources in your office, what personal resources can you call on to help develop a larger helping network to address access?
4. How might you utilize natural helping, blended, and formal networks appropriately, recognizing each category's inherent strengths and limitations?
5. Thinking outside the box, what are some resources that other local officials may not consider that you could utilize?

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CHAPTER 6

African Americans Living in Rural Community

Building Assets from an Afrocentric Perspective

Freddie L. Avant

Rural America is an enormous place, encompassing more than 75% of the land area of the United States and more than 50 million people. According to U.S. Census 2010, more than 51 million people are living in rural areas, with more than 8 million being African Americans. Geographically, 55% of African Americans live in the South, 18% live in the Midwest, 17% live in the Northeast, and 10% live in the West (U.S. Census Bureau [USCB], 2010a; U.S. Department of Agriculture [USDA], 2011, 2012). Over the last two decades, there has been a reverse migration of African Americans to the South as part of a quest to reestablish roots and improve their economic situation (Miller & Jonsson, 2001). The 2010 Census reveals that for the second time in this century, the South's African American population grew faster than that of any other region in the 2000s. Many African Americans have returned to the South because of retirements, an expanding economy, history, the climate, the pull of tradition, and the overall comfort level of being around family (Miller & Jonsson, 2001). African Americans can serve as vital resources for rural communities. For example, Miller and Jonsson indicate that African Americans returning to the South are becoming more politically active and assuming various leadership positions in their communities. By combining the skills of returning African Americans and those lifelong community leaders, social workers can help build assets for rural communities.

African Americans in rural communities have consistently been disadvantaged compared to urban African Americans and other ethnic groups living in rural areas. Unemployment among rural African Americans is twice as high as for other groups in rural areas. Rural African Americans often live in distinct communities with high poverty, a lack of opportunity, and limited economic benefits (USDA, 2010). Although the socioeconomic conditions of rural communities were more favorable at the end of the year 2000, in this decade rural areas continue to experience higher poverty rates than do urban areas. With historically higher rates of poverty and unemployment and lower levels of education, African Americans represent a disproportionate share of the disadvantaged segment of the rural population.

Now, as in the past, many of the African Americans who grow up in these areas and develop the skills to succeed must use them elsewhere, leaving behind an even poorer community (Cromartie & Stack, 1989).

Within rural areas, populations declined in the most rural and isolated counties while rising moderately in more urban counties (USCB, 2010a). Despite this decline, rural areas have seen growth in the African American population. The current U.S. Census data reveal that people of color grew from 30% to 36% of the total U.S. population, and they are projected to become greater than 50% in the year 2060 (Rastogi, Johnson, Hoeffel, & Drewery, 2011; USCB, 2010b). African Americans are one of the largest ethnic groups in the United States living in rural communities.

Demographic data suggest that within a professional lifetime of practice, a social worker most likely will come into contact with persons from cultural backgrounds other than her or his own. Thus, social work practitioners should be prepared to work competently with African Americans in rural areas. The purpose of this chapter is to examine the Afrocentric perspective and apply it to practice with African Americans in rural areas. This perspective supports the asset-building framework by emphasizing the human capacity for resiliency, strength in the face of adversity, and the right of individuals to form their own aspirations and definitions of their situations.

DIVERSITY AND SOCIAL WORK PRACTICE

Nastasi, Varjas, Bernstein, and Jayesena (2000) suggest that effective practice is based on four areas. First, there must be knowledge and understanding of the diversity of populations we serve. Second, we must be able to work with individuals from a multitude of cultures different from our own. Third, we must be able to conduct assessments that are nondiscriminatory and have high treatment validity. Finally, we must be able to develop interventions that can address all of the diverse needs of the populations we serve.

Social work has a specific commitment to understanding diversity and human strength at both the personal and political levels (Hartman, 1993; Saleebey, 1992). Therefore, it is imperative to examine and apply theories that build on human strengths. As a way to understand and meet the diverse needs of populations, different theories of cultural styles have been proposed. A considerable amount of the social work literature has been directed at addressing the concerns of people of color. The social work practice models most frequently discussed are ethnic-sensitive (Devore & Schlesinger, 1981; Lum, 1992), cross-cultural (Chau, 1992; Greene & Ephross, 1991), and the black experience-based framework (Martin & Martin, 1995). In social work practice, these models are adapted to serve people of color, with special attention given to racism (Pinderhughes, 1989; Schiele, 1996). Although these approaches stress the need for cultural awareness and sensitivity, they do not emphasize the importance of cultural values of people of color as a theoretical base for understanding and addressing problems. Moreover, practice models that are not based on the cultural values of people of color can be viewed as ethnocentric—that is, based on the belief that one set of values is the only set that can explain behavior, and it should be the basis for solving people's problems (Schiele, 1996).

Consequently, few practice models are based on theoretical foundations that mirror the diversity of cultural values and worldviews found in U.S. society (USCB, 2010a). As a result, it is important that cultural values be considered in the development of practice models. Social work educators and practitioners should begin to affirm and integrate cultural values and worldviews of African Americans in the development of practice models, scholarship, and professional practice.

In addition, it is imperative to build on the assets of people of color to strengthen their involvement in the social work process. Building assets is about establishing the positive, sustained relationships that are so critical to working with people of color in rural areas. Working with African Americans from this perspective will allow their talents, interests, and values to develop in ways that help them reach their personal goals and contribute to society. The Afrocentric perspective is an approach to working with African Americans that identifies and builds on their assets as a way to resolve problems (Schiele, 1996).

AFROCENTRIC PERSPECTIVE

Theoretical foundations are necessary for understanding and creating shared realities. The Afrocentric perspective illustrates how developing knowledge of another culture from the viewpoint of that culture can transform social work practice (Swigonski, 1996). The development of knowledge from this perspective conveys a powerful means of empowerment for clients. The Afrocentric perspective describes the ethos and values of Africans and African Americans (Everett, Chipungu, & Leashore, 1991). This perspective proposes a frame of reference in which African history, culture, and worldviews become the context for understanding Africans and African Americans (Asante, 1988).

According to Barker (1999), Afrocentric theory is an orientation or social philosophy that uses cultural values, history, and shared experiences of people of African descent as a framework to explain social phenomena and to solve human problems. It is in direct opposition to deficit models that focus exclusively on weaknesses and problems in the behaviors of people of color. This perspective provides a viewpoint from which to develop a proactive stance and emphasizes assets (Swigonski, 1996). The construction of models of human behavior from an Afrocentric perspective portrays African Americans in ways that are free from ethnocentrism.

The birth of the Afrocentric perspective paralleled the movement to redefine Blacks as African Americans—a people with their own history and culture. This new way of viewing African Americans was pioneered by Molefi Kete Asante, a professor of African American studies. The Afrocentric perspective originated from an African-centered philosophy that was called Afrocentrism. The development of Afrocentrism was viewed as being much broader than merely understanding African American culture (Asante, 1990). It advanced a strengths-based approach and countered the perception of inferiority and the political disempowerment of African Americans by affirming identities and ethnic national pride. It further validated the experiences and worldviews of African Americans.

Although the literature suggests the importance of understanding African Americans using an Afrocentric perspective, it is just as important to recognize and respect differences

within groups as it is to acknowledge differences between groups. Moreover, understanding African Americans within their context at least begins the operationalization of the maxim in social work practice that states "start where the client is." This is such an important principle for both beginning and experienced social work practitioners. Coupled with this principle, the Afrocentric perspective can be a guidepost for all social workers who work with African American populations. The Afrocentric perspective affirms three major assumptions about human beings that will be explained in more detail in this section: (1) Human identity is a collective identity; (2) the spiritual or nonmaterial component of human beings is just as important and valid as the material component; and (3) the affective approach to knowledge is epistemologically valid (Akbar, 1984; Asante, 1988; Kambon, 1992; Schiele, 1990).

Individual Identity as Collective Identity

A noteworthy characteristic central to the Afrocentric perspective is that the group is much more important than the individual. Human identity as a collective identity emphasizes the significance of culture within the social group (Asante, 1988; Baldwin & Hopkins, 1990; Schiele, 1997b). Thus, the common experiences, beliefs, and values of African Americans are validated. Most African Americans share a common history of slavery that greatly influences their lives. This history is very important and must be taken into consideration to properly understand the Afrocentric worldview (Schiele, 1990; Swigonski, 1996). Cooperation, interdependence, the collective responsibility of the individual to the group, and the commonality of individuals are highly stressed in the Afrocentric worldview. Thus, the Afrocentric perspective conceives the individual identity as a fluid and interconnected way of uniquely expressing a collective or group ethos.

This perspective does not discard the uniqueness of the individual, but it does reject the idea that the individual can be understood separately from others in his or her social group (Akbar, 1984). The focus on collectivity in the Afrocentric perspective also encourages an emphasis on sharing, cooperation, and social responsibility (Kambon, 1992; Martin & Martin, 1985). The African American family is seen as a cohesive unit. The family should not be equated with nuclear family but should, instead, include the nuclear family plus kin and other persons, blood-related or not, who share in the family group experience.

Spiritual Nature of Human Beings

The Afrocentric perspective recognizes the importance of spirituality or the nonmaterial aspects of human beings. From an Afrocentric perspective, spirituality is concerned with the ability—through our attitudes and actions—to relate to others, to ourselves, and to a Creator or a Supreme Being (Schiele, 1994). The term *spiritual* also refers to practices, insights, states of being, and frames of references most influenced by forces beyond, and inclusive of, the individual and his or her personal, interpersonal, and suprapersonal (or transcendent) experiences.

In traditional African philosophy, God, or the generative spirit, is thought to be reflected in all elements of the universe and is thus seen as the connective link between humanity and the universe (Zahan, 1979). In the Afrocentric perspective, the soul is considered just as much

a legitimate source of study as the mind and body. In addition, the soul, the mind, and the body are considered interdependent and interrelated phenomena (Lee, 2002; Schiele, 1994). Although specific teachings and beliefs vary among African Americans, there is an almost universal belief in the importance of spirituality and the influence of spiritual forces in the balance of one's life. Health and well-being are believed to be the result of the complex interplay among the physical world (i.e., our bodies), our mental processes (our thoughts and emotions), our environment (our family, culture, etc.), and the spiritual forces outside of us and the learned spiritual practices that become part of us.

From the Afrocentric perspective, spirituality is viewed very broadly. It is more than religion. It is the complex and often conflicting nature of spiritual teachings, a sense of purpose and being, of the future, and of a higher power guiding and shaping our existence. It includes religion and religious teachings from every conceivable point of view. The mind, body, and soul are believed to have equal weight and must be balanced in order to achieve a state of well-being. In the African American community, spirituality is viewed as an important factor in the mental well-being of children and families (Lee, 2002; Martin & Martin, 1985; Zahan, 1979).

Affective Knowledge

In the Afrocentric perspective, affect (feelings or emotions) is viewed as a valid source of knowing. In this perspective, reasoning or thoughts do not occur in a vacuum but are filtered through the maze of people's emotions and values (Kambon, 1992; Schiele, 1996). Thus, thoughts do not occur independently of feelings, and feelings do not occur independently of thoughts. A major principle of Afrocentricity is that emotions are the most direct experience of self (Akbar, 1984).

The Afrocentric perspective begins to build on the strengths and assets of African Americans. It is considered a social science paradigm predicated on the philosophical concepts of contemporary African Americans and traditional Africa (Akbar, 1984; Schiele, 1996). Several authors believe that the social isolation of African Americans created by slavery and racial segregation, in addition to sustaining the desire to maintain tradition, helped preserve traditional African philosophical assumptions among African Americans (Akbar, 1979; Martin & Martin, 1985). Researchers who have advanced the Afrocentric perspective acknowledge a variation in the degree of internalization of traditional African values among African Americans. However, the literature suggests that traditional African culture has survived to the point where it can support a distinct cultural and ethnic group. Therefore, the application of Eurocentric theories of human behavior to explain the behavior and ethos of African Americans is inappropriate (Akbar, 1979, 1984; Baldwin & Hopkins, 1990; Kambon, 1992).

USING AN AFROCENTRIC PERSPECTIVE TO BUILD ASSETS

Historically, African Americans have struggled in our society with social and economic policies and practices that have been extremely exclusionary. From the beginning of slavery

to the present, concern for issues of social equality and justice remain part of their lifestyle. For years, African Americans have shouldered the blame for their own oppression, as family instability, drug use, and welfare dependency were said to be the chief sources of their plight (Solomon, 1976). The Afrocentric perspective gives African Americans an identity and a sense of pride.

One important factor in understanding how to work with African Americans in rural areas is the type of lens or worldview through which they perceive their experiences. Montgomery, Fine, and Jaer-Myers (1990) define *worldview* as a structure of philosophical assumptions, values, and principles through which one may perceive the world. According to Kambon (1992), the worldview orientation is the index of functioning of people of color, especially African Americans. An Afrocentric worldview is described as a holistic perspective, assuming a spiritual/material unity and the interconnectedness of all things (Myers, 1988). It is centered in a spiritual kinship connection to African culture (Asante, 1990). Examples of values inherent in the Afrocentric worldview include cooperativeness, cohesiveness oneness with nature, spirituality, positive interpersonal relationships, and flexible time orientation (Kambon, 1992; Myers, 1988). It is well-known in the African American community that time does not control the nature and extent of the social events of the day. Many authors writing about the Afrocentric perspective suggest that those who embrace the worldview orientation to understanding African Americans build on their strengths, not their weaknesses.

This approach encourages practitioners to take an asset-building perspective when problem solving with African Americans. Incorporating African Americans' own perceptions of their problems and solutions into the problem-solving process validates their view of their situation. This approach is very important in assessing and choosing appropriate intervention strategies. African Americans are often denied the right to define themselves in their own terms or to define their experiences within their own contexts and meanings (Swigonski, 1996). When working with African Americans, using an Afrocentric perspective to understanding problems is a more culturally competent approach than applying a Eurocentric perspective. The chosen theoretical orientation will determine the view of the presenting problems and the practical solutions. In other words, meeting the needs of the individual without regard to the collective group will not address the problems.

Myers (1988) sees the Afrocentric and Eurocentric worldviews as contradicting and conflicting with one another. For example, he argues that from the Eurocentric worldview, one's self-worth is contingent on individualism and material acquisition. The Afrocentric worldview stresses cooperation, group connectedness, and kinship bonding. The lifestyle of rural African Americans is very traditional (Baldwin & Hopkins, 1990; Solomon, 1976). Relationships are defined by the people you know and the shared experiences that have strengthened relationships among people living in the rural communities. For rural African Americans, kinships and friendships are based on interpersonal and social experiences (Martinez-Brawley, 1990, 2000).

When using the Afrocentric perspective, the considerable strengths of African American families become visible. Rather than placing primary focus on the nuclear family, this perspective emphasizes the significance of the extended family in African American culture. The Afrocentric perspective redirects social work practice to address family problems by

developing support and resources that include collective efforts, self-help, and mutual aid (Everett et al., 1991). Developing resources through social, civic, fraternal, and religious groups explicitly emerged from the African value of collective work and responsibility (Everett et al., 1991). Social work practice from an Afrocentric perspective challenges the social work profession to examine other practical approaches to working with clients. Social work practitioners must develop alternative social structures that both empower and confront the oppression and injustice of existing systems and structures (Asante, 1988; Schiele, 1997a; Solomon, 1976). Competency-based practice must include placing the culture of African Americans at the center of the practice model. This requires a theoretical framework for social work practice that is asset-based, which builds on the strengths and assets of African Americans.

AFRICAN AMERICANS IN RURAL AREAS

According to the USCB (2000, 2010a), definitions of rural areas must give attention to classifications of urbanized areas (UAs) and urban clusters (UCs). UAs consist of a densely settled core of census block groups, along with surrounding census blocks that encompass a population of at least 50,000 people. UCs consist of a densely settled core of census blocks, along with adjacent densely settled census blocks that have a population of at least 2,500 but fewer than 50,000 people. Rural populations are classified as those not residing in either UAs or UCs. Based on this definition, 59.5 million people live in rural areas—a significant rural population.

Moreover, census data shows that the U.S. population is 308.7 million (USCB, 2010b). For the second time since the beginning of census reports, respondents could self-identify. This means individual and families could choose their own racial background. The census data collected on race can be separated into two categories: those who self-identify with one race and those who choose to self-identify with multiple racial groups. Of the total U.S. population, 42 million people, or 13.6%, self-identified as having a Black or African American racial background. This number includes 38.9 million people, or 12.6%, who reported only Black, in addition to 3 million people, or 1%, who reported Black as well as one or more other racial group. One way to define the African American population is to combine those respondents who reported only "Black or African American" with those who reported Black or African American as well as one or more racial group. Another way is to define the African American population by counting those who chose to identify themselves as African American only. The author chooses the former definition to discuss the African American population living in rural communities.

Using this definition, census data report approximately 14% growth in the African American population (USCB, 2010b). This definition more clearly reflects the growth of the African American population and provides a more accurate representation of the biracial and multiracial compositions of African Americans living in rural areas. Historically, racial categories have limited the extent that persons of color could identify their own ethnicity. This definition supports an asset-building perspective by allowing African Americans to recognize and value their own diversity. In addition, it embraces African Americans' ability

to identify and appreciate their racial heritage. For many years, their racial background was defined by federal and state policies.

Across the nation, rural communities differ drastically from one another. No single set of prescriptions could possibly apply to all rural communities of African Americans. However, some common characteristics of rural communities make them similar. Thus, in attempting to identify the salient characteristics that define a rural lifestyle, the focus has been on community deficits, such as poverty, the need for transportation, poor housing, inadequate education and health care systems, lack of employment opportunities, and shortage of professionals. The lifestyles of African Americans are significantly affected by these problems. For example, the poverty rate for rural African Americans (32.9%) is higher than for any other group (USDA, 2010). Rural poverty rates for African Americans are also higher in the South and West, which is where most are living (USDA, 2011).

Education is a strong predictor of income. In rural areas of the United States, level-of-education differences account for 24% of the difference in poverty rates between African Americans and people of European descent. The differences in household structure also result in higher poverty rates for African Americans in rural areas. Thirty percent of African American households are female-headed families, and one out of every four African Americans in rural areas lives in poverty (Avant, 2004). Education and household structure only partially explain the nature and extent of poverty rates of rural African Americans. Even for persons with similar education in households of the same type, poverty rates for African Americans remain high. Likely explanations of these differences include discrimination in employment and wages, and concentrations of African Americans in areas that are unable to attract high-wage employers (USDA, 2010).

Much of this discussion has focused on the problems of rural areas. Unfortunately, the literature tends to present a rural lifestyle from a deficit perspective. However, rural communities and rural lifestyles have many assets and strengths that should be used in working with African Americans. For example, rural communities have strong natural helping networks. They are rich in traditions that promote the values of independence and hard work, strong links to family and the land, and social institutions such as the church. African Americans have a strong connection to traditions, extended family, and spirituality. Understanding the strengths inherent in rural communities and lifestyles is important for the social work helping process when working with African Americans (Martinez-Brawley, 1990, 2000).

UNDERSTANDING HUMAN BEHAVIOR OF AFRICAN AMERICANS IN RURAL ENVIRONMENTS

The Afrocentric perspective can be used as a foundation for understanding the behaviors of African Americans and for implementing effective rural practice models. Most current theories of human behavior and practice models are Eurocentric models that have been adapted to work with people of color (See, 1998). The Afrocentric perspective is more applicable for understanding and working with African Americans. Many authors stress the importance of culturally sensitive practice by combining appropriate theoretical frameworks

with practice models (Avant, 2004). An Afrocentric perspective includes features that are based on African and African American assumptions that support a practical approach for understanding and addressing the needs of African Americans in rural areas (Asante, 1988). Rural social work practice is defined as the many social work–related activities that involve working with and for people in and from rural areas to bring about change in their social functioning. It is important to work with rural African Americans from a cultural or lifestyle perspective, as well as considering the geographic perspective (Daley & Avant, 1999). As African Americans migrate to rural areas, they may need services, but they could also serve as valuable resources for social work practitioners. The cultural or lifestyle perspective for defining rurality is also appropriate and applicable to working with rural African Americans who must travel to urban areas to receive services (Avant, 2004).

The Afrocentric perspective will assist social work practitioners in engaging rural African Americans in the helping process. Traditions are very strong for rural African Americans, and many traditional gatherings are held by families and communities in rural areas. The rural church continues to serve as the center of both spiritual development and social activities (See, 1998). Rural churches also function as community centers for youth and adults, serving as places where African Americans gather to meet, mingle, eat, and create social relationships. Many African American churches have created rural community life centers. They serve as resources for spiritual enhancement and community outreach for addressing many of the social and economic issues being faced by African Americans (Martin & Martin, 1985; Martinez-Brawley, 2000). Church members also create a natural support system to help one another. Pastors or spiritual leaders are primary leaders in rural communities, and many community and personal decisions are influenced by spiritual leaders. It is important that social workers include spiritual leaders, local civic groups, women's and men's clubs, and fraternities as resources.

CONCLUSION

The Afrocentric perspective provides a culturally specific approach for serving African Americans in rural areas. Although currently used primarily by African American social workers, the Afrocentric perspective and practice are tools that all social workers can use. Cheatham, Tomlinson, and Ward (1990) emphasize that embracing one's ethnic heritage is an essential part of the development process of African Americans. Schiele (1994) suggests that a positive African American identity can help foster resistance to several life problems, such as drug addiction, violence, and social injustices. The Afrocentric perspective can serve as a theoretical foundation for building assets with African Americans in rural areas.

With African Americans being one of the largest ethnic groups in rural America, the Afrocentric perspective adds a unique approach for working with this population. Although this is an important approach, it is just as important to recognize and respect differences within groups as it is to acknowledge differences between groups. Moreover, social work practice models must be eclectic and consider the context in order to engage in competent social work practice. Therefore, it is important to consider personal history, past experiences, and how context shapes one's perception of life. To be culturally competent, practitioners are

often challenged to recreate a new worldview in approaching and applying effective practices to increasingly diverse populations. On the whole, this chapter makes a contribution to the culturally diverse social work practice literature in general and to the culturally competent social work practice movement specifically. The integration of the Afrocentric perspective into practice models in rural communities will be strength-based and empowering to individuals and families of African descent.

Discussion Questions

1. Rural lifestyles are very different from urban lifestyles. These different lifestyles impact the worldviews of people of color. What are some of the assets of living in rural communities that can serve as strengths for working with African Americans? How could the identified assets/strengths be used to assist African Americans in their attempts to address the issues they face?
2. It is important for social workers to understand the lifestyles and culture of their clients to effectively assess and intervene when necessary. Discuss the significance of the application of the Afrocentric perspective and implications for practice with African Americans. How could the Afrocentric perspective be used to build on the assets/strengths of African Americans?
3. The author proposes the Afrocentric perspective as a way to begin understanding the lifestyles of African Americans in rural areas. In your opinion, is this perspective appropriate for rural social work practice? What are some strengths and limitations of this perspective? How does the Afrocentric perspective compare to other multicultural frameworks? Describe which components of the Afrocentric perspective provide a foundation for understanding assets and can be used to build on the strengths of African Americans.
4. The U.S. Census Bureau now allows individuals to self-identify in determining their races and ethnic heritage. How will this impact the lifestyles of individuals and families? What are some practical implications for rural communities and organizations?

Classroom Activities and Assignments

1. Interview someone who is considered a spiritual leader for African American people in your area. Keep in mind that spiritual leaders come from a variety of different religious traditions. Share what you learned from the interview with your class. Discuss together how that spiritual tradition may serve as an asset to African Americans.
2. Observe the lifestyles of people of color in your area. Are they visible in the community? Where do they live and work? How are their lifestyles different from others living in the area?
3. The 2010 Census data gave all individuals an opportunity to self-identify their races and ethnic backgrounds. Using census data for your area, research how this change affected the demographics of the population in the area. What are some strengths as well as limitations of this approach?

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CHAPTER 7

Latino Populations in Rural America

Using Strengths to Build Capacity

Griselda Villalobos

The immigration of Latino populations to the United States continues to increase every year. Latinos comprised 16% of the U.S. population in 2010. In other words, of the 308.7 million people residing in the United States in 2010, 50.5 million self-identified as Latino (U.S. Census Bureau, 2010). The definition used by the U.S. Census Bureau for the category "Hispanic or Latino" includes persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race (U.S. Census Bureau, 2010). Latino populations speak Spanish in various dialects, are collectivist in nature, have strong family ties, generally prefer gentle and nonconflicting interactions, and emphasize relationships more than tasks (Lafayette De Mente, 1996; Levine & Padilla, 1980; Szapocznik, Scopetta, Aranalde, & Kurtines, 1978; Triandis, Marin, Lisansky, & Betancourt, 1984). Latino populations have traditionally settled in gateway states such as California, Texas, and Florida; however, in recent years, immigration patterns have shifted to other parts of the United States. With this shift comes the need for social workers throughout the United States to learn how to work in culturally and linguistically responsive ways with this growing population. Social workers must become familiar with these groups' experiences with oppression and discrimination, their cultural characteristics, and the role of acculturation in their adaptation into a new country. This chapter provides an overview of Latino populations in the United States with an emphasis on Latinos in rural America and provides strategies for building capacity with these groups based on using culture as an asset.

NEW IMMIGRATION PATTERNS

Although Latinos continue to be concentrated in California, Texas, and Florida, immigration patterns shifted to rural areas outside of these three states beginning in the 1990s. Jensen (2006) reported that Latinos accounted for one-quarter of the total population in rural areas. Rural areas like Cass County, Illinois, saw a large increase in Latinos during the 1990s (Jensen, 2006). In 2010, the five counties with the fastest-growing Latino populations were

Luzerne County, Pennsylvania; Henry County, Georgia; Kendall County, Illinois; Douglas County, Georgia; and Shelby County, Alabama. Census estimates were surpassed in 2010 by Latinos in Alabama, North Carolina, and Louisiana, indicating immigration in these new areas was higher than expected (*USA Today*, 2011).

This new immigration pattern is significant, because rural areas are characterized by a lack of social services and low numbers of service providers, as well as a shortage of bilingual staff. The Cecil A. Sheps Research Center reported that 77% of U.S. counties had a severe shortage of mental health professionals, with over half of their needs remaining unmet. The study conducted by this center found that rural location and per capita income were the most significant indicators of unmet needs (Thomas, Ellis, Konrad, Holzer, & Morrisey, 2009). For new immigrants, access to services may be even more difficult if they do not have the necessary immigration documentation. The new immigration patterns of Latinos into rural areas not traditionally seen before requires that social workers in these areas have knowledge of the needs of this population.

NEEDS OF LATINO POPULATIONS IN RURAL AMERICA

Latino populations are increasingly settling in rural areas of the United States. Jensen (2006) reported an increase of Latino immigration to counties in North Carolina and other parts of the Southeast, interior parts of Florida, and rural counties in Arkansas and east Texas. In aggregate, Latinos are overrepresented in low socioeconomic strata (Ramirez & de la Cruz, 2003) and have low levels of educational attainment and low English proficiency, which in turn may impede access to higher-status jobs, quality health care, and attainment of public services (Gallo, Penedo, Espinosa, & Arguelles, 2009). Latinos living in rural areas have higher poverty rates than their urban counterparts (Jensen, 2006), which increases both their needs for social work services and barriers they may encounter when trying to meet these needs. Some of these barriers include low English proficiency, lack of transportation and childcare, heightened stress levels brought on by financial problems, and high uninsured rates (U.S. Department of Health and Human Services, 2001). In addition, Latinos suffer from mental health disparities caused by underutilization, poor access, lack of culturally and linguistically appropriate services, and lack of Spanish-speaking providers (Villalobos & Islas, 2012). Similarly, Latinos experience limited access to health services because of greater socioeconomic vulnerabilities (e.g., poverty, low educational attainment, higher unemployment, undocumented status), which puts them at higher risk to experience more disease burden from preventable health disparities, such as tuberculosis, diarrheal diseases, poor nutrition, obesity, and diabetes (Moya, Loza, & Lusk, 2012). The cultural characteristics of Latino populations can offer clues in understanding why these groups may encounter obstacles when attempting to adapt to a new environment.

CULTURAL CHARACTERISTICS OF LATINO POPULATIONS

There are several specific differences between the cultural characteristics inherent in Latino populations and the U.S. mainstream culture. Latino populations who embrace their culture of origin tend to be collectivist in nature and have a strong sense of family loyalty (Interian &

Diaz-Martinez, 2007). Familism is demonstrated in Latino families' tendency to make decisions in a collective manner and to protect one another from outside forces. It is also seen in how they share caretaking and disciplining of children, financial responsibility, companionship, emotional support, and problem solving (Falicov, 1982). Other cultural characteristics found in traditional Latino individuals are deference to authority and lineality (Falicov, 1982), emphasis on respect (Interian & Diaz-Martinez, 2007), formality, *simpatia* (congeniality), and *personalismo* (personalism) (LaFayette De Mente, 1996). U.S. mainstream culture promotes cultural values such as individualism, autonomy, competition, future orientation, and mastery of the environment (Atkinson, Morten, & Sue, 1998; Kim, 2007; Sue & Sue, 2003). Brammer (2004) adds that U.S. mainstream culture emphasizes emotional control, focus on the nuclear family, and dominance in their relationship to the natural world.

The differences between Latino populations and U.S. mainstream culture may pose challenges for both groups in daily interactions. For Latino populations, these differences make it difficult to understand how to navigate U.S. service provision systems. Members of the U.S. mainstream culture may not be aware of these differences and may make assumptions about Latino populations' behavioral and emotional responses to situations. For example, Latinos may be judged as uninterested or uninvolved in their children's education because they do not ask questions, when in reality they do not ask questions because they do not want to appear to be challenging school authority. In health care, Latinos may not ask questions because they tend to defer to authority (i.e., doctors), and they do not want to be perceived as making waves. The acculturation process should be considered in assessing and developing interventions to assist Latino populations, because within-group differences exist in how much individuals adhere to their culture of origin.

ACCULTURATION

An important consideration when working with Latino populations in rural areas is the role acculturation plays in their adaptation into the U.S. culture. Acculturation is a complex process that has been studied for decades. Early definitions of *acculturation* described it as a process that takes place at the cultural level when "groups of individuals having different cultures come into continued first-hand contact, with subsequent changes in the original culture patterns of either or both groups" (Redfield, Linton, & Herskovits, 1936, p. 149). Graves (1967) presented the concept of *psychological acculturation*, which refers to the changes an individual goes through in the culture-contact situation. Trimble (2005) adds the concept of *situational acculturation* and points out that people will acculturate differently depending on their circumstances. For example, Latino youth who move into a community of African Americans may begin to adopt some of the customs, language, and behaviors of the community. Mendoza (1984) suggests that people can acculturate at various rates in different areas of their life (i.e., religion, dress, and customs).

Contemporary views on acculturation have moved from describing it as a unilinear, unidimensional process to a more multilinear, multidimensional process. More recent theories of acculturation posit that there is a reciprocal interaction between immigrant

groups and American society. In other words, immigrant groups influence American society simultaneously as American society influences immigrant groups. In addition, recent theories explain the acculturation process as involving a combination of variables, rather than using a single variable (i.e., nativity, length of stay in the United States, and language use) to describe acculturation status (Abraida-Lanza, Armbrister, Florez, & Aguirre, 2006). Berry and his colleagues propose that the course of adaptation an individual goes through consists of two orthogonal processes: (1) adaptation to the norms of the new culture and (2) maintenance of the norms of the indigenous culture (Berry, Trimble, Olmedo, & Lonner, 1986).

The acculturation process can happen in different ways for different members of the same ethnic group. Sue (2005) writes that acculturation cannot be understood without considering the person's environment and the person–environment match. Marsiglia and Kulis (2009) contribute the importance of considering the impact of social class, power, and prestige on the acculturation process. The Latino population is heterogeneous, and there are within-group differences related to acculturation and the impact this has on social experiences. Two differences between the three main Latino groups (Cubans, Puerto Ricans, and Mexicans) are their reasons for leaving their country of origin and their socioeconomic status once they become established in the United States. Cubans have historically left their country because of disagreement with the political practices of Cuba. Cubans tend to find a network of support once they arrive to the United States and tend to have a higher education level than other Latino groups. These factors may result in a smoother transition for Cubans into the U.S. culture.

Puerto Rico became a commonwealth of the United States in 1952, granting U.S. citizenship to Puerto Ricans. Puerto Ricans tend to immigrate into larger cities like New York and Boston. Puerto Ricans tend to acculturate at a slower rate because of the close proximity to their homeland and the freedom they have to travel back and forth. Mexicans tend to leave Mexico for economic reasons and tend to have low academic attainment, low-level skills, and low English proficiency. These factors, the close proximity of the United States to Mexico, and the continuous immigration of Mexicans into the United States contribute to Mexicans maintaining many characteristics of their culture of origin (Altarriba & Bauer, 1998).

The study of acculturation has evolved into an understanding that there may be different elements of a person's culture of origin and the host culture at any given time (an orthogonal view of acculturation). This means a person's acculturation should not be described in *degree* or *level*, because doing this implies it is a unilinear process (Berry, 2005). Cuellar, Arnold, and Maldonado (1995) discuss the orthogonal measure of acculturation in which acculturation is plotted on four quadrants. By doing this, an individual's acculturation can be seen as having a wide range of cultural characteristics from their culture of origin and a wide range of cultural characteristics from the host culture.

Experts have found that immigrants may follow different paths in their acculturation process, which impacts the way they function in the receiving environment. In *assimilation*, individuals lose their original cultural identity as they acquire a new identity in a second culture (Berry, 1980; LaFromboise, Coleman, & Gerton, 1993). *Integration*, as defined by Berry (1980), refers to developing a bicultural orientation that successfully integrates cultural aspects of the acculturating group and the host group, making the individual feel a sense of

identification and comfort with both groups. *Separation*, or "cultural resistance" (Mendoza & Martinez, 1981), is a mode of acculturation in which the individual chooses not to identify with another cultural group and to retain a separate ethnic identification. Lastly, *marginalization*, as presented by Park (1928) and Stonequist (1937), is a state in which individuals give up their original cultural identity and then discover that they are rejected by the group to which they are acculturating.

Challenges may result depending on which mode of acculturation an individual follows. Assimilation can cause an individual to experience a sense of loss of their culture of origin because of pressures to conform to new cultural customs and beliefs. This can have deleterious effects on a person's self-esteem and sense of identity. Separation can cause individuals to isolate themselves and resist participating in systems that provide health and mental health services, because these systems are not congruent with their cultural beliefs. Marginalization can result in feelings of confusion and rejection in immigrant individuals. Individuals who experience integration, however, are better able to navigate the new host culture and can have better outcomes overall.

Social workers working with immigrant families in rural areas should consider the impact of acculturation on the family as a whole and on each individual. Social work assessments should include identifying how much an individual has acculturated into the U.S. mainstream culture and whether the individual is experiencing conflicts as a result of the acculturation process. Social workers should always consider whether health and mental health problems have a link to an individual's low acculturation level, which makes it difficult for him or her to understand U.S. service delivery systems because of a lack of information or limited English proficiency.

Similarly, culturally responsive social work assessments consider whether problems within immigrant families stem from varying levels of acculturation. Vega (1990) notes that adult immigrants acculturate slower than their children, which leads to profound intergenerational conflicts. Latino immigrant parents may experience conflicts with their children if their children acculturate at a faster rate. Conflicts may occur as parents hold on to traditional Latino values while their children begin to embrace U.S. mainstream values as a result of exposure to school and community activities. This can be seen in the case where young Latinas begin to question the authority of their fathers or when young Latinas want to participate in activities such as dating or staying out late at night. A third example is when immigrant children begin to assert themselves with their parents, which violates the family hierarchical structure. It is also important to note that researchers have found higher acculturation levels are associated with maladaptive behaviors such as drug use (Gil, Tubman, & Wagner, 2001; Gil & Vega, 1996; Szapocznik et al., 1978; Vega et al., 1986). Social workers can be instrumental in helping immigrant families to address issues that result from their efforts to adapt to a new environment.

Developing strategies for building capacity with Latinos in rural America requires having knowledge of the implications of the immigration patterns discussed previously, as well as the needs experienced by these groups as a result of their socioeconomic status, low academic achievement, and language issues. The impact of cultural characteristics within the context of acculturation is basic to understanding Latinos and developing strategies that will help empower them.

STRATEGIES FOR BUILDING CAPACITY

The following section provides a description of strategies that can be used to build capacity within Latino communities in rural America. Reconceptualizing culture as a strength requires that cultural characteristics be used to develop approaches to social services delivery. Culturally adapting psychosocial interventions increases the likelihood that Latinos will participate in health and mental health programs, because programs will make sense to them culturally. The cultural assets paradigm offers six stages to providing a holistic and culturally responsive approach to engagement, assessment, and intervention with clients.

Reconceptualizing Culture

Padilla and Villalobos (2007) suggest that Latino populations be reached by "reconceptualizing culture as a strength rather than a barrier, promoting community-level outreach methods, and increasing health care access by tackling system barriers" (p. S29). Familism, a strong sense of family care and obligation, can be used as a strength by developing programs that promote caring for one's health and mental health for the good of the family. Latino cultural characteristics of *respeto* (respect) and *simpatia* (congeniality) can be used by professionals to guide their communications with Latino clients. One prenatal clinic used group prenatal visits where Latinas were able to visit with one another while viewing prenatal educational videos. This approach to prenatal visits conveyed respect for Latinas' relational needs and their need to experience congenial interactions with health care professionals that are not rushed.

Furthermore, complementary and alternative medicine (CAM) and religious beliefs can be incorporated into health and mental health approaches for Latinos living in rural areas in order to provide services in ways that make sense to them. Inquiring about the use of CAM is essential when working with Latino clients, as it conveys acceptance and respect for their practices and beliefs, as well as offers an opportunity to provide education about possible adverse interactions between CAM and Western medicine. Conducting spiritual assessments with Latino clients is one way of considering the importance of religion and spirituality in their lives. Once the importance of religion and spirituality is established, these can be used as sources of strength and support for clients by encouraging them to use these practices to cope.

Cultural Adaptation

Culture impacts the way people view the world, how they view health and mental health, whether they seek treatment, and where they seek treatment. Another way to help reach Latino populations in rural areas in the United States is to provide services that are congruent with their cultural views and help-seeking practices. Cultural adaptation stems from the work of Sue, Zane, and Young (1994), who propose that incorporating the customs, values, and beliefs of an ethnic group into the selection, modification, or development of psychosocial therapies can increase service utilization, length of treatment, and clients' satisfaction. Cultural adaptation is the process of making mental health (and health) service delivery culturally competent. Whaley and Davis (2007) define cultural adaptation as:

> any modification to an evidence-based treatment that involves changes in approach to service delivery, in the nature of the therapeutic relationship, or in components of the treatment itself to accommodate the cultural beliefs, attitudes, and behaviors of the target population. (p. 570)

The cultural adaptation of psychosocial interventions has been growing in recent years. Bernal, Bonilla, and Bellido (1995), Bernal and Sharron-del-Rio (2001), Nagayama-Hall (2001), and Rogler, Malgady, Constantino, and Blumenthal (1987) emphasize the need to consider cultural and contextual aspects in psychosocial interventions. Bernal et al. (1995) used the Ecological Validity Model to culturally adapt several interventions for Puerto Ricans (Rossello & Bernal, 1999). The Ecological Validity Model (Bernal & Saez-Santiago, 2006) has eight components of adaptation:

- *Language*—which involves knowledge of emotional expression, mannerisms, and verbal style
- *Persons*—considering the role of ethnic and racial similarities and differences in the client-therapist dyad
- *Metaphors*—having knowledge of the symbols and concepts that are shared by a particular cultural group
- *Content*—knowing the values, customs, and traditions of an ethnic group
- *Concept*—conceptualizing and communicating the presenting problem to clients in ways that make sense to them
- *Goals*—setting goals collaboratively with clients using cultural knowledge
- *Methods*—incorporating procedures for goal attainment that are congruent with clients' culture
- *Context*—involves the consideration of broader social, economic, and political contexts, as well as acculturative stress, phases of migration, developmental stages, availability of social support, and the person's relationship to his or her country or culture of origin

Kopelowicz (1997) culturally adapted a program to work with Latinos who had been diagnosed with schizophrenia and their families. The cultural adaptations involved translating the trainer's manual and patient workbook, as well as dubbing the program videos into Spanish. Skills trainers for the program were all Mexican American and bilingual. Trainers modified their in-session activities by allowing more time for each participant to answer questions. The most relevant adaptation was allowing family members into the skills training process. Family members attended 13 group sessions in which they were taught how to be collaborating participants in the treatment process of their relative diagnosed with schizophrenia.

Programs like *La Diabetes y La Union Familiar* (Diabetes and Family Unity) use *promotoras* (community health workers) to provide health interventions that focus on family support, community, and family health behavior in an effort to appeal to the Latino cultural characteristic of *familism*. Other programs are using the nurse-*curandera*, who is trained in both folk healing practices and Western medicine. The nurse-*curandera* combines

her knowledge of science and culture to make determinations about the safety of folk healing practices and refers patients to other health care professionals when appropriate (Padilla & Villalobos, 2007).

Cultural Assets Paradigm

Social workers working with Latinos in rural areas can build capacity by using a cultural assets framework that addresses the needs of Latinos across an intervention spectrum (Delgado, 2007). Delgado (2007) proposes a cultural assets framework that consists of six stages:

1. *Assessing all systems involved in the intervention process* (i.e., social workers, the consumer group or community, and the organization sponsoring the intervention). This stage focuses on gathering information about language competencies; cultural values and beliefs; the community and its history; and the history, nature, and reputation of organizations within the Latino community (Delgado, 2007).
2. *"Identifying how individuals, groups, or a community conceptualize their context and the awareness and meaning they place on circumstances"* (Delgado, 2007, p. 181). This stage includes working with key informants in Latino communities and obtaining community buy-in.
3. *Mapping cultural assets*. Mapping can be used to identify places that play important roles in Latino communities, which may be helpful in providing outreach and educational information on services and programs.
4. *Building and sustaining relationships with the target community*. Building relationships might include holding meetings in churches, beauty parlors, restaurants, or community centers that people are familiar with and trust. Building relationships also includes spending time within the Latino community and conveying a relationship of reciprocity rather than intrusion and exploitation.
5. *Implementing individual and community-focused interventions* in places that were identified in Stage Three.
6. *Evaluating the process and output objectives* outlined in the initial stages. Using a cultural assets framework requires that success be measured in flexible and nontraditional ways. Members of the Latino community should be involved in providing feedback and recommendations for improvement of services.

The cultural assets framework can be used as a way to build capacity within Latino rural communities. Latino communities require that additional efforts be made by practitioners in the areas of engagement and relationship building because of these groups' history of being disadvantaged and the identifiable cultural differences that exist between Latino groups and the U.S. mainstream culture. Latinos in rural America need to be empowered with knowledge about how to navigate U.S. health and mental health systems. In addition, they must be taught how social services systems in the United States are different from those in their countries of origin. Capacity can also be developed in Latino populations by teaching them that assertive communication does not conflict with their cultural value of *simpatia* and

personalismo. Similarly, social workers can teach Latinos in rural areas the importance of follow-up and organizational structures in U.S. service organizations, so that they may be equipped with information about how to obtain the services needed to reach and maintain optimal health and mental health.

CONCLUSION

This chapter provided data to support a shift in immigration patterns for Latino populations from gateway states like California, Texas, and Florida, to rural areas in other states. The increase of Latino immigrants into rural communities makes it imperative that social workers become better equipped to provide services that are congruent with the population's cultural beliefs and practices. Social workers cannot continue to do business as usual if they wish to reach this underserved population. Social workers must continue to shift from the deficits view of ethnic minority populations to a strengths-based perspective. Knowledge of the impact of acculturation on immigrant adaptation is important in providing effective services to Latinos in rural areas. The strategies for building capacity in Latino rural communities presented here are a good starting point, but much work remains to be done. The journey that leads to viewing immigrants as friends rather than foes, and being different but valuable, lies ahead.

Discussion Questions

1. This chapter describes some of the problems Latinos in rural areas have in accessing mental health and health services. What strengths does this population possess that could be used to address issues with accessibility? What strengths might a rural community possess that could be used to increase their capacity to provide mental health services to the Latino population?
2. It is important for social workers to understand the cultural characteristics of Latinos to effectively assess and intervene when necessary. Compare and contrast the cultural characteristics of Latino populations and U.S. mainstream cultural characteristics. As a social worker, how might you adjust your approach to engagement, assessment, and intervention to address these differences? How might you employ the Latinos' characteristics to build their capacity to resolve issues without assistance?
3. Discuss the link between building capacity in Latinos in rural areas and the social work code of ethics. Which social work values and principles are related to building capacity in underserved populations?

Classroom Activities and Assignments

1. Cultural adaptation is a strategy that seeks to make psychosocial interventions more culturally appropriate for Latino populations. Using a local mainstream program selected by your instructor, work in groups to identify elements that need to be modified so that the program is culturally competent. Explain your changes.

2. Interview a member of a Latino group. Ask questions related to the immigration experience, cultural beliefs and customs, and challenges they have experienced in adapting to the U.S. mainstream culture.
3. Instructor: Invite a guest speaker or panel of guest speakers who are members of the Latino community. Have your students prepare questions related to the immigration experience, cultural beliefs and customs, and challenges the speaker(s) have experienced in adapting to the U.S. mainstream culture.
4. Interview a key informant in a Latino community. Ask questions related to the psychosocial and economic needs of the community. Write a policy brief based on the information gathered.

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CHAPTER 8

Building Community Among Rural Gay, Lesbian, Bisexual, and Transgendered Persons

Connecting Community Through Families of Choice

Amy C. Russell

Gay, lesbian, bisexual, and transgendered (GLBT) persons in rural communities experience different challenges than heterosexual persons in the same communities, as well as their counterparts in urban settings. Because of heterosexism and homophobia in rural and urban environments, GLBT persons have tenuous, limited, or absent opportunity to express their sexual identity when seeking entry to social locations, spiritual institutions, and employment, resulting in a forcing of invisibility or compartmentalizing their whole selves and loving relationships. This is intensified in rural cultures, where conservative values are edified and diversity is commonly devalued or simply not tolerated (Preston, D'Augelli, Cain, & Schulze, 2002). Considering that rural kinship ties are established through blood lines and marriage (Boswell, 1980), and that rural community promotes religious beliefs as guides for social norms (Preston et al., 2002), GLBT persons find they are denied the routes necessary for social acceptance, as well as not conforming to more fundamental interpretations of Christianity (Boswell, 1980; Preston et al., 2002). Additionally, GLBT persons may be seen as threats to such social, religious, and relational hierarchies, and they are overtly excluded or forced to conform (Boswell, 1980). Rural GLBT persons are thus faced with invisibility, exclusion, and even isolation when living in rural places (Fellows, 1996).

Such invisibility in the rural community is a stark contrast in comparison to the anonymity found in urban areas. An issue for rural GLBT persons is migration to urban centers, resulting in leaving their families, homes, and community in rural locations to perhaps find safety, exposure, resources, and a new GLBT community in metropolitan areas. Staying or leaving rural homes is an imperative question for a GLBT person. If leaving, however, this places the rural community at a loss, because primary assets in community building are the GLBT individuals themselves.

Asset building begins with the individual, and as individuals create community, instigation of GLBT organizations can benefit the larger community through civic engagement and investment in the community in which they reside (Oswald & Lazarevic, 2011). Visibility of the GLBT community and GLBT-specific resources operating within rural environments also keeps GLBT persons linked with their rural families of origin, which in turn increases the bond within and between both local families and community (Oswald & Lazarevic, 2011). The contrast of migration to perceived urban safety and the desire to remain in one's rural home can be integrated as an asset-building technique through individual reconciling, creation of families of choice, and extended asset building within the GLBT community. In addition to these topics, a GLBT-specific model of asset building is presented, with suggested techniques for strengthening communities.

CHALLENGES FOR RURAL GLBT INDIVIDUALS AND COMMUNITIES

Asset building for rural GLBT communities requires, first, facing the realities of discrimination against the GLBT community, whether one is GLBT or straight, urban or rural. Challenges of invisibility, which harms the rural GLBT community, and denial of civil rights impact the unique needs that are essential to building and strengthening families of choice, GLBT-specific and GLBT-friendly resources, and community capacities. Eliason and Hughes (2004) note that "in the United States and in many other societies, negative images of LGBT people are continually perpetuated in legal institutions, medical discourses, religion, and the media" (p. 636). Acceptance may be perceived as greater in urban places than in rural areas, thus leading to the assumption that treatment systems and resources are more informed of GLBT needs (Eliason & Hughes, 2004). However, these researchers found that exposure to the GLBT community, not education, increased positive attitudes toward GLBT persons (Eliason & Hughes, 2004). This result shows the critical nature of visibility for the GLBT community in rural areas.

Issues of Invisibility

Invisibility of GLBT individuals has served as both a coping mechanism and a form of oppression by the rural community. Lack of tolerance of diversity, traditional moral values, and fundamentalist religious beliefs in rural areas (Lindhorst, 1997; Smith, 1997) influence disclosure of sexuality (Smith, 1997). For example, Yarbrough (2003), in his study of gay adolescents, found that a primary stage of gay identity development, which is the coming-out process, can be arrested in rural communities; youth hesitate or cannot find a trusting person to come out to. Additionally, similar concerns of acceptance resulting in continued invisibility are found in perceptions of existing service providers in rural communities. Oswald and Lazarevic (2011), in their research of nonmetropolitan lesbian women, noted that the women either had their sexuality ignored or denied as relevant in their interactions with service providers, or were not seen as equals. Many rural locations contribute to the invisibility of the GLBT community because heterosexism and homophobia are accepted (D'Augelli & Hart, 1987). Such invisibility hinders not only the GLBT individual in development but also arrests

GLBT community development. Because exposure leads to more positive attitudes toward the GLBT community, visibility of GLBT persons is essential.

Civil and Human Rights

Conservative values impact the progress of GLBT rights and civil liberties, meaning that religion and politics are used as tools to disallow GLBT persons' entitlement to equal rights the same as heterosexual persons. This can be seen in the denial of marital, family, financial, and health care rights for homosexual persons and their families. Sometimes these denials are silent, covert, or ignored because people refuse to discuss them and/or feel they do not affect them. What is overt is that violence against GLBT persons, especially against transgendered persons, is a human rights issue. For instance, the Human Rights Campaign (HRC), an international LGBT political advocacy and research coalition, asserts that with the election of Barack Obama, the removal of Bush Administration veto threats and political blocking of GLBT equality legislation has created a positive environment for the advancement of protections and access for the GLBT community (Human Rights Campaign, 2009). HRC has set their agenda in the realms of hate crimes legislation, family and workplace protections, and health and education measures to protect the human rights of and increase equality for LGBT persons (Human Rights Campaign, 2009).

Marital Issues

Discussion in rural communities about the denial of civil rights of GLBT persons, in and of itself, is necessary to make the invisible visible (Loseke, 2001). Bringing civil rights denials to the surface will educate persons who are unaware of the importance of such rights for the GLBT community. Shulman, Weck, Schwing, Smith, and Coale (2009), in their research on nonmetropolitan GLB persons, found that among rural GLB persons, these debates were both stressful and strengthening. These authors concluded that denial of civil rights has also increased the bonds within couples and the GLBT community, and that coming together because of discrimination increases the strength within the community. Hostility and discrimination against GLBT persons—exaggerated by the absence of and action against their civil rights—is clearly a huge concern for rural communities (Oswald & Lazarevic, 2011). Opinions and actions against equal rights for all persons, especially GLBT persons, present an exceptional challenge in rural communities because of values embedded in conservative and religious values. These challenges pose a sometimes finite or developmental question to GLBT persons: whether to stay in their rural home or leave for the assumed openness and safety of urban centers.

The Question of Intranational Migration

Although some issues facing the GLBT community are the same whether in urban or rural settings, GLBT persons living in a rural context will be faced with the question of migrating to an urban area, therefore leaving their rural home. If GLBT persons leave, then they do not have powerful numbers in votes and GLBT resources are decreased. This is a common

challenge among many oppressed populations, because security and empowerment reside in a community of like others. An example can be seen in the concept of the lavender vote, or theoretical basis that if the GLBT community voted along an agenda, measures would be pushed through to protect human and civil rights (Muhlberger, 1998). A salient problem noted in Oswald and Lazarevic's (2011) research with gay and lesbian persons in non-metropolitan areas was that there were weaknesses in the GLBT community, which can be a result of lack of resources, numbers within the community, and absence of support from allies. This can be a critical point for GLBT persons when they can no longer reconcile safety in a rural context and therefore migrate to urban areas. Rural culture and context, invisibility, denial of civil rights, and the problem of migration present salient challenges when addressing asset building and community capacity for rural GLBT persons.

THREE-STAGE PROCESS FOR BUILDING COMMUNITY

In capacity-focused community development (Kretzmann & McKnight, 1996), internally focused asset building is emphasized because "the prospect for outside help is bleak indeed" (p. 24), as revealed by invisibility, civil rights violations, and migration challenges of the GLBT community. Mapping these assets starts with GLBT individuals within the community, assets being persons in the GLBT community themselves, their coping strategies, and their investment in community that is evident when remaining in their rural locations.

The second step in community building for rural GLBT persons, or the connector between internal and external assets, is the creation of families of choice. When families of choice are established in rural settings, these small communities come together to address the third step, creating external resources to educate and expose reluctant existent services to the unique needs, issues, and community development capacities of GLBT persons through the creation of allies. Because these capacities may not be connected and resources are mostly nonexistent, these assets must be linked and strengthened. Figure 8.1 is an adapted community assets map of this capacity-building process following Kretzmann and McKnight's (1993) model.

Community Building Begins With the Individual

As seen in the literature, there is opportunity for strengthening and empowerment for GLBT individuals and their relationships, even when operating in the many oppressive contexts evident in rural settings (Oswald & Lazarevic, 2011; Russell, 2008; Shulman et al., 2009). Asset building begins with the individual who creates families of choice; such resilience is evident in rural GLBT individuals in their process of internal reconciling with persons and institutions that negate or devalue their sexual identity. This stage transposes upon Kretzmann and McKnight's (1993, 1996) first step in community building, to locate all available local assets, those assets being GLBT individuals. These individuals reconcile identity with rural surroundings, make identity congruous within rural contexts, possibly migrate, and then may return to rural culture, revealing investment in relationships and rural community. Because community building begins with the GLBT individual, if

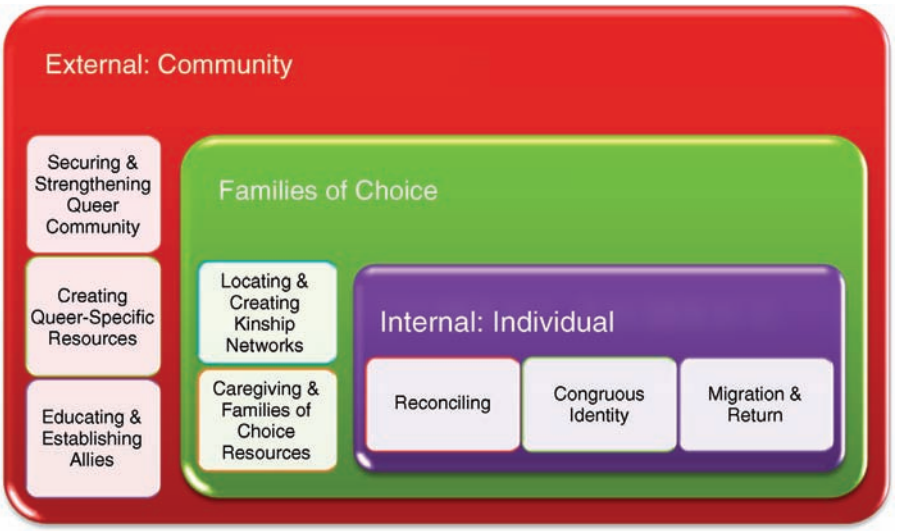

Figure 8.1 Community building among rural GLBT persons.
Adapted from Kretzmann and McKnight, 1993.

reconciliation or identity congruency within a rural home is not possible, a person may leave that rural location through migration to urban centers, thus removing a critical asset to community capacity building—the GLBT individual. The ideal would be opportunity within a rural home to access resources, embrace one's sexual identity, and find support within a GLBT community.

Although all people are unique and their individual experiences within rural contexts are their own, GLBT persons may tend to follow a similar process. Additionally, research describes how GLBT individuals follow general internal and individual processes to liberate their identity when experiencing cultural oppression (Russell, 2008, 2011). An understanding of the reasons why GLBT persons leave their rural homes is essential in asset building within rural communities to ensure the resources not found in such communities are created.

Reconciling Rural Contexts

Reconciling is an internal, cognitive, and affective act to make compatible one's sexual identity within oppressive cultural contexts found in the basic social process of liberating identity (Russell, 2011). It is an initial step in awareness that, in rural contexts, family of origin, religious institutions, and social norms may be threatened by differing sexuality. As such, GLBT persons first must decide how to face such challenges when reconciling the knowledge that their sexual identity and loving relationships are devalued. Protectively embracing sexual identity is required in reconciling; even if that identity must be suspended for a time, it remains an asset and source of strength. For lesbian women, understanding how oppressive forces operate in certain contexts, such as conservative values in rural contexts, is

helpful in creating harmony with others in those contexts (Russell, 2011). If harmony is impossible within a rural context, women find or create cultural contexts that affirm lesbian identity, such as families of choice.

Reconciling occurs in four primary cultural contexts: family of origin, work, church, and regional location. Yet, while the most painful, these contexts were the places women most desired continued connection (Russell, 2011). If family of origin and religious support are located in rural settings, then the challenge of reconciliation may be intensified because of rural conservative values. Reconciling is awareness of one's diverse sexuality within a rural context, the understanding of how such difference is received, or not, and how best to negotiate such context while valuing diverse identity.

Making Identity Congruous

Making identity congruous with cultural contexts is the problem-solving property of reconciling in liberated identity (Russell, 2011). Knowledge from reconciling that one's identity is not congruous within rural culture requires screening for safety and working out how to attain a whole sense of self, the making of congruous identity. To operate in cultural contexts that are heterosexist, creating both cultures that are inclusive and value diverse identities is essential. If making identity congruous cannot be reconciled in a rural context, then sometimes leaving that setting is required to maintain sexual identity and celebrate those loving relationships. GLBT persons may opt to leave, but there is always the option of returning. Thus, the principal choices in making identity congruous within rural surroundings are staying or leaving, finding safe contexts (migration), and returning to contexts.

Migration and Return

Physical location can pose special issues when reconciling devaluation of sexuality and loving relationships. Seeking out accepting and inclusive contexts implies seeking out metropolitan areas, which some GLBT persons perceive as possessing greater tolerance, anonymity, and open-mindedness. Migration is a conceptualized requirement to make identity congruous with one's surroundings (Russell, 2011). GLBT persons may leave rural regions where they experience incongruity to locate GLBT communities of support, gain access to resources, and create families of choice that may not be found, accessible, or possible in rural areas.

Migration is a way of leaving in an attempt to connect. For example, migration from nonmetropolitan locations and cultural contexts is a search for anonymity and an attempt to connect with the GLBT community in metropolitan areas (Russell, 2011). Because of the perception that affluence, tolerance, and education were more readily available in larger cities than in rural areas, women tended to migrate to cities to connect with the lesbian community there and/or to create a family of choice (Russell, 2011). This leaving a rural home is caused by the conflict between context and identity being too extreme, and these contexts include rural, traditional, conservative, and fundamental religious institutions, readily found in rural areas. However, the line between staying and leaving is permeable. Decisions made to disconnect and reconnect depend on the perceptions of the lesbian woman making these choices (Russell, 2011). When deciding to migrate, GLBT persons may consider education,

relationships, population, community values, and their ability to tolerate oppression in their current environment and potential urban centers.

After being away for a time, with exposure, exploration, and new knowledge of GLBT communities found in urban areas, GLBT persons are able to realize and celebrate their diverse sexuality in a more accepting location, truly embracing a congruous identity. Especially if a family of choice has been created, GLBT persons can consider returning to a given rural home, and GLBT persons do return to their rural homes (Russell, 2011). However, this return depends on the person, because returning requires their making the effort, not the context that was left. This return shows value of rural community and the relationships contained there, as well as an investment in community.

GLBT persons undergo internal processes when living in rural environments: reconciling rural contexts, making their identity congruous within them, and when unable to do so, migrating to metropolitan areas, sometimes returning to their rural homes. These processes increase power and effectiveness in the GLBT community and lead to the next stage, building GLBT families of choice.

Community Building Through Families of Choice

The second stage of asset building in community development for rural GLBT persons is the creation of families of choice and the fostering of these relationships. Parallel to Kretzmann and McKnight's (1993, 1996) model of community building, this stage is viewed as the connection of assets—GLBT individuals—"in ways that multiply their power and effectiveness" (1996, p. 24). Families of choice begin with individuals, then ripple outward toward a larger community, and address individual needs in making one's identity congruous by creating those spaces where GLBT individuals can be open about their sexual identity.

Literature presents a gap about GLBT families of choice, a much sought-after phenomenon that is known in the GLBT community; however, most research addresses areas of health care providers, comparisons of family of origin to family of choice, and the stressors of aging GLBT persons when in need of care. Families of choice can increase the positive community experiences of GLBT persons within their rural homes, if they desire to stay in nonmetropolitan settings. Keeping GLBT individuals in rural communities definitely builds assets for both the GLBT community and the larger rural community. Two routes to connecting assets in families of choice are locating and creating these kinship networks and caregiving and families of choice resources.

