

THE FUTURE OF RURAL SOCIAL WORK

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Abstract: *Over the years, the extensive literature on rural social work has been consistent in its recommendations for local community-based practice and rural generalist practice. However, rural social work is embedded in the larger social work profession which has been moving in the opposite direction from the one advocated by rural social workers. The gradual processes of centralization and specialization in the profession now make it almost impossible for social workers to use community-based generalist practice approaches in rural areas. In order to ensure a positive future for rural social work, urban and rural social workers must work together to re-introduce a level of community-based generalist practice within regionalized and specialized social and health service systems. A range of alternative approaches to link community-based rural programs with regional programs is presented.*

Keywords: Rural Social Work, Rural Definition, Service Delivery, Regionalization, Community-Based Services, Generalist Practice

BACKGROUND ON RURAL SOCIAL WORK

Rural social work has received the attention of a dedicated group of practitioners in the profession since the early work of Josephine Brown (1933), (Martinez-Brawley, 1981). In the 1970s, an expansion of interest in rural social work produced a "rural social work movement" (Davenport & Davenport, 1995; Ginsberg, 1998a). Since that time, many publications (for ex. Farley, Griffiths, Skidmore, & Thackeray, 1982; Keller & Murray, 1982; Watkins & Watkins, 1984), interest groups, and conferences attest to the success of the upsurge of activity in the field of rural social work (Hickman, 2004). Through the period of the "Farm and Rural Crisis" of the 1980s and more recently as this crisis has continued, innovative programs of rural social work have been mobilized to help farm and rural families and their communities cope with the crisis and to encourage social and economic development to help rural communities survive (Williams, 2001; Rossman & Dvorak, 2001). At the present time rural social and health services and community development programs in rural areas target a variety of issues and populations. In addition to rural agriculture and rural economic and community development ([Heartland Center for Leadership Development](#), 2005; Rural Community Development, 2005), these include rural health (Agency for Health Care Policy and Research, 1991; Evans, 2004), rural mental health (Keller & Murray, 1982; Hann-Morrison, 2003; Evans, 2004), rural substance abuse (Johnson, 1998), rural child welfare (Ray & Murty, 1990), rural domestic violence (Websdale, 1998; Murty & Schechter, 1999; Murty, 2001a), services for the elderly in rural areas (Nelson, 1980; Krout & Coward, 1998; Krout, 1998), services for rural gays and lesbians (Lindhorst, 1997), and services for people living with AIDS (*Human Services in the Rural Environment*, 1989; Rounds, 1998), to name just a few. There are also

organizations focusing on different types of services in rural areas, for example the National Rural Health Association, the National Rural Mental Health Association, and the National Rural Social Work Caucus (see notes). In spite of the diversity of types of services, rural programs share similar concerns in regard to scarce resources, highly dispersed populations, problems of transportation, and lack of trained professionals and specialists (Martinez-Brawley, 1987; Ginsberg, 1998b; Southern Regional Education Board, 1998; HHS Rural Task Force, 2002; NASW, 2002).

Throughout the years, difficulties in defining the rural concept have stimulated much discussion. The inadequacy of the commonly used definitions of rurality has been the basis of much well deserved criticism (Mermelstein & Sundet, 1989; Davenport & Davenport, 1995; York, Denton, & Moran, 1998). Any measure that classifies communities into two dichotomous groups is bound to be inadequate. For example, comparisons of US Census data, between metropolitan areas and non-metropolitan areas, or between urban and rural areas, obscure differences between communities that are more and less rural within each two groups. Many researchers and practitioners agree that urban and rural communities exist on a continuum from the most extremely urban to the most rural communities (Ginsberg, 1998b). Any particular community can be located somewhere between these two extremes. Considerable improvement in the measurement of the rural-to-urban continuum has been achieved in recent years. The term *frontier* has been developed in relation to health service, emergency medical services, and mental health services to indicate extremely low population density areas where service delivery is especially challenging (National Clearinghouse for Frontier Communities, 2004; Frontier Mental Health Services Resource Network, 2005). Another development was the county-based rural-to-urban continuum codes to classify counties on an ordinal continuum of 10 categories (Butler & Beale, 1994). Disadvantages of this county-based classification system remain because within any county, communities can range from very urban to very rural. Especially in the western part of the United States, very large counties may be classified as metropolitan because a large population center is located in one part of the county, while other parts of these large counties may be extremely sparsely populated and should be recognized as having rural characteristics. Recently, RUCA Codes have been developed using census tracts data on population size and commuting patterns to larger communities (Olaveson, Conway, & Shaver, 2004). The RUCA Codes have refined measurement on the rural-to-urban continuum. See notes at the end of this article for resources on defining rurality and for information on the county rural-urban codes, the country frontier definitions, and the new census tract RUCA Codes.

During the decades, as interest in rural social work has persisted and its literature has grown, rural communities have been changing (Wilkinson, 1982; Mermelstein & Sundet, 1998). Some urbanites have been moving to rural areas (Davenport & Davenport, 1998). New types of technology are affecting all rural communities (Enders & Seekins, 1999). Interstate highways, cellular phones, computer access to the Internet, satellite and cable television, increase in automobile transportation, have all lessened the geographical and cultural distance that separates life in rural communities from life in suburbs and population centers. The differences between urban and rural in many regions have gradually become less dramatic than they once were. In addition, new ethnic groups, immigrants and refugees,

have been arriving in America's small towns throughout the country. Many small towns that used to be homogeneous are now experiencing a sudden and unexpected increase in diversity (Snipp, 1996; Johnson, Johnson-Webb, & Farrell, 1999). In spite of these changes, the rural/urban distinction is still relevant. Characteristics of rural communities still distinguish them from the more populated urban and suburban areas. The recommendations in the rural social work literature are still relevant to rural social work today.

RECOMMENDATIONS FROM THE RURAL SOCIAL WORK LITERATURE

The central themes that recur in the rural social work literature over its long history are the importance of local community-based practice and rural generalist practice. Over the years, the extensive literature on rural social work has been consistent in its recommendations for these two related approaches to rural practice. In order to be effective, rural social workers take time to get to know the particular rural community where they work, its assets, its local organizations, its leaders, and informal helping systems (Smith, 1997; Martinez-Brawley, 1987, 1998; Ginsberg, 1998b; NASW, 2002; Menanteau-Horta, 2004; Watkins, 2004). It is necessary to build strong personal relationships with members of the community and local community leaders in order to make good use of the assets which rural communities have to offer (Rolland & Hughes, 2004; Davis & Meyer, 1996). This community-based approach also helps to gradually overcome the initial suspicion which local rural residents tend to have toward outsiders (Murty, 1984). Rural social workers must use high levels of skill and sensitivity to manage unavoidable dual relationships in rural social work to ensure that clients are protected and professional ethics are maintained (Miller, 1998).

Related to the community-based approach for rural social work is the recommendation for generalist practice (Martinez-Brawley, 1987; Davenport & Davenport, 1995; Ginsberg, 1998b; NASW, 2002). Rather than specializing in one particular method of social work practice, or a particular population in need, the rural social worker needs be able to intervene in many ways on behalf of members of the