Locating and Creating Kinship Networks

To build community through the connection of families of choice, these potential family members must first be located. Such location lies in knowing GLBT individuals and who they are so that connections can be made to create kinship networks (Oswald & Culton, 2003). "Choosing kin" (Oswald, 2002b, p. 375) is an immediate family-building process, not in the traditional sense of biological family of origin, but in creating an intimate family structure through partners, children, friends, neighbors, and sometimes biological family. The individuals who comprise families of choice are GLBT individuals, GLBT-affirming, and overall

diverse. GLBT families of choice identify familial ties and paths to "create and strengthen family networks" (Oswald, 2002b, p. 374). When choosing kin, friends become family, especially when GLBT individuals are already receiving more support from such friends than from their families of origin, who may devalue their sexuality (Oswald, 2002b; Weston, 1991).

Family of origin can be incongruous with GLBT identity, so a compromise of sexual identity expression may occur to keep these relationships intact (Russell, 2011). GLBT persons often replace an oppressive family of origin with a family of choice to fulfill familial ties. A family of choice is a fulfilling alternative because it ensures family interaction and provides protection, safety, security, and community. The family of choice is *home*. Even if families of origin are accepting and inclusive, many GLBT persons may still create a family of choice (Russell, 2008).

The interactions within small and intimate networks of GLBT families of choice are often secretive. To protect such families from outside discrimination and to enhance the growth and resilience of such families, much effort and energy is placed within the family network. This keeps the familial network secure from outside threats that may originate in one's family of origin or others that may devalue diverse sexuality in rural contexts (Cody & Welch, 1997; D'Augelli, 1988; Kramer, 1995; Oswald & Culton, 2003). Such privacy is a coping mechanism when creating families of choice within oppressive heterosexist and homophobic rural settings (D'Augelli, 1988; Kramer, 1995).

If there is a place within rural communities to celebrate diverse sexuality, this place is within families of choice. Creation of those spaces where GLBT persons can express and celebrate sexual identity may or may not be in urban areas, but in families of choice in any setting, including rural locations. Locating GLBT individuals to create families of choice, as well as locating existing families of choice, is needed to build GLBT community in rural settings.

Caregiving and Resourceful Families of Choice

Within existing kinship networks and families of choice, resources have been created and do exist in rural areas. Community building requires locating these existing resources and affirming and then strengthening what is already occurring (Kretzmann & McKnight, 1996). Research reveals these resources exist within GLBT families of choice, and they do provide quality care for loved ones. For example, Shippy's (2007) findings show that LGB adults provide both physical and emotional support for their families of choice. Half of this care provided was for partners and one-third was for friends within a network. Cohen and Murray (2006) found that family-of-choice caregivers were more likely to provide direct care, were open about their sexuality, and almost always gave emotional support.

When viewing caregiving that is already occurring within GLBT rural families of choice, there is benefit in *starting small*, rather than seeking care in metropolitan areas (Volin, 2008). Caregiving within families of choice and kinship networks allows immediate access to others for needed resources. In these arranged groups, organizing care for friends that operate out of friendship circles, especially of aging GLBT persons, is not only GLBT-affirming but also easily accessible (Volin, 2008). Many existing traditional resources, especially in caregiving, are

ill-informed of GLBT-specific needs and may be heterosexist and homophobic. Aging GLBT persons prefer families of choice and friendship circles for care because they are affirming and, comfortable, and the GLBT person's identity is congruous with the other providing the caregiving (Volin, 2008). Persons providing such support feel rewarded; additionally, there is a social benefit to smaller, more intimate communities because resource strengthening is being realized as it occurs. Although starting small is utilizing existing families of choice effectively, additional resources are needed to supplement these families of choice in the provision of caregiving.

Without the organization of families of choice into an identifiable and accessible community, some GLBT persons will be left to request assistance from traditional—perhaps prejudiced—services, where their sexual identity remains hidden. For example, adolescents in rural areas present exceptional challenges when realizing their sexuality, especially because they may not be part of a family of choice and are isolated within existing traditional institutions. Environmental resources, such as supportive adults and formal supports, provide GLBT adolescents in rural areas the needed routes to coming out and embracing their identity; however, such supports are difficult to find (Yarbrough, 2003). Although invisible in rural areas, the existing families of choice are sources of such supports. For adolescents to connect to existing families of choice and resources, visibility of these existing kinship networks is required.

Starting small, connecting GLBT individuals within rural locations, and building on the assets and resources already occurring provides needed supports to keep GLBT individuals in their rural homes. Locating these existing resources to affirm and then strengthen what is already occurring is essential in GLBT community building.

Community Building Through Connected Families of Choice

The third stage of asset building in community development for rural GLBT persons is the building of community through and beyond families of choice. Parallel to Kretzmann and McKnight's (1993, 1996) model of community building, this stage is viewed as the use of connected families of choice to reach out to the larger community, and "harnessing those local institutions that are not yet available for local development purposes" (1996, p. 24). As the community is built through the development of GLBT-specific resources and the strengthening of existing assets, this power and effectiveness can be applied to the creation of allies. This reveals GLBT community investment in the effort to build a unique rural GLBT community while attaching to the larger rural community. These efforts are contained in securing and strengthening the GLBT community, creating GLBT-specific resources, and educating and establishing allies.

Securing and Strengthening GLBT Community

When keeping GLBT persons in their rural homes is key to community building, then that community needs to be visible to locate it for strengthening. This is complicated by the issues that GLBT persons choosing to remain in rural environments can have a limited sense of community and may be excluded from their family (Kennedy, 2010). GLBT persons who have migrated to rural contexts may feel a less closed experience, but they wish to stay and

adjust to the community. Local connections and their visible accessibility are salient for both *natives* and *transplanters* in their perceptions of community (Kennedy, 2010).

An example of securing GLBT community in rural contexts comes from D'Augelli (2006), who describes how he was faced with creating a community that "did not exist" (p. 203). The author began this community building by reaching out to a key informant, another GLBT individual, and, as a gay professional in a rural location, he began linking other GLBT persons in an effort to create resources. By being open about his sexuality, he created local supports for GLBT individuals. Being an open, gay man who was also a professional and role model strengthened and secured a network that supported GLBT persons.

Oswald (2002b) proposes envisioning family—not just family of choice, but a larger component in building community—as a concept of "redefining family to be an ongoing construction that affirms human differences" (p. 380), which reaches out from family of choice into the GLBT community and beyond. Oswald notes that bringing together all kinship network relationships, a connecting of many families of choice, integrates multiple facets into a whole. Not only is there safety in numbers, but as these GLBT communities grow with additional members, resources grow in proportion to people that make up this community.

Oswald and Lazarevic (2011, p. 382) summarize the effort of strengthening and securing GLBT community perfectly: "Efforts should be made to improve nonmetropolitan community climate so that private friendship networks can be more visible if the members so desire, rather than operating as 'group closets' out of fear." This summary is consistent with information presented by Oswald and Culton (2003). Securing GLBT community is an aspect of visibility, while strengthening is connecting GLBT individuals and their existing families of choice within these rural environments.

Creating GLBT-Specific Resources

To ensure community building for GLBT persons in rural communities, resources must exist, and because these supports are rare to nonexistent, they must be created to keep the assets—GLBT individuals—in their rural homes. Openness of sexuality is linked to contexts and locations, as well as to how long an individual has been in that context. Perception of mobility, attachment to community, access to resources, and supports are primary (Kennedy, 2010). Kennedy, in his study on rural gay men, found that the longer they lived in rural communities, the more connected they felt to the larger community; however, they continued to feel limited in their openness and adjusted in more conservative ways to their surroundings.

Because families of choice and kinship networks do provide culturally appropriate and GLBT-affirming support systems and services, rural GLBT persons would logically wish to remain in rural communities if their families of choice were residing there, hence keeping the assets within the community. Community building would then imply that these GLBT-specific resources be enhanced and supported.

Research within rural GLBT populations reveals that families of choice and kinship networks' connection to at least one local GLBT organization is highly beneficial (Oswald & Lazarevic, 2011). Additionally, this research shows that for rural GLBT persons, the "best thing" about living in nonmetropolitan areas is their attachment to the GLBT community within the larger rural environment (Oswald & Culton, 2003, p. 74). These

networks—social, cultural, and institutional bases—create *gay space* (Lockard, 1989; Oswald & Masciadrelli, 2008) that enhances opportunities to create the GLBT-specific supports required by the identified GLBT community. Rural communities that contain at least one GLBT-specific resource will be deemed as more GLBT-friendly (Oswald & Lazarevic, 2011) by GLBT and non-GLBT persons alike, and can encourage asset building to remain in the rural home. Without this one GLBT-specific resource, the GLBT community will be isolated, and continually invisible, to the larger rural community.

Educating and Establishing Allies

When continuing to reside in one's rural home, GLBT persons and their families of choice show investment in the larger rural community; this residency also shows attachment to that rural home and often is an effort to reach out to non-GLBT persons to educate and establish allies for the GLBT community. From located assets, GLBT persons and families of choice foster relationships, and harness those who are not quite ready, to create a bridge to allies simply through their continued presence in that rural community.

Allies are especially important for GLBT youth. According to Yarbrough's (2003) research on gay adolescents in rural communities, rural GLBT resources are minimal or nonexistent; allies may be difficult to locate, but they can make a monumental difference in the well-being for GLBT youth, especially in the coming-out process. Professionals and practitioners may also feel threatened as GLBT allies; therefore, it is necessary to create safe places for these allies as well. However challenging, just one organization for GLBT youth makes a huge difference (Yarbrough, 2003). Making calculated disclosures to known, trusting, affirming allies also helps youth from becoming consumed by issues surrounding their sexual identity (Kennedy, 2010).

Educating and establishing allies can begin with bridging or reconnecting with families of origin. Many families of choice consist of both supportive and estranged members of their families of origin; these kinship ties are complex and diverse, and thus it is reductionist to assume how families of choice are constructed (Neville & Henrickson, 2008). For nonmetropolitan GLBT persons, reconnecting to family of origin is extremely important, and also may encourage remaining within one's rural home (Oswald, 2002a). Oswald's research on rural lesbian women and gay men shows that ritual within family of origin allows reconnection and a route to educating non-GLBT persons. In rural families of origin, if a gay relationship was more visible, then the partner was more likely to be invited, and such invitation predicted support from the entire family (Oswald, 2002a). Such connection to family of origin is a predictor to attachment to the larger rural community (Oswald & Lazarevic, 2011).

Reaching out to the rural community through GLBT-specific resources can build community. GLBT families, as shown in research, are similar in composition to other families, and thus present a bridge to allies through likeness (Oswald, 2002b). Additionally, family building in GLBT families of choice presents a unique characteristic that is inclusive of all members within a network, allowing all members, GLBT or not, access to information and support that would be otherwise unavailable (Gerstel, Feraios, & Herdt, 1989). These resources may be informal, and although created within rural GLBT families of choice, GLBT-specific resources tend to be inclusive and educate non-GLBT persons.

Finally, there are positive outcomes for all community members when GLBT persons are attached and connected to their rural homes. Oswald and Lazarevic's (2011) research with lesbian mothers revealed that GLBT organizations and interaction within families of choice created stronger attachment to rural communities. The authors further these results with asserting that such GLBT organizations and community development of GLBT assets establish investment in the larger rural community. Visibility of GLBT resources and the GLBT community is a route to not only GLBT community building, but also an asset to the larger rural community, including increasing the power and effectiveness of GLBT resources.

Educating and establishing allies to build rural GLBT communities can be realized through the location of simply one supportive adult and one GLBT organization, reconnection with families of origin, non-GLBT inclusive and GLBT-specific organizations, and GLBT attachment to the larger rural community.

CONCLUSION

An understanding of the unique challenges faced by rural GLBT persons is primary to asset building for the GLBT community. Invisibility, civil rights denials and violations, and the question of migration present unique challenges. However, characteristics and assets that GLBT individuals bring to building their community are their experiences from such challenges, which compose a special set of coping mechanisms and capacity-building facets. Although there are multidimensional challenges for rural GLBT persons, the resilience of this population is the asset required for community building. These strengths can be seen in the first stage of community building, found within the internal asset and capacity building of reconciling rural contexts, making identity congruous, and the possible migration and then return of the GLBT individual to their rural home.

Migration is a major issue in that, although it may be a crucial stage for a GLBT individual to find community and openness when expressing their sexuality in urban areas, it can also be a depletion of resources in rural areas. To keep the assets—GLBT individuals—in their rural homes if they so choose, effort needs to be directed to the unique creation of families of choice in the GLBT rural community. Families of choice as a community-building technique involves locating and creating kinship networks, identifying the resources already in action, such as caregiving in families of choice, and creating special resources for families of choice, such as connecting them to increase their power and effectiveness. A ripple effect occurs once families of choice are connected, which leads outward to the external community through securing and strengthening the GLBT community, creating GLBT-specific resources, and establishing and educating allies to harness local resources to affect change through community development, not only for the GLBT community but for the larger community as well.

Discussion Questions

1. D'Augelli describes how he was faced with creating a community that "did not exist," and as a gay male living in a rural community, as well as a professional working in that community, he began community building by reaching out to a "key informant," another GLBT individual. If you were a GLBT person living in a rural

area, and also a practitioner in that same community, how would you be a role model? What actions would you take to increase the visibility and openness of the GLBT community? How would you maintain confidentiality and safety for not only yourself but also the key informants you were linking together to build community?

2. Reconnecting to family of origin is crucial for GLBT persons in rural settings and also may encourage them to remain within their rural home. Because this reconnection is also a way to educate non-GLBT persons, as a practitioner, what steps would you take to assist in this reconnection, if desired by GLBT persons with whom you were working? How would you encourage visibility while ensuring that the GLBT person is safe and feels comfortable being out to their family of origin?
3. Because connecting families of choice is an essential stage in creating a larger, visible GLBT community in rural settings, as an outsider, how would you go about linking families of choice? Take into account the steps involved in this endeavor, such as first locating these families of choice, establishing yourself as an ally, and interacting with key informants who are insiders of the community.

Classroom Activities and Assignments

1. Investigate the process and then create a plan for establishing an allies/safe zone program following the Human Rights Campaign outline: www.hrc.org/resources/entry/establishing-an-allies-safe-zone-program. In addition to the HRC guidelines for establishing allies/safe zones, create a list, based on your knowledge of persons within rural communities, of social work practitioners, role models, power-holders, and leaders to reach out to for support. Integrate the use of recognized symbols and visual materials that would reveal safe zones and inform GLBT individuals, without the use of verbal language, of GLBT-friendly and supportive places. Compare how this activity is similar to creating safety within families of choice.
2. Considering that just one GLBT organization and/or resource increases connection in the community, is highly beneficial for quality of life, deems a rural location more GLBT-friendly, and may help GLBT persons stay in their rural homes, how would you create this one GLBT organization in a rural community? Explore the use of technology, social networking sites, the content of the organization, safety of members in the organization, and confidentiality. How would you promote your organization? How would you collaborate with the GLBT community to establish this organization? Would it be social, resource-specific, or unspecified?

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CHAPTER 9

Rural Children and Adolescents

Building Capacities Within Public Schools

Linda Openshaw

According to the U.S. Census Bureau (2010), approximately 28 million American families live in rural areas out of 132 million total housing units in the United States. When we examine youth, we find 16 million living in rural areas; that is approximately 25% of all American children and adolescents. Rural communities offer unique challenges for children and adolescents who have problems in school and at home when there are limited community resources to assist them with mental health and family problems. One of the major community resources available to all children and adolescents is the public school system. Schools have opportunities to play a substantial role in promoting emotional well-being and academic achievement of children and youth (Goldonson, 2011, p. 109). School social workers can provide a link between the child, family, school, and community to access resources. Linking rural youth and their families with schools, churches, and community programs capitalizes on the existing strengths of families and increases the capacity for community development. School social workers who utilize the systems within a rural community can build a network of services or wraparound programs through the school.

All communities have public schools, and children and adolescents spend the majority of their time in school, making schools a natural place to begin linking children and families to extended services (Chandler, 2003–2008). School social workers can be instrumental in providing both direct services and links to resources. The school social worker role consists of the following tasks (Constable, Kuzmickaite, Harrison, & Volkmann, 1999):

- Consultation and advocacy with others in the school system as a team member
- Assessment applied to a variety of roles in direct service, in consultation, and in program development
- Direct intervention with children and parents in individual, group, and family modalities
- Program development

If community service agencies provide their services in schools, those services will reach more children, and access to services will improve. Resilient children usually come from

supportive environments (Egeland, Carlson, & Sroufe, 1993), and the supportive environment these community agencies provide will help provide children with the services they need to thrive.

CONSULTATION AND ADVOCACY

Advocacy is an effective tool for school social workers to use in building a supportive environment. Advocacy on behalf of youth and their families includes the following activities (Boylan & Dalrymple, 2011):

- Breaking down the barriers that prevent clients from achieving their goals
- Challenging the disempowerment of clients
- Increasing the responsiveness of institutions
- Increasing resources and reallocating resources
- Reducing environmental risks
- Educating both clients and the system regarding client needs

Social work advocacy in rural communities should consist of social action on behalf of youth to increase the responsiveness and accountability of the social, educational, and medical resources to which they are entitled (Melton, 1987, p. 357). Children and adolescents without a strong voice are trapped by their feelings of powerlessness in various situations (Advocacy in Action, 1990; Boylan & Ing, 2005). Youth with several risk factors may feel particularly helpless. School social workers need to understand how to assess client and community needs, how to build and sustain programs and services for youth that will meet those needs, and how to secure funding for those programs and services through private, state, and federal agencies. Many rural communities have ecumenical councils or community service provider networks that meet to discuss community needs and the ways the various community agencies can address them. Where they exist, the school social worker should participate in these meetings, or work to create them if they are missing.

Like community councils and networks, wraparound programs have been successful in bringing service providers together and sustaining financial support for providers by combining funds. Many wraparound programs blend system funds from multiple agencies, such as the child welfare system, the juvenile justice systems, Medicaid, and Supplemental Security Income (Kamradt, 2001). Wraparound programs have many strengths: They are individualized, strengths-based and culturally competent; are collaborative and use natural supports; utilize a team approach; and have flexible funding and services (Burns & Goldman, 1999).

Using both formal and informal systems creates sustainability (Kamradt, 2001). What are informal networks? A family might identify one of their friends or relatives to serve as a mentor to their child or adolescent. Or, an aunt or grandparent might babysit so the parents could attend counseling sessions at school. Likewise, a neighbor may provide peer support through the church or local recreation facility. Informal systems and formal systems support each other.

In addition to informal systems, social workers may arrange formal support from teachers. Epstein (2001) describes six ways in which educators can connect with families. These connections include home-oriented practices, such as the following:

> 1) supporting family involvement in children's learning at home, and 2) strengthening effective parenting and family well-being, in part through 3) providing connections to community resources (e.g., libraries, health clinics); school-oriented actions such as recruiting families to 4) volunteer at the school and/or 5) make decisions about school governance; and communication-oriented strategies that bridge the home school gap, such as 6) talking directly with families. (Hindman & Morrison, 2011, p. 361)

Formal programs like Head Start have been successful in linking together schools, homes, and community agencies. By including families and developing support from community agencies, Head Start strategies have succeeded and provide a useful service model for other programs.

ASSESSMENT

Assessment is the foundation of any social work intervention. The critical ecological systems approach developed by Lewin (1935, 1951) and Bronfenbrenner (1979, 2005a, 2005b) provides a context for assessing the resources and services available in rural communities. People in a system share reciprocal influence; that is, they sustain and shape one another. In rural communities, the residents are embedded with their world and dependent on the social and physical environment and its resources. Any intervention that takes place in one system will impact the entire system (Rothery, 2008). Thus, assessing both the risk (needs) and protective factors (strengths) in an individual, family, and community will assist in developing community service networks or wraparound programs.

Risk Factors

Individual, family, and community assessments are necessary in establishing wraparound services and linking resources together on behalf of youth. Some of the most significant individual risk factors for youth include poor physical health or life-threatening illness, bullying, "chronic or serious mental illness, temperament—difficult or slow to warm up, mental retardation—low intelligence, childhood trauma, and antisocial peer group" (Davies, 2004, p. 106).

Family risk factors include parental incarceration or multiple military deployments, as well as "parental insecure attachment, single parenthood with lack of support, harsh parenting, family disorganization, social isolation, domestic violence, high parental conflict, separation, parenting psychopathology, parental substance abuse, parental illness, death of a parent or sibling, and foster care placement" (Davies, 2004, pp. 106–107).

The community assessment should discover the current services available and identify the risk factors that may prevent youth from obtaining services. Basic services include medical

services, mental health services, after-school programs and school-based extracurricular programs, alternative schools, church-supported groups, and links to higher education. If these services are not already available in a community, the closest available service providers should be linked to the school. Community risk factors include poverty, poor schools, dangerous neighborhoods and community violence, and lack of access to medical care, health care, and social services (Davies, 2004, p. 107). These risk factors within a community may make it impossible for youth to access services that could assist them, either because the services do not exist or because transportation to access the services is unavailable.

Protective Factors

Assets or strengths of individuals, families, and communities are often referred to as *protective factors*; that is, they protect an individual, family, or community from potential risks. Identifying assets or protective factors is a first step in building capacity. Individual youth protective factors or assets include a positive, easygoing temperament, good health, "above-average intelligence, history of adequate development, hobbies and interests, and good peer relationships" (Davies, 2004, p. 107). Family protective factors include secure attachment, parental support in times of stress, household structure, parental mentoring, positive parental relationship, parents modeling positive skills, and family expectations of prosocial behavior (Davies, 2004, pp. 107–108). Likewise, community protective factors include access to health and mental health services, adequate housing, lack of poverty, good schools, and supportive adult mentors (Davies, 2004, p. 108).

During assessment it is essential for social workers to understand how to capitalize on the strengths and assets of youth, families, and communities. Once assessment is completed, the school social worker will begin to develop an intervention strategy. The following are types of services that need to be available for adequate care of the youth in a community. Each description is followed by a case example to illustrate how the intervention or program might operate in a rural school system.

DIRECT INTERVENTIONS AND PROGRAM DEVELOPMENT

Medical and Mental Health Services

Approximately 14% to 20% of children and adolescents experience a mental health disorder annually. However, only about one-third of those experiencing mental health problems actually receive treatment for their problem (Center for School Mental Health, 2012). Seventy-five percent of youth who have access to mental health services receive those services in schools. The positive outcome of school mental health interventions includes improvements in the following (Center for School Mental Health, 2012):

- Behavioral and emotional control
- Social skills
- Test scores, particularly in reading and math
- Commitment to school—including better attendance and grades

There are currently 10.2 million children under age 17 with special health care needs in the United States. These children live in 29% of U.S. households (Looman & Lindeke, 2008). Many of these children qualify for services through Special Education and Section 504. However, those who are in need of basic health care often do not receive the services they need. These include the one-third of children in the United States without health care insurance who live in rural communities (Lichenstein, Sharma, & Wheat, 2005). Chollet and Achman (2003) believe the key to success of school-based outreach programs is to start modestly and expand to serve all uninsured children after demonstrating the value of the services. These programs are likely to be sustainable, because the funds come from the county tax base.

Often the mental health provider or the referral source for medical treatment will be the school social worker or counselor. These services may be offered through special education funding or funding from Section 504 of the Americans with Disabilities Act. Some mental health services in schools are paid for by Social Security funds for students who qualify. The school social worker may be one of the only persons on a campus whose services will be reimbursed by the federal government.

When students do not qualify for funds already provided for school use, the school social worker should build a community service network or wraparound program that includes a contract with the nearest mental health providers for services. These services should begin with an intake assessment to qualify the child and family for services. Psychiatric evaluation should also be available at least one day per month for student medication evaluations and follow-up. The following is an example of how these services can offset some serious mental health problems for youth.

A school-based program in rural Alabama's Bibb County developed an initiative to connect children with health care. The program began with teachers distributing health and health insurance surveys. Each school then hosted a health fair at which each child received a physical examination. After an initial screening, those children who had medical conditions needing treatment were referred to a physician. Through the health insurance surveys, those children in need of insurance were identified and given Medicaid and County Health Plan application forms. The funds for those students who did not have health insurance were covered through the Bibb County Child Caring Foundation (BCCCF), a program set up by local community leaders. The BCCCF program coordinated access to Medicaid and All-Kids for partial insurance, and the BCCCF covered the rest. Those eligible for the BCCCF program were those who were not eligible for Medicaid or All-Kids, who were under 19 years of age and enrolled in school. The results of the program showed an initial 6.6% decrease in uninsured children in Bibb County.

Case Example for Mental Health

Adam was in seventh grade and was attending Jenkins Middle School in rural East Texas when he was referred to the school social worker for academic, attendance, and behavioral problems at school. He wanted to sleep throughout the school day and would get angry when his teachers tried to make him do his schoolwork.

He lived with his mother and two sisters, because his father was killed in an accident when he was four years old. His mother, Janice, worked two jobs in order to support the

family, but because of the distance she had to drive to work and the small salary she made as a clerk at a convenience store and a bookkeeper for a small construction company, her salary was not adequate to support their needs. Carla, the school social worker, tried to encourage Janice to apply for food stamps, but Janice refused. Carla arranged a meeting at school with Adam, his mother, and a psychologist, who performed screenings for the county mental health agency. A psychiatrist from the county mental health agency also came to the school and met with Adam and his mother after the intake assessment was completed. He prescribed antidepressants and weekly counseling for Adam and his mother, Janice.

After two months of weekly counseling sessions at school, Adam's schoolwork and attitude improved. Receiving the mental health services at school made it possible for Adam to receive the counseling and medication he needed. Connecting mental health providers to schools provides youth and their families with the opportunity to utilize mental health services. Using the school building creates a sustainable, low-cost location for the services and assures that the youth can attend the sessions and receive consistent treatment.

ACADEMIC HELP: ALTERNATIVE SCHOOLS

Some students do not succeed in the regular school program. For these students, school social workers in rural communities can work with school administrators to provide individualized programs within high schools that are an alternative to the regular programs. Alternative programs take place during the school day, are typically held in the same building as the regular academic programs, and have the same academic and curriculum requirements as the high school in which they are housed. However, they are self-paced and allow students flexibility in scheduling.

Alternative programs usually have small class sizes and a close one-on-one relationship between the students and teacher. The curriculum is specialized, self-paced, and places the responsibility for learning on the student. Students can also receive school credit for outside experiences, such as a job, things they do at home, and volunteer experience if the hours are documented. The students may receive credit for other off-campus experiences such as attending concerts or visiting museums.

Alternative programs need community support. Students who want to receive outside credit for employment need employers who are willing to document the students' work hours and work responsibilities and report their activities to their schools. If students attend concerts or visit museums or serve as volunteers, they need adults who are willing to document and report their activities to the schools. The National Coalition of Alternative and Community Schools accredits alternative programs in order to establish consistency and to assure that the required curriculum standards are met. The use of alternative programs as an option for students who do not respond to traditional schools will help reduce the number of high school dropouts.

Case Example of Alternative Academic Programs

Lee was an 11th-grade student who was failing at school because he wanted to work full time. He had his own successful lawn care business with which he traveled to several small

communities to take care of lawns. His prices were so competitive that he had cornered the market.

Rosa Hernandez, the school social worker, met with Lee, his parents, and school officials to have him placed in an alternative program that was housed in his high school. The program met for one-half the regular school day. The work was self-paced, and students received credit for their out-of-school jobs. Lee's parents documented his out-of-school activities and reported them to the school. Lee loved just going to school in the morning and still being able to run his business in the afternoon. He was able to graduate with his peer group because he was motivated to do the work at his own pace and finished all of his 11th- and 12th-grade work on time.

Behavioral Interventions

Schools specialize in behavioral interventions by using behavior specialists, school social workers, and teachers who understand and use classroom management. However, sometimes a youth needs continuous support. The idea of wraparound services or community networks for youth with behavior problems focuses on the need for flexibility in arranging support services that meet the unique needs of the students and their families (OSEP Technical Assistance Center for Positive Behavioral Interventions and Supports, 2012). Wraparound and community-based services are ideal for behavioral interventions, because the family is placed at the center of the services. Some evidence shows that family-based systems that include teaching cognitive-behavioral therapy to children are effective in preventing antisocial behavior and future criminal activity (Augimeri, Koegl, Farrington, & Day, 2007, p. 800). Behavioral interventions that are only taught at school and not reinforced at home are not effective. Having the family as part of the intervention is key to its success.

Special services, such as Response to Intervention (RTI) and cross-battery assessments, are tools used to assess and intervene immediately when behavior problems first occur in the school environment. Both RTI and cross-battery assessments are used when a child first exhibits behavioral difficulties, and the child will be referred to a behavior specialist or school psychologist for a functional behavioral analysis. Once it is determined that the behavior deficit is not the result of cognitive disabilities, the behavior specialist or school social worker is able to write a behavior management plan to correct the inappropriate behavior. If this is not useful, then a battery of tests will be completed to help diagnose the youth's learning or behavior problems and find solutions to the problems at school.

The wraparound and positive behavior support programs that have been shown to be effective in schools include the following: (a) small group interventions; (b) individualized functional behavior assessment and plan; (c) behavior support plans that need to be reinforced at school and home; and (d) complex behavior management plans if the need arises for safety, basic needs, or cultural needs (OSEP Technical Assistance Center, 2012).

A good behavior management plan is specific and describes in detail the expectations and rewards for the student and individual roles for the student, teacher, and parents. A behavioral management plan should begin by identifying the behavior that needs to change. The plan should then describe how the behavior needs to change and identify the reinforcers

and a specific timeline for change. The plan should also include the negative outcomes if the plan is not followed.

Case Example of Behavioral Intervention

James, a fourth-grade student, did not complete his schoolwork in class and would not finish it at home. He was failing because of his lack of follow-through. To address this problem, the school social worker created a behavior management plan. The plan provided for immediate reinforcement and positive changes in James' behavior and required the following:

> James will complete his schoolwork in class for each subject. When James completes his work for each class period, he will receive a sticker. If he has five or more stickers at the end of the day, he will get to spend 30 minutes playing videogames when he gets home from school. Mom will check his daily report to ensure he has completed his work. If work is not completed at school, James will sit with his mother and complete his work from 7–8 p.m. each night. When he sits with Mom without fussing and completes his work, he will earn up to 30 minutes per day to be used on Saturday for friends to come to his home and play. If James does not complete his work at either school or home, he will have to come early to school and do his schoolwork in the library.

When behavior plans are reinforced at home, the behavior will change very quickly. Behavior management plans fail if they are too easy or too hard. They must be evaluated and reinforced consistently. Also, teachers and parents need to be sure that they are reinforcing the correct behavior. When the services are connected so that what is taught at school is reinforced at home, the consistent reinforcement will eventually help the youth to change negative behaviors.

SOCIAL SKILLS AND INDEPENDENT LIVING SKILLS

The major goals of any youth program are to prepare young people for independent living and to give them the ability to gain a public and college education so they can secure meaningful employment. Social skills are needed to become successful in one's personal life, education, and future employment. "Social competence, the ability to elicit positive responses from others, thus establishing positive relationships with both adults and peers" is considered a basic attribute in resilient children (Openshaw, 2008, p. 92). Learning social skills and becoming socially competent is critical for positive social interactions. One's ability to interact with others in a positive way affects every aspect of one's life and "will be a determining factor in later success on the job" (Openshaw, 2008, p. 167).

Social skills can be taught individually or in groups. To promote sustainability of a social skills program, the program should be incorporated into the classrooms. The school is the natural place for teaching social skills, and a social skills curriculum should be incorporated into every grade level from elementary school through junior high school. The skills can be

taught in a classroom of students, with one skill per week being introduced for students to master. The classroom teacher and parents could then reinforce using the skill correctly. Dowd and Tierney from Father Flanagan's Boys Home and Arnold P. Goldstein and Ellen McGinnis have developed programs designed to teach social skills in classrooms. These programs break down skills into basic steps that can be measured. For example, in teaching students how to follow directions, Dowd and Tierney (2005) break the skill into the following parts: (1) look at the person, (2) say "okay," (3) do what you've been asked right away, and (4) check back. Similar steps are repeated in teaching children to accept criticism, how to accept "no" for an answer, and how to greet others.

If youth do not learn social skills early in their lives, they will lack success in every aspect of their lives. A study of university faculty reported several problems in classrooms. All were linked to lack of social skills. The problems included tardiness, excessive absences, leaving class early, leaving class and returning, text messaging, use of cell phones, complaints about exams and assignments, disrespecting instructors, eating in class, disrespecting other students, and defiance toward instructors (Openshaw, 2008).

Teaching independent living skills should be combined with teaching social skills to high school students. Independent living programs have been developed in response to early studies that highlighted the many difficulties experienced by youth who age out of foster care. In 1985, Title IV-E of the Social Security Act was amended by the Independent Living Initiative (Public Law 99-272) to provide federal funds to states to help adolescents in foster care develop independent living skills. These same skills are needed by all youth as they prepare for leaving the family after high school. Youth need to become aware of how to create and follow a budget, how to care for their own clothing, how to find housing, and other adult-centered tasks.

Community agencies and public school systems should link services with universities to help coordinate college prep programs, not only for academics, but also for social skills, self-management, and independent living skills. Caring and support from a community can be manifested through the availability of resources such as housing, healthcare, education, job training, employment, and recreation. Community agencies should offer ideas about how to deal effectively with problems such as substance abuse and depression as youth prepare to live on their own.

Case Example of Social Skills

Adrianna, who was from Hungary, was in the 11th grade. Her English-language skills were excellent, but her personal hygiene and social skills were extremely weak. She had no friends and was treated with disdain by all of her peers. She did not know how to interact appropriately with others. The school social worker and Adrianna's special education teacher began a social skills program to teach her how to interact successfully with others. Part of the program included some body language training because she did not understand how close she should stand to others. She often got too close and offended others. She also did not gesture appropriately, so a mirror was used to help her become aware of how she looked to others. The training also included lessons on personal hygiene.

At first, Adrianna was not very responsive to the training. She acted as if she already knew the things being taught. However, after three months of weekly sessions, she began to

experience more positive interactions with others. Her new skills paid off both at school and in the community. Adrianna was able to find a job, and she began to prepare for community college for the following year. Her entire disposition improved as she interacted positively with others.

Social skills training, like we see in this case example of Adrianna, is appropriate for any age and offers those who have had negative relationships a chance to improve their interactions with others.

MENTORING

Middle school and high school youth are in need of guidance and support and are particularly responsive to mentoring. Mentoring is "a relationship between an older, more experienced adult and an unrelated, younger protégé—a relationship in which the adult provides ongoing guidance, instruction, and encouragement aimed at developing the competence and character of the protégé" (Jekielek, Moore, & Hair, 2002, p. 6; Rhodes, 2002, p. 3). A protective factor for youth is a caring environment with a least one adult who knows the child or adolescent well, cares deeply about the well-being of the youth, and sets positive expectations (Krovetz, 1999; Openshaw, 2008).

Mentor traits and characteristics can significantly impact the effectiveness of the relationship. There is empirical research on the "impact of mentoring traits, which include flexibility, competence, mentor personality and power" (Smith, Howard, & Harrington, 2005). Necessary characteristics for mentors have also included authenticity, nurturance, approachability, inspiration, and conscientiousness (Darwin, 1999). The most effective mentors are "principled mentors," whose attributes include integrity, courage, and care (Wilson, 1999).

Along with mentor traits and characteristics, the type of relationship between the mentor and youth is critical in determining the overall effectiveness of the mentoring. Research has identified several important characteristics of the mentoring relationship, including a feeling of closeness (Rhodes, 2002). In order to produce any positive results, the relationship must contain some degree of emotional bonding, which may include empathy and authenticity (Spencer, 2006). Time has also been found to be an extremely important element in the mentoring relationship. Both consistency and length of time of the relationship have been found to contribute directly to any positive impact produced by the relationship (DuBois & Silverthorn, 2005; Parra, DuBois, Neville, Pugh-Lilly, & Povinelli, 2002).

The effects of mentoring on youth have been documented in many research studies. Positive changes are often demonstrated in academic performance, mental health, and reduced risky behavior (Blinn-Pike, 2010; DuBois & Karcher, 2005; Rhodes, 2002; Sipe, 2002). General agreement also exists that issues such as academic performance appear to be more amenable to direct mentoring interventions than other more complex issues such as mental health or psychological functioning (Blinn-Pike, 2010; DuBois & Karcher, 2005).

A study on mentoring rural African American youth found that "behaviors such as anger, breaking the law, and substance abuse were reduced" through mentoring

(McAlpin, 2011). Mentoring relationships are more powerful and effective when youth are experiencing hardships in their lives, such as racial discrimination, and family stressors such as poverty, unemployment, and parental incarceration.

Mentoring relationships can come from a source that matches youth to mentors such as Big Brothers Big Sisters. Youth can also select their own "natural mentors." Natural mentors can be members of the family or they can come from nonfamilial relationships that are part of the youth's existing support structure (Rhodes & Davis, 1996). Natural mentors may be coaches, scout masters, or church youth leaders. The literature on both natural mentors and assigned mentors is consistent in demonstrating positive results when addressing issues such as anxiety, depression, school performance, and risky behaviors. These positive results tend to occur for males and females as well as a variety of ethnic and racial groups (Rhodes, Ebert, & Fischer, 1992; Sanchez, Esparaza, & Colon, 2008).

Case Example of Mentoring

Chuck was a young Latino boy in ninth grade when he was referred to the school social worker for nonattendance and failing grades. He had been considering joining a local gang in his rural community. His father was incarcerated on drug charges. His mother had a live-in boyfriend who abused drugs and alcohol and often hit Chuck.

When Chuck met with the school social worker, he expressed feelings of depression and hopelessness about his life, which explained his lack of interest in school. Chuck seemed excited about the possibility of a mentor when the school social worker suggested it to him. The school social worker contacted Big Brothers Big Sisters to help set up a mentoring relationship for Chuck. It took a few months to get the mentoring relationship established, but once it started, it had an immediate, profound effect on Chuck.

Chuck met with his mentor every Friday afternoon after school. The mentor would pick Chuck up at school and take him to Dairy Queen for treats. Often they would just talk at the Dairy Queen. Some weeks the mentor would take Chuck to a movie. Chuck began to look forward to the time he spent with the mentor. The mentor was a young man who had recently graduated from college and had found a job in the same rural community where Chuck lived. The mentor shared some common interests with Chuck.

The relationship lasted for four years until Chuck finished high school. He had set goals of staying away from negative peers and had stood up to his mother's abusive boyfriend. He had been able to make positive strides in his life through both the support of the school social worker and his mentor. The mentor attended Chuck's high school graduation. After graduation, Chuck had set goals to attend a community college in the nearby community.

When youth have a successful long-term mentoring relationship, they stop acting out and breaking rules and become successful (McAlpin, 2011). Utilizing existing programs such as Big Brothers Big Sisters is a way to build sustainability into a mentoring program. School social workers and counselors have the ability to identify at-risk youth who would benefit from a mentoring relationship. Once the parental permission has been obtained, the youth can be referred to a mentor.

AFTER-SCHOOL PROGRAMS

Worsening economic conditions have contributed to longer work hours for parents and increased stress in rural families. Increased stress has led to increased substance abuse and conduct problems in rural children (Conger & Elder, 1994). The longer work hours for parents have contributed to increased time alone after school for children and youth criminal activity. "Research suggests that the after-school hours are of the most risky in children's lives" (Riggs, 2006, p. 76). After-school hours between 3 p.m. and 7 p.m. appear to be a prime time for prevention and intervention services (Riggs, 2006). After-school programs have been successful in some communities in combatting the long hours of unsupervised time for youth after school.

Research by the Texas Education Agency found that youth who attended an after-school program in Texas (the 21st Century Community Learning Center) had improved attendance during the regular school day. The UCLA Center for the Study of Evaluation found that students had higher aspirations toward college and improved school attendance when they participated in after-school programs (Afterschool Alliance, 2006). Other studies report an improvement in overall academic achievement and tests. Pre-kindergarten to eighth-grade students seem to benefit most from after-school programs. Children 8 years of age and younger show improved grades and academic success when enrolled in after-school programs (Riggs & Greenberg, 2004). It is essential for school social workers who are referring students to after-school programs to do a complete assessment on each child to understand the child's developmental stage and abilities (Riggs, 2006).

Some after-school programs have an academic emphasis where students spend time continuing to learn and study. Some programs focus on teaching social skills. Some are purely recreational in nature. Many of these programs have been developed by states, such as North Carolina's "Support Our Students" program. Some of the programs have been developed by local municipalities and counties, such as Adams County, Pennsylvania's "Generacion Diez" program. Boys and Girls Clubs of America developed "Project Learn/Education Enhancement Program," focusing on tutoring and engagement skills through the use of board games, verbal activities, writing, life enhancement, and enjoyment of life activities (Afterschool Alliance, 2006, p. 7).

After-school programs, such as the California Afterschool Learning and Safe Neighborhoods Partnerships Program, provide state government matching funds to local partnerships of school districts, community groups, and local governments to provide programs for students that are both before and after school (Afterschool Alliance, 2006). In order to build a similar program in rural communities outside of California, local agencies and schools might work together to secure grant funding.

Case Example of After-School Programs

Robert was in sixth grade and was being raised by his grandmother. She worked during the day, so Robert was on his own from the end of school at 2:30 p.m. until 6:30 when his grandmother came home. He was isolated at home, playing video games. He did not have many friends at school because he was taciturn and only talked about video games. He called himself a latchkey kid and seemed to wear the title like a medal.

A community center near his school began an after-school program that included video games, basketball, and some academic help. Robert was urged by the school social worker and his grandmother to attend the center and try the program. He was reluctant at first, but after starting the program, he became less isolated and much more interactive with his peers at school. His grades improved, and so did his overall outlook about life. As we see in the case of Robert, after-school programs can provide many benefits within a positive opportunity for youth to interact with each other.

CONCLUSION

Rural communities have challenges in providing the services needed for children and adolescents who are at risk. Using the public school as a base to provide services through coordination from a school social worker, many community services can be linked together. Once the programs are established, community agencies need to keep the services going for as long as they are needed. Through consultation, advocacy, providing direct services, and program development, a school social worker can be the catalyst for creating and helping build sustainable services. Building a community network of services, such as mental health, medical services, after-school programs, alternative school programs, mentoring, and links with local universities and faith-based organizations, can expand the options for youth and families.

Discussion Questions

1. Discuss the vulnerabilities unique to youth that make it necessary for social workers to advocate for children and adolescents. Consider the steps necessary to develop effective advocacy for youth, including parental permission, access to school services, and transportation.
2. Consider the types of problems that social workers have when they personally advocate for programs that are in conflict with the policies of the agencies that they work for. An example would be a school social worker who does not believe in restraining students and yet the school district the social worker is employed by has time-out boxes that are used when special education students misbehave.
3. What developmental and behavioral issues of children and adolescents could interfere with parents utilizing community resources? How could social workers assist a family in order to help them receive access to community resources? Are these problems unique to rural communities?

Classroom Activities and Assignments

1. Research the history of several community agencies in the community where you currently live or attend college or university. What has caused some agencies to thrive while others failed? Discuss the importance of focusing on sustainability for those programs that have thrived and whether support from the public schools would help.

2. Write a one-page letter to the mayor or another leader of the town or county you grew up in. Recount the types of individual, family, and community assets that played a role in your personal development during your childhood and adolescence. The purpose of the letter is for the leader to see what works to sustain and support a student like you to be successful and make it to college. Be sure to note any programs in your school that were helpful to you and others and suggest other helpful programs that might have been introduced.
3. A rural community might not have a facility that will provide a safe place to house children or adolescents who become a threat to themselves or others during the night. Rather than transporting them 40 miles one way to the nearest mental health unit in a hospital, the local police officers usually transport them to the nearest small hospital without a psychiatric facility or place older adolescents in jail overnight. List the considerations and steps necessary to develop services for helping an adolescent who becomes a danger to him- or herself or others because of either substance abuse or psychiatric problems in a rural community.

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PART THREE

Practice Issues in Rural Contexts

Susan A. Murty

Effective rural social workers build on community assets. They are very good at assessment with individuals and families, and they are also able to identify the assets of the local community. They also connect with resources outside the local community to supplement and enhance the strengths that exist locally. They are sensitive to the local culture, and they become allies with local leaders to meet needs in the community. Rather than trying to do everything themselves, they recognize what is working well in the rural community and collaborate with local members of the community to make things happen. Finally, they are excellent advocates for their rural communities and are willing to work to change policies to improve access to resources and services for rural communities. All of these highly developed skills are essential for effective work in the rural environment.

Rural social workers cannot afford to limit themselves to a narrow set of methods or to restrict themselves to working only with a few specific populations. Rural social workers have a broad perspective on the community and its needs. Effective rural social workers are true generalist social workers who stimulate change at many levels, including change in organizations, in neighborhoods and communities, and in policy. They are able to develop new programs to meet new challenges. They can intervene in multiple ways.

Rural social work is challenging and demanding. However, keep in mind that rural social work is also infinitely rewarding. Effective rural social workers know that they have made a difference. They get the satisfaction of seeing that the results of their hard work have an impact on people's lives and on the communities they serve. The chapters in this section present excellent examples of effective rural social work. Together they will inspire and motivate you as you prepare to enter this fascinating and challenging field of social work practice.

The six chapters in this section deal with a wide range of practice situations and programs and demonstrate a variety of types of interventions; for example, they include services to meet the needs of Latino migrants, individuals at the end of their lives, people with HIV/AIDS, and populations with mental illness. What is fascinating about these chapters is not only their variety but also how much they have in common. Each of these chapters demonstrates ways to work with the unique assets of local rural communities. Each of them demonstrates an

attitude of respect and appreciation for the strengths of rural communities and shows ways to develop relationships of trust with members of the community to enhance local services.

In Chapter 10, Parrish and Trawver recommend a process based on principles of evidence-based practice that are applicable to all kinds of rural social work and all of the chapters in this section. Evidence-based practice is now widely recognized, but its application to rural practice in this chapter is unique.

Two of the chapters in this section focus on approaches to collaborating with informal support systems in rural communities. In Chapter 13, Scales and Singletary identify congregations as active organizations in rural areas and provide suggestions for ways to collaborate with them to meet community needs. They provide a very sensitive discussion of communication, culture, and organizational issues that are central to connecting with congregations in rural communities. In Chapter 12, Poole and Espadas write about ways social workers can become involved in the pathways to care used by rural Latino populations; these pathways may include both traditional healers and local congregations.

The remaining chapters in this section focus on specific needs and services. In Chapter 11, Davis discusses effective wraparound services for rural families with children experiencing mental health challenges. In Chapter 14, Cooper, Avant, and Cordova discuss ways to meet the multiple needs of people with HIV/AIDS living in rural areas. In Chapter 15, Boelk and Retrum discuss ways to serve rural patients at the end of their lives. These chapters will be of interest not only to social workers serving these particular populations but to all rural social workers, because they use approaches drawing on local assets that are essential to effective rural social work with any population.

Of special interest in the chapters in this section are examples of connecting rural communities to resources from outside of the local community. Many rural services are now provided by regional organizations with main offices based in urban areas. Effective rural social work requires highly developed skills in connecting regional resources to local people and their needs. For example, Cooper, Avant, and Cordova discuss how to connect people living with HIV/AIDS with specialized services that are not immediately accessible to them in their rural communities. They make clear the importance of a regional network of service providers and also how difficult and challenging it can be to create one. Boelk and Retrum discuss ways to connect local home-based services and support from residents of the local community with specialized medical services and treatment that hospice and palliative care organizations can access from regional sources. Effective rural social workers link local communities to the outside resources while keeping in touch with local communities and their unique needs.

I know that you will enjoy this section of the book. You will see such a wealth of varied examples of effective rural social work practice that you will be stimulated to develop additional ideas on your own. You will be inspired to incorporate the asset-based social work principles presented here into your practice as a rural social worker.

CHAPTER 10

Evidence-Based Practice in the Rural Context

Danielle E. Parrish and Kathi R. Trawver

Historically, the social work profession has grappled with ways to close the gap between research and practice. Although past efforts like the empirical practice model have provided some improvement, social workers continue to report a lack of integration of research into their practice (Mullen & Bacon, 2004; Parrish & Rubin, 2012). The most recent effort in social work to close this gap is the evidence-based practice (EBP) model. This model more explicitly operationalizes the process of integrating research and practice, including the consideration of important contextual practice issues when selecting research to guide practice decisions, such as the client's culture, the practice context, and the practitioner's practice expertise. The feasibility of this model has also been enhanced by a growing body of research on practice-related issues and the widespread dissemination of this information to social workers through a variety of online databases, training resources, and treatment modalities.

There has been a great deal of excitement about EBP within social work, because it equally weights the importance of research with contextual issues and cultural sensitivity, fitting well with our overall professional perspective of *person-in-environment*, emphasis on client *strengths and assets*, and *respect for diversity and the worth of the person*. Moreover, this model emphasizes *informed consent* and *self-determination*, where the client is provided with the research evidence emanating from a search of the available practice literature, and then empowered to make a collaborative decision with the social worker regarding the potential solution or intervention. Finally, this model emphasizes *competence*, where social workers engage in lifelong learning and training to provide the best available services to their clients. Although some social workers are discontented with the evidence-based practice model, it has been widely accepted as an important model for the profession. Moreover, various aspects of the EBP model have been endorsed by the National Association of Social Workers (NASW) Code of Ethics (2008), which states:

- Social workers should *base practice on recognized knowledge*, including empirically based knowledge (section 4.01, Competence).
- Social workers should *monitor and evaluate* policies, implementation of programs, and practice interventions (section 5.02, Evaluation and Research).

- Social workers should critically examine and *keep current* with emerging knowledge . . . and *fully utilize evaluation and research evidence* in their professional practice (section 5.02, Evaluation and Research).

Despite the widespread acceptance of EBP within social work, there remains a critical need to increase dissemination of this model and valuable resources to support its implementation among social work professionals in a variety of practice settings.

This chapter aims to provide important information on the EBP model for social work practitioners in rural settings. First, the definition and background of EBP in social work are presented, while further examining the fit of this model with an asset- and strength-based approach. Next, the extant research on EBP in rural social work is presented, followed by a discussion of the challenges and opportunities of using this model in the rural context. Several resources are provided to support implementation of EBP in rural communities, which are often fortunate to have strong social networks and capital, but where social work practitioners often face the challenges of fewer colleagues and supervisors for consultation, less frequent access to training on evidence-based interventions and programs because of travel and cost, and fewer referral options for services.

WHAT IS EVIDENCE-BASED PRACTICE?

Evidence-based practice (EBP) is a model for integrating research into practice with an overarching goal of increasing the quality and effectiveness of services. This approach has taken root within social work and allied helping fields within the last decade (Manuel, Mullen, Fang, Bellamy, & Bledsoe, 2009; Parrish & Rubin, 2011). Originally articulated within the medical profession, EBP has since been adapted for use within social work (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996; Thyer, 2004). Specifically, EBP was conceived as a *process* that integrates the best-available research evidence with the practitioner's expertise and the client's culture, values, and preferences to make the best practice decisions. This practice model has been operationalized as a five-step *process* that includes: (1) asking an answerable practice question, (2) searching for the best available research evidence to answer that question, (3) critically appraising the research for its quality and applicability, (4) integrating the best-available evidence with one's practice expertise and the client's values and preferences, while considering the practice context, to answer the question, and (5) evaluating the outcome of the practice decision and the process itself (Gibbs, 2003; Parrish & Rubin, 2011; Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000).

The *evidence-based practice process* is differentiated from the *evidence-based practices* definition, which identifies EBP as a list of interventions or practice guidelines that professional organizations or insurance companies have deemed "evidence based" given evidence for their use based on several high-quality randomized controlled trials (RCTs). To reduce the confusion between the two definitions, evidence-based practices are now referred to as *empirically supported interventions or programs*, and evidence-based practice refers to the process definition.

Guidelines for Implementing the EBP Process

There are very specific guidelines on implementing the EBP process to make the integration of research into practice more efficient. Although an in-depth description of these steps is beyond the scope of this chapter, we provide the main guidelines in the following sections, as well as some online training opportunities to further develop knowledge and skills in the EBP process (listed in Appendix B).

Step One: The EBP Question

Given the confusion between the *evidence-based practices* and *evidence-based practice process* definitions, it has been widely misconstrued that the EBP process only pertains to making decisions about how to select an intervention for a client or client system, and as such, the EBP model only deems highly controlled RCTs or other methodologies based off of such studies (e.g., meta-analysis) as valuable for practice (Adams, LeCroy, & Matto, 2009). More accurately, EBP is a process that can be used to answer many important practice questions, such as identifying risk or protective factors that may pertain to certain populations and practice issues, or identifying the meaning of a particular experience for clients who face common life challenges (Sackett et al., 2000). For example, an EBP question might include, "What is it like to experience domestic violence in a rural community where the majority of the population is Mormon?" An answer to such a question may help a social work practitioner become more sensitive to cultural religious issues that are unique to this particular rural context. Such an answer would typically draw on qualitative research methods, because these methods help us develop deeper understandings of complex phenomena or culture. As such, EBP is a process that can be used to answer a variety of practice-related questions and that values a variety of research methods, depending on the kind of EBP question.

Despite the variety of possible EBP practice questions, these questions most frequently focus on identifying the most effective intervention to use with a specific client or target population. When composing the EBP question, it is important to include detailed information concerning the client or target population's characteristics (e.g., race, ethnicity, gender, age, rural) and the desired outcome (e.g., reduce depressive symptoms). If known, the intervention/practice decision can also be included in the question (e.g., cognitive-behavioral therapy) and/or an alternative course of action (e.g., interpersonal therapy). The purpose of this question is to generate search terms for the second step of the process.

Step Two: Searching for the Best Research Evidence

Multiple online resources provide valuable information to guide practice decisions, including websites that provide systematic reviews of the research in a particular area of practice, and practice guidelines or databases with full-text articles (examples of these sites are provided at the end of the chapter). Although some websites simplify the search process by providing tables of contents or drop-down menus, it may still be necessary to search available databases for research evidence, particularly when little research is available to answer the EBP

question. Such databases used to be restricted to those affiliated with colleges or universities, but this is not the case anymore. In fact, most local library cardholders can now access high-quality databases with practice-related research remotely from the office or home using their library card information to log in.

To search databases, underline the key terms that will guide your search from your EBP question and then write down synonyms for these terms, because they may help broaden your search. For example, "adolescent" is synonymous with teenager, youth, and juvenile. If you have an important phrase, such as "child protective services," enclose it in quotation marks so it searches for the entire phrase rather than each term separately. Finally, Boolean operators, such as AND, OR, and NOT, can be used to expand or limit your search. The term AND can be used to narrow your search by requiring that all connected terms must be included in the references you are searching. The term OR is used to expand your search by including words that are synonymous; however, it is important to remember to place all of your terms connected by OR within parentheses. Finally, use the term NOT to take out words that are irrelevant to your search (e.g., you may want to include references that address "suicide attempts" NOT suicide). In addition, truncation can be used to search for variations of a word stem by using a double asterisk (**). For example, a search term *effect*** will find *effect*, *effective*, and *effectiveness*. Finally, methodological terms can be included to narrow your search to the kinds of research that will answer your question. For example, if you are searching for an effective intervention, you might include the following terms: effective AND (intervention or treatment or program).

Step Three: Evaluating the Evidence

Once you have located research evidence to answer your EBP question, the next step requires evaluating that evidence for its quality and applicability to your client and practice context. Although a detailed discussion of this step is beyond the scope of this chapter, we highly recommend Rubin and Bellamy's 2012 text for further information on this part of the process.

Step Four: Making the Practice Decision

What is particularly appealing about the EBP process for social work is its emphasis on the consideration of multiple sources of information when making a practice decision—research evidence, individual client characteristics (including their strengths), values and practice context, and practice expertise. This step prevents a cookie-cutter approach to identifying treatments, programs, or interventions. Also central to the EBP model is an emphasis on shared decision making, self-determination, and empowerment, where the practitioner presents all of the options and their evidence and jointly decides with the client what the potential course of action will be. Even if no evidence is available to answer the specific research question, the practitioner has still engaged in the EBP process by searching the literature and then selecting the best course of action based on practice judgment, consultation, or theory.

Step Five: Evaluating the Practice Decision

The fifth and final step, evaluating the outcome of the practice decision, is critical to determine if the intervention works with the client or if another course of action is needed. Even if an empirically supported intervention is selected, studies supporting these interventions only suggest an increased probability that the client will get better. For example, let's say a research study found that 70% of children whose parents receive a parent management training intervention decrease symptoms of oppositional defiant disorder compared to 30% in the control condition (where they do not receive an intervention). This means that 30% of the children whose parents received this intervention still did not improve. Your client could be like the 70%who improved, or they may be like the 30% who did not; therefore, it is important to evaluate the outcome to ensure they are benefiting from the intervention. Moreover, you may not be delivering the intervention in the same way as the providers in the intervention study, or the context may be different. This step is especially important when no research evidence is available to guide the practice decision, as we do not even have an estimate of the likelihood that they will improve. Several resources are listed at the end of the chapter that provide guidance on selecting an outcome measure to implement step 5 of the EBP process. In addition, we also highly recommend Rubin and Bellamy's (2012) book to learn more about feasible methods to evaluate practice decisions.

Many people are optimistic regarding the EBP model for social work practice, but there are still challenges in its implementation. Many social workers lack training or familiarity with the EBP process model and frequently cite time as a challenge in implementing the process (Parrish & Rubin, 2011, 2012; Rubin & Parrish, 2007). Several potential solutions have emerged, such as developing EBP teams within an agency or with professional colleagues to reduce the amount of time needed to search for research and appraise the evidence pertaining to a specific EBP question, but there remains a need to identify new approaches to make the EBP process more feasible. We hope this chapter will be one step toward making this practice model more feasible in rural settings.

EVIDENCE-BASED PRACTICE AND THE RURAL SOCIAL WORK PRACTICE SETTING

Rural social work practice is considered a distinct field of professional practice (Daley, 2010, p. 1) that focuses on the importance of the community when considering employing interventions with rural populations (Belanger, 2005; Jacobsen, 1980; Martinez-Brawley, 1993; White & Marks, 1999). It is essential, from an EBP perspective, that the larger community context is considered as an important client characteristic when making practice decisions within a rural community context. Several experts have asserted frameworks for rural social work that suggest the importance of a strengths or assets perspective when accessing rural communities, suggesting that social systems play an important role in identifying the solution (Daley & Avant, 2004; Scales & Streeter, 2004). In addition to considering and utilizing the community context in developing interventions, these

frameworks also fit with the idea of providing interventions that empower and strengthen both the individual client and the larger community. As such, the EBP model and the asset- and strength-based models are highly complementary.

Rural settings have many unique contextual issues—both strengths and challenges—when implementing evidence-based practice. Unfortunately, the literature on the translation of the EBP process to rural settings has been slower to develop, as have the development of empirically supported interventions to support such practice (HRSA, 2011). In fact, the scant literature available on rural EBP is based out of the medical and nursing professions (Olade, 2004; Parsons, Merlin, Taylor, Wilkinson, & Hiller, 2003; Taylor, Wilkinson, & Blue, 2001). This situation is concerning, as 20% of the U.S. population resides in rural areas, yet there is a shortage of health services to address the needs of most of these communities and multiple challenges in retaining rural service providers (Agency for Health Care Research and Quality, 2004; Dixon, Hook, & McGowen, 2008). However, there are many reasons for optimism regarding the implementation and feasibility of EBP for rural social workers, from emerging literature that provides guidelines on the adaptation of empirically supported programs in rural settings to multiple online and telephone support services that minimize the costs of training, travel, and services in rural communities (Dixon et al., 2008; HRSA, 2011).

A recent multimethod study, which included surveys of multiple behavioral health organizations or persons knowledgeable of these programs in rural areas, identified several characteristics related to the successful implementation of empirically supported programs in rural settings (HRSA, 2011). These themes or characteristics included that the program (a) have relevance to a rural setting either by the development or adaptation of the intervention for a specific rural community; (b) increase the availability, accessibility, or acceptability of services; (c) focus on sustainability and expansion by focusing on multiple long-term funding sources; (d) have capacity as defined by highly qualified staff and options for training; (e) successfully document their program information in policy and procedure manuals, and disseminate this information to the community and funders; (f) collect and use data to inform decision making and assess program effectiveness; and (g) engage the community by involving multiple stakeholders in the adoption, development, implementation, and expansion of a program (HRSA, 2011).

Advances in technology, wider access of high-quality Internet services within the United States, and the development of multiple online and telehealth resources provide opportunities for rural social workers to become better connected to other providers (despite the distance), gain access to a multitude of training materials and empirically supported manuals, and connect their clients to empirically supported interventions that have been effective in alleviating multiple mental health or substance abuse issues online or by phone (Dixon et al., 2008).

REAL-WORLD EXAMPLE: IMPLEMENTATION OF EVIDENCE-BASED PRACTICE IN A RURAL SETTING

A recent national review of behavioral health programs in rural settings identified an empirically supported intervention, Assertive Community Treatment (ACT), which was

adapted for use in a rural setting in Idaho (HRSA, 2011). ACT programs provide comprehensive wraparound "systems of care" behavioral health services to individuals who experience serious mental illness. Recognizing a need to expand such services to rural communities, the Idaho Region 7 ACT program was adopted and adapted to provide mental health recovery treatment to mental health court clients, with a specific focus on recovery, targeting individuals with a medium to high range of mental health severity, dual diagnosis or substance abuse or dependency, and a felony or misdemeanor charge. In this rural context, the adapted ACT approach reduced hospitalizations by 97% and jail days by 87%, with only a 20% recidivism rate among graduates (HRSA, 2011). The manual for this intervention, as well as multiple training materials, is available for free online at SAMHSA: http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345. This is one of many of SAMHSA's Knowledge Informing Transformations (KITs), which provides the program manual and guidance for the implementation of the intervention or program with consideration of cultural issues and community context, funding, sustainability, and evaluation.

The rural Idaho ACT initiative increased the relevance of its program to the community through partnership and education. The program considered its community context by engaging and educating the judicial system about mental health issues in these rural areas to make these services more acceptable for all program stakeholders, and providing in-home services to decrease barriers to service access. To increase sustainability, Idaho's State Legislature provided state funding and will likely continue to fund the program, given its cost effectiveness. It is actually helping people, saving money, and building community assets, all at the same time. This program relies on high levels of community engagement, state-wide buy-in, and collaboration to identify solutions to reduce recidivism. In this particular case, it was essential for rural communities to rally statewide financial and social support to make this program a reality and to ensure its sustainability in the rural setting.

WHAT ARE THE CHALLENGES AND POSSIBILITIES FOR IMPLEMENTING EVIDENCE-BASED PRACTICE IN RURAL SETTINGS?

Rural practice presents a unique set of factors that can both facilitate and challenge effective service delivery through the implementation of EBP. There are many positive and fulfilling aspects to social work practice in rural settings that uniquely assist with client change. Rural social workers enjoy a variety of practice experiences that foster high levels of independent and autonomous practice (Fiske, 2003) and allow for implementation of innovative and creative interventions (Green & Mason, 2003). Additionally, rural social workers may be better able to identify and engage natural community support systems to facilitate both environmental and client change than is often practical or possible in urban practice settings (Watkins, 2004). Unlike urban social workers, rural providers often live in the same communities as the clients whom they serve and may experience the professional reward of observing the impact of the delivered services and the sustained changes that their clients have made (Green & Mason, 2003).

Perhaps most challenging is the fact that rural social workers often work in isolation, having few or no immediately close colleagues or supervisors with whom they can regularly consult, discuss practice challenges, or debrief from stressful work experiences that their urban counterparts would take for granted (Pugh, 2007). Compounding this isolation is the fact that rural social workers may be significantly disadvantaged in their access to empirically supported social work services, treatments, and interventions (Riebschleger, 2007), all of which creates the critical need for rural social workers to be trained and skilled in the implementation of EBP.

No matter how well-trained and skilled in EBP a practitioner may be, the disparities experienced by rural populations, the uniqueness of rural communities and their cultures, as well as social workers' training, expertise, and access to resources may impact how easily social workers execute EBP and apply indicated empirically supported interventions. In addition, effective rural practice calls for social workers to employ an empowerment, strengths-based, and asset-building approach that endeavors to build the capacities of clients, their role in the community, and the community itself. This section examines the distinct opportunities and challenges social work practitioners may experience when seeking to employ EBP with rural populations.

Unique Rural Communities and Cultures

Rural communities are widely diverse and cannot be categorized by any one ethnic, socioeconomic, religious, or political group, or by the complex and multidimensional needs of individual community members (Cashwell & Just, 2008). Even though social workers in rural practice confront similar types of social problems as their urban counterparts (e.g., poverty, lack of affordable housing, access to health care and childcare, joblessness, transportation challenges, family violence, disabilities, substance abuse, and/or crime), the meaning of those problems and acceptable interventions within each unique rural community will vary widely. For example, while rural Iowans, Alaskans, and Texans may all experience poverty, the unique local history, natural resources, political climate, economy, and environment result in a unique context and, consequently, potential community assets and priorities, individual needs, and effective interventions will be markedly different in each of these rural settings.

Effective rural social work practice calls on social workers to understand the culture of their clients' larger systems, including the rural community, in more critical ways than is required in urban practice settings (Daley & Avant, 2004). In each community, service delivery and the social work practice environment can vary in many culturally defined ways that are affected by unique community economic factors, politics, beliefs, norms, traditions, language, laws, and even geography. What a community views as a problem, as well as community beliefs about individuals who have service needs or are receiving professional social work assistance, is especially important to understand when considering any empirically supported social work intervention. Fully appreciating, understanding, and incorporating the unique community context by utilizing a culturally sensitive perspective is essential, both when assessing the applicability of an intervention and evaluating the outcomes during the implementation of EBP in rural settings.

Resource Challenges and Opportunities

Many experts have asserted that the more rural a community is, the more social workers will struggle with access to basic client resources, specialized services, and professional development (Brownlee, Graham, Doucette, Hotson, & Halverson, 2010; Murphy & McDonald, 2004). Vast geographic distances, inclement weather conditions, a lack of public transportation, and extended travel times can compound rural practice challenges for both social workers and their clients in delivering effective social work services (Cashwell & Just, 2008). These same challenges, as well as access to rural-specific evidence, professional development opportunities, and practitioner expertise are important considerations in effective implementation of the EBP process in rural settings.

Access to Rural-Specific Evidence

Historically, access to the most current empirical evidence literature has been challenging in rural and remote settings because of both a lack of availability and nonexistent or slow Internet connectivity. Additionally, small rural libraries were likely to have limited database subscriptions, and access to those computers may not have been conveniently timed or located. However, with technological and Internet advances, rural social work practitioners now have expanded opportunities to access information and evidence needed to employ EBP (Brownlee et al., 2010). These advances call for rural social workers to develop high levels of information technology skills, which further highlights the importance of access to quality computer and communication systems.

Even though access to available evidence has been improved for rural practitioners, the evidence specific to rural populations is still developing, and much of the limited evidence comes primarily from "narratives, case studies, and/or conceptual models of rural people and communities" (Riebschleger, 2007, p. 281), rather than from larger generalizable studies. Thus, when searching the evidence, practitioners are not likely to locate empirically supported interventions specifically tested with the populations they intend to work with or within their unique practice community context. This reality points to the need for rural-based social workers to be able to meaningfully understand and discern the applicability of research findings to their own practice context. It is hoped that as the social work profession continues to develop rural-focused practice evidence, this emerging research will provide additional guidance regarding the use and adaptation of empirically supported interventions for rural populations and practice.

Professional Development

Murphy and McDonald (2004) assert that as rurality increases, access to practice evidence and training/supervision decreases. Ready access to professional development opportunities has been limited for rural practitioners. Fortunately, there are several new developments in distance learning to meet the professional development and training needs of rural social workers wishing to implement EBP. Online continuing education courses, webinars, and video streamed intervention trainings are now widely available from a variety of sources,

including professional organizations, federal agencies and their designees, universities, and individual research and training institutes (see Appendix B).

Murphy and McDonald (2004) found that rural social workers have significantly less training in understanding and evaluating the strength of empirically supported interventions and may have difficulty in translating evidence into rural practice. Although these findings are somewhat dated, they still suggest that social workers may want to seek out specific training to better understand and evaluate the strength and applicability of the available evidence for the rural context. It is encouraging that Brownlee et al. (2010) found that use of the Internet has reduced rural practitioners' feelings of isolation, improved access to professional development, and reduced the pressure to be an expert on many issues. In their study, one of the participants remarked, "You don't have to know everything; you just have to know where to find it" (p. 628).

Practitioner Expertise

Across rural communities, the lack of professional expertise and formal behavioral health or social services is well-documented (Brownlee et al., 2010). Social work positions may be unfilled for extended periods; in the meantime, rural practitioners find themselves covering these positions. Workforce issues and the unique and complex needs of high-need rural communities have necessitated that rural social workers approach practice as community-based generalists. Generalist social workers have a broad range of knowledge and skills and are able to assume multiple roles and intervene across individual, group, and community client systems, rather than practicing as specialists (Sheafor & Horejsi, 2012).

Arguably, employing EBP can be a helpful guide in supporting the varied, complex work of rural generalist practitioners. The generalists' versatility, multidimensional orientation, and systems focus, as well as the importance placed on clients' unique situations and environment, fit particularly well with the philosophy and process of EBP. When client needs simply cannot be met through locally available resources, new advances in developing tele-behavioral health networks and empirically supported online treatments for a variety of behavioral health issues may help to bridge rural gaps.

The challenges and opportunities suggest the critical need to utilize the community in developing creative options for clients in rural communities, as many issues may preclude them from accessing services. In many of these cases, the rural social worker may serve as a broker of information, linking clients to information and online services that enhance their confidentiality within a small rural setting. Several ideas and options for this approach are presented in Appendix B.

CONCLUSION

Evidence-based practice is a five-step process that helps social workers provide their clients with the most effective services in a manner that is consistent with a strength-based approach, asset building, and professional social work values. Rural social workers face unique advantages and challenges when implementing the EBP process, but access to telehealth

and the aforementioned online resources are increasing its feasibility. Future research and discourse is needed to develop additional methods to increase EBP in rural areas and effective rural-specific interventions.

Discussion Questions

1. Social workers in rural contexts often face disparate challenges in the implementation of the evidence-based practice process compared to social workers in a more urban setting, where resources, referral options, and training opportunities are more plentiful. In contrast, as the primary provider of social services, rural social workers often take on multiple practice roles to meet diverse community needs. Considering these challenges, as well as the increased availability of online resources and other recent developments to support practice, how can rural social workers utilize the five-step EBP process to increase the probability of effective service delivery within a rural community?
2. Although EBP is supported by the primary social work organizations, and the tenets of this model are supported by the NASW Code of Ethics, many practitioners and social work scholars question the validity, feasibility, and applicability of this model for social work practice. Identify the primary arguments for and against the use of the EBP process, and critically examine and discuss your own view of the process and its promise, feasibility, and applicability. Brainstorm, present, and discuss your own potential solutions for feasibility issues in a rural practice setting.
3. The EBP *process* consists of five steps: (1) develop a specific EBP question by specifying the unique client/target population characteristics or practice issue; (2) search for and (3) appraise relevant research literature; (4) make a practice decision by integrating the research evidence with practice expertise and the client/target population's culture, preferences, values, and characteristics; and (5) evaluate the outcomes of the practice decision. Compare and contrast this process with the *evidence-based practices* approach with regard to the potential for providing effective services and empowering and building assets and capacity within a rural context. Do you think the EBP process approach can be utilized to advocate for needed resources within a rural community? If yes, how? If not, why not?

Classroom Activities and Assignments

1. Identify a practice case within a rural setting from your field placement, a current or prior practice setting, or a case study provided by your instructor. This case can be at any level of practice (micro, mezzo, or macro). Discuss how you would implement the EBP process by (1) developing a specific EBP process practice question, (2) searching for research evidence using search terms from your question, (3) critically appraising the research for its reliability and validity, (4) providing a solid rationale for your practice decision based on your critical appraisal of the research, the fit with the client or target population's culture, characteristics, values, and preferences, and your own practice experience and the feasibility within the practice setting, and (5) identifying how you would evaluate the outcomes of the practice decision using a valid and reliable measurement approach. In addition to turning in a final paper,

students can work in groups to share and discuss their process and primary product from each step during different class meetings.

2. After completing assignment 1 (or each individual step of the process), have students reflect on each step or the process as a whole. Discuss as a class what was most challenging, what was most beneficial for their future practice or the current case, and what might make the process more efficient or useful in the future.

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CHAPTER 11

Wraparound in Rural Child and Youth Mental Health

Coalescing Family-Community Capacities

Tamara S. Davis

In 1961 the U.S. Joint Commission on Mental Illness and Health found that the mental health needs of children and youth were going unmet. Five decades later, communities continue their efforts to develop more effective mental health systems for children, youth, and families in the United States. National data indicate that one out of every five children will need mental health services at some point before reaching adulthood, with 9% to 13% experiencing serious emotional disturbances (U.S. Department of Health and Human Services [USDHHS], 1999). Families experiencing child mental illness often find themselves involved with multiple public service systems, including child welfare, juvenile justice, mental health, public school services, and alcohol and drug services (Garland et al., 2001). In response, the concept of *systems of care* for children's mental health was developed in the 1980s. Over the past 20-plus years, the concept has evolved to reflect a culturally and linguistically relevant community-based network of coordinated services and supports developed in partnership with families and youth who are experiencing serious mental health challenges (Stroul & Friedman, 2011).

Wraparound is the primary service delivery approach emerging from systems of care. Wraparound is an "intensive, individualized care planning and management process" that uses a team-based structure to develop holistic care plans relevant to and integrally involving a youth and his or her family in an effort to achieve positive outcomes (Miles, Brown, & The National Wraparound Initiative Implementation Work Group, 2011, p. 10). Wraparound builds on the identified strengths of the youth and family as well as the strengths, needs, and context of the community (Miles et al., 2011). The ideas behind wraparound philosophy are neither new nor exclusive to mental health. Indeed, social work has a long tradition of family-centered practice focusing on the family's contextual interface with one another and the larger environment (Best Practice/Next Practice, 2000; Hartman & Laird, 1983). Numerous variations of practice models valuing strengths-based partnerships with families and communities reach across social work areas of practice. For example, family-centered practice in "Family Group Decision Making" (American Humane Association, 2010) is an established example from child welfare. Adams and Nelson (1995) highlight additional models implemented in schools and social service programs.

Kretzmann and McKnight's (1993) well-recognized community development model provides clear guidelines on how a community can build on its assets. This model was highlighted in the Surgeon General's Report on Mental Health (USDHHS, 1999) as one recommended for developing culturally appropriate local mental health programs. Similarly, Benson (1997) and colleagues at the Search Institute launched the Healthy Communities–Healthy Youth Initiative. Their Developmental Assets model is designed to use assets and strengths of youth and communities to help youth navigate positive and healthy development. More recently, the Search Institute began expanding its model to include American Family Assets to examine the strengths and capacities within families (Syvertsen, Roehlkepartain, & Scales, 2012). Wraparound combines elements of all these models. The assets and strengths of children and youth with mental health challenges and their families are combined with community resources to ensure that children remain in the care of their families within their home communities.

The chapter begins with a discussion of mental health disorder prevalence, risk factors, barriers, and strengths of service delivery issues for children and youth in rural communities. The wraparound process is then described in detail as used within systems of care to serve children, youth, and their families that are struggling with serious mental health challenges. You will learn about the values and principles guiding these processes and how wraparound is different from traditional mental health practice. You will recognize how wraparound parallels strengths-based social work (Saleebey, 2002), strengths-based case management (Kisthardt, 1997), and previously noted assets-based models. Through this discussion, you will discern how generalist social work education prepares you to become a social work specialist through individualized wraparound care for children, youth, and families within their own communities.

MENTAL HEALTH PREVALENCE AND RISK FACTORS OF RURAL CHILDREN AND YOUTH

What Do the Prevalence Data Indicate?

Approximately 20% of all U.S. children and youth experience a diagnosable mental illness, with only about one in five receiving treatment (American Academy of Child and Adolescent Psychiatry, 2009; Kataoka, Zhang, & Wells, 2002; Merikangas et al., 2010). Half of all youth ages 13 to 18 experience a lifetime prevalence of mental illness or substance use disorder, 27.6% of which are diagnosed with severe impairment (Merikangas et al., 2010). Using available data from the 2000 U.S. Census (U.S. Census Bureau, 2001), an estimated 15.7 million children and youth under the age of 20 live outside of U.S. metropolitan areas. Hence, we can estimate that approximately 3 million children living in rural communities experience mental health challenges.

Although some research finds equivalent mental health prevalence rates among rural and urban children and youth (Moore et al., 2005), recent research indicates differences in how rural and urban children and youth experience risk and protective factors for mental health problems (Gale, Lenardson, Lambert, & Hartley, 2012). Regardless, research consistently finds that rural youth experience more unmet health care needs (DeVoe, Krois, & Stenger,

2009; Gamm, Stone, & Pittman, 2003) and live in areas that are in short supply of child and adolescent mental health care specialists (Anderson & Gittler, 2005; Hendryx, 2008). Although access to at least some level of mental health care does not differ between rural and urban children, the likelihood of receiving all needed services is lower for rural children (Lenardson, Ziller, Lambert, Race, & Yousefian, 2010) and lower for rural youth with serious mental health challenges (Gamm et al., 2003).

Differences in mental health diagnoses reflect more behavioral challenges in rural than urban children (Lenardson et al., 2010) and higher rates for rural African American children (Moore et al., 2005). Recent data reflect a continuing trend of rural youth experiencing higher rates than urban youth of substance and alcohol use (Cutrona, Halvorson, & Russell, 1996; Gale et al., 2012; Lambert, Gale, & Hartley, 2008). Cutrona et al. also reported that loneliness resulting from geographic isolation from friends is a problem for rural youth and suggested that loneliness may contribute to higher rates of suicide for rural youth, another ongoing issue (*Mental Health and Rural America*, 2005).

What Are the Mental Health Risk Factors for Rural Children and Youth?

Mental health risk factors for children and youth living in rural communities remain fairly consistent over time, with some even now more prevalent for rural youth. Risk factors include poverty; unemployment; families with public versus private health insurance; presence of a developmental disorder; family history of drug involvement; low school achievement; psychopathology; homes with only one or neither parent present; transitory housing; child abuse; and poor parenting skills (Cutrona et al., 1996; *Mental Health and Rural America*, 2005; Moore et al., 2005). Some of these risk factors are unavoidable, as they are often characteristic of living in rural areas. For example, rural communities suffer from high rates of poverty; there simply are not enough jobs for everyone. The numbers of jobs available for well-educated people and in local industry are limited. This issue only increased as the number of rural independent farms diminished over the years (Ginsberg, 1998).

In rural and urban communities alike, unemployment is tied to other risk factors, such as transitory housing and lack of health insurance and health care. Caregivers delay seeking mental health treatment when they are faced with financial barriers (*Mental Health and Rural America*, 2005). Similarly, the stress associated with the inability to provide for one's family can lead caregivers to inappropriate disciplinary action, potentially resulting in child physical abuse. Costello, Keeler, and Angold (2001) noted that significant risk factors for children included family history of mental illness, poor parenting, multiple moves, lack of parental warmth, a lack of parental supervision, and harsh punishment by parents.

MENTAL HEALTH SERVICE DELIVERY TO CHILDREN, YOUTH, AND FAMILIES IN RURAL COMMUNITIES

What Are the Challenges and Barriers for Rural Communities?

Rural communities face a different set of pervasive challenges and barriers to accessing mental health services than do inner-city communities. Key issues for rural mental health

social workers to consider include the community's external environment (geography, transportation, communication), its social and cultural environment (stigma, values, beliefs, social structures), and resource availability and access (Boydell et al., 2006; Ginsberg, 1998).

External Environment

Geography is one of the greatest barriers to accessing mental health services in rural areas. More than half of rural residents live in areas designated as having a shortage of psychological, psychiatric, or social work services (*Mental Health and Rural America*, 2005). Thus, families must travel long distances to receive whatever mental health services are available. This distance adds financial and transportation challenges for families (Boydell et al., 2006). Because availability of public transportation is limited, rural residents must depend on a privately owned vehicle. Factoring in the issue of poverty, the expense of maintaining a vehicle may leave families dependent on others to provide transportation (Ginsberg, 1998).

Geography also impacts the social worker's ability to provide services needed within a region. If traveling great distances is required to meet with families in their homes, a worker's caseload is affected. Likewise, geography impacts communication. Some families live too far away from town for a phone line, whereas others may be unable to afford phone service. Yet with continuing media advances, rural residents watch the larger society changing around them. All of these external factors contribute to the physical and emotional isolation of rural residents from the rest of the world.

Social and Cultural Environment

All rural communities possess unique values and beliefs that keep them operating as a unit. These systems were initially shaped by the agricultural community culture where everyone knew their roles within the community. However, industrialization brought many changes to rural communities, leaving them struggling with how to reshape community structures and resident roles (Keller & Murray, 1982). The value often held by rural communities to "take care of their own" and not talk to outsiders creates challenges for the mental health social worker, because this value feeds into the issue of stigma associated with mental health problems. Too often the fear associated with stigma keeps families from accessing professional mental health services (Boydell et al., 2006). Families may first seek other resources they feel are more trustworthy, such as medical professionals or clergy (Cutrona et al., 1996; Ginsberg, 1998). Given people's acquaintance with one another in rural communities, it is difficult to maintain confidentiality. Mental health social workers must consider how to personally become a part of the community in addition to gaining a working presence. This aspect of rural life presents interesting ethical dilemmas for social workers that require thoughtful individual resolution.

Resource Availability

The availability of mental health resources in rural areas is limited, particularly for children and youth (Boydell et al., 2006; *Mental Health and Rural America*, 2005). Once social workers are professionally trained in a metropolitan area, it becomes more difficult to recruit

them into rural communities (Boydell et al., 2006). If recruited, retaining them or providing them with adequate ongoing training in the mental health field presents challenges, ultimately leading to a shortage of qualified mental health providers in rural communities (Boydell et al., 2006; Cutrona et al., 1996). Lack of resources is also related to systemic issues such as poverty (Heflinger & Christens, 2006) and a lack of health insurance (McKay & Bannon, 2004). Moreover, mental health services in rural communities are long noted as fragmented, uncoordinated, or duplicative across systems. Federal policies governing Community Mental Health Centers place many regulations on funds, restricting centers to purchasing traditional categorized mental health services. Keller and Murray (1982) suggested more flexibility in governmental regulations and community involvement in planning mental health programs to allow rural communities to use funds more beneficially. Insufficient consumer involvement in rural mental health services decision making remains an issue (Ryan-Nicholls & Haggarty, 2007). Traditional clinical approaches may be necessary at times, but existing community resources and natural support systems should be targeted for enhanced development. For example, a wraparound team in one of our rural research communities created an innovative solution to the lack of available respite care. Families provided supervision to one another's children once a month as a means to obtain short periods of respite. Development of natural supports is a particular focus for wraparound plan development.

What Are the Assets and Strengths of Rural Communities?

Some challenges of mental health service provision in rural communities may be reciprocally viewed as assets or strengths. The very character of rural communities lends itself to the innovative assets- and strengths-based approaches to community and youth development presented in this book. Rural communities often find themselves well prepared to develop systems of care to support wraparound processes. The following study description speaks to several strengths commonly found in rural communities, providing potential ground for innovative mental health services development.

During the 1990s, a longitudinal study was conducted over a six-year period with more than 400 youth and families living on farms in Iowa (see Elder & Conger, 2000, for a complete description of the study and its findings). Several prominent characteristics of these rural farm communities emerged as keys to success for youth in the study. Youth and families placed specific value on family life, generational continuity, intergenerational relationships, and a parental network of social ties achieved through involvement with the local schools, a religious affiliation, and civic activities. Parents with strong community ties demonstrated increased resourcefulness, were better educated, had stronger relationships in the community, and had stronger ties to the land over generations. Parents with weak community ties had a lack of social resources. Common values of all parents included hard work, self-reliance, sense of responsibility, commitment to family life, social trust, working together, resourcefulness, nonmaterialism, community ties, and involvement in leadership for the common good. Resilience of youth in these farm communities was linked to "doing well academically, participation in a religious community, and feelings of self-confidence" (Elder & Conger, 2000, p. 207). Youth with ties to the land were more successful in all life domains than were rural youth without such ties.

The values espoused by successful youth and families in Elder and Conger's (2000) study are embedded in the Developmental Assets (Benson, 1997) and Family Assets (Syvertsen et al., 2012) models. Benson's model describes 30 to 40 youth assets associated with positive youth development and healthy communities. In Elder and Conger's study, these assets were related to family-community connectedness. Similarly, Scales et al. (2001) found that adults' increased investment in their local community was associated with their involvement with young people. Related adult values and actions included adults living in neighborhoods for longer times, attending religious services, volunteering, and participating in neighborhood/community meetings. Syvertsen et al. (2012) examined how 100 assets within American families (nuclear and extended) supported family members in attaining positive outcomes. Families with more assets were more likely to engage in healthy behaviors, experience more school success of their children, act in socially responsible ways, participate in policy activities, and spend time together serving their communities. Although the average number of family assets was lower among rural families than suburban and urban families, fewer assets were reported among families in general who experienced basic needs going unmet (Syvertsen et al., 2012).

Although noted challenges are unavoidable realities for many people living in rural areas, needed mental health services can be provided through innovative and creative problem solving using the identified assets and strengths of the community. Residents of rural, urban, and suburban communities all address similar needs, but the solutions they develop must address the unique characteristics of their communities (Heflinger & Christens, 2006).

WRAPAROUND SERVICE DELIVERY IN SYSTEMS OF CARE

Research indicates extremely high prevalence rates of psychiatric disorders in youth who are served in public systems, including child welfare, juvenile justice, mental health, public school services, and alcohol and drug services (Garland et al., 2001). Given the multiple issues and systems impacting children and families, their needs cannot be met through the mental health system alone. Rather, a broad array of comprehensive services and supports is necessary to meet the families' needs (Stroul, Blau, & Friedman, 2010). Although this lack of services is well-documented in rural communities, studies reflect that systems of care models are successful in developing a service array in urban and rural communities (Holden & Blau, 2004). The remainder of the chapter examines wraparound as implemented within systems of care.

What Are the Values and Principles of Wraparound and Systems of Care?

Wraparound as it is used in children's mental health is often developed within a systems of care context, providing a broader context for wraparound's fit within an entire system. Since the systems of care concept was first defined by Stroul and Friedman in 1986, the concept has stood the test of time. Only recently have scholars returned to a critical examination of systems of care foundations, resulting in an updated and enhanced definition based on

extensive community implementation and investment in systems of care. As currently defined, a system of care is:

> A spectrum of ***effective, community-based services and supports*** for children and youth with or at risk for mental health or other challenges and their families, that is organized into a ***coordinated network***, builds meaningful ***partnerships with families and youth***, and addresses their ***cultural and linguistic needs***, in order to help them to ***function better*** at home, in school, in the community, and throughout life. (Stroul, Goldman, Pires, & Manteuffel, 2012, p. 1)

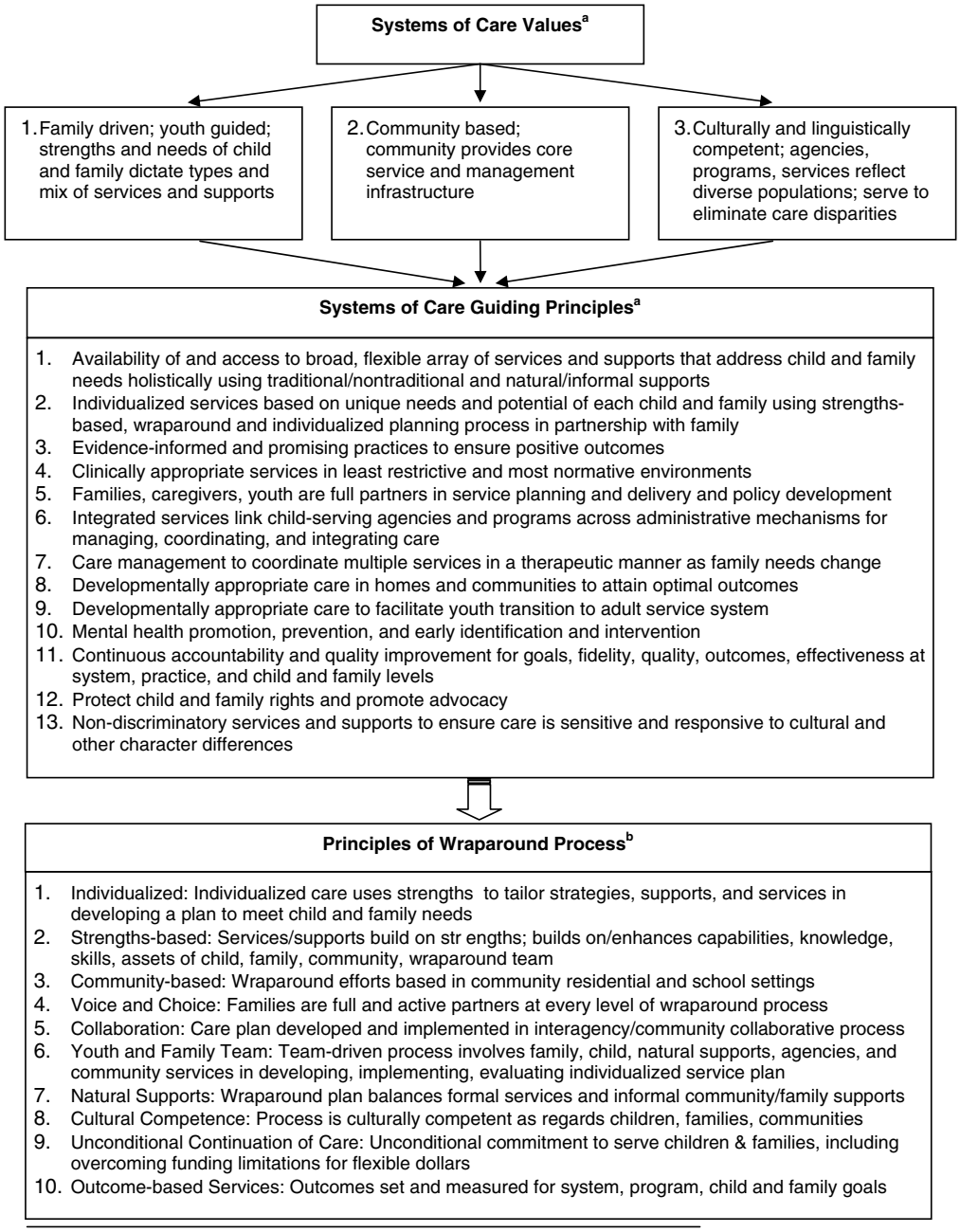
Core values maintain that systems of care must be family-driven and youth-guided, considering both strengths and needs, community-based, and culturally and linguistically competent (Stroul, Blau, & Friedman, 2010). These guiding principles embody many of the concepts underpinning family-centered social work practice, assets-based community development, and youth and family developmental assets models. Systems of care values and principles must be operationalized at practice, community, and policy levels to address the strengths and challenges of providing mental health services in rural communities. As illustrated in Figure 11.1, there is great compatibility between the principles that guide systems of care and wraparound. Wraparound involves the child and family in planning services individualized to the family's specific strengths and needs (Burns & Goldman, 1999; Miles et al., 2011).

Although wraparound may appear to focus solely on the practice level, this view does not consider what is needed at other levels of the system to support the wraparound process. For example, systems of care guiding principles 1, 4, 6, and 7 reflect access to an integrated, coordinated, and comprehensive array of services with varying levels of restrictive environments. Ensuring the availability of a service array is extremely valuable for wraparound implementation, yet such an array is largely developed through administrative ranks where policies regulate how agencies work together. Wraparound principles 1, 5, 6, 7, 8, and 9 illustrate this point. Without the system pieces in place, it is difficult to develop a truly individualized and comprehensive plan of care for a family.

As another example, systems of care guiding principles 2, 8, 9, and 13 reflect a requirement to respect everyone's individuality and plan services according to unique child and family strengths and needs. The related wraparound principles 1, 2, and 8 depend on system policies supporting these practices. Wraparound workers feel much more confident in their ability to plan and follow through on the promise of individualized and relevant services when this value of culturally responsive care is also demonstrated at administrative and policy levels. Although it is possible to provide wraparound without a system structure supporting flexible processes, it is difficult to sustain such efforts without systemic support.

What Exactly Is the Wraparound Approach?

Pulling together needed services requires service coordinators who can successfully navigate multiple service systems while individualizing work with children and families. This specialized way of working with families requires social workers to reconceptualize generalist social



[a] Stroul, Blau, & Friedman, 2010, p. 6
[b] Bruns, Walker, & The National Wraparound Initiative Advisory Group, 2008; Goldman, 1999, pp. 29–31; VanDenBerg, Bruns, & Burchard, 2003, p. 5; VanDenBerg & Grealish, 1996, p. 9

Figure 11.1 Wraparound within a systems of care framework.

work knowledge within the context of specific family situations. By engaging families in a team process of individualizing service plans to match child and family strengths and needs, the generalist social worker functions as a specialist for each individual child and family. In wraparound the coordinator role is sometimes shared with a parent peer provider or advocate (Walker et al., 2004). Wraparound defines the process (policies, practices, and steps) of providing individualized services and supports (VanDenBerg & Grealish, 1996; Walker et al., 2004), which differs from traditional service planning because it (Bruns et al., 2008; VanDenBerg & Grealish, 1996):

1. Requires an interdisciplinary child and family team to partner with the youth and family in planning for care and setting outcome-oriented goals
2. Focuses on the family as a whole
3. Focuses on the strengths and uniqueness of the child and family, including their natural supports
4. Includes flexibility in providing services needed for an individual family rather than fitting the family into a specific program, while striving to keep the child in the community
5. Emphasizes cultural competence as critical to effective practice

Wraparound has a small but growing evidence base to support its effectiveness. An extensive review of the empirical research on wraparound was conducted and reported by Walter (2008) as part of the Kansas School of Social Welfare's *Best Practices in Children's Mental Health* research report series. In her conclusion, Walter (2008) suggested that current efforts by the National Wraparound Initiative and others implementing wraparound to operationalize and measure the fidelity of wraparound's key components and processes will likely increase empirical support of the approach. A follow-up systematic review by Walter and Petr (2011) offered similar conclusions, adding that wraparound aligns well with social work values and principles.

Child and Family Teams That Focus on the Youth and Family

Perhaps one of the greatest challenges remaining for systems of care and wraparound is partnering with families (Davis, 2007; Stroul & Friedman, 1986), yet families are increasingly considered a vital resource for their children. While the value of family input is long recognized in rural communities where resources are limited, this concept challenges traditional mental health services, which typically favor provider expertise. Although accepting families as full partners is slowly evolving, the mental health field acknowledges the need to partner with caregivers in planning and delivering services for their children (Burns, Hoagwood, & Mrazek, 1999; Worthington, Hernandez, Friedman, & Uzzell, 2001) and in participating at the system level (Friesen & Stephens, 1998; USDHHS, 1999). Empowering youth and families to help develop the service model is akin to the kind of empowerment recommended in the developmental assets models. The Search Institute includes four developmental assets related to empowering youth within a community: Community Values Youth; Youth as Resources; Service to Others; and Safety (Benson, 1997; Search Institute,

2007). The institute published a book specific to empowering youth for community leadership (Curtis, 2008). In wraparound, youth are empowered to participate in their mental health care. Systems of care efforts increasingly support youth involvement and leadership and provide resources and publications to guide communities (http://www.tapartnership.org/content/youthInvolvement/default.php).

In addition to the wraparound service coordinator and family members, the family identifies team members whom they consider critical to the child's success (Bruns et al., 2008; VanDenBerg & Grealish, 1996). For example, members may include professionals from multiple service systems or a neighbor or the best friend who provides an important supportive role for the family. This team-building process helps build a community of care around a family. An integral element of the team's planning process is setting short- and long-term goals the family hopes to achieve. Progress toward goals is assessed and tracked during regular team meetings. As barriers arise, the team addresses the issues and revises the plan of care accordingly. The team holds each other accountable for following through on assigned tasks.

Feedback from rural service providers in my work suggests that agency collaboration and needing to work together comes naturally for them. Such coordination is noted as a major factor in the survival of their programs and is reflected in well-established interagency relationships. Engaging families in the wraparound process is viewed as the next step in their practice. However, rural communities also run into a few system-level challenges. One challenge is engaging families on a system level, as families are not used to being asked to participate in changing the system, and systems are not used to families sitting at the decision-making table. Agency folks find that strong relationships do not necessarily translate into policy changes. One community addressed this challenge by hiring parent peer advocates who also served as wraparound coordinators. In their dual role, they shared a place at the table with policymakers and extended their voice out into the community to advocate for change.

Strengths-Based Planning

Assessing the child, family, wraparound team, and community strengths and matching these strengths with the care plan is essential to individualized wraparound. If existing community resources do not match the strengths and needs described in the care plan, flexible resources may be identified or developed (Miles et al., 2011). Wraparound trainers call this process of assessing and matching strengths a *strengths, needs, and culture discovery* (VanDenBerg, 2007; VanDenBerg & Grealish, 1996). A similar strategy is suggested in the assets-based community development framework. First, recognize and document the capacities of individuals and organizations present in the community and build capacity from within (Kretzmann & McKnight, 1993). The Search Institute's developmental assets model is inherently strengths-based, focusing on positive youth development, prevention, and resiliency.

In a strengths, needs, and culture discovery, the wraparound service coordinator engages in a conversation with the child, family, and other team members guided by extensive questions to facilitate the strengths identification process (VanDenBerg, 2007; VanDenBerg

& Grealish, 1996). Sometimes it may be beneficial to ask other people in the family's life to identify child and family strengths. For example, questions may pertain to identifying friends of the family, individual identity, values and traditions of the family, perceptions of individual and family qualities, or skills and hobbies of family members. It is important to recognize that strengths are not used in wraparound to the exclusion of child and family needs. Rather, they are used to build on capacities of individuals and community resources.

Social work has written about the processes described for strengths-based work with families in mental health over many years. Saleebey (2002) describes processes for determining strengths and the elements of strengths-based social work practice. In an earlier version of that text, Kisthardt (1997) describes the strengths-based case management model, whereby the primary helping functions are very similar to those described within the essential elements of wraparound.

Flexible Service Planning

Another critical component of wraparound is the availability of flexible resources for use with families when individual family needs extend beyond the services available. This generally means a pool of money for use by wraparound service coordinators to obtain out-of-the-ordinary services (Lourie, Katz-Leavy, & Stroul, 1996; Miles et al., 2011). For example, in one of our rural research communities, flexible dollars were used as seed money to employ youth in community businesses. If the employment arrangement was successful, the employer took over payment of wages. Although securing these resources is often challenging, systems of care across the country find innovative ways to increase the amount of flexible dollars, even when systemic regulations create barriers. The ability to build strong interagency collaborations to support the availability and creation of flexible resources for wraparound is important to successful systems of care development (Koyanagi & Feres-Merchant, 2000). Moreover, they can be extremely valuable to creating culturally and linguistically relevant services for families.

Cultural Competence

Working with children and families in a culturally competent manner is core to wraparound and systems of care at all levels. As our society becomes more diverse, individuals and organizations must be prepared to provide services to meet the needs of a wide variety of ethnic and nonethnic cultural groups. Likewise, Benson (1997) found cultural competence key to positive development for youth and included it in the revised social competency developmental assets. He recommended that communities affirm youth heritage and encourage them to become culturally competent individuals. Institute studies suggest that the 40 developmental assets are relevant across racial and ethnic groups (Sesma & Roehlkepartain, 2003).

Addressing cultural competence in children's mental health is critical with its history of unsatisfactory mental health service system performance in serving children with diverse backgrounds (Hernandez & Isaacs, 1998; Knitzer, 1982). Unfortunately, research continues to document racial and ethnic disparities in mental health care (Garland et al., 2005; Gudiño, Lau, Yeh, McCabe, & Hough, 2009). High rates of poverty exist in rural areas, and poverty

(especially for minority children) is often associated with unmet mental health needs (Hernandez, Isaacs, Nesman, & Burns, 1998). Recognizing the importance of diversity, the following cultural competence definition guides systems of care development: "Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations" (Cross, Bazron, Dennis, & Isaacs, 1989, p. 13). The National Association of Social Workers later adopted this definition for our profession.

Cultural competence is salient for rural communities, which often include various populations of minority residents. Social work also recognizes the importance of addressing the needs of special populations in rural communities (see Ginsberg, 2005, where an entire section of the book is devoted to special rural populations). Although issues of cultural competence generally target the practitioner, systems of care value cultural competence at all levels of the system. A factor in assessing systems and organizations is whether the ethnic diversity of an agency's consumers is reflected among agency personnel. The importance of this factor manifests in the organization's ability to be culturally responsive to all community members it serves. Ultimately, rural provider agencies that lack ethnic staff of color must consider how this impacts their ability to reduce potential inequities in care.

CONCLUSION

The United States continues to experience movement toward addressing the mental health needs of children and youth with serious mental health challenges and their families. Systems of care and wraparound service delivery processes offer asset-based models for structuring and providing mental health services in rural communities. These models value children, youth, and families and place their strengths and needs at the center of the work.

Rural communities are uniquely challenged to meet mental health needs for children and families. In turn, rural communities possess particular assets that make them viable places to implement innovative and creative strategies for agencies and families to collaborate. The most important of these assets are the people of the community. As Kretzmann and McKnight (1993) so aptly state, "the raw material for community-building is the capacity of its individual members" (p. 13) and "youth can be essential contributors to the well-being and vitality of the community" (p. 29). Using the models discussed in this chapter, children and families identify their unique capacities and contributions to the community.

A well-conducted wraparound process illustrates how family-focused partnership can help a community transcend its mental health service challenges and come together to meet the needs of all its citizens (Behar, 1986). Generalist social work practitioners learn to function as family specialists through individualized wraparound planning with each child and family. Working with families from a strengths perspective offers rewards for all community members that reach far beyond interaction solely between families and practitioners. An assets approach fosters commitment from an entire community to care for all of its children, youth, and families.

Discussion Questions

1. How do systems of care and wraparound approaches to children's mental health differ from traditional mental health service delivery systems and practices? Discuss how differences found at the system (macro) level and the practice (micro) level might impact mental health social work practice in rural communities. What are some potential barriers to wraparound development in rural communities? What advantages do wraparound processes within a system of care offer a rural community over a traditional approach to care?
2. What assets and strengths are often found in rural communities that can be used to build a system of care for children with serious mental health challenges and their families? How can these assets be applied to a wraparound service delivery approach? How might a rural community implement the wraparound process without first developing a system of care?
3. Describe how rural communities and urban communities might differ in their planning and implementation of systems of care and wraparound approaches. Discuss how typical characteristics of each type of community could impact the planning and implementation processes.

Classroom Activities and Assignments

Case Vignette

Yvonne is a 29-year-old single, Mexican American mother of three children: an 11-year-old son, Raul, an 8-year-old daughter, Gloria, and a 7-year-old son, Luis. The family lives in a rural community 50 miles away from the nearest metropolitan area. Yvonne works part time as a cashier in a Dollar General store and is attending the local community college full time in hopes of getting an associate's degree in bookkeeping. The family is very involved in their church, and all three children enjoy participating in the church's youth activities. Raul seems to have a good relationship with the Youth Minister. Raul wants to go to church camp in a few months, but his attendance will depend on how he is managing his behavior.

Yvonne's parents are supportive, but they live in a metropolis. Yvonne's neighbor watches the children when they get home from school, but she has said that she can no longer keep Raul because of his behavior. Raul was diagnosed with bipolar disorder two years ago and is on several medications, which he sometimes refuses to take. Raul's intelligence test indicates he has an IQ of 110; however, he refuses to do his schoolwork. He does, however, like art class, and his art teacher sees a lot of talent in Raul's drawings. Raul generally has poor relations with his peers and was recently in an assaultive altercation with another student at school. The police were called and took Raul to juvenile detention. This was Raul's first experience with the juvenile justice system. As a result, Raul has been suspended from school for one week. The other two children are doing well in school. However, they have begun to express fear of Raul because of his explosive behavior. Yvonne was referred to wraparound services by the juvenile probation officer.

Instructions

Use the case vignette to complete the following tasks individually or in small groups:

a. Simulate the following tasks of a wraparound process: (1) identify potential wraparound team members; (2) identify potential strengths and assets of the family, other wraparound team members, and the community (remember to think outside the box); (3) identify potential cultural considerations and implications for this family; (4) link the identified strengths and assets to possible service plan activities and goals to be achieved.
b. Develop a three-month service plan using a traditional social work case management model. Compare and contrast the differences in this plan and process with the one developed using wraparound. Discuss which approach you prefer and why.
c. Interview an administrator or practitioner in a rural mental health provider agency, asking her or him to describe in detail how the agency would typically engage with this youth and family. Ask about agency policy and practices for partnering with youth and families at all levels of the service spectrum (i.e., service planning, evaluation, agency committees, policy development).

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CHAPTER 12

Help-Seeking Pathways to Care

Culturally Competent Practice With Rural Hispanics With High Migratory Traditions to the United States

Dennis L. Poole and Alex Espadas

Pathways refers to the sequence of contacts that a distressed person makes to seek help with situations that outstrip psychological, social, or financial resources for self-care (Rogler & Cortes, 1993). This sequence of contacts is not a random phenomenon. Pathways are structured patterns of interaction with social networks, informal helping systems, and formal sources of care. Psychosocial and cultural factors shape the duration and direction of these pathways.

Pathways is a unifying concept in health and mental health care. Rural social workers and other practitioners examine pathways to identify who their clients turn to for help and to plan culturally appropriate services (Salgado de Snyder, Dias-Perez, & Gonzales-Vasquez, 2003). Yet most studies focus on cultural pathways to formal services, leaving a gap in knowledge about alternative help-seeking behaviors of people who seldom use these services.

This chapter provides information and illustrates via a case study a cultural pathway model that may be used to better understand alternative and formal help-seeking behavior among rural Hispanics with high migratory traditions to the United States. The chapter is divided into the following four sections that are intended to help the reader understand the development, evolution, and application of the cultural pathway model:

- Case Illustration
- Help-Seeking Theory
- Cultural Pathway Model
- Guidelines for Interventions

Help-seeking theory provides a basis for understanding the steps people follow in seeking help for mental or physical ailments. This theoretical perspective defines and explains several concepts that illustrate the process of help-seeking behavior as a series of well-ordered and purposeful cognitive and behavioral steps, each leading to specific types of health-related

actions. The cultural pathway model adds a cultural context to help-seeking theory by the introduction of health-related beliefs and behavioral patterns of Hispanic immigrants, which may have been learned in their communities of origin and persist until they become familiar and comfortable with the health system in the United States. To illustrate the application of the help-seeking theory and cultural pathway model, several guidelines for interventions are presented to help practitioners intervene with cultural competence with Hispanic immigrant clients.

Finally, a case illustration was developed to help demonstrate the utility of help-seeking theory, cultural pathways, and recommended guidelines for interventions. The case will be revisited and discussed throughout the chapter.

CASE ILLUSTRATION

Maria is a 32-year-old female living in a rural community of South Carolina with her 34-year-old husband, Joaquin, and their three children, Lorenzo, Alberto, and Guillermo, who are 12, 10, and 8 years old, respectively. Maria and her family have been living in the United States a little over a year, having emigrated from a rural town in Campeche, Mexico. Maria speaks Spanish and very little English—just a few basic words and phrases. She does not work outside the home, and she considers taking care of her family as her primary job. Her husband works six days a week and is absent from the home most of the day, usually leaving for work at 6:30 a.m. and arriving at home a little after 8:00 p.m. on workdays. This allows him very little time to spend with his family on workdays. Maria's children are all in school, and she is their primary caretaker when they are not in school. Sundays are considered family days, and Maria and her family typically go to church, do grocery shopping, and spend the day together at home. The family has only a few acquaintances and typically does not associate with other individuals or families.

Over the past few weeks, Maria has experienced what she considers to be high levels of stress and anxiety. In addition, she has experienced a lot of tension, sleepless nights, nightmares, occasional shaking of the hands, and weight gain. She eventually speaks with a priest at her church about the situation. He subsequently arranges an appointment for her with Herminia, a Spanish-speaking social worker at a community center near Maria's house.

Maria shares with Herminia that she has been overwhelmed with *los nervios* (i.e., nerves) for about three weeks, which is causing sleep problems, shaking, and weight gain. She does not know what to do anymore; she has tried everything she knows. Herminia, asking for more details, learns that Maria first tried to "wait out" her symptoms (i.e., the concept of *controlarse* or *aguantarse*). When this did not work for her, she tried mixing some teas that she recalled her aunt saying worked for *los nervios*, along with dieting. Feeling frustrated by the persistence of her symptoms, she turned to her mother, whom she called long distance, along with some acquaintances at church, who recommended various home remedies. When her condition still did not improve, Maria finally decided to speak with her priest, thinking her only hope was a miraculous cure.

HELP-SEEKING THEORY

According to help-seeking theory, people follow a series of predictable steps to seek help for their mental or physical ailments. These steps are defined as follows:

- *Self-care*. The first step that people usually try to remedy a symptom is self-care. They attribute the symptom to a physical or psychological problem, evaluate the severity of their pain and suffering, and apply their own knowledge of healing remedies (Garces, Scarinci, & Harrison, 2006; Salgado de Snyder et al., 2003).
- *Social network*. If the symptom persists, and significantly interferes with activities of daily living, people usually seek help from resources in their social network—family and friends first, then neighbors and other acquaintances. Typically, members of the social network give counsel and emotional support, share past personal experiences with similar symptoms, and recommend ways to ameliorate the symptom. They may provide instrumental assistance as well, connecting the distressed member to help outside the social network and paying for treatment when necessary.
- *Informal helpers*. When social networks are weak, exhausted, or unable to remedy the symptom, people usually turn to community support systems for help. Community support systems consist of two types: *informal* helpers (e.g., priests, pastors, pharmacists, and folk healers) and *formal* helpers (e.g., general physicians, psychologists, psychiatrists, and social workers). Informal helpers usually provide consultation free of charge or at a modest fee. Depending on the symptom, medications may be prescribed, or rituals such as prayer, meditation, or exercise may be recommended to restore physical and emotional balance (Cabassa & Zayas, 2007; Mikhail, Wali, & Ziment, 2004).
- *Formal helpers*. If the symptom does not subside, the next step is to seek assistance from formal helpers in the community (Salgado de Snyder et al., 2003). Normally, people consult with a general physician first, who then refers them to other professionals for specialized care. The four "As" of service utilization—availability, affordability, accessibility, and acceptability—influence how soon and how often they rely on formal helpers for health and mental health care (Poole & Carlton, 1986). When professional services fall short of expectations, people usually revert to self-care, social networks, and informal helping systems in their community.
- *Gatekeepers*. Gatekeepers are people who direct or link individuals in need to potential sources of help (Cabassa & Zayas, 2007; Delgado & Tennstedt, 1997; Snowden & Yamada, 2005). Family, friends, neighbors, ministers, priests, shopkeepers, beauticians, barbers, bartenders, and folk healers frequently act as gatekeepers to formal helping services in communities. When they do not have adequate capacity to help, or when they believe more appropriate help can be found elsewhere, they refer people in need to alternative sources of care. Depending on how well they perform this function, gatekeepers can help people gain timely access to services, or channel them into inappropriate or inefficient pathways of care.

This theoretical conceptualization of help-seeking behavior may be applied to Maria's case. The steps Maria took in reaction to the symptoms she was experiencing may be understood as self-care. She initially attributed her symptoms to high levels of stress and anxiety, which she hoped would go away in time, so she tried to wait out the symptoms. When this strategy did not work, she then tried a home remedy (i.e., teas), which did not have the curative effects she hoped for.

Maria next contacted her mother and members of her church (i.e., her social network) for support and consultation. It should be noted that the supportive nature of her social network may not have been very stable considering the geographic barriers (i.e., mother lives in another country) and nature of her social relationships (i.e., acquaintances rather than friends). However, she was able to receive advice and suggestions about other self-care strategies, which ultimately did not work for her.

Feeling frustrated and concerned by the persistence of her symptoms, Maria turned to her priest (i.e., informal helper) for spiritual guidance and care. The priest did provide spiritual guidance, but he also helped Maria make contact with a social worker (i.e., formal helper) at a community center close to Maria's house. In this case, the priest also took on the role of a *gatekeeper*, in that he linked Maria to a potential source of help in the formal service system—the social worker.

As demonstrated in Maria's case, help-seeking theory is useful in understanding and conceptualizing the various steps people take in seeking help for mental or physical ailments. It should be cautioned, however, that the help-seeking behavior outlined in this theory may not apply to everyone seeking help for mental or physical problems. Rather, the theory is best used as a guide to help explore and understand a client's help-seeking beliefs and behaviors.

CULTURAL PATHWAYS TO CARE MODEL

A model that maps the pathways of Mexican rural villagers to health and mental health services is presented in Figure 12.1. This model is based on studies of inhabitants of isolated, rural villages in Mexico with a high migratory tradition to the United States (Salgado de Snyder et al., 2003; Salgado de Snyder, Dias-Perez, Maldonado, & Bautista, 1998). Even though study findings are drawn from observations and interviews with "potential migrants," the model can help U.S.-based social workers understand the help-seeking pathways of this rapidly expanding population group. The beliefs and behavioral patterns that these immigrants learned in their communities of origin generally remain until they become familiar and comfortable dealing with the new culture and health system of the United States.

This model is dynamic. Bidirectional arrows indicate that at each step of the pathway, the distressed person evaluates whether the severity of the symptom has worsened or subsided, in which case the individual would exit the pathway. The length of these arrows indicates the time elapsed and the barriers encountered in seeking help at each stage—for example, there are fewer barriers and shorter time lapses for self-care than for obtaining care from a specialist such as a psychologist. Professional services are not readily available in many remote villages of Mexico. Inhabitants, therefore, rely mostly on internal or personal resources, as well as external resources offered by members of their social network.

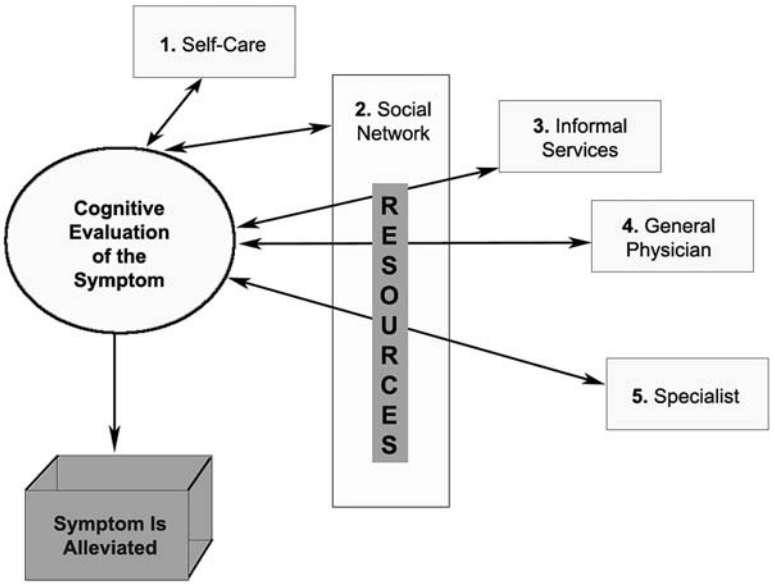

Figure 12.1 Help-seeking pathways to health and mental health care.
Salgado de Snyder et al., 2003.

The model displays five sequential help-seeking strategies that Mexican rural villagers commonly follow to relieve a physical or psychological symptom that significantly interferes with their daily functioning:

- They first use self-care strategies to address the symptom.
- If these strategies do not alleviate the symptom, they move to the second stage of the help-seeking process: seeking advice and information about healthcare remedies from family, friends, and other members of their social network.
- If the symptom persists, the next step in their help-seeking pathway is to consult with informal helpers in the local ethnomedical system—the local priest, who may provide moral support and advice; a lay nurse (*inyeccionista*), who may recommend over-the-counter medications; and folk healers (*curanderos, yerberos*, and *sobadores*), who may prescribe natural medicines, rituals, and other forms of treatment to restore physical and emotional balance. Their services may be more in harmony with the culture's views of health and mental health than those offered by formal helpers in modern medicine and psychiatry.
- Mexican rural villagers move to the fourth (consulting with a general physician) and fifth (consulting with a specialist) stages of the pathway if previous attempts to relieve the symptom have failed. Free or low-cost healing resources in their social networks and the local ethnomedical system may not be adequate to mitigate the situation. Before turning to formal helpers, however, they must consider the severity of the symptom, the cost of professional services (i.e., consultation, medication, tests,

follow-up visits, and other expenses such as travel, meals, and shelter), and the acceptability of these services. General physicians and specialists are seldom consulted because of high costs associated with their services. Moreover, the scarcity of health professionals and specialists in isolated rural communities, and differing views about health and mental health care, preclude most villagers from obtaining adequate, timely, and effective treatment through formal helping systems.

The cultural pathways to care model is useful in mapping the potential steps to care taken by Hispanic immigrants. The model expands on the help-seeking theory by incorporating the following main points:

- Beliefs and behavioral patterns learned in a country of origin may persist once the person comes to the United States.
- Help-seeking steps persist as long as symptoms are perceived as problematic, and the pathway may be exited at anytime.
- There is a temporal component, related to actual or perceived barriers, in help-seeking behavior at each stage.

Returning to Maria's case, there is evidence that beliefs and behavioral patterns she learned and practiced in her country of origin persist in the United States. For example, the application of the cultural-based practices of *controlarse* and *aguantarse* to help her manage her symptoms was followed by her use of medicinal teas as a form of treatment. Maria also persisted in her help-seeking behavior, as outlined in the model, because she continued to perceive her symptoms as serious and problematic. At each step in the model, Maria evaluated and determined the efficacy of the remedy she applied. She also determined if the symptoms were still severe enough to continue seeking a solution. In her case, symptoms were not ameliorated by her initial self-care efforts, and she perceived her symptoms as severe enough to continue seeking a solution.

It is also important to note that Maria's passage through the different levels of the cultural pathway model encompassed a temporal factor. That is, there were few barriers to her initial steps to self-care (i.e., *agauntarse* and teas), and consequently, a shorter time lapse to self-care behavior, compared to the time lapse to seek help from family and others in her social network. Barriers of geographic distance and lack of well-defined and formed intimate friendships resulted in a longer time lapse in seeking help from her social network.

The five sequential help-seeking strategies defined in the model reflect behavior as conceptualized by the help-seeking theory. They also help us understand Maria's help-seeking behaviors from a cultural perspective.

GUIDELINES FOR INTERVENTIONS ALONG CULTURAL PATHWAYS TO CARE

Even though the discussion here focuses on the help-seeking pathways of Mexican rural villagers, social workers can apply the model to many other cultural groups that migrate to

the United States from Latin America (c.f., Cabassa & Zayas, 2007; Garces et al., 2006). The model demonstrates that help-seeking is not a series of isolated behaviors triggered solely by the severity of symptoms, but a process that occurs along structured pathways in a cultural context. To intervene with cultural competence (Poole, 1998), social workers should follow six guidelines along client pathways to care:

1. *Understand the cultural cognitive evaluation of symptoms and treatments*. When coming in contact with recent immigrants from remote villages of Latin America, the social worker should be aware that this may be one of the few times they have ever talked with a health or mental health professional. The first major task, therefore, is to build trust and rapport with clients who probably hold different views about health and illness, and who may perceive professional helping systems as threatening or ineffective.

   Accordingly, the social worker must understand and appreciate cultural cognitive evaluation of symptoms and treatments. This can be done by asking the client to identify the nature and severity of symptoms. The practitioner should also ask how the person monitors and interprets physiological and subjective changes in the body. Many rural villagers in Latin America are taught from childhood to monitor their bodily functions, to identify what is normal and what is not. Only when they are cognizant that something is wrong with their body will they enter pathways to care. No differentiation is made between body and mind. Help with an emotional problem usually is not sought until it is manifested in physical symptoms such as backaches, headaches, nausea, and stomach ailments. The social worker should explore client fears and expectations of professional helping systems as well. Available treatments and the process of recovery in these systems should be explained to the client in simple words.
2. *Assess the capacity for self-care*. Given that self-care is usually the first approach to recovery, the next major task is to build confidence in the client's already existing abilities for self-care and to assume responsibility for treatment. The social worker should explore the kinds of resources the client has to address the symptom and personal efforts made thus far to restore health. Self-care strategies might include traditional practices such as the use of teas, herbs, over-the-counter medications, dietary changes, prayer, religious rituals, exercise, and rest.

   The practitioner should also assess the client's internal capacity to deal with discomfort through self-control (*controlarse*) or by holding in pain (*aguantarse*). The first strategy attempts to control a symptom through willpower, and the second strategy by temporarily giving up, in the hope that the symptom will go away on its own (Cohen, 1985).
3. *Determine the strength of the social network*. Following attempts at self-care, migrants from rural villages usually consult with members of their social networks and request advice about a symptom. The social worker should view this as the most important step in the helping process. Assistance provided by social networks will probably remain until the member fully recovers from a condition (Salgado de Snyder et al., 1998).

To determine the strength of a client's social network, the social worker should identify family, friends, neighbors, co-workers, and close acquaintances (network density), examine the history of these relationships (network duration), and assess the proximity of network members to the client (network dispersion). The social worker should also request information on the type and amount of help (instrumental or affective) available through these networks, including resources to help clients follow through with appointments and participate in treatment processes.

4. *Identify the local ethnomedical system*. Consultation with a professional is not a common behavior among recent immigrants from these cultures. Because formal services are usually difficult to obtain in their communities of origin, they have learned to rely chiefly on the services of informal helpers in the local ethnomedical system (Mora-Rios & Ito-Sugiyama, 2005; Salgado de Snyder et al., 1998). Informal helpers generally have high prestige and moral authority in their culture, and services they provide are free or low cost.

   Thus, depending on the perceived nature of a symptom, a client may have already sought counsel and advice from a priest, pharmacist, or folk healer prior to consulting a professional for help. The social worker should identify helpers in the client's local ethnomedical system. It is important to acknowledge the respected role that informal helpers occupy in the client's culture, especially when the client believes a symptom is a consequence of supernatural forces. The social worker should also assess the perceived effectiveness of these helpers in treating the presenting symptom and encourage the client to follow innocuous recommendations that may be culturally relevant.

5. *Assess barriers to utilization of professional services*. The next step in the helping process is for the social worker to assess barriers to formal services in the community. The four A's of service utilization—availability, affordability, accessibility, and acceptability—determine how soon and how often people of a different cultural background rely on professionals for health and mental health care.

   The social worker should determine whether clients have sought help from professionals in the past, and what they experienced in the process. It is important to keep in mind that many migrants from isolated, rural villages of Latin America have never been in contact with a professional, either in private consultation or in a community care center (Garces et al., 2006; Mora-Rios & Ito-Sugiyama, 2005). The cost of consultation, medications, testing, transportation, meals, and lodging precluded them from approaching professionals as potential sources of help in the past. Before referring them to professionals in the United States, the social worker must ensure that services are available, affordable, and accessible to these clients.

   The social worker should also determine the acceptability of formal support services in the community. Professionals delivering these services must be sensitive to cultural differences. For example, mental illness is a stigmatized condition that many Latin American cultures consider an incurable problem. If professionals do not take great care in the diagnosis of emotional symptoms, clients from these cultures may give up on their chances of recovery or refuse to comply with prescribed treatments. Professionals should also encourage the inclusion of harmless rituals of folk healers

(e.g., drinking one glass of water an hour before taking the medication; walking two hours a day to expel stress lodged in the body) as part of the recommended treatment. Clients and folk healers often share similar views about health, illness, and treatment expectations. Cultural convergence between formal and informal helping systems fosters self-control of the recovery process, as well as client adherence to prescribed treatments (Salgado de Snyder et al., 1998).

6. *Restructure service delivery systems*. In an era of managed care and accountability, the social worker must be attuned to factors that affect the efficiency and effectiveness of health and mental health services (Snowden & Yamada, 2005). When barriers to service utilization are insurmountable, health conditions frequently worsen, culminating in the need for expensive, comprehensive treatments. To remedy the problem, the social worker can help program managers determine the degree of fit between a service delivery system and a culture's pathways to care. Service goals are more likely to be obtained if the system is integrated with cultural cognitive evaluation of symptoms and treatments, orientations toward self-care, social networks, and local ethnomedical care.

   The social worker also can help program managers restructure service delivery systems by conceptualizing services along a continuum of care, proceeding seriatim from self-care, to social networks, to informal helpers, to professional care. If trust and rapport are established, the social worker may be viewed by clients as a member of their social network and a reliable source of advice. When this occurs, the door is open for the practitioner to involve members of the network in the health recovery process. Developing trust and rapport with informal helpers can reap similar benefits. To promote prevention and early intervention, the social worker can form partnerships with them as gatekeepers to formal services in the community.

These guidelines may be used to develop a culturally sensitive and relevant intervention plan to help Maria receive the care she needs. For example, an essential process in developing trust and rapport with Maria would be to explore and validate her understanding of her current problematic symptoms. Herminia may accomplish this task by asking Maria to identify the nature and severity of her symptoms in her own words. In Maria's case, she may define her problem in terms of physiological symptoms (e.g., body aches, lack of sleep, weight gain) rather than psychological terms such as anxiety or depression. Initially, Herminia may model Maria's description and understanding of her symptoms, and wait until a therapeutic relationship has been established to help Maria think of alternative ways to understand her symptoms (e.g., anxiety or stress caused by loss of familial network).

To further develop an understanding of Maria's view of her current problems and help-seeking behavior, Herminia may explore how her client has monitored the severity of her symptoms and how she experienced formal helpers (e.g., social workers, physicians) in the past. These guidelines will help Herminia communicate to Maria the desire to understand her current problems, as they are defined by the client, and also allow Herminia to assess Maria's ability to self-monitor her symptoms and willingness to seek formal services for her current problems.

Exploring Maria's strategies to remedy her current problematic symptoms, whether successful or not, will allow Herminia to assess her client's ability for self-care and willingness

to assume responsibility for treatment. In Maria's case, it is evident that she is willing to take proactive steps to remedy symptoms she perceives as problematic. For example, she is able to prepare and consume medicinal teas, is able to elicit and follow through on informal remedies as suggested by her mother and acquaintances from her church, and is able to seek further help in her community (i.e., her priest) and to follow-up on his suggestion to meet with Herminia, a social worker. Herminia may use these client strengths to build on Maria's confidence in her self-seeking behavior, and ultimately, if she agrees, to seek help from formal sources of care.

A critical step in assisting clients along their pathway to care is to determine the strength of their social networks, because it can provide insight into the density of their social resources. In Maria's case, her social network is not strong. She spends most of her time alone in her house. Her husband is working most of the time, and her children are at school most of the day. She does not have many friends, and she has few social contacts. Her extended family is in Mexico, and her only contact with them is via long-distance phone calls. This assessment of Maria's social network allows Herminia to work with her client to improve communication with persons in her social network and to develop strategies to strengthen her social network.

Maria has successfully identified and accessed an informal helper in her ethnomedical system (i.e., her priest). Assessing Maria's choice to confide in her priest allows Herminia to build on her client's ability to seek out help. It also allows Herminia to help Maria identify other potential influential persons in her ethnomedical system who may be supportive of her help-seeking behavior. This may be critical in Maria's case considering her weak social network.

The next step in the helping process is to assess barriers to formal services in the community. In Maria's case, Herminia may inquire about the client's experiences in accessing formal care (e.g., social workers, physicians), with inquiries focusing on the four A's of service utilization. In developing a plan to help Maria access formal care, Herminia must keep in mind that her client may not have accessed formal care in the past because of lack of availability or the high cost of professional care. Herminia must ensure that any plan developed with Maria to access formal services must include only those services that are available, affordable, and accessible to her client.

Another consideration in developing a plan to access care is the acceptability of formal supportive services in Maria's community or social network. Herminia should work with Maria to understand any concerns over possible stigma and help Maria identify sources of formal care that are sensitive to cultural differences. Lastly, to continue building on Maria's confidence in her help-seeking behavior, Herminia should encourage the inclusion of harmless home remedies or rituals. This practice promotes a cultural convergence between formal and informal care, and allows Herminia to help Maria foster a sense of self-control in her recovery process and adherence to prescribed treatments.

CONCLUSION

Pathways is a unifying concept in health and mental health care. The concept refers to the sequence of contacts that people make when they seek help with situations that outstrip their own resources for self-care. This sequence of contacts is not random, but a structured pattern of help-seeking behavior.

Rural social workers can map these patterns to identify the direction and duration of a client's cultural pathway to care, as well as to assess appropriate points of intervention. Recent immigrants from isolated, rural villages of Latin America, for example, commonly turn to members of their social network for advice and information, then to informal helpers in the culture's local ethnomedical system. Physicians and specialists are seldom consulted, mainly because of the cost of services and different cultural views of health and illness.

U.S.-based social workers can assist this rapidly expanding population group to obtain adequate, timely, and effective treatment by adhering to the six guidelines for culturally competent practice offered in this chapter. They can also help culturally diverse families mobilize internal and external resources to cope with a crisis event that disrupts normal coping patterns and traditional pathways to care.

Discussion Questions

1. Why is preserving the health capital of immigrants from Latin America in the best interest of all U.S. residents? What strengths and assets do they contribute to the social fabric of the nation?
2. How do help-seeking pathways to care vary by people with or without health insurance? With or without citizenship? Do traditional cultural pathways to care of recent rural Hispanic migrants differ from your own? How are they similar or different?
3. Compare and contrast the social network of Maria with your own. As a social work practitioner, what capacity-building strategies would you use to increase the scope and density of her network?
4. Discuss real or perceived barriers to health care in rural communities for this vulnerable cultural group, using the 4 A's model of service utilization.

Classroom Activities and Assignments

1. With a Spanish translator, converse with people in your community who have limited English-speaking ability—perhaps at a bodega, restaurant, taqueria, church, or social service agency. Ask them to describe the roles of *curanderos*, *yerberos*, *inyeccionistas*, and *sobradores* in their place of origin. Also, ask if they ever consulted with a medical doctor or a psychologist there for a health or mental health condition. In addition, ask if they ever went to a social worker for help, and if so, what kind of help did they receive?
2. Conduct a "culture-scape" of a health clinic or social service agency in your community. What evidence do you find of sensitivity to the need for acceptability in the delivery of services to this cultural group?
3. Form groups composed of two to three students to identify and describe social networks, gatekeepers, and informal helpers of recent Hispanic immigrants to your community. Analyze the strengths and capacities of these helping systems, particularly with regard to social support, resources, and access to health care.

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CHAPTER 13

Social Workers and Rural Congregations

Partnering to Build Community Capacity

T. Laine Scales and Jon Singletary

In their classic text on asset-based community development, Kretzmann and McKnight (1993) challenged social workers to recognize the richness of rural communities. We are encouraged to look upon the strengths and assets of rural life and discover the capacity of a community to be developed and enhanced. Using this strengths-based framework, social workers begin to see that people can organize and implement the structures to improve community life.

A strengths-based framework allows rural citizens to determine their own directions, set their own priorities, and utilize their own strengths to improve their communities. Some of the assets typically found in rural communities are natural resources, strong social networks, durable traditions, voluntary associations, and institutions, such as schools and religious congregations.

Stereotypes too often paint a picture of rural religious congregations as overly conservative social entities in steep decline; Neitz (2005) is among those who challenge this notion, stating that the media stereotype prevents a critical assessment of real strengths and weaknesses that exist in rural congregations. Social workers serving in rural communities have sometimes looked to rural churches as a resource in social service provision. Rural congregations help mold and shape rural communities. From frontier days to the present, people in rural communities have established and rigorously sustained regular religious gatherings. In rural life, where people are connected to nature for livelihood and recreation, there is an abiding appreciation and reverence for both divine order and supernatural intervention. A rural congregation is a conduit for invoking divine blessings and comforting those who are experiencing hardship (Aten, Mangis, & Campbell, 2010; Neitz, 2005).

Congregations have much to offer rural communities and can contribute assets of human and social capital (Boddie, 2002; Schneider, 2006). The phrase *human capital* describes how individuals contribute through congregations to rural communities; likewise, *social capital* has to do with ways that groups of people add value in their contexts. Individuals can help

one another, but as groups, they create social capital that offers even more in their communities. The potential for community support from these groups is often unrecognized and usually underutilized. Professional social workers have tremendous opportunities to make use of the naturally occurring networks in religious and community life and to broker creative partnerships. We contend that by forging stronger partnerships with rural congregations, social workers can tap into a wealth of assets for social services in rural communities. A professional social worker can provide knowledge and skills that are essential for coalition building, such as networking, referring and brokering to bring groups together, negotiating agreements and contracts, assisting with the technical aspects of service delivery, aiding in grant writing and fundraising, and demonstrating problem-solving skills that address barriers to collaboration.

Professional social work has recognized a category of *church social workers*, who are employed specifically to work with churches or church-related agencies (Garland, 1995). In this chapter we are not addressing only those who have chosen to specialize as church social workers, but rather we address any professional social worker in a rural context who is interested in collaborating with rural congregations.

Rural social workers working in any context, public or private, religious or nonsectarian, can benefit from knowing how to collaborate with churches. As social workers who have worked with congregations that are rural and Christian, our discussion and examples will be limited to this context. However, we recognize that many of these principles can be applied to other rural religious bodies.

In order to facilitate partnerships with churches, social workers need information about (1) characteristics of rural congregations, (2) effectively communicating with rural congregations, (3) congregations as community partners, and (4) locating resources for rural congregations. To more fully understand congregations as assets in a rural community, we must consider their capacity, potential, and limitations. It is worthwhile to consider the essence of rural congregations and how they function within their communities.

CHARACTERISTICS OF RURAL CONGREGATIONS

Each rural congregation is unique, and there are differences among religious traditions and denominations represented in rural communities. However, certain identifiable characteristics shape the culture of rural congregations. Expanding on a set of 10 characteristics proposed by Farley (1988) for the small church and drawing from our own experiences in rural congregational social work (Scales & Aker, 1998, 1999), we will sketch a portrait of a rural congregation. Because some of these characteristics are related to the small size of the church, rather than its rural context, they may apply to a small urban or suburban church as well. The characteristics are organized into four categories: organization, leadership, relationships, and methods. Each category presents both a potential asset and a potential challenge for the congregation and for the social worker who is considering the kinds of collaborations necessary for maximizing services within a rural community.

Organization

Rural congregations are typically single-cell, rather than complex, organizations. The hierarchy is clear and simple. If a social worker were to draw and analyze an organizational chart, he or she would see that the chain of command and the assignment of responsibilities would not be complicated. In addition, rural congregations are often small organizations that have not evolved into the complex bureaucratic structures that are characteristic of large urban churches or suburban mega-churches.

Providing worship services one day each week is seen as the primary function of a rural church, in contrast to a larger urban church, which may operate a variety of programs throughout the week. In fact, social workers hoping to facilitate social service programs may find that the small rural congregation or its leaders may view programs not directly related to worship as extraneous to the main business of the congregation. However, the fellowship that exists in rural congregations allows members to integrate their religious lives into well-ordered and well-established social and civic lives. Rural congregations may not offer a variety of programs, but they do provide an extension of the rich sense of community that can exist in a rural context (Aten, Hall, Weaver, Mangis, & Campbell, 2012).

Finally, small rural congregations are limited in terms of resources. They typically have fewer members, fewer staff, fewer volunteers, and fewer dollars than urban and suburban churches. Therefore, social workers facilitating cooperation among congregations, between congregations, and with local agencies will help enable rural congregations to make the most of their limited resources.

Leadership

Rural congregations are typically led by one full-time or part-time clergy person, with part-time personnel or volunteers assisting. There are few people to whom the clergy can delegate responsibility, so leaders tend to be very hands-on and operate as generalists. Leaders are expected to be available to address a wide variety of needs in their congregation and in the larger community.

In addition, leadership is localized, with clergy and other leaders making their own decisions. Rural church leaders may sometimes ignore directives initiated through denominational structures or other organizations that have structural authority or influence over the local congregation. Exercising tremendous autonomy in decision making, rural churches often ignore denominational directives, believing that programs designed for urban or suburban churches are irrelevant to them, or because leaders seldom notice noncompliance of a remote, often disconnected congregation.

Relationships

Rural congregations have a particular relationship style that may be noticeable to outsiders. First of all, the rural church is a people-centered place where "everyone knows my name." Rural congregants depend on one another in times of crisis and celebrate with one another in times of joy, such as the birth of a child. They value the person-to-person

relationships found both within the church and in the larger community. However, the closeness of this clan can be a barrier to outsiders, because one does not become a member simply by officially joining the church. Regardless of official church membership, one must be adopted into the church family to be a true member of the congregation. Church members typically have multiple connections with one another. For example, church elder Jose Gonzalez may be the uncle of his Sunday School teacher, Marco, as well as the father of the church secretary, Maria, while employing 10 other church members in his factory.

Methods of Helping

Members and leaders of the rural church use less-structured methods to plan and execute programs and activities. Rural congregations do very little long-range planning. Instead, programs are developed along two principle lines of action. First, congregations react quickly to needs and issues as they become known. Observers are often amazed at how quickly a rural church can collect food, clothing, furniture, or appliances simply by spreading the word or manage to buy a new furnace by passing the plate.

External projects are often designed on the spot when the need is identified. For example, one church in the Texas hill country town of Utopia learned of a family whose home had been destroyed by fire. The congregation worked quickly to mobilize the whole community in providing shelter, food, clothing, and cash donations. In the same way that a project is quickly created, it is quickly put away with little follow-up or afterthought. The old-time revivals of the rural church tradition are an example of short-term events that come quickly and are swept away as soon as the revival tent is torn down. Although this tendency to respond quickly is an asset, abrupt terminations make it difficult to sustain interest in long-term projects and partnerships.

The second way that rural congregations help is through special interests. Responses are more related to the passion of a congregant than to particular circumstances. This special interest is often the result of a personal experience or observation and a spiritually driven motivation to take action. If the congregant can communicate the need, stimulate interest in others, and organize action, then the whole church may get involved. For example, a social worker contacted a home economics teacher about a rural family who was in danger of being evicted from their home because of perceived "unsanitary housekeeping conditions." The teacher quickly established a corps of volunteers within her congregation to help her with training and mentoring the family so that they could meet the requirements and avoid being evicted. Soon, the teacher established an entire program with volunteers from several different congregations offering this service to other families in similar circumstances. A social worker could help establish collaborations between churches and other community partners (like 4-H and County Extension) for projects like this one. Once the social worker has cultivated an understanding of how the rural congregation functions, he or she can begin to prepare for communication with the congregation and other organizations about community issues. To build partnerships with a variety of agencies, social workers must communicate well with other social workers, government agencies, and congregations.

COMMUNICATING WITH RURAL CONGREGATIONS

In all types of social work practice, good communication skills are essential. We have identified six communication essentials for social workers to consider as they develop working relationships with rural congregations.

1. *Communicate with cultural sensitivity*. Social workers who have never been part of a rural congregation may find themselves in a cross-cultural context. Both the rural setting and the church context have their own languages and cultural patterns that must be learned. Garland and Conrad (1990) note that in the church context, "the Bible, theology, and Christian values and lifestyle become resources for practice." Language that includes concepts such as forgiveness, the family of God, and Christian hospitality often motivates church volunteers to participate in social service programs (p. 80).
2. *Communicate in ways that respect this group's theology of helping*. Social workers and congregants agree that social services (or physical ministries) are important, but they may disagree about the level of importance. Congregations may sometimes view physical assistance as temporal and therefore subordinate in importance to eternal things. Understanding that, for some congregations, temporal issues are filtered through eternal values is essential to communicating with congregations. Social workers may not agree with the congregation's theology or priorities, in the same way that social workers often disagree with the values and priorities of other partners. However, when each partner is respecting the other and focusing on their common desire to be an asset to the community, then the partnership can be successful.
3. *Communicate a connection to the congregation's mission*. Congregations are more willing to respond to opportunities in the community outside of the congregation when they can relate community projects to their own mission. What is the history of this group of congregants (particularly their history of helping)? What do they value most? What service activities are they already doing? Has their denomination identified particular social concerns to address? Rural congregations may tend to cling to their traditions and may be resistant to change. Although some traditions are clearly immutable, congregations with extensive traditions may be encouraged to subtly recast some traditions by changing the focus or adding new elements. For example, a rural congregation that has had a gift exchange among members for many years has now added an option to simultaneously provide a gift for a struggling family in the community. Building on structures and programs that are already in place, particularly those that have been around for a long time, may be viewed by the congregation as less threatening. Social workers with good communication skills will use creative thinking to connect current needs with established responses.
4. *Communicate in ways that respect the congregation's decision-making style*. Learning how decisions are made is critical. The decision-making path may vary greatly from one congregation to another. The polity of the larger denomination often indicates the style that is likely to be used by a congregation. But assumptions should

be avoided, because local adaptations often occur in rural communities. A recent study of congregations in a rural community suggested differences in how congregations make the decision to begin a new program (Aker, 2001). The following list suggests styles ranging from less to more autocratic in organizational decision-making style:

- Members see a need and budget funds or raise financial support.
- Members see a need and recruit others to get involved.
- Staff members or congregants identify a group of members who seem to be passionate about a certain cause.
- Committees go through a visioning process to thinking about what is possible.
- A Missions Committee may develop an idea and study its potential.
- Members present ideas to the Board of Trustees and Church Council.
- A governing board has a Missions Committee to screen all ideas.
- A governing board decides what the church will do.
- The pastor or another staff member takes the initiative.

What seems to be missing from the list is a perspective that focuses on assets. The congregation is looking for needs to address, rather than examining their assets and what they have to offer to the community. In addition, Kretzmann and McKnight (1993) recommend that churches examine what partnerships already exist in the community and see where they can join in, bringing their unique assets.

5. *Communicate information about policies and social services*. Professional social workers can provide much-needed information to congregations about policies and existing services. Social workers may provide technical assistance or information to prepare a congregation for building partnerships. They may help congregations locate resources to operate and further develop social service programs. The expertise of social workers may be needed to broker and negotiate working agreements, perhaps resulting in contracts between agencies and congregations. For example, one rural African American congregation consulted with a social worker as they applied for grant funding to sustain a program that began as a natural part of their congregational life. An astounding number of children (76) had been placed with families in the church through the state system of foster care and adoption. Social workers were involved in the process, and one social work consultant served as a resource broker, grant-writing consultant, and program evaluator for a program that would benefit the entire community.
6. *Communicate your patience and persistence*. Any partnership with a rural congregation requires patience, because congregations proceed with tasks according to their own priorities. To honor the timing and limited resources of a congregation is to patiently persist during the period from an idea's inception to a program's implementation. Follow-up for assigned tasks should be done with friendliness and understanding. The same congregation that moves swiftly to meet some needs may carefully debate over a different issue, particularly if it involves new collaborations with other organizations. A social worker must realize that in a rural community, trust and credibility are necessary for partnerships. This trust is not immediately given to the worker, but is earned over time.

RURAL CONGREGATIONS AS COMMUNITY PARTNERS

Proactive and Reactive Efforts

Congregations can be valuable partners in coalitions of organizations in rural communities. Congregations may unite with coalitions whose members may be other congregations (both interfaith and intrafaith), private agencies (including faith-based organizations), civic organizations, public agencies, local businesses, and charitable foundations (Kretzmann and McKnight, 1993; Schneider, 2006).

Coalitions may be *proactive*, establishing visible, permanent services driven by special interests of the congregation. Proactive coalitions sometimes form with unlikely partners who share a special interest for differing reasons. For example, religious bodies, community organizations, and state agencies may form partnerships to work with prisoners and their families. Interest in the welfare of clients outweighs differences for the sake of delivering services effectively in a continuous coalition.

Another type of coalition that congregations may join is *reactive*. These coalitions tend to be more spontaneous, driven by particular needs, and partners of the coalition are often determined by the nature of the need. These coalitions are often more time-limited. For example, an agency social worker providing services to a foster grandparent formed a temporary coalition involving a state agency, a community organization, a utility company, and a small congregation to assist her client who had lost her job and her electrical service at her home. The community organization negotiated with the utility company, which forgave part of the debt and allowed installments for another portion of the bill to help her become current with payments. The social worker contacted a congregation, which, although they did not know the client, rallied to pay the remaining $190 on the past-due electric bill, as well as $100 on her upcoming bill. Other members of the congregation installed a new wall gas furnace to replace several small electric space heaters in her home. Then several church members hired her to clean their homes and helped her establish a house-cleaning business that permitted her to work flexible hours and earn more income than in her previous job. By working together, the partners and the family were able to continue the placement of the foster children and avoid another disruption in their lives.

Barriers to Partnership

With patience, social workers can help churches to participate in community asset building by tapping into a congregation's resources, but several obstacles may hinder these partnerships. In a recent study, clergy in a rural community in Texas identified several barriers that prevented their churches from providing service programs that would benefit residents of their town. They noted as primary barriers a combination of overwhelming need combined with the limited resources of their congregations. Another barrier identified was congregants' lack of sensitivity to the situations of those in need. Congregations may hold particular attitudes about helping that cause them to question the legitimacy of a client's requests for assistance. Other barriers mentioned from the clergy perspective were a lack of understanding of the community's needs, lack of training and education to provide programs, and lack of

time and commitment of congregants (Aker, 2001). The priorities, values, and dynamics of a particular congregation may create barriers that frustrate the social worker. However, identifying these barriers is the first step in overcoming them, and the skilled social worker can address many of these obstacles through education of clergy and congregants.

Resources for Partnerships in Rural Communities

The assets rural congregations provide to their communities vary according to their individual resources. The tangible resources of a congregation can be easily assessed. Their willingness to utilize them for purposes beyond the congregation, however, is not so easily determined. By tangible resources, we refer to the observable items under the ownership of the congregation, such as real estate, a building, equipment, staff, volunteers, money, and vehicles. A congregation, at its discretion, may avail the community of these resources to accomplish certain service goals. However, a congregation is certainly more than its real assets. There are intangible resources as well: expertise (or access to it), power (or access to it), sanction (blessing or credibility), informal helping networks, and religious motivation (Scales & Aker, 1998).

Chief among the intangible resources is the rich social capital that exists in rural congregations. As stated earlier, rural congregations may be known primarily for their weekly worship hour on Sunday morning, but the social capital that develops in this hour extends throughout the rest of the week. Rural people have been more likely than urban people to attend church (Farley & Ruesink, 1997), and they may be more likely to believe in a religion that can answer life's problems (Glenna, 2003), but these churches are an integral aspect of rural culture that provide important spiritual, educational, social, political, and economic resources (Aten, Mangis, & Campbell, 2010). Urban people often attend church to create a sense of community that may be missing from their lives, whereas rural congregants may be able to strengthen existing social networks through participation in congregational life (Aten et al., 2012; Burkart, 1997). Although expensive social programs may not be found in rural congregations, there is a wealth of social capital as congregants work together, providing a valuable resource contributing to a wide range of rural experiences. The result is that the church is often the first place rural residents turn to for support (Aten, Topping, Denney, & Bayne, 2010).

Deanna Carlson (1999) summed up the value of religious organizations in our social systems by quoting social work pioneer Mary Richmond, who said in 1899:

> After all has been said in objection to past and present methods of charity, we must realize that, if the poor are to be effectually helped by charity, the inspiration must come from the church. The church has always been, and will continue to be, the chief source of charitable energy. (p. 2)

SOCIAL WORKERS AND RURAL CONGREGATIONS

Rural social workers are well-advised (and well-equipped) to work with congregations. Together, workers and congregations may overcome barriers to service provision and tap into the church's assets. Not only are members of rural congregations compelled by religious

beliefs to help relieve the suffering of others, but they are often capable of supplying the resources needed. Successful rural social workers will find win-win strategies in which congregations fulfill their desire to address both spiritual and physical needs, and they develop trust and credibility in the process. By understanding and participating in the local informal helping networks, congregational members are close to the needs of people in the community, in both proactive and reactive situations. With the proper approach, congregations can willingly partner with others to improve their rural communities with the faith that they can be successful even if they have limited material resources.

Social workers have the assessment skills to "begin where the client is." This includes seeing rural congregations as both a client system and a resource. Social workers in a rural context will benefit from understanding the diverse and complex nature of rural congregations, even if they are not a part of one. This chapter highlighted a few factors relevant to understanding rural congregational life. It is our hope that social workers and congregational leaders will work together in partnerships, drawing on the assets of rural settings.

Discussion Questions

1. The idea of building assets to sustain rural communities encourages groups to enter into partnerships with one another. Study the section "Characteristics of Rural Congregations." What assets of rural churches may make building partnerships with others feasible? What limitations may make it difficult? Can you think of examples in your community (rural, urban, or suburban) where churches are addressing social concerns? Do you think they could be more effective or efficient by partnering in new and different ways?
2. It is essential for social workers working with rural congregations to have strong communication skills. Review the section "Communicating With Rural Congregations." Which of the six suggestions would you find most challenging to implement? Can you think of several concrete things you can do to prepare yourself for these challenges in communication with rural congregations?
3. Social capital has to do with ways individuals make up groups that have value in their context. Individuals can help one another, but as groups, they offer a social capital that offers even more in their community. Their potential for community support is often unrecognized and usually underutilized. How can professional social workers use the naturally occurring networks in religious and community life in rural contexts?

Classroom Activities and Assignments

1. The authors note that many characteristics of rural congregations can function as both assets and limitations. Review each characteristic in the section "Characteristics of Rural Congregations." Divide into small groups, assigning each group a characteristic. Considering that characteristic, imagine two scenarios in which that characteristic would serve as an asset. Now imagine two scenarios in which that characteristic would serve as a limitation. What can social workers in the community do to encourage the congregation to understand and use that characteristic as an asset?

2. Interview a religious leader in a rural congregation. Ideally, class members would interview leaders from a variety of different religious traditions. Find out what partnerships this religious group has established with other community groups. If few (or none) have been established, what obstacles prevent such partnerships? Find out what the religious leader sees as the assets in the religious organization. Is the organization willing to offer those to the community to address concerns? What does the religious leader see as the assets of the community? Would the religious organization be likely to partner with social workers or social service organizations? If not, why not?
3. The authors discuss a variety of ways in which congregations offer spiritual, educational, social, political, and economic resources in a rural context. Although expensive social services may not be found in rural congregations, there is a wealth of social capital as congregants work together. The result is that the church is often the first place rural residents turn to for support. The authors contend that by forging stronger partnerships with rural congregations, social workers can tap into a wealth of assets for social services in rural communities. Divide into pairs, and as individuals, generate a list of possible assets a rural congregation may have to offer. Be sure to consider human, social, financial, real estate, and other types of capital. Once you have a good list, share it with your partner and examine areas of overlap. What do you see congregations having to offer rural communities?

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CHAPTER 14

Working Together to Improve Services for People Living With HIV/AIDS

An Example of Service Delivery Network Development From Rural Northeast Texas

H. Stephen Cooper, Freddie L. Avant, and Wilma Cordova[1]

Rural communities present unique characteristics that impact the ability of their members to access services and resources. Whereas some of these characteristics can serve as strengths or assets, many of them hamper the delivery of health care and social services. General characteristics that are most likely mentioned elsewhere in this book include, but are not limited to, geographic distance to services, limited or absent specialized services, transportation, and difficulties attracting and retaining trained health and human services professionals. For example, specialized health care services are typically located in urban areas. In many instances, the geographic distance to these services, combined with the absence of public transportation, interferes with or prevents rural residents from obtaining the care they need.

Of the many populations with special health care needs, we are particularly interested in people living with HIV/AIDS (PLWHA). Advancements in the care of PLWHA have greatly increased the life expectancy and quality of life for this population. However, when examined in terms of urban versus rural, there are some noticeable differences. For example, the number of HIV/AIDS cases in urban areas have either remained steady or declined, but this number is on the rise in rural areas (Berry, 2000; Reif, Golin, & Smith, 2005). These differences have been attributed to the greater availability of health care and education services in urban areas. When compared to their urban counterparts, PLWHA in rural communities tend to face a

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greater number and degree of challenges to accessing health care services. Such challenges include a lack of services, limited support services, lack of service coordination, instability of funding for hospitals, shortages of health care professionals, stigma, discrimination, isolation/loneliness, distance to general and specialized services, transportation, above-average poverty rates, and higher numbers of people without health insurance (Berry, 2000; Cordova, Cooper, & Avant, 2011; Leasure, Seideman, & Pascucci, 2009; Reif et al., 2005). It is important to note that whereas most PLWHA face a degree of stigma related to their health status, the amount of stigma attached to it tends to be greater in rural communities (Cordova et al., 2011; Leasure et al., 2009).

The aforementioned challenges and issues are consistent with those faced by residents of Northeast Texas (Cordova et al., 2011; Easley, Hodges, Avant, & Cooper, 2009). Services for PLWHA are often located in urban areas, such as Dallas and Houston, creating a critical barrier for persons who wish to seek and maintain an active treatment approach. As part of their efforts to improve the availability and quality of services for PLWHA within the region, Special Health Resources of Texas, Inc. (SHRT) sought and acquired a Special Projects of National Significance (SPNS) grant through the Health Resources and Services Administration (HRSA). The emphasis of this grant was on increasing availability of and access to oral health and dental care services to PLWHA in Northeast Texas. Specifically, it allowed for the purchase of equipment necessary to deliver services, including dental chairs, lab equipment, and x-ray equipment. The equipment supported the delivery of dental services at three of the four clinics that SHRT operates in the region. The services provided under this grant included dental case management, cleaning (hygienist), fillings, extractions, partials, bridges, and dentures.

Given the importance of health and social factors to maintaining dental health, as well as overall health, SHRT explored other avenues to improving the overall delivery of health and social services to this population. For instance, SHRT considered the possibility of developing a regional network of health care, dental care, and social service providers. The hope was that such a network could improve the efficiency and effectiveness of existing services through coordination, collaborate on the development of additional services, and engage in collective advocacy for additional regional resources. SHRT's first step in this process was to contract with the School of Social Work at Stephen F. Austin State University to study the possibility of such an endeavor and to offer specific recommendations. In this chapter, we describe the network planning project we designed to inform SHRT's efforts to build a network. Specifically, our discussion includes an overview of network development in rural areas, our network planning process, the results of the project, and the implications of our study for the development of a regional service provider network.

CONTEXT FOR PRACTICE: NORTHEAST TEXAS

Before discussing the development process, we think that it is important to describe the context in which our efforts took place. SHRT's service region consists of 23 counties that are located in the northeastern corner of Texas. The area is commonly referred to as Northeast Texas, covers approximately 15,522 square miles, and is bordered by Oklahoma, Arkansas,

and Louisiana. Twenty of the counties are classified as rural. The remaining three are not considered rural, because each contains a single incorporated city with a population greater than 50,000. However, each of the three counties includes rural areas. Furthermore, it could be logically argued that these "non-rural" or "urban" cities possess characteristics synonymous with rural areas and lifestyles. The rural nature of the region is further supported by the average population density, which is notably lower than the state average. The regional economy is heavily based in agriculture and related industries. An overview of HIV/AIDS and healthcare services in Northeast Texas, as well as an overview of SHRT's client population, is provided by the following sections.

HIV/AIDS

As of 2010, there were 1,445 people living with HIV (PLWH) residing in the Texas Department of State Health Services' (TDSHS) Public Health Region 4, which accounts for 2.2% of Texas's overall population of 65,077 PLWH (TDSHS, 2011, 2012). It is important to note that Public Health Region 4 is the same region served by SHRT and is part of a larger area commonly referred to as East Texas. The East Texas region includes Northeast Texas, Central or Deep East Texas, and Southeast Texas (excluding the Houston metro area). The East Texas region accounts for 6% of Texas's PLWH population (TDSHS, 2012). The majority (86%) of the PLWH population resides in one of Texas's five major metropolitan areas (TDSHS, 2012). Specifically, Houston (32%), Dallas (24%), Austin (7%), San Antonio (7%), and Fort Worth (6%). In light of these numbers, it is easy to understand why the urban areas receive the lion's share of the resources.

When looking at the larger East Texas area, African Americans had the highest number of cases of HIV (TDSHS, 2012). In fact, the highest morbidity rate in East Texas was among African American men ages 45 to 54 (TDSHS, 2012). It is also important to note that within this subpopulation, the most common risk category was men who have sex with men. These facts, especially the first two, are especially interesting given that African Americans are disproportionately underrepresented in the region's general population.

Whereas occurrence rates by demographic characteristics were not available for the Northeast Texas region, SHRT's data suggests that trends in Northeast Texas tend to be consistent with the larger East Texas region. It is worth mentioning that TDSHS (2011) ranked three Northeast Texas cities in the top 50 Texas cities for HIV infection (Longview—17th, Tyler—31st, and Texarkana—50th). Gregg County (Longview) was ranked sixth in the state for their rate of PLWH (268.3 per 100,000) and accompanied by three additional East Texas counties: Marion (17th), Cherokee (18th), and Anderson (19th).

Health Care Services

In terms of health care services within the Northeast Texas Region, the "hubs" are Tyler (Smith County), Longview (Gregg County), Paris (Lamar County), Palestine (Anderson County), and Texarkana (Bowie County). Specifically, these communities have regional medical/surgical hospitals and at least some specialized health and dental care professionals.

Tyler appears to have the greatest concentration of health care services in the region, including a medical training facility (University of Texas Health Science Center at Tyler). The outlying communities have varying degrees of health care resources. Eight of the 23 counties have a county health department, and the remaining counties depend on TDSHS (Easley et al., 2009). Nine of the counties have a primary health care clinic that provides primary health care, preventative health care, and serves low-income families (Easley et al., 2009). In fact, all but seven of the counties have been designated as Medically Underserved Areas (MUAs), and three of the remaining seven have been designated as partially underserved (TDSHS, 2010). Finally, many of the counties have been identified as Health Professional Shortage Areas (HPSAs), especially in one or more of the following categories: primary care, dental care, and mental health (TDSHS, 2007).

Among the 23 counties in the service region, only 10 of them have HIV/AIDS testing sites. One of the sites limits its services to current clients. In other words, it does not provide walk-in tests. Additionally, specialized dental care services for PLWHA are only available in three of the counties. Whereas there are other prevention and treatment services within the region for PLWHA, there is a noticeable shortage of programs to assist this population in meeting their basic and secondary needs, as well as those of their families. Unfortunately these circumstances are not limited to Northeast Texas but are found across the nation.

SHRT's Client Population

At the time of this study, SHRT was serving approximately 850 clients. In terms of ethnicity, the majority of the clients were African American (55%), followed by Caucasians (33%) and Hispanics and other ethnic groups (12%). The average client age was 42 years with a range of 18 to 68. As for gender, approximately 70% were male, 30% were female, and less than 1% were transgendered. A substantial portion of the client population lives in poverty and experiences a variety of challenges in accessing food, shelter, utilities, transportation, mental health care, and health care. SHRT attempts to address these issues through a variety of services, including ambulatory medical care, case management (Ryan White, substance abuse, and prevention[2]), mental health counseling, nutritional counseling, housing assistance, transportation services, and dental services. Of those clients receiving dental services, 150 of them were doing so under the SPNS dental grant.

SERVICE DELIVERY NETWORKS

Why are service delivery networks important to rural social work practice? Understanding the answer to this question is an important step toward developing an understanding of macro practice in rural areas. Let us start with the importance of service delivery networks. In the case of SHRT, their clients face multiple challenges that affect their ability to maintain

[2]The majority of case management services for PLWHA are funded by the Ryan White CARE Act and administered by HRSA. The primary focus of Ryan White case management services is on utilizing existing community resources to develop a coordinated and comprehensive health care delivery system.

their health. Imagine that you are employed by SHRT as a generalist social worker who is charged with providing case management services for clients who are living with HIV/AIDS. What basic needs might your clients have?

At the very least, all of them will need access to general and specialized health care. Additional needs are likely to include any combination of the following: dental care, mental health care, assistance with housing and utilities, transportation, and food/nutrition services. Depending on their health status, they may require additional support services, such as home health or hospice. If you approach your clients with a holistic perspective, then you would need to address all of the needs/issues that interfere with their ability to function in their environment. Is it reasonable to expect SHRT to provide all of these services to all of their clients and maintain the expectations for quality and best practices? In most cases, expecting an agency to provide all of the services necessary to meet every need of every client is unreasonable. Rather, you would most likely find yourself in a position to work with numerous agencies to assist your clients.

Given that the previous scenario is the norm, organizations have learned to work together in order to meet the various and multiple needs of their clients. From a rural perspective, networks provide a vehicle for working together to address common challenges to the delivery of social services, including meeting the multiple needs of clients, service fragmentation, resource issues, personnel shortages, and the costs of service delivery. However, as with many things, developing and managing relationships among organizations is easier said than done. Specifically, you must consider the importance of relationships among members, especially individual relationships, and the factors that influence them. You also need to choose a model or approach to network development. Whereas there are many such models, you need one that will work in a rural setting and is consistent with capacity or asset building.

Relationships

When we consider the relationships that constitute a service delivery network, we often think only of the relationships among organizations. However, those relationships are influenced by and often based on relationships among the individuals who represent the organizations. Given the multitude of relationships and variety of contexts in which they occur, you can imagine that planning and managing the relationships can be challenging. However, awareness and careful consideration of several key elements can help make this task manageable.

What do you think is the single most important element of a relationship? In our opinion, nothing is more important than trust. Individuals, families, groups, organizations, and communities all engage in relationships to meet their needs (e.g., social, economic, physical). For example, when two people engage in a relationship, each individual is expected to contribute to the relationship and does so based on an assumption that the other individual will contribute accordingly. In other words, you trust that he or she will follow through with his or her responsibilities and promises. And, because you have such confidence in him or her, you do not feel an overwhelming need to monitor his or her behavior. Rather, you operate on an assumption that he or she will continue to act in a manner that is consistent with the

established expectations. In this sense, trust is often the spark that ignites the process of developing a relationship and can hold two people together in difficult times. This holds true for relationships among organizations, including networks (Chrislip & Larson, 1994; Lackey, Freshwater, & Rupasingha, 2002; Reitan, 1998; Vangen & Huxham, 2003). Simply, trust serves as the glue that holds the network together.

This example illustrates the importance of another person's actions in developing and maintaining trust. However, it is not this simple. You must keep in mind that relationships are based on an expectation of reciprocity. In other words, you are expected to follow through on your responsibilities. For example, imagine you have helped a friend move to a new home twice within the last year. Now you are moving and need his or her help. What is your expectation of your friend? Most would expect him or her to help with the move. If he or she helps, how would that impact your relationship? How would your relationship be impacted if he or she could help you, but chose not to?

What does trust look like in the context of a network? It looks much the same way as described previously for a relationship. Imagine that you are a generalist social worker for SHRT, and the organization is engaged in a partnership with a local health care organization. Your experience has been that the program quickly assists your clients and consistently adheres to its eligibility criteria. Given this, you generally only need to follow up to make sure the client was connected to services and as necessary for evaluating client progress. In this example, it is likely that you would continue to make referrals to the organization and that SHRT would maintain the partnership.

On the other hand, what if the organization treats clients poorly, inconsistently applies their eligibility criteria, and does not follow through with services? More often than not, you and other SHRT case managers have to follow up multiple times to ensure that clients receive the services they need. In some cases, you have had to advocate on behalf of clients in order for them to access services. In this situation, it is likely that SHRT and its case managers would increase the amount of effort they put forth to monitor referrals. In doing so, let us assume that your responsibilities for managing the relationship with the health care agency suffer. In turn, they begin spending more time monitoring their referrals to you. Do you see where this is going? The key here is that the loss of trust can be a downward spiral.

Whereas our actions can damage trust, they can also foster and build trust. As previously mentioned, one of the primary methods of building trust is for you to follow through on your responsibilities. You can also solicit trust by demonstrating a willingness to work with other organizations—specifically, to compromise or meet them partway in dealing with issues. Others are more likely to work with you and compromise when you demonstrate a willingness to do the same. In addition to demonstrating a willingness to compromise and reciprocate, groups can strengthen trust by working collectively to define the issues, identify the course of action, and assign responsibilities. To illustrate this point, think about any group project that you have been involved with over your academic career. What would happen if the members were not clear on their responsibilities? It is likely that some parts of the project would be duplicated, while others went unaddressed. In terms of trust, this would most likely decrease the amount of trust among members. If this situation was completely unintentional, would it change the impact on trust? It might, but the trust among members would be impacted nonetheless.

Efforts to balance power can also facilitate the development and maintenance of relationships. In the context of network relationships, power should be balanced so that members have equal influence in the relationship, especially the decision-making process. In doing so, the ability of one member or group of members to control the process is diminished, the chances of reaching consensus are increased, and the likelihood that the voices of all stakeholder groups will be heard is greater (Cloke, Milbourne & Widdowfield, 2000; Raak & Paulus, 2001). Membership (who should be included in the relationship) and structure (rules or conditions of the relationship) help ensure trust and balance power (Cloke et al., 2000; Lackey et al., 2002). The membership should be representative of all the stakeholder groups or those groups who are either directly or indirectly impacted by the issues at hand. Of particular importance is the inclusion of groups that are typically excluded or marginalized, such as consumers of social services (Cloke et al., 2000). Finally, structure is the key to balancing power and responsibilities, which encourages trust among the members (Gibaja, 2001; Lane & Turner, 1999).

Approaches to Network Development

As for the process of building a network, several approaches are consistent with asset and capacity building. One of the more popular ones is Chrislip and Larson's (1994) *Collaborative Leadership: How Citizens and Civic Leaders Can Make a Difference*. They provide a detailed discussion of the elements and challenges to developing interorganizational relationships, as well as offer advice for developing them. Chrislip followed this publication with a prescriptive guide to developing relationships, *The Collaborative Leadership Fieldbook: A Guide for Citizens and Civic Leaders* (2002). Both of these resources informed the development of the Safe Schools/Healthy Students Collaboration in Georgetown, Texas, which is discussed later in this book (Chapter 21, by Streeter & Cooper). Other resources include a book and guide to developing relationships among businesses and nonprofits (Austin, 2000; Drucker Foundation, 2002, respectively), nonprofit and government collaboration (Linden, 2003), and a review of the literature on collaboration (Mattessich, Murray-Close, & Monsey, 2001).

Although our approach to building rural networks has been influenced by all of the elements and approaches noted thus far, the most influential source has been Poole's (2002) Community Partnership Model. Poole (2002) offers an approach to community building that is based on the following six steps or action principles: agenda building, structure, analysis, ownership, technology, and stewardship. Of particular importance to SHRT's network development project are structure, analysis, and ownership. Poole's idea of structure is consistent with our discussion in that it focuses on ensuring and balancing involvement from professionals and community stakeholders, including consumers, in all phases of the process. For example, stakeholders should be involved in analysis or the collection of information about the issue(s) and the available assets, as well as formulating solutions. In doing so, you increase their sense of responsibility or ownership of the issue(s) and solution(s). Other important results of their involvement are related to self-determination and empowerment. Specifically, involving stakeholders in a fair decision-making process allows them, rather than someone else, to identify the issues and solutions. Direct involvement in the process also

provides opportunities for them to learn how to identify issues and solutions, as well as plan and implement interventions. The stronger these skills are, the more likely the stakeholders will be able to address similar issues in the future with limited or no assistance. Finally, establishing and maintaining ownership is imperative to stewardship or efforts to sustain gains over time.

THE SHRT NETWORK DEVELOPMENT PROJECT

As previously established, developing relationships among service providers is often the key to increasing your ability to meet the multiple needs your clients face. In the case of SHRT, their clients face multiple challenges in daily living that can negatively impact their health status. Successfully addressing such challenges requires coordination of social, health, dental, and mental health services. Given the focus of the SPNS grant on increasing the availability of dental and oral health care services to PLWHA, SHRT was particularly interested in developing relationships among dental and oral health care service providers within the region. The SHRT Network Development Project was designed to include this emphasis within a broader focus on health care providers. Specifically, the project sought to engage regional stakeholders in focus group discussions to answer the following questions:

- What factors impact the delivery of dental, oral, and primary health care services to clients who have been diagnosed with HIV/AIDS?
- What specific actions could be implemented in the next three years to improve the delivery of dental, oral, and primary health care services to clients who have been diagnosed with HIV/AIDS?
- In terms of dental and oral health care, what are the most important or crucial actions?
- In terms of primary health care, what are the most important or crucial actions?

The information gathered during the focus group meetings informed the development of survey instruments that collected additional information from stakeholders. All of the data collected informed recommendations to SHRT regarding the development of a regional network of dental and health care providers that would work together to improve the delivery of services to PLWHA. The method and results of the project are presented in this section.

Method

Project Preparation

The first step in the preparation process was to plan the focus groups and identify participants. Given the large number of potential participants and the size of SHRT's service region, we held focus group meetings in four communities located across the region. One meeting for providers and a separate meeting for consumers was held in each of the communities. Each meeting was held in an SHRT facility, included refreshments, and lasted about two hours. We facilitated each of the focus group meetings.

In order to ensure the study was representative of all the relevant stakeholders, members of the following groups were invited to participate: consumers, dental care providers, primary health care providers, hospital staff, and health educators. We worked with SHRT's staff to identify potential participants via non-probability purposive sampling. Once identified, potential participants were contacted by an SHRT staff member and invited to participate in the project. The conversation included a discussion of the project's purpose, expectations, methods, risks/benefits, and confidentiality. A similar method was utilized to recruit additional participants to rate the items generated by the focus groups. These participants were only asked to complete the rating instruments. SHRT distributed packets containing a consent form, demographic profile, rating instruments, and a postage-paid self-addressed envelope to their staff, consumers, and other relevant community stakeholders.

The second item addressed during project preparation was the development of the focus prompt, which served as a guiding framework for the development of specific action statements. We employed two focus prompts, one to identify factors that affect service delivery and one to identify actions that could be taken to improve service delivery. The focus prompts are as follows:

- *Focus Prompt 1*: One factor that impacts the delivery of dental, oral, and/or primary health care services to clients is . . .
- *Focus Prompt 2*: One specific idea that SHRT could implement in the next three years to improve the delivery of dental, oral, and/or primary health care services to clients is . . .

The final step in the planning process was to identify the rating criteria for the action statements. Given the project's purpose, participants were asked to identify the frequency at which they experience the factors that affect service delivery and to assign a degree of importance to the ideas for improving service delivery. The rating criteria are as follows:

- *Frequency*. How often have you experienced this factor while delivering/receiving services (dental, oral, and/or primary health)? 1 = None of the time; 2 = Very rarely; 3 = Some of the time; 4 = Most of the time; 5 = All of the time; 6 = Not applicable
- *Importance*. How important is this idea to improving the delivery of services (dental, oral, and/or primary health)? 1 = Not important; 2 = Somewhat important; 3 = Important; 4 = Extremely important; 5 = Don't know

Identifying Factors and Ideas

Once we completed the preparation phase, we facilitated eight separate focus group sessions throughout the region. Each group met for approximately two hours to identify the various factors that impact service delivery and specific actions that could improve the delivery of services. Specifically, we began by asking each participant to work independently to identify three responses for each of the focus prompts. We then went around the room and asked each participant to share one response to the first focus prompt. The process was repeated until each member had shared all of his or her ideas. As the participants were sharing their ideas,

one of us recorded the ideas in a word processing program. The ideas were projected on a screen so that participants could ensure that they were recorded as intended. Once the recording process was complete, the group reviewed the ideas to eliminate duplicate statements. In an attempt to limit the amount of duplication, we provided the second and subsequent groups with a list of the statements that had been generated up to that point. It is important to note that the groups were only allowed to edit the ideas that were identified during their session. Even though we facilitated the meetings, the participants were responsible for guiding the process and generating the results.

Analyzing Factors and Ideas

After all of the focus group meetings were completed, we reviewed the factors that were generated in response to the first focus prompt and organized them into groups based on their conceptual similarity. Our decisions were informed by a thematic analysis and based on consensus. The factors were then used to create an instrument to measure how often each one of the factors was experienced by participants. The instrument included the following open-ended items:

- Can you think of any factors, other than those listed above, that impact the delivery of services (dental, oral, and/or primary health)? If so, please explain.
- Comments:

The same process was used to create an instrument that would measure the importance of each of the ideas for improving service delivery (second focus prompt). The instrument included the following open-ended items:

- Do you have any ideas, other than those listed above, that SHRT could implement in the next three years to improve the delivery of services (dental, oral, and/or primary health)? If so, please explain.
- Comments:

Once the rating data was collected, it was entered into SPSS and analyzed. Specifically, we calculated the mean score and standard deviation for each factor and idea. Our original intent was to make comparisons among the different stakeholder groups. However, these plans were significantly impacted by the low return rate. As for the four open-ended items, we aggregated the responses for each item and reviewed them for common themes. We then grouped the responses by common theme and reviewed them again for consistency with the related theme. Comparisons were also made among different constituent groups in order to identify similarities and differences in their responses. The results of our analysis are discussed later in the chapter.

Subjects

As mentioned earlier, the goal of our subject selection process was to create a sample representative of all the relevant stakeholder groups. We were successful in recruiting a group

that appears to be representative of SHRT employees. However, the low participation and response rates for consumers suggest the need for caution when generalizing the results to this group. Also, the lack of representation from providers other than SHRT prevents generalization of the results to service providers in general. Descriptions of the participants for the focus groups and rating process are provided in the following sections.

Focus Groups Whereas we had hoped that each of the focus groups would have between 10 and 20 participants (80 to 120 total participants), only 38 of the potential participants chose to attend the focus group meetings. Despite SHRT's efforts to recruit a representative group, all but one of the service providers were employed by SHRT. In terms of the characteristics of the focus group participants, 26 (68.4%) were service providers, 9 (23.7%) were consumers, 1 (2.6%) self-identified as other, and 2 (5.3%) chose not to identify their role. Twenty (52.6%) of the respondents were female, 16 (42.1%) were male, and 2 (5.3%) chose not to respond. The average age of the respondents was 45.44 (sd = 9.863). In terms of ethnicity, 20 (52.6%) of the respondents self-identified as White/European, 11 (28.9%) as African American, 4 (10.5%) as Latino/Hispanic, and 1 (2.6%) as Native American. Two of the subjects chose not to respond to this question. The following information was also collected but not included here for the sake of brevity: education, county of residence, employment status, area of employment, primary job responsibilities, and professional licenses.

Rating Rating instruments were distributed to focus group participants, as well as additional stakeholders who were identified by SHRT via the purposive non-probability sampling process we described earlier in the chapter. A total of 525 instrument packets were distributed to the following stakeholder groups (each group is followed by the number of packets distributed and the number returned): SHRT staff (75/26), SHRT Board of Directors (11/2), Longview clients (100/17), Tyler clients (100/3), Texarkana clients (100/19), Paris clients (50/5), Longview community members (25/8), Tyler community members (25/0), Texarkana community members (25/2), and Paris community members (25/0). Of the 525 instrument packets, 82 were returned (15.6% return rate). We took several actions to increase return rates, including follow-up contacts with participants and extension of the deadline for return. However, they did not result in a significant increase in the return rate. It is important to note that the return rate for consumers limits our ability to generalize the results to the larger population (45 out of 350 potential consumers or 12.9% return rate). The same holds true for community members.

In terms of the characteristics of the rating participants, 31 (37.8%) were service providers, 45 (54.9%) were consumers, 3 (3.7%) were advocates, 1 (1.2%) identified as other, and 2 (2.4%) were SHRT board members. Twenty-seven of the service providers were employed by SHRT, and 24 of them were from the Tyler area. Twenty-nine of the clients who responded were recipients of dental care services. Thirty-three (40.2%) of the respondents resided in the Texarkana area, 48 (58.5%) of the respondents resided in the Tyler area, and 1 chose not to respond. Twenty-seven of the 42 respondents (51.2%) were female and 40 (48.8%) were male. The average age of the respondents was 45.24 (sd = 11.02), with the youngest being 22 and the oldest being 70. As for ethnicity, 44 (53.7%) of the respondents

self-identified as White/European, 32 (39.0%) as African American, 4 (4.95%) as Latino/Hispanic, and 1 (1.2%) as Asian American/Pacific Islander. One of the subjects chose not to respond to this item. The following information was also collected, but not included here: education, county of residence, employment status, area of employment, primary job responsibilities, and professional licenses.

Limitations

As we mentioned earlier, there are several key limitations with the study, all of which you should keep in mind when reviewing the results. First, the limited representation of consumers significantly challenges our ability to generalize the results to SHRT's overall consumer population. In other words, we are concerned that the opinions of the consumers who participated may or may not be the same as or similar to those of the consumers who chose not to participate. We share this same concern about service providers. Specifically, the majority of the service providers were employed by SHRT, which limits our ability to make generalizations to the broader population of service providers who work with the client population. This is especially important given that the primary purpose of the project was to inform the development of a network of service providers. Finally, the issues with representation restricted our ability to analyze the data and compare the responses of the stakeholder groups. The ability to make comparisons is especially important in this case, because they could have assisted us with identifying points of consensus and disagreement, both of which are helpful when developing relationships among groups.

Results

The eight focus groups identified 98 factors that impact the delivery of services. The factors were generated by the participants in response to the following focus prompt: "One factor that impacts the delivery of dental, oral, and/or primary health care services to clients is . . ." The focus groups also identified 86 ideas that could be implemented in order to improve the delivery of services. These ideas were generated in response to the following prompt: "One specific idea that SHRT could implement in the next three years to improve the delivery of dental, oral, and/or primary health care services to clients is . . ."

The process of analyzing the factors and ideas included the following steps: (1) organizing the factors and ideas into groups based on their similarities, (2) examining the rating responses for the factors and ideas, and (3) analyzing the narrative responses. A discussion of each of these steps follows. For the purposes of this chapter, we have decided to focus our attention on the ideas and their implications for the development of a service provider network.

Organizing the Ideas

Once all of the focus groups had met, the researchers began the process of organizing the 86 factors into groups based on their conceptual similarity. The first step in the process was to organize the ideas into groups based on common themes or concepts. We then reviewed the groups in order to identify groups that were similar enough to be combined. Once it

was apparent that the remaining groups were too dissimilar to be combined, we ended the process. The end result was 23 groups of statements.

Rating the Ideas

After the ideas were organized into conceptual groups, we created an instrument to measure participants' perceptions of the importance of each idea. Specifically, we asked participants to tell how important each idea was to the overall goal of improving service delivery. Participants rated each idea using the following rating scale:

Importance: How important is this idea to improving the delivery of services (dental, oral, and/or primary health)? 1 = Not important; 2 = Somewhat important; 3 = Important; 4 = Extremely important; 5 = Don't know

The ideas rating instrument was distributed to participants using the process outlined in the Method section. Once the rating data was collected and entered into SPSS, the mean score and standard deviation for each idea and group of ideas was calculated for all participants, as well as providers, consumers, and dental clients. See Appendix C,"Ideas Ratings for Service Providers and Consumers (Mean Scores)" for the results.

When planning the project, our intent was to make comparisons among the various stakeholder groups. These comparisons would have assisted us in identifying similarities and differences in perceptions among the groups. Such information can be extremely helpful when developing a network. For example, similarities in perceptions indicate points of agreement, which can be used to build consensus. On the other hand, identifying differences can alert you to potential points of contention. If you know about these beforehand, you can be proactive in your efforts to address them. For instance, you could use the points of agreement to build consensus before tackling the more difficult issues. Unfortunately, the sample did not allow for such comparisons. However, we chose to include a few areas of agreement in this chapter to illustrate the above points.

In order to illustrate the importance of comparisons among stakeholder groups, we conducted a set of comparisons between clients residing in the Tyler and Texarkana Health Service Delivery Areas (HSDAs). We made the comparisons using independent group *t*-tests and found statistically significant differences for the following groups/items: Public Education/Awareness (26), Dental Services (37), and Community Services—Dental Care (86). The results for each of these items are discussed as follows:

26. *Involve clients in the efforts to educate the community about HIV/AIDS* ($t = -2.676$, $df = 36$, $p = .011$, $\alpha = 0.05$). Clients residing in the Texarkana HSDA tended to rate the importance of this idea lower (3.00) than clients residing in the Tyler HSDA (3.71).
37. *Provide dental services in Paris* ($t = 2.342$, $df = 18.852$, $p = .030$, $\alpha = 0.05$). Clients residing in the Texarkana HSDA tended to rate the importance of this idea higher (3.86) than clients residing in the Tyler HSDA (3.29).
86. *Recruit local professionals to provide specialized dental services* ($t = 2.435$, $df = 36$, $p = .020$, $\alpha = 0.05$). Clients residing in the Texarkana HSDA tended to rate the importance of this idea higher (3.70) than clients residing in the Tyler HSDA (3.07).

It is possible that these differences could be points of contention or disagreement in the planning process. An awareness of such allows for proactive efforts to address potential conflict. It is important to note that the assumption of a normal distribution was violated for each of these items. Given that the results could be caused by the distribution of scores rather than differences in the means, the results should be interpreted with caution.

Narrative Questions

In addition to rating the ideas, participants were asked to complete two additional open-ended items. For each of the two questions, we aggregated the responses and reviewed them for common themes. We then grouped the responses by common theme and reviewed each group of responses for consistency with the related theme. Because of the limited number of responses, we did not make comparisons among the stakeholder groups.

The first item on the rating instrument was: "Do you have any ideas, other than those listed above, that SHRT could implement in the next three years to improve the delivery of services (dental, oral, and/or primary health)? If so, please explain." Seventeen participants responded to this item, and most of the responses focused on the expansion of services. Several participants mentioned the need for dental and medical services in Paris, especially time with a dentist. For example:

Accessibility to a Dr. regularly in Paris so we don't have to go to other Dr. or clinics for medical care or to ER.
Dentist services are never available.
More clinic days in Paris; dental, mental, and group meetings at night in Paris.
Allow clients more access to a physician instead of a nurse practitioner.
Find grants that would incite [sic] a resident to move to Texarkana, Tyler, and Paris to practice as an infectious disease specialist.

The other common suggestion was the implementation of mental health services, especially counseling and support groups. Finally, there were several suggestions that did not fit into these categories, but they are worth mentioning. One participant recommended increasing staff salaries. Another recommended the creation of a feedback mechanism for clients that would allow them to "review and see that their concerns are being addressed." The last suggestion was to implement a sliding-scale structure to subsidize expenses related to service delivery.

The second narrative item on the rating instrument solicited general comments regarding actions that could be taken to improve the delivery of services. Ten participants chose to respond to this item. The most common theme was appreciation for the services provided by SHRT. Examples of such include:

I thank God for SHRT staff.
Great job from a client of Special Health Services.
Overall services are good, especially where most ALL HIV infectious disease specialist will not see patients with Medicare/OMB benefits in Dallas area.

The following comment was especially interesting in that it echoes the concerns about autonomy that were raised during the focus group meetings:

> *Texarkana and the surroundings [areas] in Bowie County have a population big enough to have better services for HIV patients. Our funds should not be managed in Houston, TX! East Texas should partner with Dallas, TX, to get as many services as they have there.*

Specifically, some participants took issue with the inclusion of SHRT's service region in the TDSHS HIV/STD Service Area 4, which includes Galveston, Beaumont, and Houston. The primary concern was that the distribution of resources within the region was not equitable.

DISCUSSION

Before discussing the results, we believe that it is important to reiterate that the overall purpose of this project was to inform efforts to improve the quality of services to PLWHA in the Northeast Texas Region. Specifically, SHRT sought to develop a better understanding of the factors, needs, and dynamics in the region in hopes that such an understanding would inform the development of a service delivery network. Given this, our discussion will focus on the implications of the results for network development. As you are reading the discussion, please keep in mind the limitations outlined in the results section.

Participants offered a variety of suggestions for improving services that were being provided by SHRT at the time of the study. For example, several ideas focused on expanding existing dental services and increasing accessibility (e.g., evening and weekend dental appointments). On the other hand, many of the suggestions focused on offering and expanding services that fall outside of SHRT's auspices. For instance, service providers placed a high degree of importance on efforts to improve service efficiency (Statements 29 and 30) and efforts to develop relationships with other providers (Statements 73, 74, and 75). Clients emphasized the need for mental health services (Statement 44) and assistance with accessing available social services (Statements 50, 76, and 77). Clients and providers from across the region were concerned about the lack of specialized health and dental care services. This was especially true for those residing in the areas surrounding Paris and Texarkana. Given that it is unreasonable to expect SHRT to offer all of these services, the solution lies in developing relationships with local providers in order to increase the accessibility of existing services and address gaps in services.

Developing these relationships in the context of a network would allow providers and community stakeholders to work together to address their concerns. A network could also serve as a:

- Forum for discussing possible collaborative solutions
- Source of support for the implementation of solutions

- Collective regional voice when advocating for necessary changes in policies, funding, and other such efforts
- Central mechanism for collecting information about the population, regional and local needs, and service delivery outcomes

These efforts could easily serve as a foundation for the creation of a comprehensive continuum of medical, dental, and social support services for clients.

Whereas the results suggest the need for relationships among providers of health and social services, the lack of participation from community-based service providers raises several potential concerns. First of all, without their input, we can only speculate as to their perceptions. It is possible that they do not see a need for additional services and/or collaborative efforts among providers. Their lack of participation also leads us to question the degree of importance they place on SHRT's efforts to improve service delivery. In other words, did they choose not to participate because they do not value the services SHRT provides and/or the population they serve? And, if this is the case, is it because of unfamiliarity with SHRT and/or the stigma associated with PLWHA? Or, was the lack of participation related to another factor, such as the process used to recruit participants? Unfortunately, the perceptions shared by SHRT's clients and staff via the focus group meetings suggest that the lack of participation is because of the stigma tied to HIV/AIDS and a lack of formal interaction among SHRT and the relevant community providers.

Why is it important to determine the reason(s) behind the lack of participation from community-based service providers? Those reasons are important for determining a starting point for network development. For instance, if the lack of participation is caused by stigma and misconceptions about the client population, then the relationship process would need to start with educating the providers and community about HIV/AIDs and serving PLWHA. How might the approach differ if the issue is related to a lack of understanding about SHRT's services and roles, rather than stigma?

Once SHRT is able to identify the underlying issue(s), they can move forward with developing relationships with the relevant health and human services providers. For the sake of the example, we are going to assume that the issue is related to stigma and a lack of interaction among providers. As we noted earlier, relationships are the key elements of developing and maintaining a network. Therefore, the first step in the development process should be for SHRT to focus on developing relationships with community-based service providers and other relevant community stakeholders. A likely starting place for such efforts is education and awareness. In addition to initiating or planting a seed for future relationships, visiting agencies to exchange information about services and related topics would help SHRT in their efforts to identify potential network members and provide information about relevant resources and assets. All of this information would assist in developing the foundation for the next step in the process, which is to begin developing the network's structure and membership. It is important to note that this process is also consistent with the focus group results (e.g., Statements 24, 29, 30, 50, 73, 74, and 75).

As with choosing any intervention, the key to selecting a structure is to identify the best approach or model for the context in which you intend to utilize it. In this case, we need a structure that will achieve balance in representation across stakeholder groups and the

region. The structure should also be flexible enough to accommodate growth and change as the network evolves. For example, each county could form an advisory board that represents consumers, service providers, and other community stakeholders. A representative from each local board could form a regional advisory board that coordinates regional efforts. Such a structure would allow for both local and regional ownership and control over the efforts to improve services. It also focuses the region's efforts, which could help with initiatives to acquire funding and other necessary resources.

Finally, in planning for the development of a network, it is important to consider the potential challenges and how you could address them using the available assets or strengths. In terms of strengths, SHRT has a solid reputation among its clients for providing quality services, advocating for its clients, and most important, caring about the well-being of their clients. Evidence of such was provided during the current project and is consistent with the results of previous annual client satisfaction surveys. SHRT has had a notable degree of success in securing external funding, especially in terms of state and federal grants, and they have a positive working relationship with several key government health and human services agencies.

However, SHRT appears to face several key challenges to developing a network and addressing the need for comprehensive services for its clients. The primary concern is the lack of participation in this project from service providers and community members. As previously noted, this could indicate a lack of support from the community and an absence of the key relationships necessary for building a network. Developing community relationships and support is also confounded by the stigma attached to HIV/AIDS and PLWHA. More than likely, SHRT will have to focus its initial efforts on reducing stigma through education and awareness initiatives. Finally, the Northeast Texas Region has to compete with urban areas for resources and services. Many of the necessary steps for addressing the identified issues will require additional resources, many of which will have to come from outside of the region. Despite these challenges, it is reasonable to believe that the issues can be addressed via a combination of determination and efforts to build on the existing strengths.

CONCLUSION

The purpose of this project was to explore the possibility of developing a regional network of health and social service providers that could assist in improving the availability and quality of services for PLWHA. Despite the noted limitations, we believe that the information obtained has utility in terms of thinking about the development of a network. Specifically, it provides preliminary information about ideas for improving services, as well as potential strengths and challenges. Regardless of the approach that SHRT employs to address the challenges, it should emphasize collective action that engages all stakeholders in the process. Doing so has a greater chance of resolving the issues and increasing the stakeholders' capacity to address similar issues in the future. Finally, the current and subsequent projects have the potential to further our understanding of the context of rural social service delivery, including the lifestyles, challenges, and strengths of rural residents and communities. Such an understanding is imperative to rural social work practice, including planning and delivering

effective services to PLWHA. As rural social work practitioners, educators, and researchers, we are strongly committed to this endeavor.

Discussion Questions

1. Developing relationships and trust are two extremely important attributes of building social networks. Considering the various challenges facing rural communities, how might building a social network more effectively address issues of social and economic justice? How might it address issues of diversity?
2. What challenges might you encounter if you were to develop a network of rural service providers? What specific knowledge and skills would you need in order to overcome the identified challenges?
3. How might the development of a rural service provider network assist in your efforts to empower stakeholders and ensure their right to self-determination?
4. What specific steps would you take in the development of a network structure that ensures that power, membership, and decision-making responsibilities are balanced across the stakeholder groups?

Classroom Activities and Assignments

1. Work in groups to review the recommendations offered in the discussion section. Develop a plan that outlines how you would go about implementing them. How might your process differ if you were working with an urban community rather than a rural one?
2. Work in groups to conduct a brief needs assessment that focuses on PLWHA in your region. What challenges do they face? What strengths/assets (individual, family, group, organizational, and community) are present in the community? How might the strengths/assets be employed to address the identified challenges?
3. If you are in a rural area, how does the situation described in Activity 2 differ from the nearest urban community? If you are in an urban area, make this comparison to the nearest rural community.
4. Work in groups to formulate a plan for addressing the challenges identified in Activity 2. At least one of the elements of your plan should involve organizations and/or stakeholder groups working together to address the challenges. Identify at least two potential local, state, and/or federal funding sources that might provide support for your plan.

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CHAPTER 15

Building Capacity to Overcome Challenges in the Delivery of Hospice and Palliative Care in Rural Communities

Amy Z. Boelk and Jessica H. Retrum

The main strength I see is the ability to function within the resources available. Most rural hospice families are not looking for social service help to make it work. Because of this, they are often problem solvers who are willing to be part of the health care team. Friendship and family ties provide more emotional and concrete assistance in rural communities, as people more readily accept that they will have to pitch in. They don't expect any outside agency to step in and fill their needs. There is a sense of community pride and closeness, and respect for the elder generation plays a major role in hospice care in rural areas.

—Hospice Social Worker

Along with concerns surrounding America's growing aging population, rising healthcare costs, and advances in medical technology, an emerging focus on the health care and social service needs of rural dwellers is taking place. The population of rural America is becoming older, as young people move to urban areas in higher numbers, immigration rates decline, and retirees increasingly settle into rural areas (Murty, 2001; National Advisory Committee on Rural Health and Human Services [NACRHHS], 2008). As approximately 25% of all elders now live in rural areas, policy makers, practitioners, and researchers increasingly consider how to meet their resulting complex service needs (NACRHHS, 2008; National Rural Health Association, 2001). The known health care access challenges facing rural areas raise important concerns about the availability and quality of services.

Although a focus on palliative care is growing in a variety of practice settings, the hospice model continues to be the most comprehensive approach to serving people impacted by terminal illness. The influence of home-based hospice programs in rural communities is significant, extending into the far reaches of the nation's countryside, where other providers and programs often do not travel. Rural dwellers approaching end of life are faced with many of the same challenges as those in urban areas in terms of accessing services and maintaining

independence, but demographic, socioeconomic, and system factors make these challenges more difficult to overcome in the rural context (NACRHHS, 2004).

Although significant challenges exist, rural communities have many strengths and assets that can be fostered by professionals. Social workers are valuable interdisciplinary team members with special expertise in resource coordination, advocacy for vulnerable populations, relationship building, and community development. They have much insight into the social structure and culture of communities, the needs of dying individuals and their families, and how existing problems might be creatively addressed with a strengths-based perspective. They are skilled at identifying gaps in services and supports and are well-positioned to build capacity in rural communities for the provision of high-quality hospice and palliative care.

This chapter outlines the challenges faced in providing hospice and palliative care in rural communities as evidenced in the existing literature. Included are results from a recent national survey of the perceptions of rural hospice and palliative care social workers, a portion of which have been reported elsewhere (Haxton & Boelk, 2010). The 107-item web-based survey completed by 343 hospice social workers representing 40 states aimed to gain insight into a variety of issues associated with end-of-life care in rural communities. The social workers surveyed provide valuable insight through their identification of strengths of rural communities, strategies for overcoming existing challenges, and wished-for resources. They share creative strategies already in use as well as recommendations for improvement. Suggestions for building capacity generated through their insights follow the literature review, revealing ways to capitalize on existing strengths.

REVIEWING THE LITERATURE: CHALLENGES FOR HOSPICE AND PALLIATIVE CARE IN RURAL COMMUNITIES

We begin by reviewing previous research findings that have revealed existing challenges related to hospice service delivery, financial issues, access and use of hospice and other services, and supports for patients and their social work providers. To effectively build capacity, the realities and implications of these challenges must be acknowledged and understood. At the practice level, comprehensive community assessments must include attention to the strengths and assets present, as well as the needs and challenges that must be overcome. Capacity-building efforts demonstrate success in addressing important rural challenges through practice, policy, and research initiatives (Scales & Streeter, 2003). This chapter presents these challenges as a foundation for discussing strengths and assets that can be fostered to build capacity for the provision of hospice and palliative care in rural communities.

Hospice Service Delivery

Trends in the hospice service delivery system pose challenges for families and hospice providers. The consolidation, centralization, and regionalization of health and social services

to enhance productivity, cost effectiveness, and efficiency have resulted in the creation of large rural service areas (Murty, 2001). The geographic reality of serving rural areas creates difficulties with transportation, costs, communication, and service coordination, ultimately generating concerns about quality care. Barriers related to distance, particularly in inclement weather, often interrupt necessary palliative and hospice care for those residing in rural communities (Waldrop & Kirkendall, 2010).

The survey of hospice social workers revealed that 43% of the participants serving rural areas as a significant part of their caseloads averaged more than 21 miles each way to patients' homes, and 17% stated that they averaged more than 31 miles each way (Haxton & Boelk, 2010). To put this in perspective, a full-time social worker serving a rural area could drive more than 1,000 miles in an average week. In this same study, many respondents indicated concerns about travel time, fuel costs, and reimbursement. One social worker indicated, for example, "the hospice I worked for had one central office in one of the three counties we served and this often resulted in travel times to patient homes in excess of an hour to an hour and a half" (Haxton & Boelk, 2010, p. 535).

Financial Issues

Rural communities are more likely to have higher poverty rates, slowing economies, and more uninsured individuals (NACRHHS, 2008; National Rural Health Association, 2001; Rogers, 2002), so families tend to have fewer resources to work with when hospice and palliative care are needed. Furthermore, hospice reimbursement rates are not adjusted for differences in costs that may be significantly higher for rural programs, including travel, staff time, and lack of access to low-cost supplies (Casey, Moscovice, Virnig, & Kind, 2003; DeCourtney, Jones, Merriman, Heavener, & Branch, 2003; Huskamp, Buntin, Wang, & Newhouse, 2001; Virnig, Moscovice, Durham, & Casey, 2004). One participant in the survey of rural hospice social workers suggested the need for "adequate reimbursement for mileage so that I do not lose money every time I drive to patients' homes" (Haxton & Boelk, 2010, p. 535).

Hospice Access and Utilization

There is limited access to and knowledge about hospice and palliative care in rural America (Artnak, McGraw, & Stanley, 2011), and rural Medicare beneficiaries are less likely than their urban counterparts to receive hospice care (Casey et al., 2003; Virnig et al., 2004). A lower level of service awareness and acceptance exists in rural areas (NACRHHS, 2004; National Rural Health Association, 2001), and there tend to be fewer end-of-life advocates who can educate people and connect them to useful resources (Commission on End-of-Life Care, 2000–2001). Rural areas are less likely to be exposed to media campaigns, educational offerings, and outreach efforts (Tolle, Rosenfeld, Tilden, & Park, 1999). Even when rural dwellers know about hospice and other services, they are less inclined to use them. One study suggested that rural families do not ask for information because they do not want to be perceived as abusing the system (Wilkes, White, & O'Riordan, 2000). Although the values of community and mutuality present in rural communities are an asset, they also present

challenges for those attempting to increase utilization and make meaningful changes (Pesut, Bottorff, & Robinson, 2011).

The survey of hospice social workers revealed five main reasons perceived to contribute to the underutilization of hospice by rural dwellers (Haxton & Boelk, 2010):

1. Rural people tend to be more self-sufficient, independent, and private.
2. Rural people are less likely to trust outsiders and formal programs, being less likely to welcome them into their homes and lives. There is a "distrust of hospice motives" and "suspicion of health care staff from the big city."
3. Rural dwellers simply have less knowledge of hospice services and benefits and are more susceptible to believing common hospice myths because of a lack of accurate information. Only one-fourth of the social workers surveyed reported being significantly involved in outreach and education efforts targeted at rural communities.
4. Rural people tend to rely more on informal sources of support and less on formal programs. They indicated a "we take care of our own" attitude that causes them to rely more heavily on family and community. This statement by a social worker illustrates these first four points:

   > People who live in the little towns surrounding where I live are used to not having any services. They have always had to "drive to town" to get everything they need: medical care, dental care, groceries, pharmacy. . . . They are therefore more self-sufficient. They usually have family support or close neighbors. They are used to having to help each other out and they know each other really well. Sometimes they can be wary of strangers. Families that own farms worry about "losing the farm" if grandma has to go into a nursing home. I think they think of us in that sense also.

5. Rural people simply have less actual access, because their geographic region is lacking a hospice service or access to general medical care, or medical providers do not refer to hospice consistently as indicated here:

   > There is a sense among rural physicians that the services are not available or allow them less control of the patient care. This is an issue along with the sense on the patient's part that they and their doctor should be able to meet all the needs of the patient.

Access to Other Services and Supports

The rural population tends to be more isolated and less mobile, living far from specialized medical care and other services (McGrath, 2000; Rogers, 2002). Rural dwellers typically lack access to an effective public transportation system and often have to travel long distances to access services, traveling many miles to reach proficient providers and receive diagnosis and treatment of life-threatening illnesses (NACRHHS, 2004; National Rural Health

Association, 2001). Furthermore, rural areas tend to have more limited phone access, cell phone service, and computer access (Finke, Bowannie, & Kitzes, 2004; McGrath, 2000).

Community-based alternatives to nursing home care are lacking in many rural areas, and programs are often scaled-down urban models (National Rural Health Association, 2001). Services such as adult day care, respite care, home-delivered meals, and volunteer services are less likely to be available to rural residents because of funding and staffing challenges (NACRHHS, 2004). Medicaid-financed home- and community-based services waiver programs, which promote alternatives to nursing home use, are often limited in scope and targeted toward urban areas (National Rural Health Association, 2001). Community-based residential facilities are lacking in rural areas for people without caregivers and for those who are too ill to be cared for at home (Casey et al., 2003). Staffing of health and social service programs is also challenging (Finke et al., 2004; McGrath, 2000), as rural health care providers struggle with recruiting and retaining licensed, trained health professionals (NACRHHS, 2008; National Rural Health Association, 2001; Rogers, 2002).

Most families capitalize on informal supports to meet the care needs of dying family members. Increasing numbers of young people are leaving rural areas for urban settings, though, causing a shortage of family help. As a result, people living in rural communities have an increased likelihood of dying in a nursing home or hospital, away from family, friends, and familiar surroundings (DeCourtney et al., 2003; NACRHHS, 2004; National Rural Health Association, 2001). A central focus of the hospice philosophy is helping patients and families maintain control, as a sense of control is thought to result in a better death and more effective coping (Redding, 2000). Rural dwellers may be at a disadvantage and have less control at the end-of-life in terms of where they live out their remaining days.

Social workers surveyed agreed with these findings, as they rated several community resource issues as significantly challenging in their work (Haxton & Boelk, 2010). They indicated the need for additional, accessible, reliable, and affordable programming in the areas of in-home and community-based mental health, adult day services, lifeline, interpreter services, volunteer support, support groups, respite, home-delivered meals, private-hire caregivers, home health assistance, inpatient hospice, hospice group home services, skilled nursing facilities, assisted living, and transportation.

Professional Support for Social Workers

Hospice social workers in rural settings face multiple contemporary barriers in their daily work (Van Vorst et al., 2006). As such, professional support is vital for the provision of high-quality end-of-life care. Social workers practicing in rural areas seem to be at a disadvantage, though, in terms of training and educational opportunities. They often lack academic preparation and training for their work in end-of-life and rural settings (Csikai and Raymer, 2005; McGrath, 2000). Furthermore, the identification of mechanisms that encourage evaluation of social work practice in hospice has been identified as a priority (Doherty & DeWeaver, 2004), with implications for the rural context.

According to the survey of hospice social workers, those working in rural communities assume additional roles, such as bereavement counselor, volunteer coordinator, outreach coordinator, program director, and intake coordinator, as part of a single position at a higher

rate than do those serving primarily urban areas (Haxton & Boelk, 2010). As such, rural hospice social workers often balance a variety of responsibilities that require an extensive skill set, while working in an environment with significant system, financial, access, and resource challenges. The survey further revealed that many (26%) felt their social work education did little or nothing to prepare them for work in a rural setting (Haxton & Boelk, 2010), and they identified several professional challenges perceived to be more problematic when serving rural areas. These included lack of anonymity as a professional, professional isolation, access to relevant continuing education, and support to evaluate one's own practice.

BUILDING CAPACITY: INSIGHTS FROM RURAL HOSPICE SOCIAL WORKERS

Now that we have outlined the challenges associated with hospice and palliative care in rural communities, we move on to a discussion of strengths and innovative approaches. In each section, the insights of social workers surveyed are highlighted, as are suggestions for building capacity generated from their ideas. A capacity-building approach suggests that communities have the ability to respond to their own challenges and to assist individuals and families residing there (Murty, 2004). The approaches identified by the hospice social workers surveyed fall in line with this approach, allowing us to put forth suggestions for improving end-of-life care in rural communities.

Dwell on Strengths and Start "Where They Are At"

Hospice social workers surveyed supported the existing notion that a focus on strengths can aid in overcoming challenges. Almost all social workers (92.4%) expressed a belief that rural communities have unique strengths that professionals can take advantage of to provide better services (Haxton & Boelk, 2010). Respondents highlighted four categories of strengths of their rural clients that they capitalize on to meet needs. Their rural clients (1) have better informal support networks (i.e., family, friendship networks, faith communities), (2) are more independent in spirit and have a sense of personal responsibility, (3) are creative and resourceful—they are able to "do more with less," and (4) have rural service providers who collaborate and network more closely.

The hospice social workers also indicated the need to meet the patient and family "where they are at," empowering them, promoting their strengths, and focusing on building trust and rapport. They stressed a need to work with families from their own perspectives, promote self-determination, and display respect for different ways of living. The following statements by social workers shed light on this approach:

> *I honor their strengths and never come in acting like I'm going to "show them the way."*
> *I engage [the] family much more in rural [areas] prior to beginning work on issues and needs. This might mean having coffee, touring their farm, or getting to know their family history.*

> *I have had to abandon some of the deeply engrained notions of not sharing of myself. It helps that they know my kids go to the local school, or where I live, as there is strengthening of rapport there. I also respect the boundaries that are there in the self-reliance and reluctance to "use" a social worker or talk to a counselor.*

Social workers in every area of practice and in communities of all sizes utilize the strengths perspective and a start "where they are at" approach as a foundation for their work. We suggest that social workers providing end-of-life care within a rural context seek to identify and elucidate strengths *with* their clients and deliberately integrate individual, family, and community strengths into plans of care, which are often exclusively problem-focused. When strengths are named and acknowledged by patients, families, and the interdisciplinary team, they are more likely to be utilized constructively to empower people to maintain dignity and control at the end of life. We also suggest that programs allocate more time for social workers to engage with clients during the referral and assessment processes, and to carefully consider boundary adjustments that may be appropriate for this particular context. Rigid boundaries typically promoted by the social work profession are not always realistic or useful in the rural context (Green, Gregory, & Mason 2006; Halverson & Brownlee, 2010; Pugh, 2007).

Education With a Hometown Twist

The survey revealed the need to devote more time and attention to community education to overcome challenges related to rural hospice access and utilization. Education of patients, families, other professionals, and the broader community through such strategies as word of mouth, participating in public speaking engagements and community presentations, educating through churches and businesses, talking about hospice with friends and others outside of work, and providing education on other topics (i.e., advance planning) were identified as effective ways to increase the visibility of hospice and develop trust. As examples, social workers indicated the following with respect to education:

> *We need to offer more education to the physicians about hospice care, as they are often the "gatekeepers." We also need to offer more education to the Area Agency on Aging, nursing homes, and to clergy about what hospice truly is to eliminate the misconceptions.*
>
> *It would help to have good marketing programs that target all community events, and hospice should become the "expert" on such important areas as advance care planning and grief support.*
>
> *I spend a lot of time explaining finances so people realize it is not going to cost them personally, that it is part of their Medicare benefit, and that it is not charity. I try to break through any barriers that the family is putting up due to misconceptions.*

Social workers can play important roles in identifying the types of advertising methods that work for a particular community through use of their community assessment, outreach, and relationship-building skills. Along with their team members, social workers may serve as local

community educators to spread the word about hospice as a resource. In some communities, approaching civic groups, churches, and local nursing homes and attendance at key community events may be a sound strategy. Television, radio, or billboard advertisements may reach the most people in some communities. The need for public awareness and media strategies specific to the rural context has been identified in the area of child welfare through the Rural Success Project (UNC Chapel Hill School of Social Work, 2005), which provides a media guide with ideas that might be useful for hospice and palliative care programs.

We also suggest that social workers and their supervisors remain cognizant of the importance of strengthening nurse and physician education programs to facilitate trust, more timely referrals, and enhanced collaboration. Many larger hospice programs have physician education programs, and national efforts are underway to prepare physicians for specific work in end-of-life care (e.g., physicians can be board certified in hospice and palliative medicine). Physicians and nurses serving rural areas may not have awareness and easy access to such initiatives, though, and as such, rural hospice programs can provide valuable education that will ultimately help patients and families receive appropriate care.

Creative Support Networks

Creativity with generating formal and informal support for families facing terminal illness is a necessity for all hospice social workers, regardless of community size. It is even more vital in environments where few formal services exist and hospice programs may be small, and may help patients to die in their homes, if desired. The following represent just a few of the examples social workers shared:

I try to be creative, such as having frozen meals delivered to a friend or relative in the city who will then deliver to the rural area.

I try to coordinate with small communities close by to see if they can be of assistance, to possibly utilize each other's services, even though it may include some travel.

I talk to churches, family members, and neighbors to access resources close to each patient. Taking the time to better understand the community and family and friendship networks helps greatly with providing services.

I attempt to think outside the box, and brainstorm with team members to problem solve. I find that if I call an agency and explain what I am looking for, they are willing to point me in the right direction. Persistence pays off. The solution is not always at an agency, but sometimes in the community at large.

We additionally recommend some broader strategies to build capacity in this area. One suggestion is to build networks of support specific to each patient. Although social workers certainly have the skill to assist families with this process, a model called *Share the Care*™ provides a framework specific to organizing a group to care for someone with a serious illness (Capossela & Warnock, 2004). Gaventa (2001) provides further ideas for professionals to utilize in "creating and energizing caring communities" in end-of-life care, which includes collaboration among formal and informal sources of support. Both of these strategies build on the strengths of rural people by relying naturally on informal support, appreciating the

tendencies toward self-reliance and independence, and tapping into their creative problem-solving potential. In building individualized networks of support, social workers demonstrate skill in assessing local resources, identifying family and community strengths, and coordinating supports in a patient-centered, culturally sensitive way.

A second suggestion for building capacity in the area of support networks is to work with local people to develop and maintain support groups, thereby addressing caregiver, bereaved family member, and community needs, as well as raising awareness and trust of hospice as an active presence in the community. Recruiting local facilitators may further serve these functions by engaging trusted individuals with "insider perspectives," and stronger awareness of community dynamics. One online resource, GriefShare (www.griefshare.org/startagroup), provides resources for developing church-based grief support groups, and additional ideas pertaining to group development in rural communities exist (e.g., Gray, Zide, & Wilker, 2000; Roberto, Van Amburg, & Orleans, 1994; Wilker & Lowell, 1996).

A third suggestion for generating creative support networks is to develop resource directories specific to each local community for use when assisting families in that area. Such directories might include information on formal providers, as well as individuals, businesses, and other groups that are willing to assist in some way. For example, perhaps a restaurant will provide home-delivered meals on an ad hoc basis, or a civic group has members who are willing to provide volunteer transportation, grocery shopping, yardwork, or respite. Time is often of the essence in hospice care, as patient and family needs may change quickly, and an existing directory may aid in quickly identifying sources of support. Social workers are particularly equipped to take on such an endeavor because of their expertise in identifying systems of support and organizing resources.

Teamwork, Collaboration, and Networking

The hospice social workers who were surveyed stressed the need for teamwork, collaboration, and networking to best serve rural communities. They stressed the need to involve not only the hospice program, but also physicians, other social workers, and other health and social service providers for the purposes of service provision, consultation, and support. The following statements illuminate the importance of this approach:

> *I seek team members out for advice and brainstorming as well as those who have been in the area for a lengthy time and have resource knowledge. We are a team and operate as such when dealing with problems or rejoicing.*
>
> *I meet with other providers, and I encourage assisted living facility staff, nursing home staff, patients' families, and others involved to attend hospice meetings.*
>
> *We need more collaboration with other social workers in the community, perhaps quarterly social work gatherings. I wish we had a formal or informal network of* ***skilled*** *social workers nearby for consultation.*

The hospice model is one of teamwork and collaboration, and such efforts are integrated into the way that professionals are supported and consumers are served. In addition to existing efforts, we offer some broader suggestions for building capacity in this regard. First,

building relationships with other social workers might provide valuable access to information on services and approaches, as well as opportunities for case processing, consultation, and support. Such efforts can be accomplished on the local level, through statewide hospice and palliative care organizations, and/or nationally through organizations like the Social Work in Hospice and Palliative Care Network (www.swhpn.org). To connect with others, social workers might organize regular local meetings, attend conferences, access online information, and participate in online discussions or listserves.

Second, generating a stronger local team of hospice volunteers may assist not only with patient/family support but also raise the visibility of hospice, enhance team functioning, maximize word-of-mouth marketing, and help rural people to take care of their own. Hospice volunteers have important contributions to make, serving as crucial links in the network of care in rural communities (McKee, Kelley, Guirguis-Younger, MacLean, & Nadin, 2010). Social workers can help recruit, train, and mentor local volunteers to enhance patient/family care and augment professional services.

Third, we suggest development of local end-of-life community coalitions to build capacity in rural communities. In doing so, communities can be motivated to identify and address concerns related to end-of-life care through local initiatives and advocacy efforts. A local coalition might include key health and social service professionals, members of civic groups, clergy, funeral providers, and others who have a vested interest in promoting responsive end-of-life care. One resource, Caring Connections (www.caringinfo.org/i4a/pages/index.cfm?pageid=3381), provides valuable online information on how to develop and maintain a successful end-of-life coalition. Similarly, a development strategy called Comprehensive Community Initiatives might also be useful in rural areas (Messinger, 2004). The approach uses coalitions of public and private agencies, religious organizations, neighborhood groups, community leaders, and individuals in the community to work together on neighborhood councils, task forces, planning committees, and advisory boards to identify community needs and to develop and implement a comprehensive plan for multisystem change. Finally, several communities have coordinated successful volunteer hospice models supported through local community members and resources, without the support of Medicare benefit funding (Liao & Garrison-Jakel, 2011). Social workers might consider spearheading development of such coalitions and collaborative work, foster their success, and assist with carrying out initiatives.

On the Road Again

Creativity with travel issues was stressed by the social workers surveyed as of utmost importance. They identified several strategies to overcome barriers, including the need for better technology to enhance their practice while traveling and to deal with distance issues (i.e., laptop computers, tele-health/hospice capabilities, cell phone service, mobile copy machines, GPS systems). The following quotes illustrate some of the strategies employed:

> *We often combine staff visits (I will visit along with a chaplain, for example) to decrease the number of cars traveling. This also decreases the overall number of visits the family is receiving per week, which many rural families appreciate.*

Our agency tries to balance caseloads to accommodate for more travel time in those areas. We try to assign team members who live nearby to improve response time.
I utilize programs that provide services by mail or computer if it is difficult for the patient and family to get out or travel.

In addition to specific strategies used by social workers, we offer two broad suggestions that may build capacity with respect to travel. First, advocacy efforts need to be made to address the discrepancy between Medicare reimbursement and actual costs when serving rural populations. Mileage reimbursement rates, staffing ratios, and patient care costs associated with rural clients should be investigated and adjusted to ensure higher-quality care and adequacy of resources and support for staff. A focus might also be advocating for funding to purchase technology that will keep rural practitioners safe, enhance their ability to communicate in remote areas, and serve patients more effectively and efficiently. Educating and then encouraging policy makers to act at the local, state, and federal levels to consider the unique needs of rural populations and health providers is an important advocacy strategy.

Second, hospice programs might consider deliberate efforts to employ social workers who live specifically in the communities served. In the survey, social workers were asked whether such an arrangement was a benefit or a detriment to their work, and 71% indicated that it benefited their work either very much or quite a bit (Haxton & Boelk, 2010). Having hospice social workers living in the communities served is a potential benefit, not only with respect to travel, response time, and access, but also in terms of understanding of the community, ease of networking and establishing rapport, and generation of hospice referrals. Efforts are underway to recruit and train other professionals (e.g., dentists, physicians) for direct service to rural communities, and perhaps social work might consider this as well.

Enhance Knowledge and Skill for Social Work Practice

The survey revealed the need for attention to social workers' ongoing knowledge and skill development to provide end-of-life care and fulfill multiple roles in the rural context. The social workers surveyed frequently expressed a wish for more accessible, affordable, and relevant continuing education opportunities. They indicated the importance of appropriate supervision and mechanisms to evaluate their practice. Specific statements to this effect included:

It would be helpful to have more education about the differences in rural versus urban communities in regard to hospice care.
*We need more **relevant** continuing education at an advanced level.*
*I take challenges to my supervisor, who is great at helping me process and develop a plan. I talk with team members to assess issues and how **we** should address them.*

We suggest some capacity-building efforts particular to social work knowledge and skill. First, the multiple roles that rural hospice social workers perform should be more clearly acknowledged and accommodated by either increasing FTE hours needed for social workers or providing more supportive assistance so they are able to meet the often complex and

multifaceted needs of clients. Social workers serving a rural clientele should receive training in micro-, mezzo-, and macro-level interventions and cross-training for other positions they may hold. Because rural programs are often in need of additional funding, training and support for grant writing should also be considered.

Second, continuing education provided locally that is relevant to the particular practice issues that rural hospice social workers face is important. Neighboring hospices could come together through their local and state professional associations to organize regular continuing education events, either at stand-alone conferences or as part of larger health-related conferences. Hospices could also support and encourage peer review processes that allow social workers to gather and discuss best practices.

Third, the effective use of supervision is paramount to effective social work practice and ongoing skill development. It provides a mechanism by which social workers gain support and guidance, process challenging client situations, and evaluate their own practice. Many competencies are recognized as important by the hospice and palliative care social work communities (Bosma et al., 2010; Gwyther et al., 2005), yet challenges such as lack of appropriate supervision and continuing education do exist (Csikai & Raymer, 2005). This makes it difficult to achieve competency and consciously evaluate practice. Hospice organizations can do more to support social workers who seek out appropriate supervision and necessary continuing education through allocating adequate time and resources for these activities.

CONCLUSION

Although very real challenges exist in the provision of end-of-life services in rural communities, social workers are well-positioned to build capacity for compassionate quality care. Social workers are skillful in using a strengths-based approach, providing client and community education, identifying and generating unique sources of support, providing leadership on their interdisciplinary teams, collaborating and networking with other professionals, and advocating for improved funding and programming. They demonstrate skill in working within the parameters of existing service structures and supports, while directing attention to deficiencies and solutions. The recommendations offered in this chapter acknowledge the quality work already being performed and motivate current and prospective future rural hospice practitioners to further strengthen their practice, programs, and communities.

Discussion Questions

1. Previous research has helped us understand that challenges exist in rural communities, primarily related to hospice service delivery, financial issues, access and use of hospice and other services, and supports for patients and their social work providers. Why is previous research important to our efforts to build capacity to address the hospice and palliative care needs of individuals, families, and communities in rural settings?

2. After reviewing the general environmental and professional challenges, discuss what specific scenarios you might find as a new hospice and/or palliative care social worker serving a rural community. What are some challenges you might anticipate in your work? How might you focus on asset building?
3. In the Haxton and Boelk study, hospice social workers shared strategies that are already in place as well as recommendations for improvement when it comes to high-quality practice in rural settings. What are some ways you may find the training and support you need to work in such a setting?

Classroom Activities and Assignments

1. Visit the Hospice Foundation of America's "learn more" segment entitled "Hospice in Rural Areas" at www.hospicefoundation.org/educate-yourself#rural Review the fact sheet and slideshow, which provide general information about hospice, rural America, challenges for hospice in rural communities, and best practices for rural hospice. Discuss the challenges that you might find in a rural area in your region, as well as the strengths/assets that might be present to help you engage in best practices.
2. Visit the Dartmouth Atlas of Health Care at www.dartmouthatlas.org. For more than 20 years, this project has documented glaring variations in how medical resources are distributed and used in the United States. The project uses Medicare data to provide information and analysis about national, regional, and local markets, as well as hospitals and their affiliated physicians. This research helps policy makers, the media, health care analysts, and others improve their understanding of our health care system, and it forms the foundation for many of the efforts to improve health and health systems across the United States. Compare regions in your state with other parts of the country to broaden your understanding of existing disparities. Discuss strategies for addressing these disparities as they relate to rural communities.
3. Visit the Share the Care website at www.sharethecare.org Share the Care is a nonprofit organization seeking to improve the quality of life of persons who are seriously ill, disabled, or experiencing the challenges of aging, and to reduce the stress, depression, isolation, and economic hardship that are often experienced by their family caregivers. This model encourages ordinary people to pool their efforts to help ease the burden on family caregivers and help those without family nearby. It has the potential to shift the current paradigm to a cost-effective, supportive, community-based alternative for caregiving. View the website for access to the model and philosophy, stories from those who have utilized it, and resources to get started. Discuss how this approach might build the capacity of rural-dwelling families who often have fewer formal resources to utilize.
4. Request an interview or guest presentation with a hospice social worker whose service area includes a rural area. Pose questions regarding the unique challenges faced, as well as strategies for building capacity.

Internet Resources

- Hospice Foundation of America: www.hospicefoundation.org
- National Association of Social Workers Standards for Social Work Practice in Palliative and End of Life Care: www.naswdc.org/practice/bereavement/standards/standards0504New.pdf
- National Palliative Care Research Center: www.npcrc.org
- National Rural Health Association: www.ruralhealthweb.org
- National Rural Social Work Caucus: www.ruralsocialwork.org
- Rural Assistance Center: www.raconline.org
- Rural Policy Research Institute: www.rupri.org/index.php
- Social Work Hospice & Palliative Care Network: www.swhpn.org
- U.S. Department of Health and Human Services, Health Resources and Services Administration, Rural Health: www.hrsa.gov/ruralhealth/
- U.S. Department of Health and Human Services, National Advisory Committee on Rural Health and Human Services: www.hrsa.gov/advisorycommittees/rural/

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PART FOUR

Policy Issues Affecting Rural Populations

F. Ellen Netting

Although there are many definitions of *policy*, a fairly general one is that policy is a course of action. An *issue* by definition implies disagreement. Therefore, a policy issue is a course of action about which people disagree. If there is no disagreement about what course to take, then there is no issue; everyone could simply move forward to do what needs to be done. This is rarely the case. Thus, policy issues provoke social workers to use their best critical thinking skills in assessing complex situations and in considering an array of policy options. Those options may represent very different philosophical assumptions about what course of action to take.

Three sets of policy issues affecting rural populations are the focus of this section: how to sustain rural communities, how to address homelessness in rural America, and how to use geographic information systems (GIS) mapping in rural areas. On the surface, most people might rally to these three concerns. Certainly one wants to sustain rural communities! What is the issue here? Addressing homelessness in rural America is critically important. No one should be homeless! So why is this an issue? And using GIS mapping seems pretty logical if the technology is available. So what's the issue? In short, on the surface the intent of many policies are seen as logical, reasonable, and a no-brainer. So why do people disagree?

This reminds me of my early practice experience when a National Health Care Campaign was launched many years ago. The goal was to be sure everyone had access to health care. Strange bedfellows emerged in the process; it was difficult to find any association or group that did not agree that everyone in the United States should have access to health care. Not only was the National Association of Social Workers on board, but they were on board with the American Medical Association. The coalition to push for health care access for everyone was strong and diverse. Certainly, this campaign would move forward. Becoming involved in this process revealed that there can be agreement about a basic policy goal or intent, but when it comes to how that goal will be carried out, contentiousness emerges. It was around the potential courses of action (the policy options) where disagreements arose and around which the campaign eventually disintegrated. Most people could agree that there was a need for change, but fewer agreed on the course of action.

In Chapter 16, Belanger focuses on the concepts of capacity and sustainability. She enlightens the reader about the big picture of a global world in which human needs and the ability to address those needs are totally interconnected. Sustainable development means being stewards of current needs in ways that do not cause harm to the needs of future generations. Natural resources are often produced and/or gathered in rural communities to meet the needs of other communities of people, whether it is growing corn, mining coal, or protecting wildlife. The capacity to access or produce these resources must be joined with a commitment to sustainability, and Belanger acknowledges that "the interests of rural residents, at-risk populations, and ecology can easily be threatened by economic interests without education, community involvement, and advocacy." The policy intent or goal of sustainable development may be given lip service, but when it comes to special interests that need resources for the use and comfort of multiple groups far beyond these rural areas, policy options may in fact exploit the very communities in which these resources are produced, mined, or gathered. Social workers are in a unique position to advocate for policy options that are congruent with the intent of sustainable development.

Winship writes about homeless families in rural America in Chapter 17. Again, policies with the intent of reducing homelessness are often embraced by multiple interest groups. The policy issue, however, is *how* to go about the process of addressing the needs of homeless families. One of the concerns related to homelessness in rural areas is that homeless persons are more visible in urban communities. Even the definition of what constitutes homelessness may vary in rural areas, where a family may live in an abandoned barn or set up camp in a remote area. Winship points out that there are multiple categories of homelessness in rural areas and offers insight into how national policy options are not always sensitive to rural environments. Even state policies may deplete rather than enhance resources in rural communities, given the distance and time constraints. Social workers need to be cognizant of potentially different assets in rural and urban communities in order to advocate for and participate in creative policy development and program design.

In Chapter 18, Aguiniga and Davis elaborate on geographic information systems (GIS) as a technological tool that can be used in problem identification, needs assessment, policy development, and program design. They point out that social workers have not always embraced the most current technology, but that GIS data allow social workers to identify community trends and to advocate for identified needs. Whereas Belanger focuses on how rural sustainability requires knowledge of community needs, Aguiniga and Davis demonstrate how GIS data can be used to identify changing community needs. Using tools to assess needs and trends can lead to the development of data-based policies, through which programs to address real needs can be designed. For example, if social workers want to contribute to a sustainable rural community that has many homeless families and individuals, GIS could be used as a tool to map out where pockets of homeless people exist and to target policies and programs to specific rural areas. Similarly, GIS mapping could be used to reveal trends in immigrant populations moving into rural communities or could focus on transportation resources that are available or lacking, could pinpoint where services are located, and distances residents have to travel to access these services.

Policy issues must be considered in context. The concepts of capacity and sustainability are global concerns for rural and urban communities throughout the world. Each community

is embedded within a larger society and an even larger environment. With their person-in-environment perspective, social workers can contextualize policies and programs so that the assets of rural communities and the strengths of rural population groups are highlighted. Social workers can use tools such as GIS mapping to offer policy makers the data they need to make informed decisions. The chapters in this section offer ways to critically think about policy issues, approaches to document the assets of rural communities, and how to advocate for change.

CHAPTER 16

Capacity for Conservation

Rural Communities Address Sustainability for Global Impact

Kathleen Belanger

In December 1968, *Apollo VIII* astronauts became the first humans to see the earth as they orbited the moon, and on Christmas Eve astronaut William Anders took an unplanned photograph of the earth as seen from space. "For the first time in history, humankind looked at Earth and saw not a jigsaw puzzle of states and countries on an uninspiring flat map, but rather a whole planet uninterrupted by boundaries, a fragile sphere of dazzling beauty floating alone in a dangerous void. This was a home worthy of careful stewardship (Coulter, D., 2009)." The late nature photographer Galen Rowell described this photo as "the most influential environmental photograph ever taken" (NASA, 2009). This photograph and those taken from space since then demonstrated two essential truths: (1) that the earth is one system; and (2) that what is done on one part of the earth influences the rest of the earth, now and for years to come. We are one community.

Many earlier voices attempted to draw our attention to the world's ecological vulnerability. In 1845, Henry David Thoreau began constructing his cabin on Walden Pond in Massachusetts, chronicling his interactions with the environment and the economic and cultural impact of man on the woods (Thoreau, 1854/1995). In 1949, Aldo Leopold wrote *A Sand County Almanac*, recounting experiences in the wilderness, and questioning the wisdom of conservation policies of the time (Leopold, 1949/1986). Wendell Berry, Kentucky poet, philosopher, and preacher, wrote extensively from 1960 to the present, describing agrarian communities, the ecosystem, and farm life and its demise over decades, characterizing the economic policies that tear asunder "the union between individual people and individual places" as "professional condescension" and "blind" and "ruinous" (Berry, 1990/2010, p. 115). Rachel Carson (1962/2002) challenged the widespread use of pesticides, and particularly DDT, as a threat to humans and the cause of the death of wildlife, leading to a *Silent Spring* when birds will no longer be alive to sing.

The first Earth Day, April 22, 1970, raised awareness across the United States. The U.S. Environmental Protection Agency (EPA) was formed in December 1970. In 1971, Frances Moore Lappe, who was concerned not only with health, but also with food production that was reliant on meat, introduced her *Diet for a Small Planet* (Lappe, 1971), advocating

vegetarianism as justice for animals, healthy for humans, and protective for our small planet. Following the OPEC oil crisis in 1972 and concern with acid rain, threats to the earth's ozone layer, and other environmental challenges, the World Watch Institute was founded in 1975.

Extensive scientific research and environmental disasters followed in the 1980s and 1990s: the Three Mile Island nuclear accident in 1979; increased scientific findings related to pollution, greenhouse gases, and global warming; the discovery of a hole in the ozone layer in 1985; toxic chemical leaks by Union Carbide in India; the nuclear reactor explosion in Chernobyl in 1986; and the *Exxon Valdez* spill in 1989. Thirty-five years after Lappe's proposed *Diet for a Small Planet*, Michael Pollan (2006) tracked current methods for the production of meat and other products (agribusiness) as damaging ecosystems, health, and essential elements of the economy, while Bill McKibben (2007) challenged the notion that "more is better" and proposed a return to local and quality food production as more sustainable. The *Deepwater Horizon* oil spill off the Gulf of Mexico in 2010 was the largest oil spill in U.S. history (EPA, 2012).

OVERVIEW OF SUSTAINABILITY

The *Merriam-Webster* online dictionary defines *sustainable* as "capable of being sustained; relating to, or being a method of harvesting or using a resource so that the resource is not depleted or permanently damaged" and "of or relating to a lifestyle involving the use of sustainable methods." We can think of buying a car that can be sustained (able to make the payments, pay for car insurance and repairs), entering into relationships that can be sustained (time, energy, proximity, etc.), or even building nonprofit organizations or structuring social work positions that are sustainable.

In 1983, the United Nations established the World Commission on Environment and Development, chaired by Gro Harlem Brundtland, with the charge of exploring long-term environmental strategies for the global community. In its report titled "Our Common Future" (Brundtland, 1987), the commission defined *sustainable development* as "development that meets the needs of the present without compromising the ability of future generations to meet their own needs" (Ch. 2, IV, p. 1). It further described the spheres of global concern not only as environmental, but also including social, economic, and cultural issues. In 1992, the United Nations held its first global Conference on Environment and Development (UNCED) in Rio de Janeiro, Brazil, affirming the challenges posed by current production and consumption patterns, and reaffirming the pillars of focus as environmental, economic, and social (including cultural). Its 10th anniversary World Summit on Sustainable Development (WSSD) was held in Johannesburg, South Africa, in 2002, and its 20th anniversary Conference on Sustainable Development was held in 2012 in Rio de Janeiro, to assess progress and implementation gaps in working toward sustainability; renewing commitments to work for increased sustainability through specific steps and programs; and clarifying new challenges. All three conferences included goals to increase awareness, to create educational materials for broad use so as to engage partners globally in sustainable development, and to create tracking and measurement tools.

Further Defining and Developing Sustainability for Educational Purposes

The United Nations Educational, Scientific, and Cultural Organization (UNESCO) developed an online curriculum for education about sustainability to create a better world for this generation and future generations of all living things on planet Earth. UNESCO focuses on 12 themes within the spheres of environmental, social, cultural, and economic sustainability: biodiversity, climate change, cultural diversity, indigenous knowledge, poverty reduction, gender equality, health promotion, sustainable lifestyles, peace and human security, water, and sustainable urbanization.

The World Bank was an early leader in promoting sustainability, and particularly educational material and definitions relating to sustainability (World Bank, n.d.). Their Development Education Program provides tools to explore needs related to social (including cultural), economic, and environmental sustainability. However, it suggests that conflicts often exist among these needs, not only in the lives of individuals, but also conflicts among individuals, groups, communities, and nations. It describes social, economic, and environmental needs as a sort of puzzle with a variety of components, and suggests that individuals jot down 5 to 10 needs in their own lives and examine the interplay and conflicts among them. In fact, the World Bank experienced difficulties in balancing those needs, as evidenced in its Independent Evaluation Group report (2010), which suggested that more attention be given to social and environmental needs and not primarily on financial outcomes, in the projects funded for community sustainability.

Measuring Sustainability

The Brundtland Commission took years to define sustainable development and to consider which needs to include in the commission's report. However, concepts are more specifically defined by their measurement, and the relative importance and weight of various indicators in their measurement. There are also, practically speaking, three major schools of thought about the relative importance of those needs. Some people emphasize the importance of a stable economy and tend to view efforts to sustain the economy as sustainable community development. The corporate view of sustainability is often an economic one. Others emphasize the economy, but as it impacts the social needs of all. The root cause, in their view, of problems with sustainability is because of economic disparities, or the degradation of some to increase the economic well-being of others. Their view of the economy necessitates an understanding of social and cultural concerns. For example, will new economic ventures in a rural community destroy important landmarks or community centers like the "old school" or other buildings that have cultural meaning? Still others consider sustainability as primarily referencing ecological sustainability, or the sustainability of the geographic environment, including water and soil conservation and conservation of natural resources such as oil, gas, farmland, and timber. Finally, others promote a balanced view of all three components.

In 1999, the Environmental Sustainability Index was created by Yale University and Columbia University to measure how successful countries were in achieving their goals for the environment. The Index was refined over several years and then replaced by the

Environmental Performance Index (EPI), in an attempt to simplify and be able to compare changes over time in countries' environmental health and ecosystem vitality. The 2012 report ranks the United States as a "moderate performer," 49th out of 132 countries. The EPI considers environmental health and ecosystem vitality in its measurement, with indicators including child mortality, access to drinking water, pesticide regulation, forest loss, and many other measures (see http://epi.yale.edu).

The Happy Planet Index (HPI) is a more recent index, using several indicators to determine the extent to which various countries most efficiently use their resources to maximize long and healthy lives. It does *not* measure happiness as such, but measures life expectancy, well-being, and ecological footprint. For example, the U.S. HPI score in 2012 was 37.3, with a ranking of 105 out of 151 countries. Although the United States ranked 17th in experienced well-being and 33rd in life expectancy, it has a very high ecological footprint, for which it ranked 145th out of 151 countries. In addition to calculating the HPI for countries, individuals can complete a brief survey to determine how much of the planet's resources one is using compared with one's fair share, and the results indicate what can be done by the individual to use fewer resources and increase sustainability (see www.happyplanetindex.org).

The economy is often measured by the gross national product (GNP) per capita. The GNP is calculated by adding the total goods and services produced in a year and dividing the total by the number of people. The World Bank's measurements highlight the disparity in GNP by countries. One-sixth of the world's people survive with an income of less than $1 per day, and most of those people live in South Asia or Africa. There are few farmers (less than 6%) in high-income countries, but farmers comprise the majority (60%) of the population in low- and middle-income countries. What does this say about our food production and hunger? What does this say about rurality? The GNP often correlates with other indicators of positive well-being: health, literacy, longevity, and so on. The World Bank's Development Education Program also uses several measures of population growth and birth and death records to determine social indicators of sustainability.

IMPORTANCE OF SUSTAINABILITY TO RURAL COMMUNITIES AND TO POPULATIONS AT RISK

Nearly all of the aforementioned ecological disasters, including the *Exxon Valdez* spill and Three Mile Island, and even much of the *Deepwater Horizon* spill, damaged rural ecosystems and rural livelihoods (farming, dairy, fishing, etc.). In addition to unplanned disasters, rural America's resources are often owned and controlled by absentee corporations in their quest for energy in the form of coal, oil, and gas (Perks, 2009). In addition, the quest by agribusiness for inexpensive crops grown without concern for the soil or the rural ecosystems, along with overcrowded cattle, chicken, and other livestock raised with such methods, threaten water resources and land (Berry, 1997; McKibben, 2007; Pollan, 2006).

The current raging debate over "fracking," or the hydraulic fracturing of the earth's layer of shale to retrieve natural gas, is a good example. The United States requires natural gas for energy. New technology has been developed that provides a means to drill through shale deep

in the earth, but there are numerous questions about the safety of fracking. Some evidence shows that sufficient risk is posed by leaks in the concrete casings inside the well bores, leakage and spilling of the toxic fluid stored as a by-product in open pits, hazards to wildlife, and possible permanent contamination to the water supply (Fischetti, 2010; Mooney, 2011). Depending on the definition of rurality, 81% to 99% of the land in the United States is rural (ERS, 2012), housing the country's natural resources, including the water supply for people, agriculture, and wildlife. There is enough concern about these processes that some states have placed a moratorium on them until testing can be completed. But the interests of rural residents, at-risk populations, and ecology can easily be threatened by economic interests without education, community involvement, and advocacy.

Sustainability and Social Work

Sustainability is an important foundation on which social work is built. In 2012, the conference theme for the Council on Social Work Education's Annual Program Meeting was "Promoting Sustainability in Social Work." The National Association of Social Workers (NASW) demonstrates the profession's concern for the people of the world, not only through its core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence and the profession's ethical values, but through its Code of Ethics (NASW, 2008). In particular, standard 6.01, which begins: "Social workers should promote the general welfare of society, from local to global levels, and the development of people, their communities, and their environments." As social workers, we are to promote the general welfare, social justice, and assure that the basic needs of all are met, in our own communities, in our own country, and globally (Mary, 2008).

In addition, the social work concern for populations at risk, locally and globally, requires attention to environmental issues that most impact the rural poor and even wildlife and plant life (Dewane, 2011; Dominelli, 2011; McKinnon, 2008). The ecological systems approach is a natural fit for social workers, and social workers must understand the ecological systems within which clients live (Norton, 2012; Peeters, 2012). Social workers are also well suited to interdisciplinary partnerships in addressing environmental concerns (Schmitz, Matyók, Sloan, & James, 2012). Jones (2010) suggests ways to integrate sustainable community practice into the social work curriculum through transformative learning, utilizing processes of reflection and dialogue and action—processes social workers already engage in with systems of all sizes. In addition, rural social work practitioners already understand the importance of relationships in rural communities (Belanger, 2005), particularly because social capital is critical to the wealth of rural communities.

Using Social Capital for Rural Sustainability

Social workers and other human service professionals are already engaged in sustainable community practice in rural communities in numerous ways by creating and expanding relationships, or social capital. In Humboldt County, California, for example, local farmers produce food through sustainable farming methods, sell fresh produce to the area schools,

and assist more than half of the county's schools in planting gardens for use in school food services. In addition, funds were able to be used to purchase local produce and support local sustainable farming methods for distribution to families in need (Stubblefield, Steinburg, Ollar, Ybarra, & Stewart, 2011). Several states have arranged for Supplemental Nutrition Assistance Program (SNAP) recipients to purchase their food at local farmers' markets (USDA, 2010), contributing both to the economy and to the recipient families' nutrition.

The Stephen F. Austin State University School of Social Work engaged in several collaborations to increase sustainability locally and in nearby cities and towns. Collaborating with Health Sciences, students assisted a nearby city in analyzing the "walkability" and "bikability" of their neighborhoods, while other classes are engaged in helping another very rural town to collaborate in assessing and investing in community sustainability. A class engaged in studying sustainability created a pamphlet demonstrating simple steps that individuals, families, groups, communities, and organizations can take to increase sustainability. A collaboration with Forestry resulted in identifying, marking, and repairing area cemeteries, a task that is essential for sustaining the culture of many communities of color. These efforts have had several elements in common:

- Recognizing the important role of diverse members of the community
- Engaging all members for the health and well-being of community members
- Recognizing the importance of education for all community members in sustainability in order to advocate for healthy preservation of land and conservation of natural resources
- Acknowleding the importance of active stewardship for rural sustainability
- Being willing to engage in action and advocacy

In addition, social work efforts have understood the importance of the social, environmental, and economic needs of communities, known as the triple bottom-line model, considering their relative importance.

Suggestions for Living Sustainably

Wendell Berry recommends in numerous essays a reuniting of people with the land, humility in learning from the land, and simplicity and mercy in dealing with one another and creation. For example, in his essay on "The Pleasures of Eating" (1990/2010, pp. 149–150), Berry provides us with suggestions for eating responsibly:

1. Participate in food production to the extent that you can
2. Prepare your own food
3. Learn the origins of the food you buy, and buy the food that is produced closest to your home
4. Whenever possible, deal directly with a local farmer, gardener, or orchardist
5. Learn, in self-defense, as much as you can of the economy and the ecology of industrial food production. What is added to food that is not food, and what do you pay for these additions?

6. Learn what is involved in the best farming and gardening
7. Learn as much as you can of the life histories of the food species

We can take his recommendations for eating and translate them into responsible living that "promote(s) the general welfare of society"—first in our own homes, then in our communities, in our states, in our country, and globally. However, any ways in which people can reduce consumption, buy locally, reuse materials, recycle, take nondamaging methods of transportation (walking, bicycling), quit using plastic water bottles and plastic bags, consume more earth-friendly foods, and teach others to do the same, will advance all parts of the triple bottom line: environment, economy, and society.

CONCLUSION

It is reported (American Chesterton Society, 2012) that in the early 20th century, the *Times of London* asked famous British authors to submit their views about what is wrong with the world. Author G. K. Chesterton entered a very short submission, only two words: "I am." The hope for rural communities, for rural social work, and for sustaining rural ecosystems, rural economies, rural culture, rural families, and rural people is for each of us to take responsibility for sustaining one another in humility with the land, in our own place, with a reduced footprint and a generous outstretched hand that not only reaches one another, but reaches toward the future. Who else could be more helpful, more humble, and more collaboratively engaged in this than rural social workers?

Discussion Questions

1. Examine the definitions of sustainability. What do you think of the triple bottom line of social, environmental, and economic needs? Do you think each of the factors imbedded in sustainability are equal? Why or why not?
2. The Happy Planet Index allows you to determine your own ecological footprint (www.happyplanetindex.org). How many "hectares" do you consume? How does that make you feel, particularly in light of the NASW Code of Ethics? What specific steps can you take to reduce your global footprint?
3. What obligation do you think social workers have to live more sustainably, and to promote sustainable living in their communities, nationally, and in the world? Is it just too much to expect social workers to engage in this practice, in addition to other ways of caring for those who are at risk?

Classroom Activities and Assignments

1. Go to The Story of Stuff Project website (www.storyofstuff.org) and view the video called "The Story of Stuff." Divide into small groups and ask students to determine how much stuff they have needlessly added to landfills. Ask each group to identify

and commit to at least three specific actions they can take to reduce their consumerism. Have each group track their efforts for two weeks and report the results in class.

2. Explore the controversy surrounding hydraulic fracturing or "fracking." Is it a concern for your community? Is it already occurring? What educational materials are available locally to inform community members? What can an individual student do to engage in transformative learning: reflection, dialogue, and action?
3. Review Wendell Berry's suggestions for eating responsibly. How can you as an individual engage in responsible eating? How can these suggestions impact your families, your peer groups, the organizations in which you work, and your communities to eat responsibly?
4. What organizations are working on sustainability issues in your community? Learn about those organizations. Identify one organization and, working with the staff of the organization, develop a project the class can complete in one semester to be better stewards of rural land.

Internet Resources

- United Nations Educational, Scientific, and Cultural Organization (UNESCO), Education for Sustainable Development (ESD) e-learning module: www.unesco.org/new/en/education/themes/leading-the-international-agenda/education-for-sustainable-development/esd-e-module/
- World Bank Learning Modules on population growth rates, life expectancy at birth (social), GNP (economic), and access to safe water (environmental): www.worldbank.org/depweb/english/modules/index.html

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CHAPTER 17

Living in Limbo

Homeless Families in Rural America

Jim Winship

When you think of someone who is homeless, what is the first image that comes to mind? (Close your eyes and wait for the image to appear.) Where is the person? For most students (and most Americans), the image is likely to be that of an older man in shabby clothes, drinking from a bottle in a long paper bag, or a woman dressed in seven layers of clothing, pushing all her belongings in a shopping cart, mumbling to herself. The scene or locale for both of these figures is likely to be in a city. If you were familiar with homelessness in rural America, these images might have occurred to you:

- A family living in an abandoned farmhouse on the Great Plains, without running water or electricity
- A 15-year-old boy, who is unable to stay with his mom and younger sister in a family shelter, because no males over 13 are allowed to stay there; he "couch surfs," staying a few days or a week with a succession of relatives, friends, and acquaintances in his small town
- A family living in a camper all year around (in Wisconsin or Florida!)
- A family living for a month in a hotel paid for by vouchers from the Salvation Army, then "doubled up," living with relatives for two weeks, then living in their van for a week until they get more vouchers to go back to a cheap motel

Even if you are familiar with homelessness in rural areas, there are special cases of homelessness on some Native American reservations and on the U.S.–Mexico border.

On many reservations, private financing for housing is rare because of legal issues with land ownership—much of the land is owned by the tribe, not individual tribal members. This can lead to long periods of time on waiting lists to get tribally owned housing. A housing inventory conducted on the New Mexico Pueblo de Acoma reservation found that 155 of the 700 occupied housing units were overcrowded. On tribal lands in Arizona, some individuals live in dry riverbeds or in outbuildings such as barns or backyard sheds (U.S. Government Accountability Office, 2010).

Complicating the distinction between being homeless and being housed is the emergence of *colonias* along the border between the United States and Mexico. Since the passage of the North American Free Trade Agreement (NAFTA) in 1994, there has been a growth of small,

unplanned communities. Many Mexicans and other Latin Americans who moved to this country for jobs find themselves too poor to afford regular housing. According to an ABC News report in 2012, half a million people live in an estimated 2,000 *colonias* spread across the 1,000-mile-plus border between Texas and Mexico. In most of these communities, there is no running water, sewage, or regular garbage collection. In some, there is no electricity (Quiñones, Newman, & Sherwood, 2012). Although individuals living in a shack with no electricity, running water, or indoor plumbing still have a roof over their heads, their housing is so inadequate that they are considered homeless.

UNDERSTANDING RURAL HOMELESSNESS

Widespread homelessness in the United States is a relatively recent phenomenon and, for a variety of reasons, has been seen as an urban phenomenon affecting single adults. This chapter explores the impact of the recession that started in 2008 on homelessness and the reasons for the increase in homelessness for families in rural America over the past decades. It explores connections between rural poverty and rural homelessness, as well as the impact of limited public transportation and housing availability in rural areas and cutbacks in federal housing programs. Finally, the chapter examines how federal and state governments have addressed homelessness, particularly in terms of building assets and capacities.

Increase in Homelessness as a Result of the 2008 Recession

The numbers of homeless persons rose sharply nationwide beginning in 2007. The recession hit children and families especially hard. According to the National Center on Family Homelessness, family homelessness increased 38% from 2007 to 2010 (National Center on Family Homelessness, 2011). Dennis Culhane, a University of Pennsylvania professor of social policy, stated that the report

> paints a bleaker picture than one by the Department of Housing and Urban Development, which nonetheless reported a 28 percent increase in homeless families, from 131,000 in 2007 to 168,000 in 2010. HUD's numbers are much smaller because they count only families living on the street or in emergency shelters. (Memmott, 2011, p. 1)

Although there has not been a systematic study of rural homelessness since the 2008 recession, news reports in Missouri and Pennsylvania speak to increases in rural homelessness in those states (Layne, 2012; Miller, 2012).

Understanding and Counting Homelessness in Rural Areas

Categories of those who are homeless have been described as:

- *Single-parent households*, primarily women who have left or are leaving relationships, who have been evicted for failure to pay rent, removed on vacate orders (from

a Health Department for unsafe habitation where they were living), burned out, or turned out by family or friends with whom they had been doubling up

- *Single men*, either indigenous to the community or on the road, who are out of work, are increasingly of ethnic minority status, and often have rudimentary or obsolete job skills, the younger men tending to have job histories concentrated in the peripheral job market
- *Single women* of all ages who have lost husbands or mates, have been turned out by friends or family, or simply cannot keep up with rising rents (many of these have children, who are either staying with family members, are in foster care, or are grown)
- *Individuals with serious disabilities, severe and persistent mental illness, or long-standing substance abuse problems* in particular—some have been hospitalized, others not, and all have lost whatever precarious accommodations they once had and are at a severe disadvantage in competing for the affordable housing that remains
- *Ex-offenders* released from jail or prison to fall back on their own meager resources, who face discrimination in securing jobs
- *Homeless youths*, who are especially vulnerable to the depredations of the street—some having been ejected from households that are unwilling or unable to support them any longer, and some having been victims of abuse or having aged out of foster care
- *A host of smaller groups*, including the displaced elderly, victims of domestic violence, and legal and undocumented immigrants (Hopper, 1997, pp. 22–23)

Several problems arise in estimating the number of people who are homeless. This is typified by the bumper sticker put out by the National Coalition for the Homeless, "If you lived here, you'd be home now." H. C. Covington, who provides technical assistance for programs serving homeless persons in rural areas, states that he has been collecting local and statewide reports for 10 years and has yet to see two reports that use the exact same methodology (Covington, 2002).

The rural context makes gathering data even more difficult. "We have no national database to track the rural homeless, in part because it is so difficult," says Gene Summers, a professor in the Department of Rural Sociology at the University of Wisconsin in Madison. "The rural environment helps to disguise the hardship" (Wilkinson, 1999, p. 2). In rural areas, you find fewer individuals who fit the image of a homeless man or woman sleeping on the streets or in a shelter. Instead, many homeless are "doubled up" with families or friends, sleeping in a tent or camper, or perhaps in abandoned vehicles (Shamblin, Williams, & Bellaw, 2012).

"How many people are homeless?" The initial answer to that question is "It all depends." There is no universally agreed-upon definition of homelessness, and federal agencies providing services to those experiencing homelessness do not have a common definition. As illustrated earlier in the chapter, there will be a difference in the estimates of homelessness, depending on whether one counts as homeless those who are doubled up for economic reasons. In addition to the two factors of the period of homelessness and the definition of homelessness, the methodology for counting the homeless also influences the numbers. For

example, does the report include counts on one day only, or does it measure an unduplicated count over several days or weeks?

It is easier to count homeless persons in urban, rather than in rural, settings. Far fewer of those who are homeless in rural areas reside in shelters. Furthermore, those sleeping outside in urban parks and under bridges are easier to locate than those in rural areas sleeping outside in areas that are much less visible. Additionally, homeless families in campgrounds in the summer are difficult to distinguish from vacationing families.

The principal way that the Department of Housing and Urban Development (HUD) counts homeless persons is through a point-in-time count in a 24-hour period in January. Although January was chosen because shelter use is higher in winter months, this may lead to an undercount of homeless persons who are not in shelters. In the northern part of the United States, those in rural areas who are not in shelters generally stay in places that are not visible by the volunteers doing the point-in-time count (e.g., living in a barn, or in a car).

Most everyone would agree that the family living in their van is homeless, as is the person sleeping under the bridge or in the woods. However, one also needs to include persons living in situations of acute housing distress that are not generally associated with homelessness—the family "doubled up" who stays in the living room of the sister's apartment for two weeks, the person living in the abandoned farmhouse without plumbing or electricity, the family who spends the summer at a campground.

Yvonne Vissing, author of *Out of Sight, Out of Mind: Homeless Children and Families in Small-Town America*, defines rural homelessness as "lack of a consistent, safe physical structure and the emotional deprivation that occurs as a result" (1996, p. 8). According to Vissing, this includes housing displacement and housing distress, which means the habitation has safety concerns or lacks electricity, heating, water, or sewage.

For this chapter, an individual or family is considered homeless if they:

- Slept in limited or no shelter for any length of time (i.e., outdoors, in one's car)
- Slept in shelters or missions operated by religious organizations or public agencies that serve homeless people and charge either no fee or a minimal fee
- Slept in inexpensive hotels or motels where the actual length of stay or intent to stay was 45 days or fewer
- Slept in other unique situations where the actual length of stay or intent to stay was 45 days or fewer, including staying with family or friends for short periods for other than economic reasons (doubled-up)
- Slept in housing conditions that are considered to be unsafe

REASONS FOR THE GROWTH IN HOMELESSNESS

The growth in rural homelessness can be traced both to national trends over the last 30-plus years as well as several factors specific to rural areas. The trends that are most significant are poverty, transportation issues for the rural poor, the rise in housing costs, the availability of affordable housing, and cutbacks in federal government funding for housing programs.

Poverty and Rural Poverty

One cannot understand homelessness in rural areas without first understanding rural poverty. Think of being poor as *living on the edge*, having barely enough money to meet basic needs. For a low-income working single parent, for example, income may meet expenses if everything works out just right. However, any number of circumstances may push that family over the edge—a sick child, which forces the parent to miss several days at work (at a job with no sick pay), an unusually cold winter, which increases utility payments, or unexpected car repairs. In choosing between paying bills, sometimes rent payments are not the most critical priority, and if the rent gets too far behind, the family may get evicted.

Most people who are poor are not poor most of the time. According to two noted poverty researchers, nearly two-thirds of all Americans and more than 90% of African Americans will experience at least one year of living below the poverty line during their lifetime. According to the authors, "For the majority of Americans, the question is not if they will experience poverty, but when. Rather than an isolated event that occurs only to what has been labeled the 'underclass,' the reality is that the majority of Americans will encounter poverty firsthand during their adult lifetimes" (Rank & Hirschl, 1999, pp. 211). And some of those who are poor will become homeless.

According to Janet Fitchen (1993), lack of awareness of the extent of poverty in rural areas is a result of the dispersed nature of poverty in rural areas. Rural areas are more economically mixed settings than urban areas. I live in a town with 6,000 permanent residents and sent my children to an elementary school in the countryside, where family income of the most affluent children was at least 10 times that of the least affluent children. Looking at the children, it was often difficult to determine who were the children of a veterinarian or M.D. and who were the children whose parent(s) were marginally in the workplace. The rural poor are hidden from outsiders because they are not as concentrated in groups as the poor are in central cities.

Although the social and economic integration in rural areas is often greater than in urban areas, the job market and other factors are often problematic for low-income rural residents. The availability of jobs, especially well-paying jobs, continues to be an issue in rural America. The 2008 recession affected rural populations slightly less severely than urban residents. The unemployment rate in nonurban counties was 8.2% in 2010, lower than the 9.2% for urban residents. However, the unemployment rate for adults with less than a high school diploma was 14% (Economic Research Service, United States Department of Agriculture, 2011). Although the unemployment rate was lower, the poverty rate was higher in nonmetropolitan than metropolitan areas. In 2010, nearly 7.9 million people living in nonmetropolitan areas (16.5% of the nonmetropolitan population) were poor. The metropolitan area poverty rate increased from 13.9% in 2009 to 14.9% in 2010.

Jobs are not equally available in all rural areas. Twenty-three percent of all rural counties are persistently poor counties, as 20% or more of the population in these counties has been living in poverty for the last three decades. A disproportionate number of these counties are in the deep South (Rural Policy Research Institute, n.d.a).

Transportation Issues for the Rural Poor

Jobs are not equally available in all rural areas, and rural residents often need to travel distances within rural counties and from county to county to find employment. Perhaps the biggest difference between being poor in rural areas as compared to being poor in central cities is the lack of public transportation. Nearly 80% of rural counties have no public bus service, compared to 2% of urban counties. It is difficult to have public transportation in sparsely settled areas, because the routes to remote parts of counties are long, and the ridership is not large enough to make these routes cost effective. Only 43% of the rural poor were found in one study to have a car, and only 4% of public assistance recipients owned a vehicle (Rural Policy Research Institute, n.d.b).

The connection between car ownership and homelessness was clear to me on my first trip to a homeless shelter in a rural area 15 years ago, as part of a church group that was serving a meal at the shelter. Sitting down with the residents at the meal, I was listening to one young couple describe how they became homeless and ended up at the shelter. They were both working at low-paying jobs at a nursing home 20-some miles from their house. Their old car broke down, they could not get to work for over a week, and so they lost their jobs, leading to their being unable to pay their rent and losing their housing.

Housing Availability

Without sufficient income, people can become homeless. The availability of decent and affordable housing influences whether individuals living on the edge can prevent becoming homeless. When determining housing availability, social workers must consider three questions: Is there any housing available? Is the housing in decent shape? Is it affordable? According to the Housing Assistance Council:

> Rural rental households tend to have lower incomes and experience some of the most significant housing problems in the United States. Renter-occupied households in rural areas are twice as likely to live in substandard housing than their owner counterparts. Additionally, over half of all rural households with multiple housing problems (e.g., quality, crowding, or affordability) are renters. (2010, p. 1)

Rural homelessness is often precipitated by families having to leave their housing because of a structural or health and safety concern. When families relocate to safer housing, the higher rent is often too much for them to manage (Fitchen, 1992).

The National Low-Income Housing Coalition (2012) published a study showing the hourly wage needed to rent a one-bedroom or two-bedroom apartment in every county in the United States. In *Out of Reach 2012*, their findings demonstrated that while housing was not as expensive in rural areas, wages were also lower. The housing wage (the amount needed to rent a two-bedroom apartment) was $9.87, lower than the metropolitan housing wage of $12.21. However, they also found that at the state level, the nonmetropolitan two-bedroom housing wage exceeded the renter wage in all but five states. Families who have to pay a high

percentage of their income for rent are particularly vulnerable when their income is reduced for any reason.

Decreased Government Support for Housing

For many low-income individuals, government support for housing can allow them to get into housing and stay housed. To understand government support for housing (or any program) over time, it is important to take inflation into account. A program that had a $100 million allocation in 1969 and a $150 million allocation in 2013 has suffered an actual reduction in inflation-adjusted dollars. My family bought a new Volvo for $3,300 in 1969; new 2013 Volvos start at more than seven times that amount.

Funds for subsidized housing programs reached their peak in 1978, with more than $94 billion (using the value of the dollar in 2012). When Ronald Reagan became president in 1980, he vowed to cut spending for social programs. He was not successful in cutting spending in many areas, but he did substantially cut spending on housing programs, to $19 billion (in 2012 inflation-adjusted dollars) in 1983. Support for subsidized housing has never approached the 1970s levels.

Differences Between Those Who Are Homeless in Rural and Urban Areas

Although many of the reasons for being homeless—poverty and the gap between wages and housing costs, the lack of housing—may be similar for urban and rural areas, studies reveal several differences. In general, rural homeless clients have experienced fewer and shorter episodes of homelessness during their lifetimes. Fifty-five percent of rural clients have been homeless for three months or less, compared with 22% to 27% of central city and suburban homeless clients. In addition, only 27% have been homeless for more than a year, compared with 48% of central city and 49% of suburban clients (Interagency Council on the Homeless, 1999).

Families make up a larger percentage of those who are homeless in rural areas as compared to urban areas. Given the increase over the last few years in the percentage of families experiencing homelessness (Memmott, 2011), this greatly affects rural areas. The largest statewide study of the rural homeless was conducted in Ohio in 1993. Findings from this study indicate that homeless people in rural areas are younger, are more likely to be single women or mothers with children, are more highly educated, and are less likely to be disabled. Economic factors are more likely to lead to homelessness in rural areas than are mental illness or drug and alcohol abuse (First, Fife, & Toomey, 1994). The rural women in this study identified family conflict and dissolution as the primary contributor to their homelessness nearly 38% of the time (Cummins, First, & Toomey, 1998).

A 2001 study of homelessness in Virginia found that more than half of the homeless (53%) were women. Lack of affordable housing was described as the paramount reason for homelessness, closely followed by domestic violence, family breakup, and mental illness (Koebel, Murphy, & Brown, 2001). These findings parallel an earlier study in Kentucky (Post, 2002), where there was a higher percentage of homeless women and families in rural

areas than in urban areas, and where domestic violence was more of a factor in leading to homelessness in rural parts of the state. More than half of the homeless in rural Colorado are families with children (Colorado Coalition for the Homeless, 2000).

Rural areas differ widely from one to another. Communities with economies based on tourism, such as those in Colorado with ski resort areas and gateways to national parks, forests, and monuments, have been experiencing extreme shortages of affordable housing and rising homelessness. These areas often have an abundance of low-wage, seasonal jobs. Service-industry workers, who cannot afford housing in the communities where they are employed, frequently must live in neighboring communities and face long commutes. Those without transportation or resources are at great risk of homelessness.

In comparison with urban areas, fewer of those experiencing homelessness in rural areas have mental illnesses. In Appalachian Ohio, people experiencing homelessness have more years of schooling, tend to be younger, and are more likely to be female-headed families with children (Robertson, Harris, Fritz, Nofsinger, & Fischer, 2007).

Responses to Homelessness on the National Level

In the early 1980s, when homelessness was becoming more visible in the United States, most programs to address problems associated with homelessness were created, funded, and administered at the grassroots level. The administration of President Ronald Reagan believed that states and local jurisdictions were best equipped to handle their own homeless problems, and not the federal government (remember that Reagan cut funds for subsidized housing almost 80% in his first years as President).

As the number of homeless people grew during the mid-1980s, pressure grew to address the problems of homelessness in a tangible way from the top down, with the federal government as an active participant in addressing the needs of homeless people. In 1986, Congress passed a few small parts of the Homeless Persons' Survival Act. Later that same year, legislation containing Title I of the Homeless Persons' Survival Act—emergency relief provisions for shelter, food, mobile health care, and transitional housing—was introduced as the Urgent Relief for the Homeless Act. After an intensive advocacy campaign, the legislation was passed by large bipartisan majorities in both houses of Congress in 1987. After the death of its chief Republican sponsor, Representative Stewart B. McKinney of Connecticut, the act was renamed the McKinney Homeless Assistance Act. It was signed into law by President Ronald Reagan on July 22, 1987. The bill was renamed the McKinney-Vento Homeless Assistance Act in 2001 to honor the late Bruce Vento, a Minnesota Congressman who was an advocate for services for those in homeless situations. The programs that most directly support families in homeless situations, through the U.S. Department of Housing and Urban Development, are as follows:

Emergency Shelter Grants (ESG) funds are granted on a formula basis to states and communities to finance renovation, major rehabilitation, or conversion of buildings for use as emergency shelter or transitional housing for people experiencing homelessness; essential services; payment of operating costs of facilities for people experiencing homelessness; and homelessness prevention.

Supportive Housing Program (SHP) new and renewal funds are awarded on a competitive basis to states, communities, and nonprofit organizations to finance transitional housing, permanent supportive housing, supportive services, innovative and alternative housing, and safe havens.

There is also funding under the McKinney-Vento Act for Section 8 Moderate Rehabilitation for Single Room Occupancy (SRO) Dwellings for Homeless Individuals and Shelter Plus Care funding for homeless people with disabilities.

Funding under the McKinney-Vento Act is categorical funding, and it is important to distinguish between categorical programs and entitlement programs. In entitlement programs, a person who meets the qualifications (poor enough or disabled enough, for example) automatically qualifies for government-sponsored services or benefits. For example, Supplemental Security Income (SSI) is an entitlement program for those with disabilities who do not qualify for Social Security Disability and the poor aged. Student financial aid programs such as Pell Grants and Work Study programs are also federally funded entitlement programs.

For categorical programs, the federal government makes available a specific funding amount to the states, and the states decide how to spend the funds on communities or programs throughout the state. Criteria often originate from the federal or state level to determine how the money can be spent. In the case of homeless assistance programs, like many other categorical programs, nonprofit organizations (and occasionally local governments) submit applications to the state, and the state chooses the recipients and the amounts. This differs from Food Stamps, for example, in which each county in the nation is mandated to have staff to determine eligibility and provide Food Stamps to eligible individuals and families.

In 2009, Congress passed the *Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act*, which reauthorized the McKinney-Vento Homeless Assistance programs and made some considerable changes to the program. These changes include the following:

- Increased emphasis on homeless families with children
- Increased emphasis on homelessness prevention
- Incentives for developing permanent supportive housing
- Greater financial discretionary authority to rural communities

Funding from the federal government can be considered inadequate in several respects. Funding for all HUD programs for the homeless totaled slightly more than $2 billion for fiscal year 2013 (National Alliance to End Homelessness, 2012).

The categorical funding from the federal government to the states is then distributed through community decision-making bodies, Continuums of Care, to local organizations, most of them not-for-profit organizations not linked to larger organizations; more than 90% of homeless shelters in Wisconsin, for example, are local nonprofits not associated with a larger organization (like Catholic Charities or the Salvation Army). This categorical funding is never sufficient to fully fund an emergency shelter, so an emergency shelter in a

rural county exists when a nonprofit organization with enough commitment and fund-raising capability can begin and maintain services.

A homeless family in a rural area may be lucky enough to be in a county where there are services, but many are not that lucky. In Maine, a 63-bed multipurpose shelter is the only facility that serves the entire homeless population in a county of nearly 1,000 square miles. In addition, four of the 16 counties in Maine are without emergency shelters, and 25% of those counties use hotels as their option for housing individuals who are homeless in the winter (U.S. Government Accountability Office, 2010).

The extent of services for those experiencing homelessness varies by state. In Wisconsin, a decade ago, no services were available in more than 15% of the state's counties. With a change to multicounty Continuum of Care organizations, funding is now provided for homeless services that cover all of the counties (Iverson, 2012).

In addition to scarce funding, technological limitations can affect access to services. According to a 2010 General Accounting Office report:

> Some rural areas do not have broadband services and some providers we spoke with said that they are excluded from some of the communications and resources available over the Internet. For instance, HUD regional office officials acknowledged that some rural service providers have been unable to connect to some of their technical assistance workshops and learn about application preparation, project administration, and management. (U.S. General Accounting Office, 2010, p. 30)

RECOGNIZING THE ASSETS OF THOSE EXPERIENCING HOMELESSNESS

Several recent reports counter earlier research claiming that homeless adults have weak social networks. Data from in-depth interviews with 55 homeless adults in Michigan's sparsely populated Upper Peninsula show that most interviewees maintained some degree of ongoing relationships with family and friends. These supports did provide important help, but in many cases the family members' own struggles limited the assistance they could provide (Hilton & DeJong, 2010). This study conducted in a rural area is consistent with a recent national study that found an unexpectedly high number of homeless people who stay in contact, albeit sporadically, with housed family members and friends (Lee, Tyler, & Wright, 2010).

In the previously cited study in Michgan's Upper Peninsula, Hilton and DeJong (2010) also found that "although homelessness is not a preferred choice, it is, for some, a manageable reality. For others, the experience elicits panic and despair" (p. 24). This finding reminds us that a tremendous range exists within any group of human beings in their ability to cope with challenging situations. Some individuals are skilled at utilizing resources from family, friends, and social service organizations and at not being overwhelmed by worries about the future; others have less ability to use these adaptive behaviors.

Paying Attention to Assets in Policies and Programs

There is a need to adopt asset-building policies to ensure that all Americans are equipped with the individual resources that are essential to meaningful opportunity. One means for achieving that goal is to provide universal access to assets that foster independence and growth, not distinguishing between those who are "truly needy" and those who are "not quite needy enough." A second characteristic of asset-based policies is that they not only supply remedies to correct deficiencies, but they also provide a means for individuals to build capacity for thriving. Finally, good policies should enhance the infrastructure of opportunity (Beefermen, 2001). Unfortunately, many policies and programs designed to help those experiencing homelessness have not been planned or implemented from a capacity-building perspective. However, some promising approaches can recognize, build on, and enhance the assets of those experiencing homelessness.

Programs that work to prevent homelessness and attempt to minimize moving out of the locality keep intact the social network of homeless adults and minimize the impact of dislocation on adults and children. The title of this chapter comes from a statement that one homeless woman made to me while I was conducting a parent support group at a rural shelter: "I feel like I'm living in limbo."

Programs that prevent homelessness and minimize moving also acknowledge the sense of place for the children involved. In the *Power of Place*, Galagher (1993) describes how children learn state-appropriate behavior during childhood. Children learn how to match emotional states and behavior (e.g., sleep, excitement, and concentration) to specific places: home, playground, and/or school. This is an essential part of establishing one's identity and, in familiar settings, can be a more powerful determinant of children's behavior than their personalities. Being homeless disrupts this sense of identity with the loss of predictable places where the child has learned what she or he can and cannot do (Locke, Garrison, & Winship, 1998).

"Housing-first" policies are asset-centered rather than deficit-centered. Working with families who ordinarily might not be able to secure permanent housing, groups using these policies place the family in housing and concurrently add the services and support. Housing-first policies start with the assumption that people in homeless situations need to be housed; they may not need counseling or other supporting services.

Policies can be oriented to more than helping persons escape homelessness. Earlier in this chapter, being in poverty was described as *living on the edge*. If a person is poor and has a couple of bad breaks or makes a bad decision, that person can fall off the edge into homelessness. Programs that only help individuals escape the worst-case situation in essence help them back onto that precarious edge.

The problem of homelessness in rural areas also needs to be considered in the larger context of the lack of housing and of economic opportunities that are ongoing in rural America. Universal policies that strengthen the economic, housing, and transportation infrastructure of rural areas will make it easier for those who are homeless, on the brink of homelessness, and all low-income rural residents to obtain and maintain economic security. When more programs and policies are designed to help families and individuals develop their capacities and assets so that they have greater stability and success, the nation will have made real progress. Then there will be fewer people "living in limbo."

Discussion Questions

1. What are three barriers to stable housing that families who are homeless in rural areas of the United States face that are generally not major obstacles for homeless families in urban settings? Are there barriers for urban homeless families that are not found in rural areas?
2. "Housing-first" policies were discussed in the chapter as an example of policies that are not deficit-based. However, they do not enhance the economic or housing infrastructure of rural areas. What is one policy that would bolster the economic or housing infrastructure in rural America?

Classroom Activities and Assignments

1. Select a rural county with which you are familiar. In talking with social service providers, try to understand both the extent of family homelessness and the nature of the services provided to those in homeless situations. If there appears to be considerable unmet need, what two factors would contribute to the needs not being fully met?
2. The Fair Market Rent measures the monthly rental cost for a two-bedroom apartment in good condition. The National Low-Income Housing Coalition's website (www.nlihc.org) has the Fair Market Rent for every county in the United States (go to the section under Resource Library called "Out of Reach"). Find the Fair Market Rent for a county with which you are familiar. In your opinion, how difficult is it going to be for low-wage-earning families to make enough money to be able to pay housing and other costs in that county and stay out of homelessness?

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CHAPTER 18

Location Matters

Using GIS Mapping to Address Policy Issues in Rural Areas

Donna M. Aguiniga and Amanda Davis

Place is critical to social work. Social workers do not reside in a vacuum but are instead integral components of the communities in which they live and work. Effective social work practice is tied to place and its inhabitants, with the work being done often complex and hands-on. In rural communities, this may be even more so, as social workers often cannot physically remove themselves from the notice of those they serve. Despite social work's connection to the community, to *place*, the profession does not use knowledge of place to its best advantage. Modern technology has created a digital form of mapping and spatial analysis through the use of geographic information systems (GIS) data and technology. GIS data provides a way to understand and communicate information about the people and environment and how the two interact as a system. However, social work has failed to embrace the full potential of GIS technology. Although the use of GIS mapping has flourished in other disciplines, social work has failed to keep up with technological developments in this field (Hillier, 2007; Queralt & Witte, 1998).

At its most basic, GIS can identify the physical locations and impact areas of institutions within communities. GIS data uses digital representations to generate locations and phenomena that occur on or near the Earth's surface (ESRI, 2006). GIS offers social workers the opportunity to create maps that highlight the assets, challenges, and changes of rural populations. It allows social workers to pinpoint resources and serves as a reference source for end users. A deeper understanding of GIS allows social workers to identify trends that occur or have occurred in their communities over time. A change in the number, type, or location of social services, businesses, voluntary organizations, and/or recreational activities can help users identify positive or negative change within a geographic area. GIS can also be used to identify potential social justice issues within a community. By tracking the geographic distribution of residents' income, property values, or property taxes and comparing these figures to demographic, employment, and other data, trends may appear that illustrate exploitive practices.

Yet, GIS can go beyond just providing visual evidence of social injustice. "GIS can be used to document disparity, but it can also be used to take the next step and plan more

effective and efficient services" (Hillier, 2007, p. 213). The practical application of GIS can help social workers identify a community's strengths and vulnerabilities and work with community members to advocate for policies and programs that will assist communities and clients in reaching their goals. This chapter examines the history of GIS mapping technology, issues in rural America, and the use of GIS in rural social work. Additionally, this chapter addresses how social workers can and should utilize this technology and its role in policy practice.

HISTORY OF GIS

The role of mapping and analyzing the geographic location of people and phenomena has a long history in social sciences. The use of maps as a visual tool to convey information about economic and service trends in the social services field dates back more than 100 years. Charles Booth (1889) created the *Descriptive Map of East End Poverty*, the first of what would become a series of maps developed to convey the economic status of residents of the greater London area. Booth's work was pivotal in creating recognition that social issues, such as poverty, could be presented in a format that conveyed a greater depth of information than could be found solely in numbers. Although numbers told how many residents fell into each economic class, Booth's map allowed the viewer to see *where* economic classes lived in relation to each other.

In 1893, the U.S. Congress commissioned a national survey of American cities to evaluate the scope of urban poverty (Wright, 1894). In Chicago, Florence Kelley was selected to lead the survey efforts. Based on their survey work, Kelley and her colleagues at the Hull House Settlement in Chicago, Illinois, published the *Hull House Maps and Papers* (Residents of Hull House, 1895). Their work provided a revolutionary analysis of social inequality as it relates to geographic location (Steinberg & Steinberg, 2006). Broadly modeled after the *East End* map, Kelley and colleagues developed a map that illustrated both the wages and nationalities of the inhabitants around Hull House (Schultz, 2007). This combination of economics and nationality provided a new way to examine racial and class divisions and trends in urban America.

Much of the early development of GIS technology, inspired by the overall advances in computer technology, arose in North America in the 1950s and 1960s. Roger Tomlinson, a geographer who was experienced with land surveys, and the Harvard Lab for Computer Graphics and Spatial Analysis were both instrumental in the 1960s in the development of GIS technologies (Chrisman, 2005; Coppock & Rhind, 1991; Malczewski, 2004). Tomlinson championed technology as a way to complete the Canada Land Inventory and led the development of the Canada Geographic Information System, perhaps the earliest computer-based GIS system. The Harvard Lab created SYMAP, the first "widely distributed computer package for handling geographical data" (Coppock & Rhind, 1991, p. 28). One of the early U.S. government pioneers in GIS was the U.S. Census Bureau. The Bureau first began exploring the potential of GIS in 1967, after recognizing the potential of *geocoding*—assigning geographic identifiers to map features and records—in aiding census accuracy and collection (Malczewski, 2004).

Advances in computer technology in the 1980s further influenced the development of GIS. As computers became both increasingly affordable and powerful, GIS was more accessible to state and local governments and universities. By the 1990s, GIS was equipped with a familiar interface for users, with "on-screen 'buttons' and drop-down menus" (Malczewski, 2004, p. 12). As the Internet has grown, access to GIS capabilities has rapidly increased. GIS can be distributed via the Internet in a variety of applications: data sharing, data searches, data processing, and location-based services (Peng & Tsou, 2003). Data sharing allows original files to be downloaded, allowing the end users to generate their own GIS output. Data searches can be used to access either static or real-time maps created by others, such as current traffic conditions or local weather radar. Data processing allows users to complete their own spatial analyses. Lastly, location-based services, perhaps the most familiar to a layperson, allow the user to locate a destination and determine optimal transportation routes. Currently, the phenomenon of "volunteered geographic information," maps created by the general public and made available online, has been aided by the development of websites such as Google Earth and Wikimapia (Goodchild, 2007, p. 212).

Despite these groundbreaking developments in GIS technology, social work has failed to integrate advances in technology and the application of those tools to benefit community development and policy advocacy. Although some recent examples highlight the potential of GIS (cf. Freisthler, Lery, Gruenewald, & Chow, 2006; Gjesfjeld & Jung, 2011; Kim, Hong, Treering, & Sim, 2012), its use by the profession could be expanded, particularly in rural social work. The success of social service interventions is greatly impacted by geographic location, including distance between needs and services (Coulton, 2005). Hillier (2007) emphasized the fundamental role GIS could play in the profession when she stated, "GIS represents a new technology that allows social workers to reinvigorate the tradition of the early mapmakers, with their emphasis on understanding people in their environment" (p. 207).

RURAL ISSUES

Identifying the challenges and assets of a rural community allows social workers to tailor their services to the needs and resources available to them. Rural America faces the loss of population, industry, and social services. These losses have a negative effect on social and human capital within a community. As resources become increasingly scarce in some communities, it is imperative that programs are efficient and cost effective. This is not a simple proposition, however, as the needs of individual rural counties can be unique and varied. For example, some communities face environmental challenges, including pollution and exposure to environmental toxins, whereas others face interpersonal challenges, such as language restrictions, racism, or homophobia, or social challenges, such as illiteracy or low educational attainment.

GIS is well-suited to help rural social service agencies and communities better understand the needs of residents. It can be used to pinpoint both challenges and assets, and to help create a plan for positive change in communities. The capacity of spatial mapping to identify

vulnerability and strengths, from the micro to the macro level, can also be used to identify trends in key factors that impact rural America.

In rural communities, strengths, assets, and capacities often take the shape of voluntary associations, the strong networks of both formal and informal relationships between community members, the town's history and traditions, and the land itself. Building on the skills and talents of residents is viewed as the best way to handle community issues and can be empowering (Beaulieu, 2002). GIS is a natural tool to help communities identify assets and strategize how they can best be used. By utilizing GIS software, social workers can collaborate with community leaders and interested parties to pinpoint challenges, the populations affected by them, and the community's natural defenses to help overcome challenges. Moreover, identifying assets can create links between those who need intervention and the service providers who can help. The potential of GIS in rural communities will be demonstrated through an examination of several rural issues, such as poverty, demographic shifts, and accessibility of goods and services.

Poverty

One of the most significant problems facing rural communities is the high rates of poverty experienced by many rural residents. Nonmetro poverty rates were 16.6% in 2009; by comparison, metropolitan poverty rates were at 13.3% (Kusmin, 2011). For many of the poor residing in rural America, poverty has become an intergenerational trend. The Economic Research Service (2012) defines persistent poverty counties as those that have recorded 20% or higher rates of poverty for the 1970, 1980, 1990, and 2000 decennial censuses. Of the 386 counties classified as persistently poor, 340 (88%) are in rural areas; approximately 14% of the rural population resides within those counties (Joliffe, 2004). The use of GIS allows viewers to see the geographic concentration of persistent poverty in several regions of the country: the South, the Appalachians, the Texas–Mexico border, and Native American/Alaskan Native reservations (see Figure 18.1). Because of the sheer length and depth of poverty experienced by these counties, creativity and reactive policy measures are necessary to provide a sufficient range of services and development opportunities for these areas to thrive.

Rural poverty is also more likely to affect racial and ethnic minority groups. A significant portion of the persistently poor counties are counties with historically high populations of black, Hispanic, and Native American citizens. Research has shown that Black, Native American, and Hispanic residents in rural areas are approximately 2.5 to 3 times more likely to be poor than White rural residents (Joliffe, 2004). The other significant grouping is found in the Southern Highland counties, more commonly known as the Appalachian region, whose residents have a unique ethnic identity in the United States (Beale, 2004).

Mapping a community can illustrate social vulnerability within its populations. Morrow (1999) discusses factors, such as race and poverty, that can make a population more vulnerable to risk from natural disasters in U.S. society. Morrow contends that identifying these populations within a community can facilitate planning for service provision. In addition, mapping the residence patterns of the impoverished can draw attention to environmental factors that could be obstacles to success for marginalized groups. In some rural

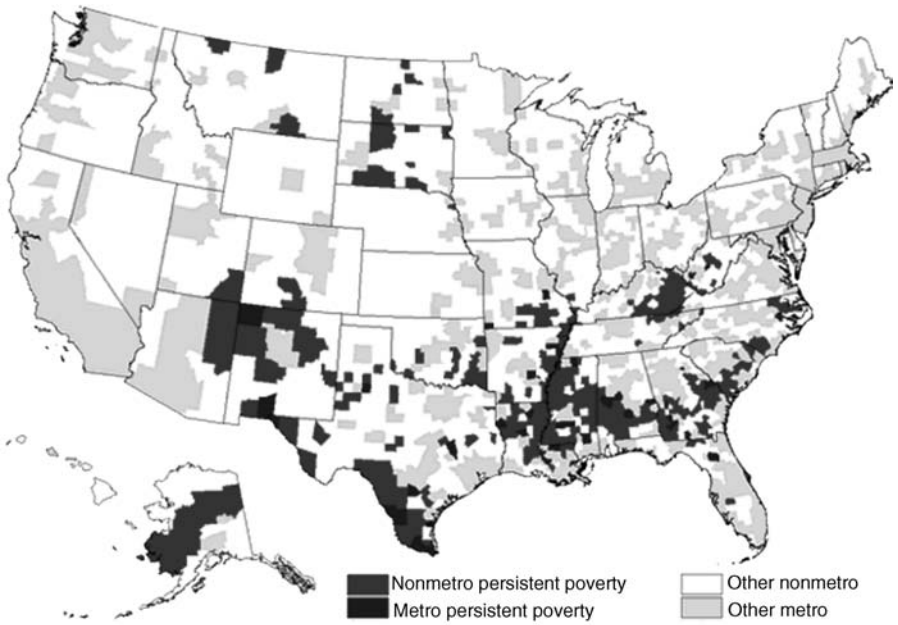

Figure 18.1 Persistent poverty counties in the United States, 1970–2000.
Source: Economic Research Service, USDA, 2012.

communities, people in poverty are exposed to environmental hazards, such as nuclear power plants or waste disposal sites, that compromise healthy living.

Changing Populations

Many rural communities are experiencing shifts in the age distribution of their residents. This is a two-pronged problem. First, rural America is experiencing a growing population of older adults caused by many older Americans who are aging in their home communities and by those who have moved to a rural community in their retirement (Johnson, 2006; McLaughlin & Jensen, 1998). Second, many of the younger residents of rural communities are moving away for either educational or career opportunities (Johnson, 2006; Smith-Mello, 1996). As more rural youth attain higher levels of education, rural communities are experiencing a phenomenon called *rural brain drain*, as better-educated rural residents move to metropolitan areas (Weber, Marre, Fisher, Gibbs, & Cromartie, 2007). This phenomenon leaves communities with a declining workforce as older persons retire and there is no younger generation to step into the jobs. A shrinking workforce can make it difficult for communities to provide adequate social services, attract new industries and businesses, and maintain social support networks.

On a hopeful note for rural area populations, there has been a significant increase in the number of racial and ethnic minority group immigrants to rural areas. Almost one-third of the population increase between 2000 and 2004 in rural areas was a result of immigration (Johnson, 2006). Furthermore, recent immigrants to rural areas tend to be between the ages of 18 and 64, with approximately 75% of adult immigrants being married (Jensen, 2006). Immigrants often have children once they are settled into their new communities, thus adding to the rural population growth (Mather & Pollard, 2007).

There is, however, a significant area of concern regarding immigration to rural areas. Recent rural immigrants are very likely to be undereducated and impoverished. The types of employment, particularly farm work and in manufacturing and processing plants, that are typically available to immigrants may not be sufficient to pull these residents out of poverty (Jensen, 2006; Mather & Pollard, 2007). Kim and colleagues (2012) found that mapping the needs of Korean American immigrants in Chicago highlighted needed changes in the social services being provided. Programs that had been providing services to immigrants since the 1970s and 1980s needed to adapt to changing demographics, including more geographically isolated older adults. GIS technology, coupled with Exploratory Spatial Data Analysis, helped provide new insight into immigrant settlement and economic patterns. This same type of assessment would be useful in rural communities that struggle to understand the needs of new immigrant residents. A more simplistic, but perhaps equally beneficial, use of GIS with the immigrant population might be the creation of a series of location-based maps that highlight key locations in the community. Maps could be developed that focus on community assets such as social services, social supports (e.g., churches, recreational groups), and basic goods and services. New residents could use these maps to help them become acclimated to the community and to help them access community resources.

Accessibility of Goods and Services

The accessibility of goods and services is often a critical issue in rural communities. Social service organizations may themselves be a challenge for community residents. In rural areas, social service providers can be geographically spread, causing undue hardship on those with limited transportation, time, or other resources that grant them access to full participation in social services. Mapping the location of services within a community may help identify a location that is accessible to the greatest number of potential clients who could benefit from the development of a new service site.

Moving beyond the boundaries of the local rural community, residents face even greater difficulty in meeting their needs. This may mean that people simply do without. Chan, Hart, and Goodman (2006) found that rural residents often forego recommended specialized medical care that requires travel. In a recent study, Gjesfield and Jung (2011) utilized GIS to analyze the distance that expectant mothers must travel in rural North Dakota to receive hospital care. Their research documented the considerable distances (more than 40 miles) that more than 17% of women had to travel. This study illustrates two factors—health care access and transportation needs—that are common challenges in rural communities. Similarly, food deserts are a challenge in some rural communities, and GIS has been used to identify and provide supporting evidence of this problem. In an analysis of 36 rural counties in the

Mississippi River Lower Delta, Kaufman (1999) used GIS to measure food accessibility. He found that low-income households utilizing food stamps have less access to large food retailers, resulting in higher food costs and reduced selection.

GIS can streamline the process of connecting rural residents to services by allowing social workers and community members to visualize barriers to community assets. Transportation barriers that often isolate residents from community resources can be the focus of a GIS map used to identify and improve public transportation routes. For example, one possible approach would be to identify routes from residential areas to anchor institutions, such as a community center or school. The presence (or lack) of sidewalks and bike paths may reveal alternative transportation options. By creating a community that is pedestrian-friendly, residents without vehicles may be better able to access services. A map could also be used to advocate for in-community support programs or services. Identified needs can be coupled with community assets, thus preventing duplication of efforts and helping communities and agencies plan new or expanding programs to be located in areas where they will do the greatest good. Furthermore, by pinpointing the placement of grocery stores and their availability to residents, community developers could strategically target advocacy needs and utilize community assets, such as local farmers, to address the deficit.

TRACKING SERVICE UTILIZATION AND CHANGES

Once social workers are familiar with the needs of their service population and have identified local challenges and assets, GIS can be used to track service utilization and changes in their communities. Mapping social service utilization also allows social workers to find gaps in provision and ensure that they are not inadvertently underserving vulnerable population groups. Agency records can be used to track service utilization. Data can be drawn from intake and other forms to create GIS images of client demographics, residency patterns, income levels, needs, and assets. The GIS images created from agency data can be compared to data from the larger population to determine whether any underserved groups exist. For instance, if a significant portion of a service area is Hispanic, but an agency within that area has very few Hispanic clients, it could indicate that a barrier to service exists for this population.

GIS mapping can also be used to determine the effectiveness of interventions. By creating a GIS image of assets and challenges before and after a community development project, social workers can track the scope and impact of their efforts. Have the assets increased in size or number? Have the challenges decreased as intended, or instead moved to a different location within the community?

Analyzing changes within a community over time creates a guide for understanding the community. A baseline measurement allows social workers and community managers to see the community in a neutral state without intervention. Community agents can then implement changes and determine progress toward goals. Tracking allows interested parties to see what challenges may lie ahead in order to prepare for specific situations and to continually refine strategies to better meet new or transformed challenges. Lastly, tracking the changes in a community can be a powerful tool to encourage to community leaders to build on successes.

GIS AND POLICY

GIS can be used to help social workers advocate for policies and programs that serve the needs of rural residents. Policy development and implementation should take into consideration a variety of information, input, and system levels when considering which actions to take. Some past policy efforts have failed to consider the long-term impact on people, communities, and/or the natural environment. Intervention efforts and policy should be developed based on a thorough understanding of the dynamics occurring in rural areas. However, policy can often be short-sighted or implemented in times of disarray without a proper analysis of the assets and challenges of an area. This can be especially true for rural residents who have to combat political actions that are based on the needs and desires of constituents in urban areas. Rural communities seeking to improve their opportunities need to have a reasoned and clear voice in policy development and implementation. To do this, they must identify the subsystems that exist within the larger community system (i.e., education systems, racial/ethnic minority populations, and faith communities). Understanding the relationship between the system and subsystems is critical to tapping into underutilized resources that will benefit the community.

The spatial analysis and data presentation tools of GIS mean that it is an ideal tool to generate information that can be directly used to formulate policy and program change (Ghose & Huxhold, 2002). For example, education systems are highly politicized in both rural and urban areas, but the frequency with which school consolidation and closure occurs in rural communities intensifies its politicization. School consolidation is often a referendum decision and is voted on by affected community members (Farmer, 2009). Maps can be a powerful illustrator of the effects of school consolidation and can allow voters to see a visual representation of the impact of such a decision. An effective use of GIS technology would be to map each school's current school district, its associated travel times, and collaborative institutions (such as libraries and businesses frequented by students and parents). A second map can forecast the changes in school district geographic area, travel times, and collaborative institutions. Allowing voters to see the potential effects of their decision to consolidate schools can give them the opportunity to make a more informed decision.

Using GIS in Rural Policy Work

Because of the rapid growth of GIS technologies in the last few years, data is readily available on the Internet from government sites, universities, and corporations. Users must first consider the purpose of the map and the availability of the desired data. The U.S. Census Bureau provides free GIS data and has integrated free mapping software onto its American FactFinder site. Utilizing data from the census and other sites, it is possible to make *thematic maps*. Thematic maps, such as Figure 18.2 , illustrate the spatial or geographic distribution of population characteristics or other aspects of interest (e.g., agricultural use). Using free mapping sites, such as Google Maps, *reference maps* can easily be made (see Figure 18.2). Reference maps show boundaries, names, and/or the geographic location of features.

When using GIS to create visualizations of data, individuals need to identify, prior to construction, the boundaries of the map. These boundaries include both depth and breadth—

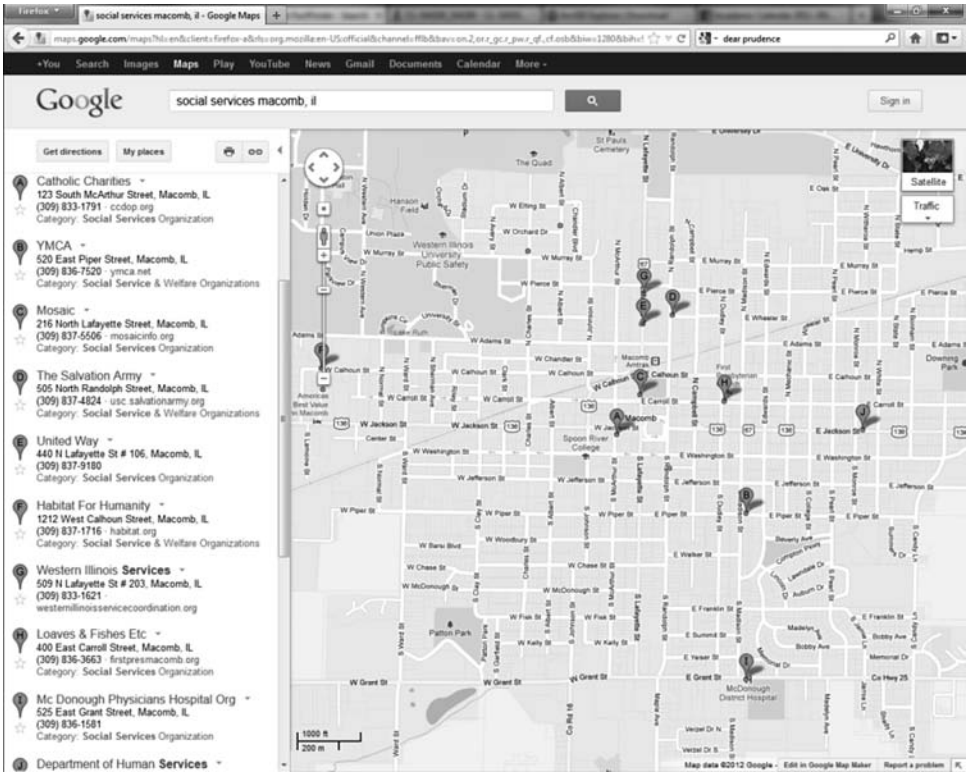

Figure 18.2 Screenshot of sample reference map created using Google Maps.

the level of detail being conveyed and the outer constraints of the map. This is particularly relevant when trying to use GIS maps to influence policy development. For example, a rural town trying to convey its isolation from necessary resources and the corresponding transportation needs should think carefully about the outer limits of the map. If the map is constrained to the town's boundaries, stakeholders would be unable to fully understand the challenges that residents face accessing resources. If the map is pulled out to the state level, the emphasis on the distances between service providers and clients may become too abstract to make an impact. A map that clearly delineates the town and the surrounding communities that have the needed resources might best convey the message of distance and need.

Protecting personal information is critical to ensuring the confidentiality that builds confidence in social work relationships. It is imperative that when mapping social service use, attention is given to removing any information that could inadvertently identify an individual's personal information, especially if the products of GIS mapping will be made available to the public or used outside of the social work setting. This is particularly important in rural areas, where the small population size may make it easy for community members to ascertain identities. Depending on the purpose and topic of the map, it may be

necessary for smaller groups to be pooled together in order to protect participant anonymity. For instance, an agency may indicate the number of individuals in an area with a need for disability services instead of identifying the specific types of disabilities reported.

Populations can be better understood by identifying demographic data. Demographic data describes the characteristics of specific groups or individuals, including age, race, ethnicity, religion, and sexual orientation. It can also include such factors as income level, educational attainment, homeowner status, and employment. These data are important for several reasons. Minority status could make some individuals or groups vulnerable to discrimination or even violence. In contrast, group membership can also be a source of personal identity. For individuals with minority status in a community, belonging to a group that shares the same minority characteristics can be a source of support and strength. Understanding population characteristics in a social worker's service area can allow social service providers to tailor their services to meet the needs of all groups, including those of minority status. It can make social workers aware of community members who may have little power or voice to effect change. Social workers can provide the support that unique populations need and are entitled to only if they know these groups are a part of the community. By identifying population characteristics in a service area, social workers can work toward inclusiveness in their home communities.

Contemporary social workers can follow the example of their predecessors by thinking critically about their service area. Demographic data combined with an overlay of educational attainment or income level is a good starting point, and this information can inspire curiosity in other combinations of community data. Consider other intersections of important data: veteran status and substance abuse; housing status and educational attainment; age and access to transportation; disability and handicapped-accessible public spaces; households with children and safe play areas; public transportation and access to secondary education; vacant buildings and crime statistics. Having accurate information about the population within a service area is the first step toward understanding the unique characteristics of the populations served and creating and implementing effective interventions.

PARTICIPATORY GIS

A participatory approach to policy advocacy and capacity building dovetails nicely with the potential of GIS technologies. Like participatory action research, which promotes change through the actions of oppressed peoples (Healy, 2001), participatory GIS facilitates community involvement and group decision making in prioritizing spatial planning (Dennis, 2006; Elwood, 2006, 2011; McCall, 2003). Members of groups most often excluded or underrepresented can be targeted to participate in the planning process, encouraging greater buy-in and empowerment (Hillier, 2007). GIS influences how people think about needs, and the inclusion of qualitative data to GIS research allows residents to share their own narratives about their communities (Dennis, 2006). McCall (2003) argues that participatory GIS has considerable potential for examining issues such as poverty and discrimination in rural communities. He further suggests that participation must be fundamentally tied to the use of GIS in order for it to empower, rather than exploit,

local people. This type of participatory research involves engaging participants throughout the entirety of the project, including the provision of education that is necessary to understand GIS technology and the research process.

Participatory GIS that engages diverse community stakeholders naturally complements the goals of an asset-building community development model. The value of local knowledge, and the donation of time and energy by community members to this process, should not be overlooked as an important community asset. It is common practice in asset building to utilize neighborhood asset maps and capacity inventories to gather information about existing assets within a community. Hillier (2007) notes "while this process of inventorying community resources does not necessarily involve literal mapping, GIS has been used to facilitate such inventories" (p. 212). A natural progression is to use GIS mapping tools to overlay these assets onto a map of the community. Analysis can be done to help community members better understand the location of assets in relation to each other, their accessibility, and areas of the community that may benefit from increased attention. Creating asset maps and capacity inventories throughout the process will also allow stakeholders to ascertain where gaps exist in community involvement. Pinkett (2003) reviewed the importance of community engagement with asset-based community development and the "exploration of assets" as a useful component of the process at a low-to-moderate housing development. Maps of the study catchment area highlighted the potential value of mapping as a way to identify the location of critical assets.

Conversely, the value of participatory GIS can be realized when advocating to political leaders and policy makers. A years-long grassroots campaign in Hurricane Katrina–affected New Orleans highlights the potential of GIS technology in advocacy work. Churches Supporting Churches, a coalition dedicated to redevelopment needs of the socially and economically vulnerable populations of New Orleans, utilized GIS technology in its campaign to help policy makers understand the needs of residents.

If policy decisions are typically made at a larger scale than the local community, then GIS has the potential to help community members bring that scale down through using "community driven data collection at the neighborhood scale" (Duval-Diop, Curtis, & Clark, 2010, p. 46). Data from this neighborhood level allows for people's voices to be heard and for the needs of less politically connected neighborhoods to not get lost in city-scale planning. This same technique of managing the scale of the data would be beneficial for rural areas, whose unique perspectives often get overshadowed by discussions of larger cities and statewide policies.

CHALLENGES WITH GIS

As with any technology, cautions should be noted when using GIS. It can be challenging for communities or organizations to acquire GIS software or to have the time to gather and manage the data (Dennis, 2006; Ghose & Huxhold, 2002). However, sophisticated software is not always necessary to take advantage of the benefits of mapping. Some small communities may be able to collect data and color-code maps or create reference maps by hand. For rural communities that do acquire GIS software, few social workers may be available or

willing to learn the technology, and those who do will have to incorporate its use into an already full schedule. Even if an organization has the staff and technology available, access to data can be limited, and data accuracy is not ensured.

Government agencies often control access to data, and if they do not view community organizations as important partners in planning, they may not feel the need to collaborate freely with the community (Ghose, 2011). This can increase costs and cause further delay as additional time and resources will be needed to obtain accurate, usable data. In addition, McCall (2003) discusses the challenges in accessing "protected or confidential" data, such as sites for hunting and traditional cultural boundaries, that the owners may not want to disclose for inclusion in a mapping project. In addition, data for rural areas, particularly for the smallest towns and villages, may simply not exist. For example, the American Community Survey administered by the U.S. Census Bureau is conducted on a yearly basis for communities with populations of 65,000 or greater, every three years for communities of 20,000 or greater, but only once every five years for all areas (American Community Survey Office, 2012).

Once appropriate data is obtained, additional care must be given to presentation. GIS can create visually pleasing maps that can easily be changed due to the ability to switch layers; the flip side is that presentation may trump substance (McCall, 2003). The abundance of free data and the ability to create multiple layers of mapping can result in misleading or unclear information. Without a clear vision of what should be included, the map may be crowded, visually unappealing, and lose the central message. Furthermore, GIS uses *layers* of data to build maps. Multiple layers of data allows for the presentation of multiple viewpoints. Although the ability to present multiple viewpoints through multiple layers of data is a strength of GIS (McCall, 2003), multiple layers can cloud the viewer's perception of the issues.

Moreover, there needs to be an awareness of the potential for its misuse. As with any tool, GIS products may be manipulated to reflect the goals of those who control its use. Participation in spatial planning may be driven by different agendas, and empowerment of marginalized groups may be overlooked to instead serve the desires of those with political connections (Ghose, 2011; McCall, 2003). Social workers who become proficient in GIS must take care that they do not unintentionally disempower marginalized groups. Care should be taken to neither monopolize the technology nor use jargon that shuts out community members, but to instead work in partnership with community residents. Additional turmoil can occur when people disagree about what to prioritize or select projects they think will be well received instead of staying committed to actual community needs (Elwood, 2006). Finally, in the social service field, GIS analysis may be viewed as "predeterministic and quantitative in nature" (Kim et al., 2012). Social workers may shy away from its use, not realizing that GIS can be coupled with qualitative data to provide a richer understanding of the environmental context.

CONCLUSION

The use of GIS data and technology is becoming more common, both in the United States and worldwide. While other professions are utilizing the benefits of GIS technology, social workers have not yet fully integrated GIS imaging and spatial analysis into practice. GIS

is not a panacea to the challenges of identifying assets and establishing sound policy in rural areas, but it is an effective tool that can be used to create strategic plans, identify vulnerable groups, and recognize opportunities to help rural communities achieve their goals. If rural America does not want its assets and needs discounted, then stakeholders must learn to employ this valuable community engagement and planning tool. Social workers, through their community building skills, connections with area agencies, and commitment to social justice, can take a leadership role in bringing GIS to the rural community.

Discussion Questions

1. Imagine that you are a single head of household with three children under age seven. Your case worker has provided you with a GIS map of your town. What features do you hope he or she has included in your map? What features would you hope to see if you were physically handicapped? If you were working through substance abuse? If you were a non-English-speaking resident? If you had a mental illness?
2. Social workers must often justify the funding of social services. In what ways could a GIS map help in doing so? How would you change your map to best convey information to local public officials? Business owners? Farmers? Youth? Other groups?
3. Some rural areas are suffering from loss of population. How can GIS be used to highlight rural areas' attractions and draw residents?
4. In order to be useful, a map must be seen. What techniques can a social worker use to publicize a useful image that he or she has created? Who might be interested? How can a social worker generate interest?

Classroom Activities and Assignments

1. Imagine you are the Social Service Liaison on your county board, and you will be hosting an informational booth at the county fair. You want to provide a comprehensive map of your county's social service agencies to visitors of your booth. Using Google Maps, create a map of the social services that are provided in your county. Has your map illustrated any opportunities to identify underserved populations?
2. Select a rural town in your state. Imagine you are a service provider for the homeless population in this community. A client has recently become unemployed and homeless, and she is in need of shelter, food, and clothing. Find the nearest emergency homeless shelter that accepts families with children. Identify food and clothing pantries, as well as the nearest unemployment office. Create a map for your client that includes public transportation routes. Is your client able to reach each destination via public transportation?
3. Your City Council wants to draft an ordinance that would allow the establishment of a factory in the part of town that is zoned for manufacturing. The factory is expected to employ 100 people. Create a map that can help the City Council draft an ordinance that would best serve the community. Things to consider: transportation routes for heavy trucks; increases or decreases to property values; impact zones for noise; and the demographic characteristics of the residents at distances of one-half mile, one mile, and two miles of the factory.

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PART FIVE

Using Research to Evaluate Practice in Rural Settings

Dennis L. Poole

Capacity building and research go hand in hand. Knowledge generated through research informs asset-building processes, heightens sensitivity to local perspectives, improves the accuracy of assessments, and enhances the potential to achieve outcomes in policies and programs through stronger social networks. Research is not the only source of knowledge, but unlike intuition and practice wisdom, research generates knowledge through systematic observations and scientific methods.

Social workers have contributed significantly to research in rural communities. Still, we owe a great historical debt to rural sociologists, the first social scientists to study rural community as a shared way of life. They contributed to decades of research on rural community development processes, laying the early conceptual foundations of asset-based development.

Research begins by asking people the right questions. Typically the questions are related to accountability: What services do people want and need? How should a program be designed or strengthened? Do clients benefit more from one program than another? Are outcomes achieved efficiently? Community leaders usually ask broader questions—about future sustainability, for example. We must respond to these questions even though they do not fit neatly within the particular service domain of our agency. When building capacity, the rural social worker is a jack-of-all-trades.

Research questions usually flow from problem statements. This is not surprising. Many professionals have been taught that the purpose of research is to help people solve complex and difficult problems. But putting human problems at the starting point of research reinforces the tendency to view rural communities from the perspective of deficits.

Chapter 19, by Susan Murty, focuses on the use of an assessment framework for rural research. Diverse methods are discussed, along with challenges, such as the reluctance of residents to discuss needs and issues with outsiders. To succeed, Murty recommends that we utilize participatory research approaches that embrace the community as a full partner, foster community trust and ownership, and involve local citizens throughout all or most phases of the process. Mapping the assets of a rural community is a good way for us to begin. Murty

also emphasizes that obligations and responsibilities come with research. As researchers, we must give something back to the community to increase its assets rather than merely enhance our own portfolios.

One of the most effective participatory action research methods is concept mapping, especially when used in combination with software available at Concept Systems, Inc. in Ithaca, New York. William Trochim, the genius who originally developed the software, calls it "hard art." Chapter 20, by Tamara Davis and Steve Cooper, describes the use of concept mapping as a strengths-based approach to assessment, planning, and evaluation. Two case examples illustrate the use of concept mapping—and the software—in rural areas. One case focuses on the development of a strategic plan to improve health and behavioral health services, and the other case on the definition and assessment of cultural competence in a children's mental health system of care. The authors consider both benefits and challenges of using concept mapping in rural areas.

The final chapter, Chapter 21, contributed by Cal Streeter and Steve Cooper, demonstrates the use of social network analysis in rural research. They begin with an example of a personal or informal social network that provides help from neighbors and friends in a crisis situation. They introduce the basic concepts of social network analysis, and then provide graphic models to help us visualize the flow of resources and information between actors in social networks. Rural social networks, they observe, are usually easier to develop and manage, because they tend to be smaller and denser than social networks in urban communities. Streeter and Cooper provide an example of social network analysis in the Safe Schools/Healthy Students Collaboration. With a strengths-based perspective, collaborators utilized social network analysis to assess structural relationships between community actors early in the project. Strategic efforts eventually strengthened the capacity of these networks to promote healthy child development, prevent violence and drug abuse, and create safe school environments.

Professional education equips social workers with knowledge and skills in research. Here we emphasize that the chief end of research in asset building is to serve as a catalyst for community action. Our primary role is not to conduct research on rural communities per se, but rather to facilitate participatory processes that generate knowledge for capacity building purposes. The findings should cry out for community attention and action.

CHAPTER 19

Using an Assessment Framework for Research in a Rural Context

Susan A. Murty

Many rural social workers have contributed to our understanding of rural communities based on practice experience and anecdotal evidence. Nevertheless, research is necessary to confirm what has been reported, determine its validity, and add to our understanding. Research will help us identify the strengths and assets of rural populations and communities, become aware of their needs and concerns, evaluate the success of social work practice interventions, and develop recommendations for policy and practice in rural communities. To be sure that we are providing services that meet the needs of rural communities, we have a responsibility to carry out community-based research and use the results of research with rural populations and rural communities.

This chapter discusses types of rural research and the challenges you are likely to encounter in carrying out rural research. It argues that successful rural research is grounded in an understanding of rural community assets and strengths. Examples of rural social work research that draws on community assets are provided for readers, so you can get ideas about how to design a rural research project.

RURAL RESEARCH LITERATURE

Unfortunately there is not enough research on rural populations and communities to ensure that rural practice is using the strengths and capacities of rural communities and meeting their needs. There are many reasons for the scarcity of rural research. Because fewer people live in rural areas than in urban areas, some people consider rural communities less important just on the basis of population size alone. Another issue has to do with sampling. A random sample of the population of the country as a whole or a state or large region results in more urban than rural participants. Therefore, less information about rural residents is gathered from random samples. This problem can be overcome by oversampling residents of rural areas and using statistical methods to analyze the data, even though it requires some effort. In addition, there has been a tendency to apply urban models of practice to rural areas, rather than to examine how well these methods work in the rural context. This "urban paradigm" has discouraged research on rural social work practice (Slovak, Sparks, & Hall, 2011).

Defining Rural

An additional factor that has made rural research challenging relates to defining what is rural. Surprisingly, the rural variable has been difficult to operationalize. This has been especially important in research using existing data sets and research carrying out large-scale questionnaire and survey studies over large geographic areas. In these studies the results gathered from rural and urban areas are compared. Over the years, different definitions of rurality have been used. One approach has been to use dichotomous definitions dividing geographic areas into two categories: rural and urban. For example, the U.S. Bureau of Census has used two dichotomous variables: metropolitan versus nonmetropolitan areas (referring to counties), and urban and rural places (referring to places with populations of 2,500 or more and places with less than 2,500). Unfortunately, in some research, comparisons are made between rural and urban residents or counties, but the definition of rural and urban used is not included. In such cases, it is common that the metropolitan/nonmetropolitan variable is used to identify "urban" and "rural" counties (Dimah & Dimah, 2004).

It is evident to most people familiar with rural areas that assigning places and people to one of two categories, rural and urban, is problematic. Rural and urban places are actually on a continuum, and particular geographic areas can be located at various points between the two extremes. For example, a small town in Iowa would be located somewhere between the most urban (e.g., New York City or Los Angeles) and the most rural places (e.g., a remote Alaskan village or a remote ranch in Montana). Assigning places to one of two categories, urban and rural, can be very misleading. For example, a metropolitan county in Nevada will be identified as urban because there is a large metropolitan city located in it, but the county is actually made up almost entirely of extremely rural areas and places with low-density population.

To avoid using a two-category variable, various methods have been developed to assign values on the rural-to-urban continuum as a continuous variable. For example the U.S. Department of Agriculture has developed Urban Rural Continuum Codes ("Beale Codes"), which rate counties on an ordinal scale between zero and nine (nine being the most rural). They have also developed Urban Influence Codes for counties and Rural Commuting Area Codes (RUCA Codes), which identify census tracts on an urban-to-rural continuum (U.S. Department of Agriculture, 2012a). All of these codes can be used in research comparing data collected from different points on the urban-to-rural continuum. Dahly and Adair (2007) have proposed a new scale of "urbanicity" that ranges from urban to rural. According to Keller, Murray, and Hargrove (1999), "research methodology should be encouraged that moves away from simplistic conceptualizations of rural or urban and toward better conceived and better measured models of rurality" (p. 319).

Diversity in Rural Research

In addition, the diversity of rural areas makes the problem of studying rural areas even more complex. Although urban areas are becoming more alike as urban culture and centralization of the economy spread throughout all regions of the United States, rural areas still tend to retain unique differences. Different types of rural areas have been identified as "frontier," "remote," and "island" (Gray, 2011; U.S. Department of Agriculture, 2012b). There is a great deal of

diversity in rural areas, including a range of diverse populations that vary from region to region. For example, some regions have many rural Native Americans, whereas others have more rural African Americans. Latinos are now a growing population throughout the rural regions of the United States. Even in a region like the Midwest, there are growing numbers of refugees and immigrants, as well as a variety of religious and cultural minority groups, in rural areas.

Although many researchers agree on some general characteristics of rural areas, it is misleading to characterize rural areas as if they were all alike. Rather than combining data from large numbers of areas that can be defined as rural, it makes sense to carry out studies of a variety of particular rural communities. Although there are differences of opinion about what exactly is rural and what is urban, it is still possible to study communities that would be generally identified as rural and learn about their characteristics.

RURAL RESEARCH METHODS

General research methods can be applied to research about rural communities and populations. Examples of useful research methods include:

- Analysis of existing data archives, such as census data and data available from state agencies
- Surveys (which gather data using questionnaires and interviews)
- Qualitative, phenomenological research and ethnographic research, which gather data using observations, in-depth interviews, and other qualitative research methods (Aisbett, 2006)
- Focus groups, which gather data from a small group of participants who respond to a set of questions (Krueger, 2009)
- Social network analysis (Ennis & West, 2010; Murty, 1998)
- Concept mapping (Streeter, Franklin, Kim, & Tripodi, 2011)
- Participatory Action Research (Moxley, Alvarez, Gutierrez, & Johnson, 2003)
- Program evaluation (Secret, Abell, & Berlin, 2011)

Research methods may need to be adapted to a particular rural community in order to produce valid results. Rather than using one standard research protocol throughout a large study area, it may be necessary to use local knowledge and an understanding of the context, strengths, and needs of a particular community. For example, Mitchell and Schmidt (2011) found that methods used in large-scale studies about drug abuse did not apply to a rural community they studied. Using a panel of youth, they adapted a survey to be responsive to the context of the community, and the results they obtained were distinct from patterns that were prevalent in surveys of metropolitan regions.

Challenges to Rural Research

When conducting research in rural areas, researchers are likely to encounter several barriers. Many rural communities are suspicious of outsiders (Quandt, McDonald, Bell, & Arcury,

1999). They may avoid participating in a formal research project, especially if it is planned by outsiders who represent formal agencies from outside the community. In some cases, rural communities become frustrated and avoid participating in repeated studies that do not appear to result in any benefit to the community (Berardi & Donnelly, 1999; Shore, 2006). An additional concern that is especially important in rural areas is protecting confidentiality. In rural communities, residents tend to know a lot about each other, so special efforts need to be made to protect the privacy of participants in research (Mitchell & Schmidt, 2011).

Another issue is that rural residents are often loyal to their communities, and they hesitate to discuss their needs, problems, and deficits with outsiders. This is one of the reasons why it is important to acknowledge and highlight the strengths and assets of a rural community as you do your initial work.

Rural communities often neglect or ignore groups of residents who are different from the dominant culture of the community. Rural residents may exclude members of minority groups from the social networks of the community, or even deny that such groups exist in their community. You will need to spend enough time in the community to identify its minority groups and also to assess their assets and strengths.

For all of these reasons, small community-based studies using qualitative and ethnographic methods, interviews, and focus groups have been recommended for rural research; these methods allow the researchers to make contacts, collaborate with local community members, and develop the trust of the community before initiating research (Chadiha et al., 2004). Research methods have been recommended that involve local citizens in the research process and that draw on the strengths and assets of the community.

Participatory Action Research is recommended in particular because it develops research objectives and methods alongside members of the local community (Blair & Minkler, 2009; Shore, 2006; Slovak et al., 2011). The results are shared with the community and used to achieve its goals. In order to carry out this type of research, it is necessary to identify the assets of the community, develop the trust of local community members, leaders, and stakeholders, and build partnerships with them. This type of approach is likely to overcome some of the barriers that researchers encounter in rural communities, such as distrust, suspicion, and concerns about confidentiality. When the community feels some ownership over the project, many of their concerns are lessened as you "embrace the community as full partner in the research process and empower better translation of research into application" (Slovak et al., 2011, p. 436).

Strengths of Rural Communities

Although there are challenges to conducting research in rural communities, there are also positive characteristics that are typical of many rural communities and that assist in community-based research. A typical needs assessment approach might miss these important community strengths, such as the following:

- Rural communities often have tightly knit, dense social networks in which people know each other in multiple ways.
- Many rural communities have a tradition and perception of communal responsibility (Martinez-Brawley, 1998).

- Many rural communities advocate the motto "We take care of our own." Rather than sending people to specialists and counselors, rural residents often help each other out in informal ways.
- Many rural communities have strong local organizations and institutions. Once you get to know them, you will be surprised how much they do in the community.
- Informal groups provide valuable support for and influence over residents of rural communities.
- Most rural communities have a few easily identified active community leaders.

Community leaders spearhead many of the community's activities and projects. They usually have multiple roles in the community, holding both formal offices and informal leadership roles in clubs and organizations. If the rural social worker can identify them and establish a relationship with them, then these leaders can be valuable community partners. They can influence community members to consider new ideas, participate in new projects, and integrate members of diverse groups into their activities (Shore, 2006). Developing your research plan in partnership with the community and its leaders helps ensure that your research will be a success (Berardi & Donnelly, 1999).

Successful rural community-based research is based on a foundation of learning about the strengths of a rural community before beginning a research project. This is known as *mapping the assets of the community*. The challenge of mapping the assets of a rural community and learning about its strengths is that each rural community is a little different. Urban communities tend to have a fairly predictable set of formal resources, but each rural community tends to be somewhat unique, and its resources may be more hidden. In the next section, you will learn how to identify some of the assets of a rural community. In order to apply what you learn, you will have to spend some time in a particular rural community to discover its assets. Mapping rural community assets takes time. It cannot be done from your armchair or in front of your computer. It requires local visits, observation, and interaction over a period of time. Procedures for mapping community assets are presented in the next section.

MAPPING THE ASSETS OF A RURAL COMMUNITY

The goal of asset mapping is to find out the strengths of a particular community. Who are the strong community leaders? What organizations get things done there? Where do people go to discuss things and get help with problems? What resources are available and where are they? This approach is an application of the strengths approach recommended by Saleebey (2002) applied at the community level. It is based on an understanding that communities have the capacity to deal with their own problems and to assist individuals and families who live there when they need help. To be consistent with this approach, rural research should be carried out in partnership with community members and building on the capacities and assets that already exist in the community.

To locate community assets in an urban community, you might start by studying the phone book or a directory of social services. For example, the United Way often publishes a

list of the social services that they fund. Or you might go to an organization that provides information and referral and ask them about the resources and organizations. However, in rural communities, it is not so easy. There are fewer formal organizations. There may be many resources and assets, but it is not obvious what they are. They are likely to be informal, and there may not be any lists you can refer to. You will have to work a little harder to find the assets. If you take on the challenge, it is kind of like a treasure hunt to search for the assets of a rural community.

To identify local associations and institutions in a rural community, talk to local citizens, leaders, and residents. In this way you can get in touch with the network of connections that underlies a neighborhood (Kretzmann & McKnight, 1993). In this way you can uncover what Wilkinson (1991) calls the *interactional community*. A wide variety of local associations can be identified, such as churches, neighborhood associations, sports leagues, study groups, collectors' groups, business organizations, and self-help groups. Kretzmann and McKnight (1993) emphasize that valuable assets may be informal:

> There are many associations that are informal groups without officers or even a name. However, they do vital community work. The fact that these associations don't have a formal name should not keep us from recognizing what a powerful community force they are. (p. 112)

The assets in a rural community can be mapped using a series of steps. It is often helpful to begin with a local newspaper. Most rural communities have a weekly newspaper that contains local community news that will help identify informal leaders and groups. A telephone book can also be helpful, although the current trend to include rural communities in large regional telephone books makes this resource less easy to use for this purpose. Also, it is important to note that many organizations are not listed in the phone book. Note that local businesses and employers may be providing resources. For example, it is not uncommon for feed stores, taverns, and beauty parlors to provide informal social support in rural communities. Look for local city and county services, such as a police station or sheriff's department, public library, senior center, the volunteer fire department, and the local schools. Look for community organizations and service clubs, such as the Rotary Club, the Lions, and the Elks. Note if there is a community center. Determine how many churches there are and where they are located. Try to identify informal groups that announce meetings and events in the newspaper.

Follow your initial assessment with visits to the community. Locate the sites that are to be found in most rural communities, such as the post office, library, city hall, firehouse, the churches, grocery stores, community center, restaurants, taverns, laundromat, bank, medical clinic, school buildings, cemetery, mobile home park, and area of newly constructed housing. Identify any historical buildings. Find out if there is a museum. Does the American Legion or the Veterans of Foreign Wars have a meeting hall? Visit the Chamber of Commerce and pick up any local information they have there. Look for a bulletin board where local people post notices and information. These are general suggestions, but be sure to search out the unique things that this particular community has to offer. Get into conversation with some residents and talk about the town, emphasizing the positive things you have noticed.

Search for the names of community leaders. For example, in one community in eastern Iowa, when I asked who would assist a family in need, I received the same name repeatedly from various members of the community and even from people outside of the community. They all named a woman who had been involved in setting up a local food pantry and was working with others to welcome and assist newcomers to the community. It was clear that I had identified a central figure who was an asset to the community. In fact, this woman was so busy, I had difficulty arranging to meet with her. I finally had to arrange to meet with her while she was volunteering at a local blood drive!

It is a good idea to expand your asset assessment by attending community events, such as the annual parade, the county fair, and any community festivals, celebrations, or open houses. Better still, volunteer to help with some of these events. Over time, you may be able to become acquainted with a local community leader who will serve as your "key informant" or "cultural guide" as you learn more about the community (Ungar, Manuel, Mealey, Thomas, & Campbell, 2004). As you become trusted and valued, you will be able to draw on more of the assets of the community to carry out research in the community. Although the community asset assessment is now being recommended for urban and suburban communities too, this approach is *essential* for successful community-based research on rural communities.

EXAMPLES OF RESEARCH STUDIES

The following summaries of rural research studies provide examples of how these research methods might be used to study rural communities. They may also help you think about how research could help inform your professional practice.

Analysis of Existing Data Sets

Dimah and Dimah (2004) carried out research analyzing state data that had been collected concerning elder abuse cases that had been investigated in counties in the state. Elder abuse cases were sampled from metropolitan and from nonmetropolitan counties in the state. More rural women in the study had experienced physical abuse, emotional abuse, and deprivation than the urban women.

Surveys

Gumpert, Saltman, and Sauer-Jones (2000) carried out research using a questionnaire mailed to rural social work practitioners asking about their experiences in rural practice. Open- and closed-ended questions were used to gather data about the kinds of work they engaged in and the characteristics of the communities they worked in.

Landsman (2002) surveyed employees in county offices of one state's child welfare program. The county rural continuum codes were used to compare counties at different points on the urban-to-rural continuum. Differences in characteristics of staff, specialization in practice, job satisfaction, and characteristics of the county offices were identified across the rural-to-urban continuum.

Interviews

Chadiha et al. (2004) used in-person interviews with caregivers of rural African American elders to determine characteristics of the caregivers. They found that when contacts with the elder were made in-person by local African American interviewers, they obtained more referrals to interview the caregiver than when the initial contact with the elder was carried out by telephone from a central office.

Focus Groups

Cochran et al. (2002) used focus groups to identify problems described by poor rural families living in poverty. Based on the results, these researchers made suggestions for improving services for families like these, which included improving community partnership opportunities and improving access to child care, housing, and medical benefits.

Social Network Analysis

Goldbarg and Brown (2010) used social network analysis to study the social networks of rural African Americans who were using drugs. The results identified differences between the networks of rural male and female drug users and suggested that network-level interventions might be effective.

Conceptual Mapping

Qualitative interviews were carried out by Ivanova and Brown (2011) to identify the point of view of Aboriginal foster parents about their own strengths. The results were then grouped using multidimensional scaling and cluster analysis to form a conceptual map of their perceived strengths. In the results, the authors highlighted the strengths that were unique to Aboriginal foster parents.

Participatory Action Research

Berardi and Donnelly (1999) carried out a study aimed at improving sanitation in an Alaskan village using Participatory Action Research methods. Native authorities and elders gave permission for the study, community members were included in planning and carrying out the research, including group interviews and community activities, and the results were provided to the village to assist them in planning and communicating with state and federal authorities.

Lewis (2011) used qualitative interviews and a Community-Based Participatory Research approach to study Alaskan Native elders' perceptions of successful aging. Twenty-six elders in six villages in Southwest Alaska participated in the interviews. The researchers obtained permission and agreement on the research question from the communities before beginning the project. Community members participated in planning and carrying out the research in ways that would be culturally appropriate. The results were

shared with the communities. The findings revealed the perceptions of the Alaskan Native elders themselves on what makes for successful aging. The results should be useful in understanding what will allow these elders to remain in their own homes and villages.

Program Evaluation

Butler (2006) used a mixed-method study to evaluate the Senior Companion Program in a very rural county in Maine. In addition to standardized scales measuring loneliness, depression, and social network participation, open-ended questions were used to gather data from clients and volunteers. Word-for-word quotes from the answers illustrated the positive impact of the program.

CONCLUSION

To contribute to research on rural community practice, you will need to study particular rural communities and identify their assets. You will spend time getting to know the community, its residents, its community leaders, and its resources, both formal and informal. Take time to develop trust with members of the community. Based on that foundation, you will be able to develop your research design and obtain community permission, involvement, and partnerships that will help with the project. By gaining access to the people who can provide the data you will need, you can utilize their assistance in adapting your research methods to the community and its culture. You will be able to work with local people as you carry out the research and focus on community issues that are important to the residents of the community. The resulting research project will be an example of a community partnership.

However, along with the advantages of community partnership in community-based rural research, there come obligations and responsibilities. You need to treat your community partners as peers in the research process and respect the strengths of the community. You need to respond to the community's concerns about the research methods and share the results with them, as well as assisting the residents in using the information to benefit the community. To sum it up, you have an obligation to give something back to the community that has welcomed you and given you access. In that way you will contribute to the assets of the community you study and add to its strengths and capacities.

Discussion Questions

1. What can you learn about the assets of rural communities from quantitative data? Give some examples. What can you learn about community assets from qualitative data? What are the advantages and disadvantages of each?
2. Give examples of informal resources and assets you might find in a rural community. It is usually more difficult to identify these informal resources and assets than the formal ones. Why is that? Why do rural social workers need to know about these informal resources in order to do effective research in a rural community?

Classroom Activities and Assignments

1. List four communities that you know. Pick one that is very urban and one that is only moderately urban. Then pick another that is somewhat rural and one that is very rural. Next to each one, write a sentence identifying at least one characteristic that makes it either rural or urban from your point of view. After you have completed your list, find a partner in your class and compare your lists. Discuss your perceptions. Do you see rural and urban in different ways? What kinds of experiences have you had that may have affected your perceptions? In a large group or class discussion, compare your perceptions with other class members. See if you can develop a definition of rural or urban that you can all agree on.
2. Divide the class into groups to assess different rural communities. Using local newspapers and a phone book provided by instructor, identify as many of the formal and informal resources in the community as you can. Be sure to read the local news and "gossip columns" in the paper to make sure you do not miss anything. Compare the assets that your group found with the ones identified by the other groups. Discuss why they are different.
3. Divide the class into small groups. Take a field trip to visit a rural community. Each group will spend at least three or four hours and see what resources and assets it can identify just by driving or walking around, noticing things. Try to get into conversation with some people you meet. Give some thought to explaining who you are and what you are doing. Try to locate a bulletin board where people post local notices. Try a laundromat or bank. What kinds of local assets can you spot on the bulletin board? Buy a copy of the local newspaper. It may be a weekly paper. Go through the newspaper and identify clubs and groups that meet in the community. Note what community activities are scheduled. Based on what you learn, identify as many assets as you can. Try to find answers to some of the following questions:
   - What businesses are in town? What is missing? Can you tell if any of the businesses provide informal resources or support?
   - What informal groups, clubs, churches, and organizations are active in town?
   - What local government offices did you find? Is there a fire department? If so, is it a volunteer fire department?
   - Are there school buildings located in the community? Or do children travel to a consolidated school outside of the local community? Is there one school or separate elementary, middle, and high schools?
   - Where do people work? Do any large businesses employ people locally?
   - Where do people gather to chat?
   - What kind of housing do you see? Are there new housing developments? Trailer parks? Older homes? What is the condition of the housing? Are there better houses in one part of town and worse houses in another part of town?
   - Where can people shop in the town? Where do people go to shop for things that are not available in town?

- What can people do for fun in town? Is there a community hall or center that can be used for groups to meet and have celebrations?
- Can you identify any ethnic or racial or subcultural groups in the community?

After you have spent three or four hours in the community, meet with your classmates and compare notes on what you have learned. Discuss how you could use the data you have gathered to initiate a research project in the community.

4. In small groups, formulate a research question related to rural social work. Next, develop a research plan and methods for gathering data in a rural community to answer the question. Identify the local community assets and strengths that you will need to draw on to complete your research on this question. For example, who is interested in the research question in the community? Who will you need to get permission from? Who can help make the contacts you need in the community? How will you approach the people in the community to participate in the research study? How will you overcome distrust and suspicion of community members?

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CHAPTER 20

Using Concept Mapping for Assessment and Planning in Rural Communities

Identifying Capacities Through Participation

Tamara S. Davis and H. Stephen Cooper

A variety of approaches is available to assess and plan for human services in communities. Some approaches offer more research or expert-based paradigms. Others are more strengths- and grassroots-oriented. As we consider assessment and planning in rural communities, the latter are generally preferable to ensuring a sustainable impact. This chapter highlights the use of *concept mapping* as a specific strengths-based and community-focused assessment and planning approach. Two case examples are used to illustrate how concept mapping can be implemented in rural communities. One example illustrates an effort to develop a strategic plan for improving health and behavioral health services. The second illustrates how the method was used to define and assess cultural competence for a children's mental health system of care. Each of these efforts resulted in significant improvement in the service being delivered in these communities.

COMMUNITY ASSESSMENT AND PLANNING APPROACHES

Community assessment and planning most often involve the use of a variety of methods to gather essential information. For example, epidemiological approaches are essential to helping us understand health-related needs in geographically defined communities. Surveys are another common approach to assessing and planning for services in communities. Surveys are often designed locally to gather information through predetermined questions and response options. They may also utilize open-ended questions that solicit brief textual descriptions or narratives. Surveys may be offered in some form of face-to-face completion, with more being offered via online technology. Once survey or epidemiological data are collected and analyzed, researchers sift through the information and prepare

recommendations based on the findings. The entire process may or may not include key community stakeholders' voices at any one stage of assessment planning, implementation, analysis, or reporting. As a result, assessment findings may be placed in the context of literature and researcher expertise without a rich understanding of the data in the context of the specific community.

Strengths-based community planning approaches are characteristic of involving community residents and stakeholders throughout the assessment and planning process and focus on a community's assets rather than its needs. Kretzmann and McKnight's (1993) long-established asset-based community development model described elsewhere in this text guides communities in identifying and building on its assets. Ohmer and DeMasi (2009) describe a model of consensus organizing that utilizes community assets and residents in combination with external sources to organize and build capacity within a community. Similar to both of these models, concept mapping (Kane & Trochim, 2007) utilizes a participatory framework to involve community members in gathering information to assess, understand, and plan for action around a particular aspect of a community. The remainder of the chapter provides an overview of the concept mapping approach and offers examples of its implementation in rural communities.

OVERVIEW OF CONCEPT MAPPING

Concept mapping brings a group of people together in dialogue around an identified topic or issue and provides a structured way of gathering information while retaining the context of the group throughout the process (Concept Systems, 2001; Kane & Trochim, 2007; Trochim, 1989). The process is participatory in that community members are included from the initial planning stages through interpretation of the data. This level of community participation is critical to collecting valid information and interpreting it through a contextualized lens.

Concept mapping uses a mixed-methods assessment approach to understand ideas from multiple participants. That is, a qualitative research design is used in combination with quantitative analytic techniques. The method is flexible enough to incorporate a mix of data collection processes. The statistical techniques behind the method provide a way of structuring ideas gathered and examining how participants perceive the relationships among the ideas. The process also provides a means for tracking over time the impact of actions taken based on the information gathered.

Uses of Concept Mapping

Concept mapping has been used by many scholars as a useful method for engaging diverse populations, such as ethnic and racially diverse groups, geographically diverse groups, age-based groups, and sexual and gender minority populations. Some examples of the method's application across these groups include program planning and needs assessment (Johnsen, Biegel, & Shafran, 2000; Trochim, Cook, & Setze, 1994), program fidelity assessment (Shern, Trochim, & LaComb, 1995), and culturally related assessment (Biegel, Johnsen, &

Shafran, 1997; Davis, 2007). Herman, Onaga, Pernice-Duca, Oh, and Ferguson (2005) used concept mapping to explore community development in clubhouse programs.

Concept mapping has also served to engage youth in a variety of capacities, such as community assessment and development (Davis, Saltzburg, & Locke, 2010; Jones & Perkins, 2003; Ridings et al., 2008) and program development (Borden et al., 2006; Campbell-Heider, Tuttle, Bidwell-Cerone, Richeson, & Collins, 2003; Perkins et al., 2007; Streeter, Franklin, Kim, & Tripodi, 2011). Other efforts sought to gather youth perceptions of their experiences with psychotherapy (Paulson & Everall, 2003) and adoption (Ryan & Nalavany, 2003). The method has also captured youth ideas of strategies for individual development (Ries, Voorhees, Gittelsohn, Roche, & Astone, 2008) and coping with stressors (Chun & Springer, 2005).

The Concept Mapping Process

The concept mapping process generally follows six stages, as shown in Figure 20.1.

Stage One: Project Planning

This stage involves preparation of the assessment design. This process is similar to other participatory assessment planning efforts, including developing the specific questions guiding the assessment, identifying stakeholders and assessment participants, and making logistical arrangements for the assessment. A critical step to defining the assessment's purpose is

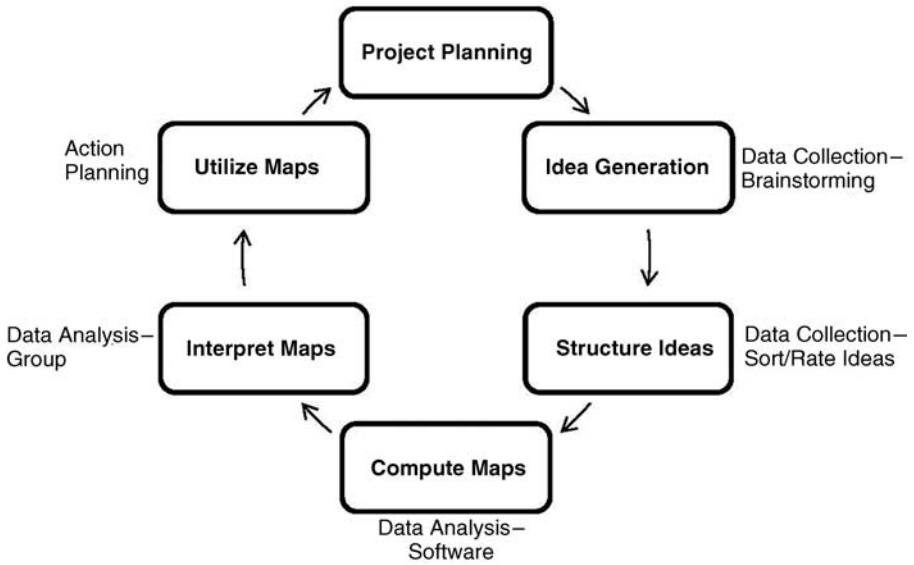

Figure 20.1 Concept mapping process for assessment and planning.
Data drawn from Concept Systems, 2001; Kane & Trochim, 2007.

developing a focus statement or focus prompt, as it shapes the process and outcome of the assessment and provides the foundation for the remaining stages of the process (Concept Systems, 2001). The focus prompt must be specific, action-oriented, and focused on the purpose of the assessment. Phrased as a sentence stem, participants will complete the focus prompt as if completing a sentence. For example, using a focus prompt from an assessment described later, participants were asked to complete the following sentence:

I know services to families are culturally competent when _____.

Stage Two: Idea Generation

This stage uses a brainstorming technique to facilitate the gathering of descriptive statements. Participants are asked to respond to the focus prompt by completing the sentence. A minimum of 30 to 40 and no more than 100 brainstormed ideas are recommended (Concept Systems, 2001; Kane & Trochim, 2007). If hundreds of ideas are generated, then the list needs to be reduced to a maximum of 125 ideas. Brainstorming can be conducted through a variety of individual or group, face-to-face or electronic approaches.

Stage Three: Structure Ideas

In this stage, participants are asked to individually sort the brainstormed statements by grouping them into piles in a way that makes conceptual sense based on the purpose of the effort. The sorting process is used to organize the information and give meaning to the data. Participants also use Likert-type scales to rate each of the brainstormed statements based on some predetermined criteria to give interpretive value to each statement. For example, participants may be asked to rate how important each idea is to building a cohesive community or how feasible it might be to act on a particular idea in the community.

Stage Four: Compute Maps

Several statistical analyses are conducted in stage four, producing graphical maps to represent the ideas. Multidimensional scaling (MDS) is the key analysis in concept mapping. This multivariate statistical technique was developed in the social sciences to examine societal structures (Davison, 1983). MDS creates a point map illustrating the underlying structure of how participants view the relationship between statements. Each person's individual sort is entered into the software to produce an aggregated conceptual map. A minimum of 10 to 15 sorters is required for a valid analysis (Jackson & Trochim, 2002; Trochim, 1993), although obtaining 35 sorters has shown to produce a more reliable map. The MDS analysis provides a goodness-of-fit measure called a *stress value* to measure the stability of the map. Stress values attained in concept mapping analyses typically range between .15 and .35, with an average range of .27 to .30 (Rosas & Kane, 2012; Trochim, 1993).

After the point map is obtained, a cluster analysis helps organize the ideas placed on the point map. The assessment team determines how many clusters make sense for the ideas generated, as there is no mathematical solution to determine the best number of clusters (Hair, Anderson, Tatham, & Black, 1998). A bridging analysis then produces bridging values

to show how ideas are grouped in different areas of the point map (Concept Systems, 2001). Lower bridging values reflect areas where ideas were most often sorted together. Higher bridging values mean ideas were more often sorted with ideas across the map. Label analysis, the final map analysis, involves a statistical process to determine the best-fitting label (generated by the sorters) for each cluster.

Stage Five: Interpret Maps

Stage Five involves sharing the results of the analysis with participants and obtaining their feedback and clarification of the concept map. Following an initial analysis of the data by the concept mapping facilitator, a group of participants assist in interpreting the meaning of the maps and graphs. Together the facilitator and participants decide on the number of clusters needed to best reflect their ideas and decide on cluster labels. The cluster labeling discussion helps the group understand the meanings behind the groupings of ideas.

Finally, once the final cluster map is determined, comparative graphs are created from the rating scales to show how different groups of participants valued the ideas. Average ratings are created for each statement and cluster for every rating scale. These ratings are displayed on a variety of pictorial maps and graphs for easier understanding of the data. A pattern match (or ladder graph) is drawn to compare ratings between groupings of individuals or between averages of rating scales. A correlation coefficient shows the consistency between participant group ratings.

Stage Six: Utilize Maps

In this final stage, participants use the findings from the assessment to plan for action. Based on the information gathered, strengths and potential areas for capacity building are identified. A detailed, user-friendly report of the findings can incorporate many of the graphical diagrams for community use in planning and evaluation.

Case Studies

Following are two case studies demonstrating the use of concept mapping in rural communities in Texas. Both cases addressed issues relevant to mental health service systems. The first case example illustrates how the method was used with stakeholders across a rural region in East Texas to develop a strategic plan to guide improvement of the health and behavioral health care service delivery system. The second example illustrates how the method was used in a multiple-county West Texas area to conceptualize cultural competence in children's mental health services and to assess the system's capacity to provide culturally responsive care.

RURAL EAST TEXAS HEALTH NETWORK (RETHN)

In Texas, state-funded mental health services are provided via contract between the Department of State Health Services (DSHS) and a local mental health authority (LMHA). The

LMHA is responsible for providing services to eligible clients who reside within the LMHA's geographic service region. In response to budget issues, the Texas Legislature made substantial cuts in funding for mental health services. One of the most detrimental cost-saving measures was the narrowing of the eligibility criteria for state-funded adult mental health services. Specifically, the priority population was limited to those with at least one of the following diagnoses: major depressive disorder, schizophrenia, and/or bipolar disorder. Furthermore, each LMHA's contract specified the number of priority population clients to be served, and LMHAs were penalized for underserving as well as overserving. Once an LMHA reached its limit, the remaining eligible clients were placed on a waiting list until a slot opened. These changes were especially difficult for rural areas, which typically did not have a tax base that would allow for the allocation of local funds to bolster mental health services.

In Deep East Texas, a rural region located in the central portion of East Texas, the reduction in mental health services was accompanied by difficulties in recruiting and retaining mental health service providers, especially psychiatrists and licensed mental health clinicians. All of these factors combined led to a substantial increase in the number of mental health crises in the region and a lack of resources necessary to resolve them. The situation presented several challenges for the LMHA, local law enforcement agencies, courts, and hospitals. For example, the increase in mental health crises resulted in substantial costs for hospitals and local law enforcement agencies (e.g., personnel, overtime, fuel, vehicle maintenance).

In response to this situation, the LMHA and a school of social work in the region began working together to build a regional stakeholder network to focus on addressing issues with the delivery of mental health and primary health care services. Given the large size of the region (12 counties and 9,906 square miles), it was obvious that financial resources were necessary for planning and developing the network. The group applied for and received a Network Development Planning Grant from the Office of Rural Health Policy (ORHP), a part of the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (USDHHS).

The primary goals of the Network Development Planning Grant were to develop the structure, governance, and membership of the network, as well as a three-year strategic plan to guide the activities of the RETHN. The network development process was guided by the Community Building Partnership Model (Poole, 2002). The model consists of six action principles: agenda building, structure, analysis, ownership, technology, and stewardship. This model emphasizes the development and maintenance of community ownership of the issue and its resolution. Ownership is dependent upon stakeholder involvement. At the very least, community members must have an opportunity for input in the process. Concept mapping allows for stakeholder input and, with careful planning, it can accommodate a large number of participants. The Community Building Partnership Model is also closely tied to capacity building in that it emphasizes the identification and utilization of community strengths/assets, participatory decision making, and community action research. All of these elements are imperative to the success and long-term sustainability of efforts to bring about change in communities (Cloke, Milbourne, & Widdowfield, 2000; Poole, 1997, 2002; Raak & Paulus, 2001; Vangen & Huxham, 2003).

Concept Mapping and Strategic Planning

The primary focus of the RETHN during its first year was the development of a three-year strategic plan that would guide regional efforts to address issues with behavioral and primary health care services in Deep East Texas. The first step in the process was the implementation of a concept mapping project, a useful tool for program planning and evaluation (Kane & Trochim, 2007; Trochim, 1989; Trochim, Milstein, Wood, Jackson, & Pressler, 2004). The project involved stakeholders from across the region in the identification of elements that would eventually constitute the strategic plan. Specifically, focus group meetings were held in six locations across the Deep East Texas region. Although this process was cumbersome, the facilitators chose to hold focus groups across the region in hopes of ensuring equal opportunity for participation in the process. The first round of focus group meetings involved participants in the generation of actions statements by responding to the following focus prompt:

> "One specific idea that the Rural East Texas Health Network could implement in the next three years to improve the delivery of primary health care and behavioral health care services is _____."

Seventy-three participants from across the region were invited to participate, and 52 chose to be involved. Those 52 participants identified 142 specific actions that the RETHN could take to improve primary health care and behavioral health care services in the region.

The second round of focus groups involved participants in sorting and rating the 142 action items. The original 73 participants were invited to participate in the second round of meetings, and 30 chose to do so. The sorting process resulted in a point map with a stress value of .29, which falls in the acceptable range (Trochim, 1993). The next step was to identify the clusters and generate a cluster map. The process resulted in a cluster map consisting of the following six conceptual domains: (1) education, training, and legislation, (2) law enforcement, corrections, and courts, (3) improving service delivery, (4) mental health and substance abuse services, (5) service accessibility, and (6) funding and prescription medications. Figure 20.2 shows the cluster point map.

As for the rating process, participants were asked to rate each of the action statements based on the following rating criteria:

- How important is this idea to improving the delivery of primary health care services?
- How important is this idea to improving the delivery of behavioral health care services?
- To what extent is this idea currently implemented overall?

The first two criteria informed the researchers' recommendations for actions to include in the strategic plan (i.e., statements with a greater degree of perceived importance were more likely to be included than those with less importance). The third rating criterion is important to implementing the strategic plan in that it can assist with decisions regarding

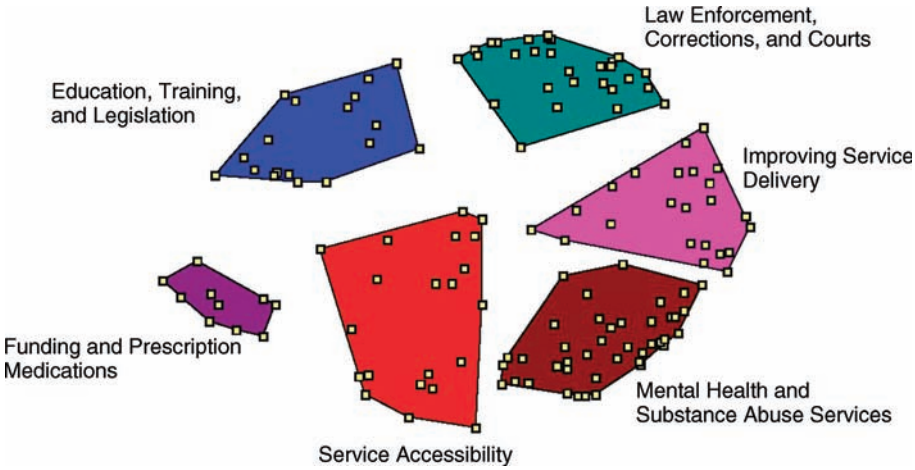

Figure 20.2 Cluster point map (without statement numbers).

resource allocation. Specifically, if an action statement is implemented to an appropriate degree, one would need only to allocate enough resources to maintain it. However, if it is not implemented to a sufficient degree, then more resources would need to be dedicated to the action.

All individuals invited to participate in the focus groups were also invited to rate the action statements. The 30 individuals who participated in the second round of focus meetings completed the rating instruments after they sorted the action statements. Rating instruments were mailed to the other 43 individuals, and 14 chose to return the rating instruments. Finally, rating instruments were sent to stakeholders who did not participate in the focus group process, including service providers, consumers, and community members. These efforts together resulted in 73 participants in the rating process.

The rating data informed the creation of point rating and cluster rating maps for each of the three rating criteria. For the sake of brevity, the discussion is limited to the cluster rating maps. The cluster rating maps for importance indicated that all clusters were comparable in degree of importance, which is supported by the narrow range of cluster scores for primary health care and behavioral health care (3.00 to 3.16 and 3.15 to 3.38, respectively). In terms of implementation, the rating scores were fairly consistent and indicated less than adequate implementation, as indicated by the narrow range of cluster scores (1.75 to 1.82). The cluster rating map is presented in Figure 20.3 as an example of the output.

Whereas the information presented thus far is important to strategic planning, perhaps the most important output is provided by pattern matching and go-zones. As previously noted, pattern matching allows researchers to make comparisons between participant groups. Pattern matches are based on Pearson's *r*, which indicates the degree of similarity or consistency between the groups (see Figures 20.6 and 20.7 in the next section for examples of a pattern match). The importance of this match to strategic planning is that it alerts researchers to potential points of consensus and disagreement, allowing one to engage in

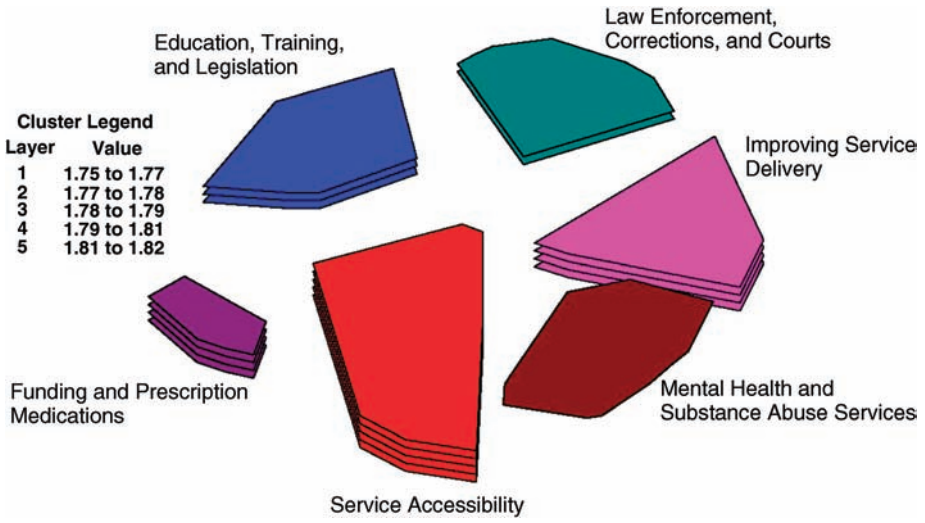

Figure 20.3 Cluster rating map (Implementation).

proactive problem solving. Imagine you are facilitating the strategic planning process for the RETHN. In this case, you would know that during the focus group meetings, the smaller counties expressed a substantial degree of concern that the larger counties would view things differently and dominate the decision-making process. However, you would have the following information before the first regional strategic planning meeting:

- The responses of the two groups for primary health care were moderately consistent or similar and move in the same direction ($r = .49$). In other words, clusters ranked high by one group were ranked high by the other group.
- The responses for behavioral health care yielded an r of .05, which suggests the possibility of disagreement between the two groups on the importance of the action statements to behavioral health care.
- The responses for implementation had a very low degree of disagreement ($r = -.19$) between the groups in terms of the degree to which each action is implemented.

How could this information be valuable in helping you address the concerns expressed by the smaller counties? Simply stated, pattern matching data would allow you to enter the first meeting with a strategy to use points of agreement to build group consensus and cohesion. Doing so sets the stage for working with the group to address more difficult and controversial issues. Such an approach is preferable to walking into the meeting with a limited understanding of the issue and broaching a topic that leads to a substantial conflict.

Another useful tool is the go-zone map, which assists in examining the relationship between two rating scales. The go-zone map is simply a graphical representation of a

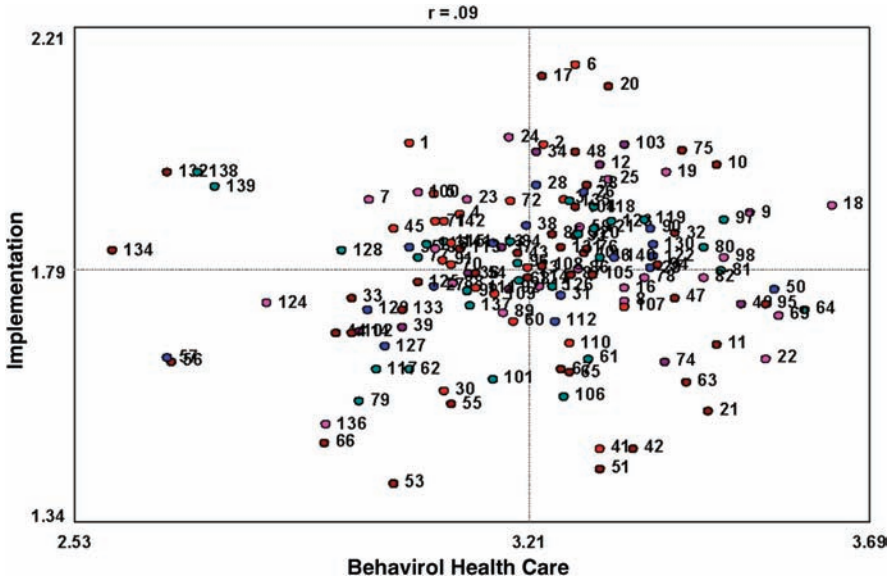

Figure 20.4 Importance to behavioral health care and implementation (go-zone).

bivariate plot between two variables or rating scales (Trochim et al., 2004). In this case, you could compare both primary health care and behavioral health care to implementation. For example, we will look at the behavioral health care and implementation (Figure 20.4).

The lower-right quadrant of the map contains action statements that were rated higher for importance and lower for implementation (statements that were viewed as important, but not implemented to an appropriate degree). In terms of the strategic plan, these items would be considered priority in the contexts of inclusion and resource allocation.

Benefits of the Process

The results from the concept mapping project informed the facilitators' efforts to assist the regional stakeholders in the development of a three-year strategic plan. The strategic plan was approved and implemented by the RETHN's membership, has been updated as appropriate, and continues to guide the RETHN's efforts.

Whereas there are many benefits to using concept mapping for strategic planning, in this case the most important one was the opportunity for stakeholders to come together and offer ideas that would eventually become a regional strategic plan. Many of the RETHN members continue to comment about the process and the fact that their ideas were evident in the plan. The following stakeholder quote from a subsequent network evaluation speaks to this and other benefits:

> I do believe the quality has improved since RETHN began but it is an opinion based on experience with no real data to back up my impression. I believe the Network has been beneficial in a number of ways including improving communication of the stakeholders in the region. All the players—ER staff, mental health providers, law enforcement, and judicial representatives all have an impact and were impacted by our "broken system." Once we got them all in the room together we were able to hear what each of us brought to the table and what effect our part had on each other and the clients we serve in the different capacities. I think this allowed us to reach common ground to formulate plans, protocols and procedures that improved many aspects of the process and ultimately improved the care rendered, timeliness of the care and efficiency of all the stakeholders." (Administrator, Regional Hospital)

This quote also highlights the role concept mapping can play in developing a community's sense of ownership or responsibility for an issue and its solution. Specifically, concept mapping provides multiple opportunities for stakeholders to be involved in identifying and solving community issues. Including community stakeholders in problem-solving processes has several benefits, including increasing the public's understanding of the issue, fostering a sense of shared responsibility for the issue, helping to identify potential partners, and strengthening relationships (Poole, 2002).

In the case of the RETHN, the concept mapping project and resulting strategic plan served as a catalyst for several key successes during the first and subsequent years. For instance, the network members developed a common protocol for handling psychiatric crises. The protocol reduced confusion and conflict, which in turn strengthened relationships among the various entities. RETHN members worked together to sustain the network for one year after the first HRSA grant ended and to obtain a three-year Network Development Grant by the ORHP to support network expansion. The spirit of cooperation has continued and served as a catalyst for regional and state advocacy efforts that helped the region secure $1.66 million in state crisis redesign funds and 25% matching funds from local county governments to support the development of the Mental Health Emergency Center (MHEC), a regional psychiatric crisis stabilization unit. The following statement clearly conveys the importance of these successes:

> I can't overemphasize the benefits that the RETHN and MHEC have brought to East Texas. Many colleagues across the state are envious of the partnership we have formed with the mental health community, and we have a role model application that should be applied in rural areas across the state of Texas. (Sheriff, Local County)

It is important to note that the MHEC's innovations in service delivery earned it an American Psychiatric Association's Gold Achievement Award for community-based programs in 2011. All of the aforementioned successes have perpetuated the development of ownership and trust among RETHN's members. More importantly, they can be traced back to the foundation created by the concept mapping project and the resulting strategic plan, which has been maintained and continues to guide the RETHN's efforts.

ASSESSING CULTURAL COMPETENCE IN A RURAL SYSTEM OF CARE FOR CHILDREN'S MENTAL HEALTH

This case example describes concept mapping's application to generate conceptualizations of cultural competence from the perspectives of adult family members and providers participating in the children's mental health service community. Differences and similarities in these conceptualizations were then examined among groups of community participants. The effort also explored concept mapping as a viable option to conceptualize and assess cultural competence in service systems of care.

Community Description

At the time of the assessment, the West Texas Community (WTC) system of care was in its second year of development and received some monetary support from the state. The WTC spans 10 rural counties in its geographic catchment area. The counties cover more than 9,000 square miles, with a combined population of approximately 100,000 people. The economy is agricultural-based, and approximately 23% of families live below the poverty level. The community estimates that 50% of its ethnically diverse youth live in homes receiving some form of public assistance. Its system of care for children's mental health targeted children and youth ages 10 to 17 who were at risk of incarceration or other out-of-home placement. Primary objectives of the WTC included increasing family involvement at the local practice, program, and system levels, while maximizing and coordinating funds to provide individualized and cost-efficient services.

Assessment Process

A specialized team was assembled to conduct the assessment. The core team included a Family Evaluator, who was the parent of a child with serious mental health challenges, two experienced teachers and trainers of cultural diversity, and a lead investigator who brought personal multicultural experience, knowledge of systems of care processes, and knowledge of concept mapping. All four female members were master's-level social workers. Two team members were Mexican American and fully bilingual in English and Spanish, one was African American, and one was Caucasian. After being trained by the team leader in facilitating concept mapping, all members traveled to the community to conduct the assessment.

Volunteers from the local community worked with the core team to plan the assessment. Staff and families from the children's mental health service community used flyers in English and Spanish to recruit others to participate in the assessment. Eligible adult participants included family caregivers, agency staff and administrators, members of the local community advisory boards, and any other community members involved in or targeted for the system of care effort.

A series of three-day meetings was facilitated with the WTC. The community was responsible for making logistical arrangements. Staff assisted in providing transportation for families as some families drove up to 90 miles one way to participate. Food and beverages

were provided at all meetings, reimbursement for family participant transportation expenses was offered, and childcare provisions were covered for family participants at the same location where the meetings were held.

Data Collection

Day One consisted of statement generation for separate groups of family members and professionals. A total of 66 community members participated in the assessment, including 42 adult family members and 24 adult nonfamily members. Of the total, 36% were Mexican American, most of whom were family participants. The family group was conducted simultaneously in English and Spanish. Each brainstorming session lasted 1.5 to 2 hours. The facilitators engaged participants in a discussion about the meaning of cultural competence, asking them to think out loud first about the meaning of culture and then about competence. The two concepts were then put together for discussion, leading participants into brainstorming.

To ensure the focus prompt was relevant to the community populations, three prompts reflecting the same ideas were developed to provide different ways of hearing the prompt. Participants could respond by completing any of the following three sentences with specific examples:

I know services to families are culturally competent when _____.
I know services to families are respectful when _____.
I know services are culturally responsive when _____.

Groups were facilitated as open dialogues, applying general rules of brainstorming. The facilitator guided the discussions such that everyone had an opportunity to participate. As responses were generated, they were typed into a computer and projected onto a wall for all participants to view. The facilitators and recorders worked with participants to ensure that the statements were written in the participants' words and clearly articulated participant ideas. Index cards were distributed to participants in the event that they had ideas to include but were not comfortable voicing them in front of the group. Participants could either leave their cards at their seats or turn them in as they left the room. All index cards left behind were collected and reviewed for additional input. Every family participant received a Wal-Mart gift card in the amount of $10 to compensate them for their time.

Throughout Day One the research team also worked to prepare for the next day's tasks. This included working with the community to get feedback on the process and to confirm logistical arrangements. At the conclusion of Day One, statements generated from each of the brainstorming sessions were combined into one list without any data reduction. Using the combined list, sets of sort cards and rating sheets were prepared for Day Two.

On Day Two, the WTC chose to schedule separate meeting times for adult family and professional (nonfamily) participants to complete the sorting and rating processes. A total of 92% of family participants and 65% of professional participants returned for Day Two. Each participant was given a set of cards, with a separate card reflecting each statement generated. Participants individually sorted the cards with instructions to organize the cards into piles in whatever way made the most conceptual sense to them. Participants were

instructed not to sort the cards according to any kind of rank ordering. They were then asked to place a rubber band around each pile and give each pile a short label that best reflected the pile's contents.

Two rating scales were completed by all participants as follows:

1. How important is this example for meeting the unique needs of families?
   5 = Extremely Important; 4 = Very Important; 3 = Fairly Important; 2 = A Little Important; 1 = Not Important
2. How often is this example demonstrated in your community's system of care?
   5 = Always Demonstrated; 4 = Usually Demonstrated; 3 = Sometimes Demonstrated; 2 = Rarely Demonstrated; 1 = Never Demonstrated

Professional (nonfamily) participants additionally completed the following rating question:

3. To what extent is this statement covered under *your agency's* policies?
   3 = Fully Covered; 2 = Somewhat Covered; 1 = Not Covered; 0 = I Don't Know

The family evaluator sat with a group of five Spanish-speaking participants and orally translated the statements into Spanish in order to engage participants in the rating process. The question was read to participants, with time allowed to complete the appropriate item on the scaling form. Given the short turnaround from statement generation to sorting and rating, the statements could not be translated into Spanish in written form. Therefore, this group of participants did not participate in the sorting process. It took an average of 1 to 1.5 hours to complete the sorting and rating tasks. Each adult family participant received a Wal-Mart gift card in the amount of $25 to compensate them for their time. At the conclusion of Day Two, the assessment team gathered the information together from the two days and prepared for Day Three. Data were entered into the computer, and preliminary analysis of the concept mapping results was conducted.

Interpreting the Data

The brainstormed list served as the participants' conceptual definition of the construct. Using the sorting and rating data obtained from participants' preliminary analysis of the data, results were generated by the assessment team. A meeting was held on Day Three to receive interpretive feedback from a select number of systems of care members (chosen by local communities) to make the final cluster determination. Participants dialogued about potential meanings of the results. Variations in the number of clusters were examined, along with the labels assigned by the software. After the group chose the number of clusters necessary to best reflect the ideas generated, they engaged in a cluster labeling discussion to facilitate a better understanding of meanings behind groupings of ideas. Once the final map was determined, initial cluster rating maps and pattern matches were produced and shown to participants. Concept mapping provided a means to immediately share results with the community.

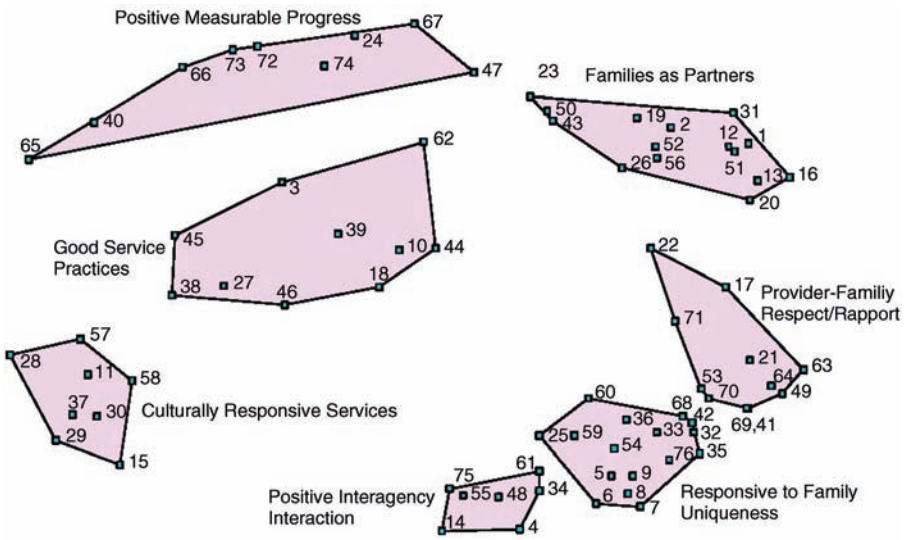

Figure 20.5 WTC point cluster map (stress value = .226).

Findings for Action Planning

Participants in the WTC community brainstormed 76 statements and structured their map around seven areas of cultural competence: Families as Partners, Good Service Practices, Positive Measurable Progress, Culturally Responsive Services, Positive Interagency Interaction, Responsive to Family Uniqueness, and Provider-Family Respect/Rapport. Figure 20.5 illustrates the point map of the 76 statements and the seven clusters within which the statements were grouped. Table 20.1 provides a sample of the ideas reflected in each cluster.

Ratings

All of the clusters were rated as important. Overall, all of the clusters except *Culturally Responsive Services* were rated above 4.0 (very important), ranging from 3.75 to 4.48. Although the cluster rank ordering for importance was similar across groups, there were some differences and similarities among groups. For example, the People of Color group rated all clusters more important than the White/European group. However, the average cluster importance ratings for the Mexican American group were lower than the ratings for the combined People of Color group.

Because the previous case example illustrated the cluster rating map and go-zone, this example illustrates the pattern match diagram. Figure 20.6 illustrates the importance pattern match comparison between the family and nonfamily group participants. Cluster labels appear down the sides of the ladder in descending order of importance for both groups. Because all importance ratings fell between 3 and 5, the graph is set up to show

Table 20.1 Examples of Statements in WTC Clusters

Cluster 1: Families as Partners—Families have a voice and choice about what's going on; families are active in all aspects of services; families report back that they feel respected; I know I am part of the team.
Cluster 2: Good Service Practices—Family programs fit the scheduling needs of the family; there is easy accessibility for families to providers; not only parents are treated with respect, but so are the kids.
Cluster 3: Positive Measurable Progress—There are ways to measure achievement; the needs of the family are met; families can tell there is change/growth in themselves; kids learn to express their feelings with words instead of with anger.
Cluster 4: Culturally Responsive Services—There are a lot of options for services; services are provided in different languages; employees are representative of the population.
Cluster 5: Positive Interagency Interaction—Providers don't pass the buck from one organization to another; providers are educated to cultural differences; providers use a multidisciplinary approach.
Cluster 6: Responsive to Family Uniqueness—Providers listen; providers work with the entire family rather than only the child; providers are willing to ask questions to learn about families' cultures; providers don't impose their own solutions on families; providers care.
Cluster 7: Provider-Family Respect/Rapport—Trust is built between providers and families; providers value family's input; providers have good communication with the children.

only a 3–5 scale. The $r = .95$ shown at the bottom of the ladder indicates that there is a very strong level of consistency between the two groups in their patterns of cluster average ratings of importance. Although the two groups' patterns of cluster averages are nearly the same, the diagonal lines indicate that the nonfamily group rated all clusters higher than the family group. As indicated by the last diagonal line on the ladder graph, the cluster with the largest rating difference is *Culturally Responsive Services*.

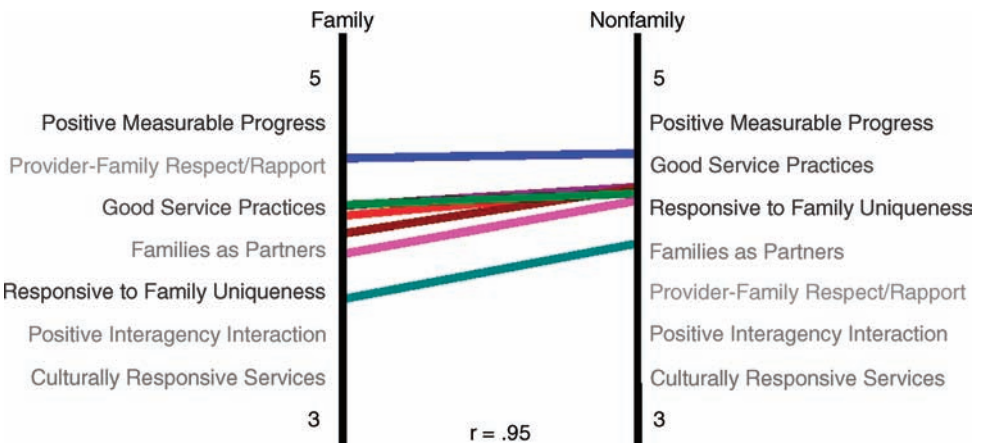

Figure 20.6 WTC family/nonfamily importance pattern match.

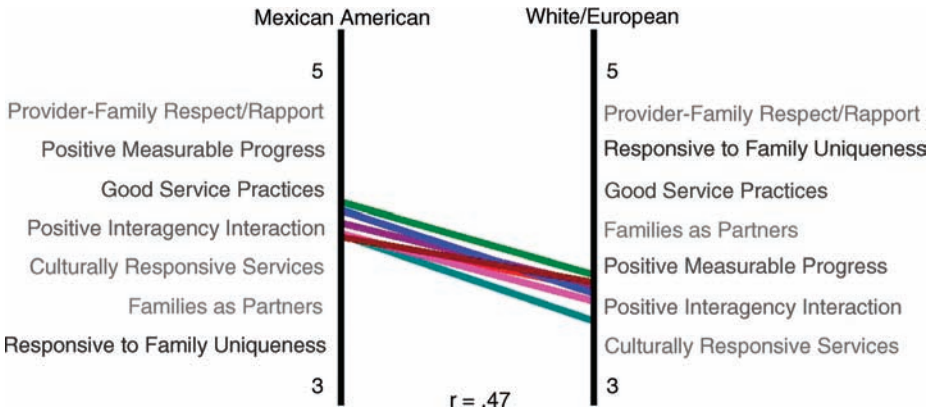

Figure 20.7 Mexican/Mexican American and White/European frequency of demonstration pattern match.

All clusters were rated between 3.51 and 3.81 in frequency of demonstration, meaning that all groups viewed the clusters within a narrow range above "sometimes demonstrated." The *Provider-Family Respect/Rapport* cluster received the highest rating of demonstration (3.81) by all groups. Interestingly, the nonfamily group's rating of *Families as Partners* (3.44) was lower than all other groups. The *Culturally Responsive Services* cluster was rated the least demonstrated (3.35 to 3.71) by all groups except the Mexican American group (3.90). *Responsive to Family Uniqueness* was ranked least demonstrated of all clusters by the Mexican/Mexican American group and People of Color group (which had two clusters equally rated last). In contrast, the nonfamily and White/European groups rated this cluster as the second most demonstrated.

Demonstration ratings by the Mexican/Mexican American group were distinctly higher across all clusters than any other group. Figure 20.7 illustrates the demonstration pattern match comparison between the Mexican American and White/European groups. There is a moderate ($r = .47$) relationship between the consistency in patterns of average ratings. As indicated by the diagonal lines, Mexican/Mexican American participants rated all clusters as more often demonstrated than participants in the White/European group. Many additional pattern matches were created to examine several additional comparisons, including one between importance and frequency of demonstration ratings ($r = .70$).

Nonfamily participants rated the statements on the degree to which they are covered in system policies. Overall, participants perceived that more agency policies included statements pertaining to *Provider-Family Respect/Rapport* and *Culturally Responsive Services* than statements in other clusters. The nonfamily People of Color group ranked *Families as Partners* as the second most covered cluster in policies, distinctly higher than the White/European and overall ratings. The White/European group policy ratings were lower across all clusters than the People of Color group. *Positive Interagency Interaction* was rated as least covered in policy by the People of Color group, whereas *Responsive to Family Uniqueness* was rated least covered in policy by the White/European group.

Benefits of Concept Mapping

As used with WTC, concept mapping offered a transparent, participatory process from inception to data interpretation. The method offered an inclusive process for diverse family consumers and professional providers to give input into defining and assessing cultural competence. In this way, the process built consensus and capacity of the community's system of care to serve its unique populations. The process was well aligned with the systems of care values and principles the community sought to implement. A mix of textual and numerical data was obtained and illustrated through easily understood visual graphics to describe the capacities and areas for potential growth in the children's mental health service system. The findings allowed for comparisons among participant groups and helped establish a baseline for further development of cultural competence. Moreover, the process informed policy development and plans for training in the children's mental health system. Community investment in the assessment was key to maintaining the level of state support for the local community in developing its system of care. In sum, concept mapping offered an effective alternative method for conceptualizing and assessing culturally responsive practice within a rural cultural context.

CONCLUSION

This chapter offered an introduction, overview, and case examples of using concept mapping for assessment and planning in rural communities. The examples provided a sampling of ways the method can be implemented. The RETHN example illustrated a series of focus group and mail-based data collection efforts. The WTC effort illustrated a process of collaborating with the community to implement a three-day on-site data collection and interpretation process. Each of these efforts resulted in attaining the inclusion of intended participants and reaching the stated goals of the efforts.

Concept mapping does not come without some relevant challenges for rural communities. As noted in the WTC example, it can be difficult to implement the process in more than one language at a time. It also requires a certain degree of literacy, regardless of language used in the process. Distances that people must travel for face-to-face meetings can also present challenges. Although concept mapping is now available through a web-based application, implementation requires participant access to technology and the Internet. Finally, the use of the software can be expensive for communities that are not adequately resourced for the effort. A license appropriate for the number of expected participants is required for each use of the software.

The case study descriptions also highlighted several benefits to using concept mapping for assessment and planning. It has great capacity to bring together disparate groups of people to dialogue and build consensus. Each individual's voice is accounted for in a transparent approach that is coupled with sophisticated statistical analytic techniques. Implementation of the process builds community among participants, who then take ownership of the effort and create plans for action. The output created through the process provides user-friendly diagrams that aid in understanding issues and prioritizing actions around capacities. The

method further allows for the data to be used for ongoing monitoring and evaluation of progress. Concept mapping is a mixed-method approach to evaluation and research and as such provides a bridge between quantitative and qualitative research paradigms. It offers a participatory process to engage participants in a strengths-based process to build community capacity.

Discussion Questions

1. How is concept mapping different from some more traditional community assessment and planning approaches (e.g., Strengths, Weaknesses, Opportunities, Threats [SWOT])?
2. What specific features of concept mapping make it a viable option for assessment and planning in rural communities? Which features would be most appealing to you as a future rural social worker?
3. How might some of the challenges noted in using concept mapping in rural communities be addressed and managed?

Classroom Activities and Assignments

1. Identify a change effort that is needed in your field agency or community. Consider the kinds of information that would be helpful to moving the change effort forward and determine whether concept mapping might be an appropriate method for gathering needed information. If so, develop a focus prompt to guide idea generation around your topic of interest. Remember, the focus prompt must be specific, action-oriented, and focused on the purpose of the assessment. Phrase it as a stem phrase for participants to complete as if completing a sentence.
2. Using the focus prompt developed in the previous activity, lead a group (perhaps your classmates) in a brainstorming session to generate statements that would be included in a concept mapping effort. Remember to state your general rules for brainstorming (e.g., only one person speaks at a time, no judging of any person's brainstormed idea, one idea per sentence). If available, have someone assist you by typing the statements on a computer that is projected onto a screen. Be sure to ask participants for clarification as needed.

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CHAPTER 21

Rural Networks

Using Social Network Analysis to Understand Communities

Calvin L. Streeter and H. Stephen Cooper

Christakis and Fowler (2009, p. 6) use the following scenario to emphasize the power of social networks:

> Suppose you arrive home from work one day and find your house is on fire. Fortunately, there is a stream running very near your house. So you grab a bucket and begin running back and forth to the stream as quickly as you can. Soon you are exhausted and the house is in danger of being consumed by fire. But you are in luck, your neighbors see the fire and they come running with their buckets to help. Each of them fills his bucket and runs to the house, throwing water on the fire. Some of your neighbors are older and they soon become tired. Others are not strong enough to carry a full bucket of water so their buckets are only half full. Others are very fast runners but they spill much of the water as they run from the stream to your house. It looks like your house may still be doomed. Being a good social worker, you quickly recognize that your neighbors represent a potential resource, but they just need to be organized. You quickly have your neighbors form a line from the stream to your house. Buckets of water are passed up the line toward the house and empty buckets go back to the stream. This eliminates the need to run back and forth to the stream and even the weaker and less coordinated neighbors can pass the bucket down the line. With this quick action, your house is saved.

What you have created is a simple social network. A social network can be defined as any bounded set of connected social units (Streeter & Gillespie, 1992). This simple definition highlights three important characteristics of social networks. First, social networks have boundaries. That is, some criterion exists to determine membership in the network. In some networks, such as family systems and work teams, boundaries are relatively straightforward and easy to define. However, some social networks are also embedded in larger social systems. Therefore, it is sometimes difficult to distinguish between a network and its broader social context. Think about your personal friendship network. You have known some of your

friends for a long time and may be very close to them. Others you met only recently or they are only casual acquaintances. As Christakis and Fowler (2009) point out, your friends also have friends whom you may not know personally but who may influence your ideas, opinions, and behaviors through their mutual relationship with your friends. So when we look at a social network, it is important that we think about its boundaries to determine who is part of the social network and who is not.

The second key element of the definition is *connectedness*. To be part of a social network, each member must have either actual or potential connections to at least one other member of the network. Although some members may be peripheral in the network or almost completely isolated, each one must somehow be connected to other members if that member is to be considered part of the network. Those relationships often represent an important form of social support, but social networks not only serve as the basis for collective support, they also connect members to valuable resources (Ersing & Kost, 2012).

Social exchange is central to the concept of social networks. In fact, social networks are, by and large, mechanisms of exchange: exchange of ideas, information, support, and other resources that make it possible for us to function each day. Social exchange implies a transaction between the network members. Resources flow from one member to another, and the structure of the social network emerges through such transactions. Norms of reciprocity are often inherent in social exchanges, and the extent to which exchange relationships are reciprocal has important implications for the distribution of power and influence in social networks.

The third key part of the definition is the idea of social units. The concept of a social network can be easily applied to a wide range of social units. Social networks may comprise individuals, as in the case of social support networks, but networks may also comprise social service agencies, social institutions in local communities, or nations in the global economy. In a diverse profession like social work, the concept of social networks has direct applications for clinical practice, social policy analysis, community organization, and organizational management.

Hardcastle, Powers, and Wenocur (2011) note that assessing, developing, and managing social networks—and helping our clients to assess, manage, and develop their social networks—is at the heart of social work practice. Social networks and networking are inherent in social work's person-in-environment perspective. All individuals are embedded in a web of social connections and relationships. Those social relationships may represent very close bonds between family and friends or more casual interactions with people we meet at church, school, health clubs, and through volunteer activities.

Social workers' interest in social networks is not limited to personal networks. Social networks can also comprise groups, organizations, communities, and other social entities. Much of our practice in rural communities may focus on building relationships and social exchange networks among organizations, service providers, policy makers, and other macro-level social units.

SOCIAL NETWORK ANALYSIS

Assessing, developing, and managing social networks can be very complex. In order for social workers to incorporate social network analysis into their professional practice, it is important that they understand some basic concepts and theories related to social networks.

The idea of social network analysis is quite simple. A social network comprises a set of social units that have some type of relationship or interaction with one another. Social network analysis provides a method for understanding the social structure created by those relationships and describing the pattern of social connections that tie the units together. In general, there are two approaches to social network analysis. For relatively simple networks, we can produce graphic models that help us visualize patterns of social relationships; but for large, complex networks, it is useful to record the data into matrices and use a computer program to calculate indexes and others indicators that describe the network. For our purposes here, we will first present a visual analysis of a simple network to illustrate some of the basic concepts of social network analysis.

Visual imagery has played a significant role in social network analysis since its inception. Drawing on the pioneering work of Moreno (1934), most graphic models of networks are presented as sociograms, which display the relationships among network members in two-dimensional space. Members of the network are represented as points or nodes, with lines drawn between pairs of nodes to show a relationship between them. An arrow is sometimes used to show the directional flow of resources in an exchange network. Figure 21.1 represents a simple network with five social units. Let's assume it represents a set of organizations providing services to children and families in a rural community.

By visually inspecting this simple network, we can begin to identify some important features of the network. For example, member A is connected to the network by only one relationship, and that link represents a one-way or nonreciprocal flow of some resource. That is, it sends something to member B but does not receive anything in return. It might be considered a peripheral member to this network. Of course, peripheral does not mean A is unimportant. It may play a critical role in the network, perhaps a major source of funding for this service delivery system. Peripheral simply means it is not located in a central position in the network.

We also see that member B acts as a bridge between member A and the other members of the network. This position is sometimes referred to as a *boundary spanner*, because member B mediates the relationship between member A and the other members in this network. The arrows connecting member B with members C, D, and E are also one-way or nonreciprocal,

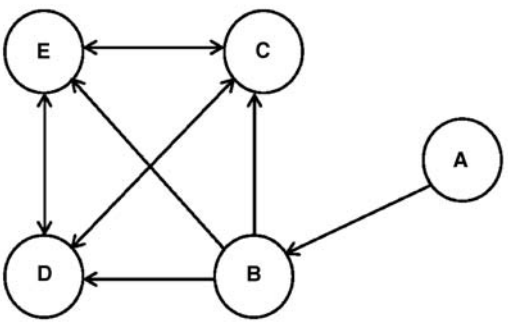

Figure 21.1 Simple network map.

indicating that member B controls the flow of some kind of resource into the network, giving it some measure of power or influence in this network. For example, member B may be a fiscal agent who distributes funding from a government program to service providers in a local social service delivery system.

Members C, D, and E are tightly connected to one another through reciprocal or two-way relationships in which resources or information flow in both directions between the actors. In network terms, they represent a clique. That is, they share a similar pattern of relationships to the rest of the network, and they are tightly connected to one another.

There are several practical advantages to using graphic models to portray the structural relationships of the network. As one can see from this simple network map, graphic displays can convey a vivid image of the network that produces an intuitive understanding of the network structure that is difficult to achieve in any other way. In fact, some have argued that points and lines are the most natural way to represent social networks (Klovdahl, 1981).

The advantages of graphic methods are offset by serious limitations. For one thing, by altering slightly the assumptions underlying a network map, it is possible to produce an almost unlimited number of diagrams, each conveying a dramatically different picture of the network. For example, one might assume that members A and B both have relationships with other actors who are not part of this network. If one expands the boundaries of the network, it would likely produce a much different picture of the network. Given the fact that networks tend to be embedded within larger networks, defining the boundaries of the network is a critical part of the social network analysis process. In addition, as the number of social units and the number of connections among social units increase, interpretation of the graphic diagram becomes increasingly difficult. For large, densely connected networks, visual displays can be so complex that they can confuse, rather than clarify, our understanding of the network's structure.

When analyzing social networks, we often use several quantitative measures to help us understand different dimensions of the network. *Network size* refers to the number of social units in the network. Network size can vary from a few social units, such as a close friendship circle, to an almost infinite number of units, such as virtual networks like Facebook and Twitter. In the network in Figure 21.1, the size is small, with only five social units. In general, larger networks are more complex, providing a greater number of potential exchange partners and more resources to the network. But large networks also require greater effort to manage and may be less efficient in providing resource exchange opportunities. Although rural social workers often face limited resources, the smaller social networks found in many rural communities are much easier to develop and manage than the larger networks found in urban environments.

Another important concept is *network density*. It is rare, in most networks, for all members to be directly connected to all others in the network. Network density tells us what percentage of the total possible connections among network members actually exist. The total number of possible connections can be determined by squaring the number of social units in the network ($N \times N$). But because social units cannot have a connection to themselves, we must also subtract the number of social units in the network to determine the number of possible connections. In the network in Figure 21.1, the number of possible connections among the five social actors would be 20. Five times five is 25 minus 5,

the number of social units. In this network, if every social unit were connected to every other social unit through a reciprocal relationship, there would be 20 connections among the social units.

Now we need to determine the number of actual connections. The easiest way to do that is to count the number of arrowheads on the lines connecting the social actors. When we do that, we find there are 10 arrowheads. So the density of this network is $10 \div 20 = .50$. That is, 50% of all possible connections among the social units actually exist.

People tend to think that more density is good, but it is rarely that simple. It may be that not all social units need to be connected to one another in order for the network to function effectively. Because it requires resources to establish and maintain network relationships, unnecessary connections may represent inefficiency or wasted resources in the network. In general, smaller networks tend to be more densely connected than larger networks. Again, for rural social workers, densely connected smaller networks may be easier to develop and manage than the large complex networks found in many urban settings.

Reachability refers to the extent to which a social unit is accessible to other network units. The more social units a unit can reach in the network, the greater their potential influence in the network. If a social unit cannot reach others, it is unlikely they will be able to influence the attitudes, opinions, or behaviors of the other members. If we look again at our simple network, member A can reach all other social units in the network. Member B can reach C, D, and E, and C, D, and E can only reach each other. They cannot reach either B or A. So, member A has the greatest potential for influencing others in this network, followed by B.

Closely related to the concept of reachability is the idea of *centrality*. Centrality refers to a social unit's position in the network relative to other social units. There are several ways to measure centrality in social network analysis, but the simplest measure is called *degree centrality*. Degree centrality refers to the number of direct connections a social unit has to others in the network. In our simple network, member A has only one direct connection to the network. Member B has four direct connections. Members C, D, and E each have three direct connections. So, B has the greatest degree centrality in this network.

Centrality and reachability are both considered indicators of power and influence in a network. In this case, member A has the greatest reachability and has the ability to influence all other social units in the network. Member B has the greatest centrality, and hence the greatest potential power, because it controls the flow of resources from A to the rest of the network.

Given that we typically think of relationships among network members in a positive light, it is important to keep in mind that relationships may also be used in a negative manner. This is commonly referred to as the "dark side" of social networks. Examples of such include exclusion of members from decision-making processes, efforts to force member conformity, and denial of access to resources (Raab & Milward, 2003; Schulman & Anderson, 1999). In the previous example, the nature of B's position allows it to restrict A's participation in the network and to prevent the other members from accessing A's resources. If B were so inclined, it could use its position to force the other members to conform to its expectations, even if doing so was detrimental to the others.

THE SAFE SCHOOLS/HEALTHY STUDENT (SS/HS) COLLABORATION

To illustrate how one might use social network analysis to assess, manage, and develop a social network, we present a network analysis from a school-based project called the Safe Schools/Healthy Students (SS/HS) Collaboration. The SS/HS Collaboration was part of a national demonstration project to help school districts develop community-based collaborations that would promote healthy childhood development, prevent violence and drug abuse in schools, and create a safe school environment. Funding for the project continued for three years and was focused on six essential program elements: (1) a safe school environment; (2) alcohol, drug, and violence prevention and early intervention programs; (3) school and community mental health prevention and treatment; (4) early childhood social and emotional development; (5) school reform; and (6) safe school policies. To achieve these program goals, this SS/HS project developed three additional goals: (1) create a community-wide collaboration between schools, public services, social agencies, and neighborhoods; (2) use the SS/HS program as a tool to leverage other needed community resources that were not funded through the SS/HS grant; and (3) use an asset-building, strengths-based approach in achieving all program goals.

The overall evaluation of the SS/HS Collaboration was multifaceted and complex. The social network analysis reported here is a small part of a much larger evaluation. This part of the evaluation was designed to assess how the community-based collaboration changed and evolved over the three years of the project. To assess the community collaboration, the 23 collaboration partners were asked to complete a survey called the *network mapping survey*, developed by the evaluation team to collect data for the social network analysis. The network mapping survey contained four sections. Section I requested background information about the organization, such as organization type, number of staff, use of volunteers, and number of clients served. Section II asked about the kinds of services each partner provides and whether those services were provided as part of the SS/HS Collaboration. Section III provided the data for the social network analysis and asked questions about the existence of a relationship with other collaboration partners, client referral patterns, information exchanges, joint treatment planning, and relationships mediated by a case manager. Section IV asked respondents to provide narrative statements that illustrate examples of cooperation and disagreement that occurred within the collaboration.

In order to assess how the collaboration evolved over the three years of the grant, it was important to gather data on the network at two points in time: (1) when the project first began, and (2) as the grant neared the end of its third year. Comparing the network patterns at these two points in time provided a graphic picture of the evolution of the collaboration network over the three years.

To obtain a true picture of how the collaboration changed over the three years, it was necessary to distinguish among three types of organizations. To do so, the network maps use three different-shaded nodes to represent the 23 collaboration partners. Black nodes represent programs that were part of the foundation group in the original collaboration that developed the SS/HS grant proposal. Gray nodes represent programs that were recruited to become part of an expanded collaboration network during the development of the SS/HS grant proposal. White nodes represent programs that

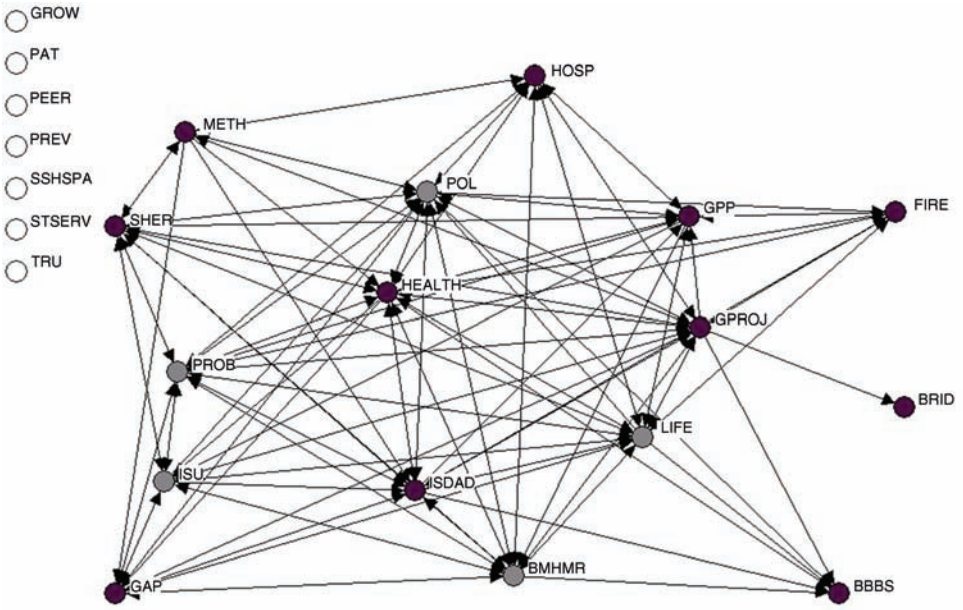

Figure 21.2 Network map showing relationships among collaboration partners at the start of SS/HS Collaboration project.

were not part of the original collaboration but became part of the network as a result of the SS/HS grant.

Because of the complexity of this social network, the analysis was performed using UCINET, Version 6 (Borgatti, Everett, & Freeman, 2002), a comprehensive network analysis software program. The network maps show the collaboration based on identified relationships among the collaboration partners. That is, each collaboration partner was given a list of all partners in the collaboration and asked to identify those with whom their organization or program had a working relationship. As noted earlier, they did this twice, once with the start of the project as the reference and then three years later when the project ended.

The network maps presented in Figures 21.2 and 21.3 show the relationship patterns at the beginning of the project and three years later when the project ended, along with overall network density scores for each map. First visual impressions of the maps indicate that, in the beginning, several partners were not part of the network. Recall that they were new programs that were developed during the three years of the grant. They did not exist in the beginning. However, by the end of the project, the network had expanded to include the seven new partners, and the collaboration partners are much more densely connected to one another. That is, there are more lines connecting the members of the collaboration. Both of these changes reflect substantial development of the SS/HS collaboration during the three years of the project.

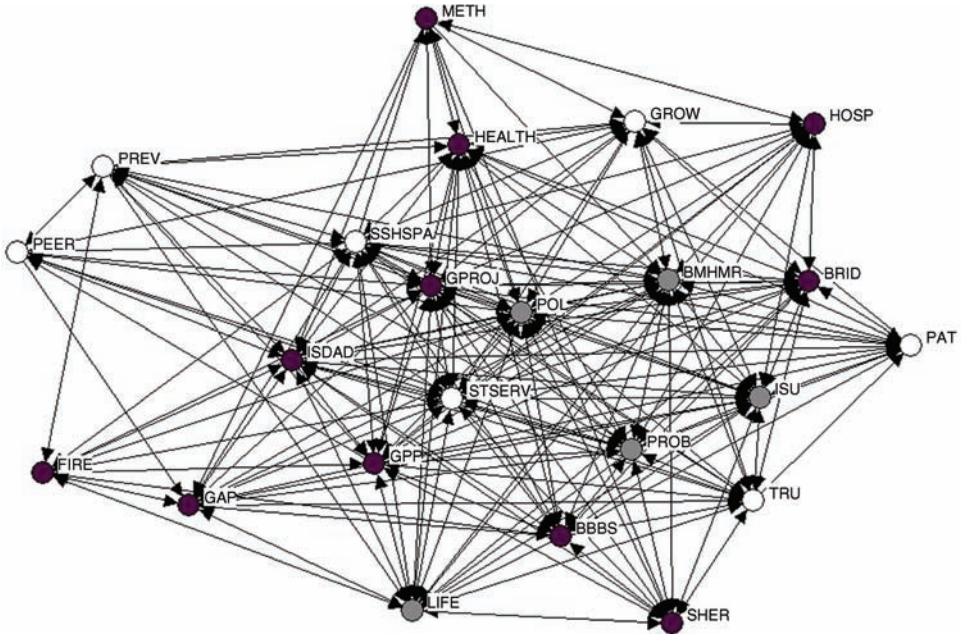

Figure 21.3 Network map showing relationships among collaboration partners at the end of SS/HS Collaboration project.

This perception is confirmed by looking at density scores for the two networks. Remember that network density is determined by dividing the number of actual relationships among the partners by the total number of possible relationships. For the first map, the network density score is .2787. This means that at the start of the project about 28% of all possible relationships in the network actually existed. In contrast, the second map has a network density score of .6630, indicating that by the end of the project that percentage had increased to just over 66%. This means that the collaboration partners were much more tightly connected to one another at the end of the project than they were when the SS/HS Collaboration began.

To further illustrate how the network changed during the three years of the project, it is possible to look at changes in the relationships of each of the collaboration partners. Social network analysis allows us to look at each partner's relationship with each other partner in the network. These are called ego-networks, where each partner is considered an ego, and all other members of the network are considered alter egos. Table 21.1 shows changes in the size of each partner's ego-network, the number of ties from each partner to the overall network, and a measure of ego-network density at the beginning of the project and again when the project ended.

Ego-network size indicates the number of other network partners with whom each member has a direct relationship. Although there are 23 partners in the network, actors cannot be connected to themselves, so the maximum ego-network size for any partner is

Table 21.1 Ego-Network Size, Number of Ties, and Density of Collabration Partners When the Project Began and When it Ended

	Beginning			End		
Collaboration Partners	Size	Ties	Density	Size	Ties	Density
Big Brothers/Big Sisters (BBBS)	6	28	.9333	17	216	.7941
Bluebonnet Trails MHMR (BMHMR)	12	95	.7197	21	277	.6595
Bridges to Growth (BRID)	2	1	.5000	16	198	.8250
Georgetown Alternative Program (GAP)	9	57	.7917	15	156	.7429
Georgetown Fire Department (GFD)	7	38	.9048	10	76	.8444
GISD Administration (ISDAD)	13	102	.6538	21	274	.6524
Georgetown Police Department (POL)	14	116	.6374	22	296	.6407
Georgetown Prevention Project (GPP)	11	92	.8364	20	265	.6974
The Georgetown Project (GPROJ)	15	114	.5429	22	295	.6385
Growthlines (GROW)	0	0	.0000	15	149	.7095
Georgetown Hospital (HOSP)	8	42	.7500	12	102	.7727
Intervention Services Unlimited (ISU)	10	79	.8778	18	231	.7549
Lifesteps (LIFE)	13	106	.6795	18	232	.7582
Methodist Church (METH)	7	33	.7857	10	66	.7333
Parents as Teachers (PAT)	0	0	.0000	14	160	.8791
Peer Mediation/Teen Leadership (PEER)	0	0	.0000	11	92	.8364
Prevention Curriculum (PREV)	0	0	.0000	13	127	.8141
Juvenile Probation (PROB)	12	101	.7652	19	244	.7135
SSHS Program Administration (SSHSPA)	0	0	.0000	21	272	.6476
Student Support Services (STSERV)	0	0	.0000	21	286	.6810
GISD Truancy Officer (TRU)	0	0	.0000	16	189	.7875
Williamson County Health Dist. (HEALTH)	14	116	.6374	16	176	.7333
Williamson County Sheriff Dept. (SHER)	10	68	.7556	12	105	.7955

23 minus itself, or 22. Ties refers to the number of connections among all actors in the ego-network. In this network, the maximum number of possible connections in the network would be 23 times 23 minus 23, or 506. So, if a partner was connected to each of the other 22 partners, and each of those partners is connected to all other collaboration partners, there would be 506 ties in the ego-network. Like network density, ego-network density indicates the proportion of all possible connections in each ego-network that are actually present and may reflect the number of constraints and opportunities the ego faces in its ego-networks.

To help interpret this table, look at the first program listed, Big Brothers/Big Sisters (BBBS). In the beginning its ego-network size was 6—itself and 5 other collaboration partners. From our calculation of overall network density, we know there are 30 possible connections in this ego network ($6 \times 6 = 36 - 6 = 30$). There are 28 total ties or connections among the partners in this ego-network, giving us a density score of $28 \div 30 = .9333$. This means that 93.3% of all possible connections in this ego-network actually exist. By the end of the project, Big Brothers/Big Sisters was connected to 17 of 22 partners and had 216 total ties to its ego-network. This represents a nearly three-fold increase in the size of its ego-network.

The density score is actually lower at the end of the project, but it has a much larger ego-network and is still very tightly connected, with 79.4% of all possible ties actually present in the network. Recall from our earlier discussion of network density that larger networks tend to be less densely connected.

Looking at Table 21.1, it is clear that both the ego-network size and the number of total ties for each partner dramatically increased during the three years of the project. Seven programs were not connected to any other members of the collaboration in the beginning. However, by the end of the project they all appear to be well connected to the network and integral to the collaboration effort.

Another way to evaluate the network is to examine each social unit's position in the network relative to other social units. The relations each social unit has with others in the network can impose constraints on the unit, or offer the unit opportunities (Hanneman & Riddle, 2005). Social units that face fewer constraints than others, or who have more opportunities than others, are often in a favorable position in the network. A common way to measure network position is to assess centrality. There are three common indicators of centrality used in network analysis: degree, closeness, and betweenness.

We discussed *degree* earlier, which refers to the number of direct connections the social unit has to the network. Social units that have more direct ties to others in the network often have alternative ways to satisfy needs, greater access to the resources of the network, and hence are less dependent on other individual actors. Degree centrality has been criticized because it only takes into account the direct ties that an actor has with others in the network. *Closeness*, like reachability, looks at the distance from one social unit to all others in the network. Social units that can reach other social units, or be reached by others, through shorter paths may have positions of influence in the network. *Betweenness* refers to the extent to which a social unit lies between other social units (i.e., is a boundary spanner). That is, they may act as intermediaries so that other social units can only connect with one another through a third party. Being in a position that lies between others obviously puts a social actor in a favorable position relative to others in the network.

Table 21.2 shows the three measures of centrality for each of the collaboration partners in the beginning and three years later when the project ended. By examining the table, we see that all three centrality scores increased dramatically from the beginning to the end. In the beginning, The Georgetown Project was clearly the most central partner in the collaboration. In particular, its betweenness score of 7.8 is much larger than the betweenness score of any other actor. This indicates that in the beginning it acted as an intermediary for relationships between others in the network.

It might be surprising to some that this organization would have such a central position in the network, because it does not work directly with clients. It is a small nongovernmental organization (NGO) that describes its role in the community as that of a catalyst for building an infrastructure of services for children and youth. It was instrumental in bringing people together to write the initial grant application for the SS/HS project, and it had facilitated several community-based collaborations in the past. So, while it does not service clients directly, it was clearly in a position to facilitate the community collaboration when it began.

By the end of the project, the centrality scores for all partners had increased, indicating that the network was much more tightly connected than in the beginning. The Georgetown

Table 21.2 Degree, Closeness, and Betweenness Centrality for Collaboration Partners When the Project Began and When It Ended

	Beginning			End		
Collaboration Partners	Degree	Close	Between	Degree	Close	Between
Big Brothers/Big Sisters (BBBS)	27.2	11.8	0.0	77.2	81.4	0.7
Bluebonnet Trails MHMR (BMHMR)	54.5	12.2	0.7	95.4	95.6	2.2
Bridges to Growth (BRID)	4.5	11.5	0.0	72.7	78.5	0.4
Georgetown Alternative Program (GAP)	40.9	12.0	0.2	68.1	75.8	0.9
Georgetown Fire Department (GFD)	31.8	11.9	0.0	45.4	64.7	0.0
GISD Administration (ISDAD)	59.0	12.3	1.3	95.4	95.6	2.4
Georgetown Police Department (POL)	63.6	12.4	1.7	100.0	100.0	2.9
Georgetown Prevention Project (GPP)	50.0	12.2	0.4	90.9	91.6	1.9
The Georgetown Project (GPROJ)	68.1	12.5	7.8	100.0	100.0	2.9
Growthlines (GROW)	0.0	4.3	0.0	68.1	75.8	1.0
Georgetown Hospital (HOSP)	36.3	12.0	0.2	54.5	68.7	0.3
Intervention Services Unlimited (ISU)	45.4	12.1	0.1	81.8	84.6	0.8
Lifesteps (LIFE)	59.0	12.3	1.1	81.8	84.6	1.2
Methodist Church (METH)	31.8	11.9	0.2	45.4	64.7	0.4
Parents as Teachers (PAT)	0.0	4.3	0.0	63.6	73.3	0.1
Peer Mediation/Teen Leadership (PEER)	0.0	4.3	0.0	50.0	66.6	0.1
Prevention Curriculum (PREV)	0.0	4.3	0.0	59.0	70.9	0.4
Juvenile Probation (PROB)	54.5	12.2	0.6	86.3	88.0	1.4
SSHS Program Administration (SSHSPA)	0.0	4.3	0.0	95.4	95.6	2.4
Student Support Services (STSERV)	0.0	4.3	0.0	95.4	95.6	2.2
GISD Truancy Officer (TRU)	0.0	4.3	0.0	72.7	78.5	0.4
Williamson County Health Dist. (HEALTH)	63.6	12.4	1.7	72.7	78.5	0.7
Williamson County Sheriff Dept. (SHER)	45.4	12.1	0.3	54.5	68.7	0.3

Project is still in a central position in the network, but several collaboration partners have centrality scores comparable to The Georgetown Project, indicating that these organizations are now in positions where they link together different social units in the network.

To gain a more comprehensive understanding of how the collaboration changed over time, additional social network analyses were performed to assess changes in the collaboration over the three years of the project. For example, separate analyses were conducted to assess changes in client referral patterns in the collaboration, the flow of information among collaboration partners, the extent to which collaboration partners shared the same clients or engaged in joint treatment planning, and the extent to which the relationship among partners was facilitated by a case manager. Each of these network analyses provides a different understanding of how the structural relationships evolved and changed over the three years of the SS/HS initiative. All of the network analyses showed that, by the end of the project, the collaboration partners had become much more tightly connected, and the community collaboration was much more fully integrated in its working relationships.

CONCLUSION

Relationships between social units are basic to our conceptualization and understanding of social systems. Theoretical approaches to understanding social systems, such as general systems theory, have long been criticized for high levels of abstraction and operational inadequacy (Buckley, 1968). Social network analysis represents one methodology that can be used to overcome these difficulties by specifying and operationally defining basic dimensions of the relationships that bind together the social units in any system. It can also be applied across a wide range of different social units, contexts, and social systems. It can be used to examine personal social support systems and kinship groups, as well as relationships among work teams within an organizational context, or relationships reflected in trade policies among nation-states in the global economy. As shown in this chapter, social network analysis can be a useful tool for evaluating the evolution of a community-based collaboration that was designed to promote healthy childhood development, prevent violence and drug abuse in schools, and create a safe school environment.

Overall measures of network relations provide descriptions of both the content and form of social systems. The size and density of the overall network and the structural position of individual actors based on their ego-network relationships all reflect important social conditions. Measures of size, density, and centrality provide information on context and thus give an important foundation on which to study the structure and processes of social systems. In addition, although not reported in this chapter, partitioning networks into subsystems using structural equivalence analysis can reveal modes of operation and establish patterns of interdependency in large complex social networks. Descriptions of subgroups and the relations between subgroups offer great potential for documenting situational determinants and contingencies in theory.

Each of the different techniques used in network analysis have advantages and disadvantages. Graphic depictions of unit-specific relations provide useful overall impressions, particularly when one can compare the network over time. Such impressions facilitate an intuitive understanding of the social structure of a network and how that network changes over time. The disadvantage is that the description reflected in each network map is static and limited to single-variable accounts. More abstract graphic depictions based on types of units or social roles provide greater generalizability and also allow the researcher greater control in illustrating aspects of the network.

Although not presented in the chapter, structural equivalence analysis offers a method of clustering network actors to discover homogeneous subgroups within networks. Although such analysis can be complicated and difficult to interpret, it is valuable because it offers a window into the substructure of complex social systems. The measures of network relations that are produced with various cluster analyses represent basic features of social systems. Partitioning of overall density relations into the specific density relations among structurally equivalent positions can reveal the most dramatic changes in these relationships.

Network analysis is also effective when it is combined with other analysis methods to develop and test theory. Identifying clusters and subgroups, and observing patterns in graphic models, are techniques that enhance descriptions of members' behavior and the systems within which the behavior takes place. But testing hypotheses about networks requires

comparable data from many networks, or large networks with many subgroups, so that the output from network analysis may be imported into standard data files for conventional quantitative analysis.

Discussion Questions

1. How might you use social network analysis to better understand helping and/or social service networks in your community? If you do not live in a rural community, talk hypothetically about how this would apply to a rural community. How might it be different in rural communities from urban or suburban communities? How might it be similar?
2. If you were responsible for helping to develop a rural health care provider network in your area, how might you use social network analysis to guide its development? How might you use it to evaluate your efforts?
3. In your opinion, what are the strengths of the social network analysis approach to understanding social capital and human service systems in rural areas? What are the weaknesses? Are there unique challenges or opportunities to using social network analysis in rural areas?
4. Consider Hardcastle, Powers, and Wenocur's statement that "assessing, developing and managing social networks, and helping our clients to assess, manage and develop their social networks, is at the heart of social work practice." What do you think they mean by that statement? How might that statement guide your professional practice in rural areas?
5. How might you employ social network analysis in an assets- or strengths-based approach to social work practice with a rural community or rural social service system?

Classroom Activities and Assignments

1. Depending on the size of the class, this activity may require dividing the class into smaller groups. Groups of 10 to 15 students work best for this activity. On a large piece of flipchart paper, write the names of the students in the class or group. Arrange the names so that they are in a circle around the paper. Next, ask the members of the group to look at the names on the paper and write down the names of those students with whom they have been in a class before. Then go around the room and have each student read the names of the other students with whom they have previously been in class. As they read the names, use a pencil to draw a line connecting their name to the other students' names. After each student has read the names and the map is complete, look at the map. What can you say about the connections among the members of the class based on this question? Are you surprised by anything you see? Why or why not? Next, repeat the activity, only this time develop the map based on the question: Which other students do you socialize with outside of class? After completing the map, how does this map compare to the first map? Is it more or less densely connected? Why do you think that is? Finally, repeat the process with a final question: Which other students in the class have you studied with in preparation for a

test? How does this map compare to the other two maps? Why do you think they look different?

2. Interview the head of a local social service agency. Ask them to identify all other agencies and organizations they work with as they pursue their mission. The list should include both service providers and funders. List all organizations they identify and create four columns next to the list of names. Label column 1 "refer to" and column 2 "refer from." Label column 3 "funding to" and column 4 "funding from." Now read them the list and ask them which organizations they refer clients to and who they receive client referrals from, and record their answers in columns 1 and 2. Next ask them which organizations they receive funding from and who they send funding to. Now use this information to create two network maps showing the client referral relationships and funding relationships of this organization. Are the maps similar or different? Why do you think that is? How might you combine these two maps to create one map that clearly reflects both client referral and funding relationship? Hint, think about how colors or shapes might help distinguish between these two types of relationships.

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APPENDIX A

NASW Rural Policy Statement

Policy statement[1] approved by the NASW Delegate Assembly, August 2011. This statement supersedes the policy statement on Rural Social Work approved by the Delegate Assembly in August 2002. For further information, contact the National Association of Social Workers, 750 First Street NE, Suite 700, Washington, DC 20002-4241. Telephone: 202-408-8600; e-mail: press@nazvdc.org

BACKGROUND

The historical roots of social work are generally traced to urban communities, yet social work practice that specifically addresses the needs of rural individuals and communities is equally as important, as nearly 50 million Americans (or 17% of the U.S. population) live in rural areas. Rural areas extend across 80% of the land area and cover approximately 2,000 counties (U.S. Department of Agriculture Rural Development [USDARD], n.d.).

Social workers practicing in rural areas have historically sought to resolve issues of equity, service availability, and isolation that adversely affect residents. They also work to support and advocate for vulnerable and at-risk people living in rural communities. Individuals and families in rural areas face a host of challenges that often result in inequality and disenfranchisement.

RURAL INEQUALITY

Individuals who live in rural areas are more likely than their urban counterparts to have no form of health coverage, to neglect seeing a physician due to cost, to have no dental care, to

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smoke, to be obese, and to suffer from chronic illness (North Carolina Rural Health Research and Policy Analysis Center, 2010). For those who do seek treatment, it is often a challenging undertaking, as only 10% of physicians practice in rural America (National Rural Health Association [NRHA], n.d.).

Rural residents are also more likely to suffer from the consequences of poverty. Great wealth has been extracted from rural America, yet it remains the site of some of the nation's most intense and persistent poverty. According to the USDARD (n.d.), people in rural areas experience lower income levels, higher unemployment, and higher poverty rates than people in urban areas. Rural poverty rose significantly by 2009, reaching 16.6%. Residents in some parts of the country, such as Appalachia or along the Texas-Mexico border, experience poverty rates of 30% to 50% (Ambrosino, Ambrosino, Heffernan, & Shuttlesworth, 2008). Over 400 rural counties had poverty rates of 20% or more in 2000, which is well above the national average. Median household income in rural areas now stands at 78.7% of the metropolitan median. Areas with high levels of poverty are concentrated in the South, and reflect the relatively low incomes of racial and ethnic minorities, female-headed families, and households with children (USDARD, n.d.).

In addition to significant levels of rural poverty, the past decade has continued a 30-year trend toward rising government transfer payments, such as Food Stamps and subsidies for health care, to rural residents. These payments now account for 22.7% of personal income, compared with 13.6% in metropolitan areas. The majority of these transfers were due to the high cost of health care (USDARD, n.d.). Yet Medicare payments to rural hospitals and physicians are dramatically less than those in urban areas for equivalent services. This correlates closely with the fact that more than 470 rural hospitals have closed in the past 25 years. Rural residents are also less likely to have employer-provided health care coverage or prescription drug coverage and rely more heavily on the federal Food Stamp program (NRHA, n.d.).

ACCESS TO CARE

Many rural areas are considered health professional shortage areas, as defined by the U.S. Department of Health and Human Services, with a shortage of primary medical care, dental, or mental health providers (Health Resources and Services Administration, n.d.). There are 2,157 health professional shortage areas in rural and frontier areas of all states and U.S. territories, compared with 910 in urban areas (NRHA, n.d.). The geographic distribution of social workers is uneven, resulting in gaps in access for those in rural areas (Whitaker, Weismiller, & Clark, 2006). Rural communities may have fewer formal resources, and those that do exist are taxed beyond their limits (Hepworth, Rooney, & Rooney, 2010). Rural areas may offer public welfare services, mental health and developmental disabilities outreach centers, and public health services. Available services are usually understaffed, offer limited assistance, and often are accessible by traveling long distances (Ambrosino et al., 2008).

With respect toward mental health care, President George W. Bush's New Freedom Commission on Mental Health reported that the vast majority of Americans living in underserved, rural, and remote areas experience disparities in mental health services. The

commission concluded that "rural issues are often misunderstood, minimized, and not considered in forming national mental health policy. Too often, policies and practices developed for metropolitan areas are erroneously assumed to apply to rural areas" (President's New Freedom Commission Report, 2003). Twenty percent of rural areas lack mental health services, compared with 5% of metropolitan areas (NRHA, n.d.).

Furthermore, the health and human services that do exist in rural areas are diminished by issues related to levels of professional training among staff (Daley & Avant, 1999; Ginsberg, 2005). Rural agencies generally face shortages of professional social workers. Bachelor's-level social workers provide higher proportions of the services in rural communities than in urban communities (Daley & Avant, 1999; Johnson, 1980), and many of their colleagues lack professional social work education. Given the low salaries and high caseloads characteristic of practice in the public sector, particularly in rural areas, it is not surprising that graduates of accredited BSW and MSW programs seek employment opportunities elsewhere, which leaves a void in the public sector that is often filled by people with degrees in disciplines other than social work (Lohmann & Lohmann, 2010).

Another area of great inequality, which has an effect on the health and well-being of residents in rural locales, is the digital divide. Rural areas have historically been the last to receive telecommunication investments and are behind in Internet usage. The Obama administration stated that "Modern technology is critical to the expansion of business, education, and health care opportunities in rural areas and the competitiveness of the nation's small towns and rural communities" (White House, n.d.). In 2007, 63% of rural residents, compared with 73% of urban residents, used the Internet somewhere. The cost to provide a rural household with telecommunication services has always been higher than for an urban household. Outside of larger rural towns, cable companies are bypassing rural areas for the most part (USDARD, n.d).

DIVERSITY

Social workers practicing in rural areas must be prepared to work with diverse populations and communities (Davenport & Davenport, 2008). Rural areas are increasingly diverse, which brings with it challenges and opportunities. Many rural areas struggle with the economic and social changes brought about by in-migration and immigration of outside populations. All of these groups bring new and different languages, cultures, and beliefs to the rural communities, with the resulting pressure on educational, health, and human services resources and on a community's ability to accept and blend these individuals into the community fabric (Hagan, 2011; Nelson, Lee, & Nelson, 2009).

Racial and ethnic minorities now make up 18.3% of rural residents. African Americans are the largest minority group in these areas; however, Hispanics and Asians are the fastest-growing populations (USDARD, n.d.).

Although rural areas struggle with a disproportionate share of poverty, people of color in rural areas bear an even greater burden. Rural non-Hispanic Black Americans had the highest incidence of poverty in 2009, at 32.2%. The 2009 poverty rate for rural Hispanics was 27.8%. These rates were more than twice the poverty rates for non-Hispanic White

Americans at 13.3%. Rural Native Americans and Black Americans are three times more likely to live in low-income families, and consequently, they are more likely to use public services than non-Hispanic White Americans (USDARD, n.d.).

In addition, poverty is higher for children in rural areas. The child poverty rate in rural areas was 23.5%, compared with 20.2% in metropolitan areas, in 2009. At the other end of the aging spectrum, rural areas have a larger share of older people (15%) than the population as a whole (12%). Compared with their urban peers, older rural Americans generally have less income, lower educational attainment, and a higher dependence on social security income (USDARD, n.d.). Finally, a large rural population with specific needs are members of the military and veterans. U.S. service members in recent conflicts are increasingly drawn from rural areas and return to live in those areas. More than 44% of U.S. military recruits come from rural areas ("Youths in Rural U.S.," 2005), with an opposite trend in larger cities. Veterans who live in rural settings have greater health care needs than their urban counterparts, yet they access health care systems less often. Although rural veterans may use psychiatric services less than their urban counterparts, those who are diagnosed with psychiatric disorders are sicker than urban veterans. As a result of increasingly diverse rural communities, social workers must continually seek to be culturally competent as they work with individuals from a variety of backgrounds, races and ethnicities, and income and education levels. In different parts of the country, the ability to speak dual languages, particularly Spanish, or have access to interpreter services, is also important.

By recognizing all of these diversity factors, rural social work practice contributes to the social work mission of advocating for social justice and extending access to services for underserved populations. These and other factors raise crucial issues for social work practice and educational preparation for social work practice in rural areas.

ISSUE STATEMENT

In response to the challenges facing rural areas, social workers have a unique and important role to play to help ensure the health and well-being of all rural residents. However, they struggle with numerous workforce challenges that may never be faced, or faced to a lesser degree, by their urban counterparts. Rural social workers must care for the increasing number of clients in need of social work services, while dealing with insufficient numbers of professional social work colleagues to provide care, as well as a lack of sufficient social work supervision, high caseloads, the lowest social work salaries of any geographic location, the tendency for agencies to hire non–social workers who lack professional training to fill social work positions, and complicated ethical challenges (Whitaker et al., 2006).

Professional recruitment and retention issues are, in part, by-products of a social work educational system that developed largely from urban roots. Consequently, most social workers receive little content on rural social work in their professional education. This creates a major barrier to developing a social work labor force prepared to address the needs of rural clients and communities and poses a deficit for social workers practicing in rural areas. Rural social work knowledge is important for all social workers, as rural people migrate to urban centers seeking economic opportunity in the face of joblessness, disaster, and conflict. Social

workers practicing in urban areas will benefit from knowledge of practice skills that are most effective with rural individuals, families, and communities.

Rural social work practice requires a sophisticated level of understanding of values and ethics and highly developed skills in applying them: "Many of the skills needed to practice social work are the same as those that urban social workers use, an important difference is the emphasis on informal and personal relationships in rural settings" (Ambrosino et al., 2008, p. 398).

Small communities pose unique service challenges because of the low numbers of professional social workers, the importance of interacting with providers and community members who have limited understanding of professional ethics, and the close-knit nature of rural communities. Rural social workers must learn to practice with a lack of anonymity, because it is often the case that everyone appears to know what everyone else is doing (Davenport & Davenport, 2008). Effective rural practice often involves locality-based community development that may make maintaining professional distance something that is considered inappropriate and may limit effectiveness. Protecting clients from any negative consequences of dual relationships in rural settings has less to do with limiting social relationships and more to do with setting clear boundaries. In fact, nonsexual dual and multiple relationships may even be seen as a strength, if not a necessity, of a good social worker (Bodor, 2005).

Rural communities often retain traditional structures, both informal and faith-based service delivery systems, that can be either assets or challenges. These structures provide self-monitoring and vigilance, making rural communities sometimes safer than urban areas, and encourage a strong informal helping system. However, the same structures may be less hospitable to those perceived as outside of the mainstream culture, such as people of color, women, or gay, lesbian, bisexual, and transgender people. Residents of rural areas may be judgmental toward clients and services that reflect cultures and lifestyles different from community norms. Social workers who are not from the community may also find it more of a challenge to establish effective working relationships due to the close-knit nature of the rural community. Education of community members requires a sustained effort based on trust.

The overall understanding of rural people and cultures is a pressing issue of cultural competence in the social work profession. All social workers should seek to understand the unique challenges and assets within rural communities. All of the issues previously discussed raise crucial issues for social work practice and educational preparation for social workers in rural areas.

POLICY STATEMENT

NASW supports the following:

- Recognition of the importance of rural populations to the nation's economy and cultural identity by all social workers and society as a whole
- Legislation and policy that improves rural infrastructure, economic development, and access to health care, transportation, education, and social services

- Advocacy for social work practice and policy that addresses the unique needs of rural clients, particularly those who are vulnerable and oppressed, while recognizing the strengths and assets of rural communities
- Culturally competent practice, research, and education specific to rural cultures, diversity, and people in a contextual framework at the bachelor's and master's levels
- The development and application of ethical principles for professional practice with rural populations
- Policies that attract and retain social workers in rural settings by creating incentives, networking, professional development, and role modeling for effective practice
- Continuing education opportunities for social workers to provide a broad range of services, including clinical and health practice, community organization, administration and management, public welfare, and community-based services for rural people
- Promotion of the effectiveness of professional social workers in helping rural people to capitalize on their strengths, improve their lives, maintain healthy families, and improve their communities
- Development and extension of expanded technology for professional development as well as for rural clients and communities, and the ethical use of technology in service delivery

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APPENDIX B

Online Training and Resources on the EBP Process and Practice Issues for Rural Settings

TRAINING

Services for Australian Rural and Remote Allied Health (SARRAH), a guide on translating evidence-based practice into rural settings: http://www.sarrahtraining.com.au/site/index.cfm?display=143717&filter=i&leca=611&did=94487486

Office of Behavioral & Social Sciences Research, National Institutes of Health with Northwestern University. The training on the EBP process is free of charge with registration: www.ebbp.org/training.html

The Wilma and Albert Musher Program at Columbia University School of Social Work online modules on EBP: www.columbia.edu/cu/musher/Website/Website/EBP_Online-Training.htm

Dr. Leonard Gibbs, *Evidence-Based Practice for the Helping Professions*, a supplement to this text: www.evidence.brookscole.com. Published 2002 by Brooks/Cole.

Dr. Allen Rubin's and Jennifer Bellamy's text: *Practitioner's Guide to Using Research for Evidence-Based Practice* (2nd ed.). A practitioner-friendly guide for appraising the research evidence and feasibly evaluating practice decisions. Published 2012 by John Wiley & Sons.

FINDING THE BEST RESEARCH EVIDENCE

Rural Behavioral Health Programs and Promising Practices: www.hrsa.gov/ruralhealth/pdf/ruralbehavioralmanual05312011.pdf

The Cochrane Collaboration Library and Database: www.cochrane.org

The Campbell Collaboration Library and Database: www.campbellcollaboration.org

National Center for Trauma-Informed Care: Trauma-informed care and trauma services: www.samhsa.gov/nctic/

Office of Juvenile Justice and Delinquency Prevention (OJJDP) Model Programs Guide: www.ojjdp.gov/mpg/search.aspx

California Evidence-Based Clearinghouse for Child Welfare (CEBC): www.cachildwelfareclearinghouse.org/

Principles of Drug Addiction Treatment: A Research-Based Guide (2nd ed.), NIDA: www.drugabuse.gov/publications/principles-drug-addiction-treatment/evidence-based-approaches-to-drug-addiction-treatment

American Psychological Association (APA) Guidelines: www.div12.org

National Guidelines Clearinghouse (DHHS): www.guidelines.gov

The Journal of Evidence-Based Social Work: www.tandfonline.com/toc/webs20/current

Anxiety and Depression Association of America: www.adaa.org

Social Work Policy Institute EBP: www.socialworkpolicy.org/research/evidence-based-practice-2.html

SOURCES TO FIND TOOLS TO EVALUATE PRACTICE DECISIONS

APA Online Guide to Accessing and Using Psychological Assessment Instruments: www.apa.org/science/faq-findtests.html

Alcohol & Drug Abuse Institute, Screening & Assessment Database: http://lib.adai.washington.edu/instruments/

Buros Institute of Mental Measurements: www.unl.edu/buros

Psychological Measures for Asian American Populations: www.columbia.edu/cu/ssw/projects/pmap/

University of Miami College of Psychology: www.psy.miami.edu/faculty/ccarver/CCscales.html

Psychology Department at Muhlenberg University: www.muhlenberg.edu/depts/psychology/Measures.html

National Center for PTSD, Department of Veteran Affairs: www.ncptsd.va.gov/ncmain/assessment/

WALMYR Scales: www.walmyr.com/index.html

Books for Locating Standardized Measures:

Corcoran, K., & Fischer, J. (2007). *Measures for clinical practice: A sourcebook* (4th ed., 2 vols.). New York, NY: Free Press.

Maltby, J., Lewis, C. A., & Hill, A. (Eds.). (2000). *Commissioned reviews of 250 psychological tests* (2 vols.). Wales, UK: Edwin Mellen Press.

ONLINE TREATMENT FOR CLIENTS

Beating the Blues: Computerized Cognitive Therapy for Depression and Anxiety. This computerized CBT program has been shown to be effective in multiple randomized controlled trials: http://beatingtheblues.co.uk

ONLINE MANUALS FOR EMPIRICALLY SUPPORTED INTERVENTIONS

An Individual Drug Counseling Approach to Treat Cocaine Addiction: The Collaborative Cocaine Treatment Study Model (NIDA): http://archives.drugabuse.gov/TXManuals/IDCA/IDCA1.html

A Cognitive-Behavioral Approach: Treating Cocaine Addiction (NIDA): http://archives.drugabuse.gov/TXManuals/CBT/CBT1.html

A Community Reinforcement Approach: Treating Cocaine Addiction: http://archives.drugabuse.gov/TXManuals/CRA/CRA1.html

Approaches to Drug Abuse Counseling (NIDA): http://archives.drugabuse.gov/ADAC/ADAC1.html

Substance Abuse and Mental Health Services Administration (SAMHSA) provides free online manuals in multiple treatment areas (the TIP series), which can also be ordered for free in print. Multiple manuals are available (e.g., motivational interviewing, cognitive-behavioral interventions, family treatment): http://store.samhsa.gov/home

COMMUNITY HEALTH PROMOTION RESOURCES

National Institute on Drug Abuse (NIDA) Drug Pubs: http://drugpubs.drugabuse.gov

Substance Abuse and Mental Health Services Administration (SAMHSA): http://store.samhsa.gov/home

Centers for Disease Control and Prevention (CDC): www.cdc.gov/Publications/

APPENDIX C

Ideas Ratings for Service Providers and Consumers (Mean Scores)

#	Group/Statement	All	Providers	Consumers	Dental
Staff Training/Continuing Education					
1.	Ensure that staff have access to current continuing education opportunities	3.76	3.77	3.78	3.84
2.	Provide staff with the skills necessary to empower clients to comply with agency protocols and expectations	3.84	3.87	3.83	3.80
3.	Educate staff about regulations that impact service delivery	3.78	3.70	3.83	3.84
4.	Educate all SHRT staff about protocols for the dental and oral health program	3.69	3.66	3.73	3.77
5.	Train staff in motivational interviewing	3.63	3.69	3.60	3.69
6.	Provide staff training on stress management	3.68	3.76	3.70	3.70
	Average	3.72	3.73	3.74	3.75
	Standard Deviations	.334	.292	.355	.345
Client Education					
7.	Ensure that clients have access to current continuing education opportunities	3.43	3.10	3.67	3.74
8.	Implement individual client education plans that focus on treatment recommendations	3.53	3.31	3.70	3.70
9.	Educate clients about agency protocols and expectations	3.65	3.53	3.78	3.76
10.	Empower clients to assume responsibility for complying with agency protocols and expectations	3.67	3.73	3.62	3.54

(*continued*)

#	Group/Statement	All	Providers	Consumers	Dental
11.	Educate clients about services available through SHRT	3.77	3.70	3.85	3.80
12.	Educate clients about services available in the community	3.75	3.80	3.76	3.69
13.	Assist clients in developing skills related to medication compliance	3.82	3.83	3.83	3.77
14.	Assist clients in developing skills related to compliance with treatment recommendations	3.79	3.83	3.83	3.81
15.	Provide educational services that are appropriate for all levels of cognitive functioning	3.60	3.70	3.56	3.52
16.	Provide educational services that are sensitive to cultural beliefs	3.40	3.70	3.26	3.24
17.	Involve clients in efforts to educate other clients about the importance of treatment compliance	3.54	3.42	3.62	3.75
18.	Talk with clients about what to expect before their dental appointments	3.49	3.52	3.50	3.48
19.	Provide a resource library for clients	3.16	3.00	3.33	3.31
20.	Educate clients about the importance of oral and dental health	3.63	3.63	3.66	3.61
21.	Provide literacy tutorials for clients	3.25	3.26	3.22	3.11
	Average	3.55	3.54	3.58	3.53
	Standard Deviations	.404	.362	.426	.453
Confidentiality					
22.	Ensure that the environment maintains client confidentiality	3.87	3.97	3.79	3.73
23.	Create a separate waiting area for dental clients	2.51	2.63	2.50	2.38
	Average	3.01	3.18	2.91	2.75
	Standard Deviations	.829	.737	.892	.863
Public Education/Awareness					
24.	Implement a public awareness program that involves all community stakeholders (e.g., community leaders, public officials, churches, schools)	3.44	3.59	3.29	3.17
25.	Educate the community about Universal Precautions	3.65	3.55	3.68	3.50
26.	Involve clients in efforts to educate the community about HIV/AIDS	3.38	3.54	3.32	3.26
27.	Create position(s) in the local communities for public relations and education	3.44	3.56	3.38	3.20
28.	Increase community support	3.67	3.83	3.54	3.44
	Average	3.53	3.61	3.47	3.36
	Standard Deviations	.589	.503	.666	.782

#	Group/Statement	All	Providers	Consumers	Dental
Service Efficiency					
29.	Improve communication among service providers	3.67	3.90	3.51	3.32
30.	Improve efficiency in coordinating case management, dental health care, and primary health care services	3.66	3.80	3.55	3.46
	Average	3.66	3.85	3.57	3.39
	Standard Deviations	.604	.326	.736	.852
Transportation					
31.	Offer gas vouchers to clients in order to assist with transportation to services	3.15	2.89	3.39	3.48
32.	Assist clients with transportation for nonmedical services	2.78	2.27	3.16	3.22
	Average	3.00	2.61	3.29	3.33
	Standard Deviations	.878	.870	.818	.832
Dental Services					
33.	Secure financial resources to support the expansion of dental services	3.64	3.59	3.68	3.67
34.	Allocate at least one full day of dental services per month for Paris	3.55	3.67	3.45	3.37
35.	Allocate at least one full day of dental services per month for Texarkana	3.60	3.64	3.61	3.50
36.	Schedule dental slots at least three months in advance	3.00	2.79	3.13	3.13
37.	Provide dental services in Paris	3.51	3.32	3.64	3.59
38.	Reserve a block of dental appointments specifically for new clients	3.35	3.50	3.32	3.25
39.	Provide funding to assist clients with oral surgery services	3.49	3.46	3.54	3.52
40.	Provide dental services at least four times a month in each location	3.38	3.15	3.53	3.58
41.	Implement a protocol for dental emergencies	3.58	3.62	3.54	3.50
42.	Schedule specific days in each location for dental services	3.50	3.45	3.58	3.52
43.	Give clients the option to upgrade their dentures and partials for a fee	3.23	3.07	3.35	3.16
	Average	3.41	3.36	3.46	3.40
	Standard Deviations	.492	.444	.536	.574
Mental Health Services					
44.	Make mental health services available to all clients	3.70	3.66	3.74	3.74
	Standard Deviations	.608	.670	.581	.594

(*continued*)

#	Group/Statement	All	Providers	Consumers	Dental
Marketing					
45.	Educate the community about Special Health Resources for Texas	3.70	3.80	3.62	3.58
46.	Educate the medical community about Special Health Resources for Texas	3.79	3.90	3.73	3.68
	Average	3.75	3.85	3.68	3.64
	Standard Deviations	.517	.375	.584	.641
Client Support					
47.	Offer peer support programs for clients	3.45	3.38	3.55	3.50
48.	Provide clients with opportunities for social interaction	3.17	2.89	3.40	3.44
49.	Assist clients in developing social support networks	3.31	3.11	3.46	3.50
50.	Assist clients with accessing available support services, such as housing, food, etc.	3.67	3.52	3.81	3.77
51.	Assist clients with funeral planning	2.93	2.46	3.28	3.13
52.	Provide home-based support services for clients	3.16	2.64	3.49	3.54
53.	Offer assistance with utility bills (e.g., electricity, water, sewage)	3.34	3.21	3.47	3.37
54.	Create opportunities for clients and significant others to engage in social activities (e.g., holiday gatherings, social events)	2.86	2.55	3.05	2.81
55.	Make referrals for legal services	3.16	2.80	3.40	3.27
	Average	3.22	2.98	3.40	3.30
	Standard Deviations	.711	.663	.737	.834
Client Housing					
56.	Offer transitional living services for clients who are recovering from substance abuse or addiction	3.03	2.93	3.12	3.08
57.	Offer supportive living services for clients	3.15	2.79	3.40	3.35
58.	Raise the caps on housing assistance	3.18	2.92	3.32	3.17
	Average	3.12	2.83	3.30	3.20
	Standard Deviations	.812	.795	.812	.904
Technology					
59.	Secure funding to purchase e-pocrates software (treatment software) and portable devices	3.15	3.24	3.12	2.86
60.	Use appointment scheduling software	3.34	3.44	3.31	3.18
	Average	3.25	3.33	3.24	3.07
	Standard Deviations	.850	.809	.895	1.05
Staff-Client Interaction					
61.	Create regular opportunities for clients to meet with staff and discuss concerns about services	3.31	3.28	3.36	3.17

#	Group/Statement	All	Providers	Consumers	Dental
62.	Provide staff training on effective communication with clients	3.55	3.65	3.51	3.38
	Average	3.43	3.48	3.44	3.29
	Standard Deviations	.651	.491	.776	.885
Medications					
63.	Offer medication assistance for all medications	3.53	3.34	3.64	3.65
64.	Offer assistance with prescriptions	3.53	3.50	3.62	3.58
	Average	3.53	3.42	3.63	3.62
	Standard Deviations	.663	.603	.699	.817
Service Accessibility					
65.	Offer clinic services in the evenings	3.13	2.93	3.27	3.13
66.	Offer clinic services on Saturdays	2.81	2.59	2.94	2.91
	Average	2.99	2.78	3.12	3.00
	Standard Deviations	1.05	1.21	.938	1.08
Staff Involvement					
67.	Have staff participate in community meetings	3.14	3.17	3.19	3.13
68.	Involve staff in identifying potential grants for services	3.34	3.11	3.46	3.38
	Average	3.23	3.13	3.34	3.25
	Standard Deviations	.896	.840	.918	1.02
Staff Support					
69.	Provide a peer support program for employees	3.18	3.07	3.26	3.00
	Standard Deviations	.900	.780	1.02	1.17
Health Care Services					
70.	Offer medical clinic services in Tyler	3.66	3.67	3.70	3.59
71.	Offer medical x-ray services for clients	3.36	3.14	3.51	3.44
72.	Recruit epidemiologists to the local communities	3.30	3.24	3.41	3.38
	Average	3.44	3.33	3.55	3.47
	Standard Deviations	.690	.558	.757	.849
Interorganizational Relationships					
73.	Establish relationships with medical service providers	3.56	3.71	3.46	3.38
74.	Establish relationships with dental service providers	3.55	3.65	3.50	3.44
75.	Create position(s) in the local communities to manage relationships with medical and dental service providers	3.51	3.56	3.50	3.38
	Average	3.54	3.63	3.50	3.42
	Standard Deviations	.680	.567	.778	.880

(*continued*)

#	Group/Statement	All	Providers	Consumers	Dental
Services					
76.	Offer vision care services	3.53	3.31	3.67	3.62
77.	Offer crown and denture services	3.46	3.26	3.66	3.62
78.	Implement a volunteer program for clients	3.18	2.78	3.51	3.48
79.	Offer a food pantry for clients	3.32	2.78	3.75	3.68
80.	Offer clothing resources for clients	3.10	2.50	3.58	3.48
81.	Offer job placement services for clients	3.21	2.68	3.61	3.57
82.	Offer a day program for clients	2.92	2.38	3.31	3.22
	Average	3.26	2.87	3.57	3.49
	Standard Deviations	.703	.737	.550	.616
Staffing					
83.	Base case management service providers in the local community	3.25	3.00	3.47	3.43
84.	Increase the number of staff	3.25	3.42	3.09	3.24
	Average	3.25	3.20	3.32	3.33
	Standard Deviations	.691	.609	.731	.677
Community Services- Primary Health Care					
85.	Increase the accessibility of local primary care physicians for clients with HIV/AIDS	3.69	3.68	3.70	3.69
	Standard Deviations	.583	.627	.564	.618
Community Services- Dental Care					
86.	Recruit local professionals to provide specialized dental services	3.46	3.46	3.46	3.46
	Standard Deviations	.811	.793	.822	.779

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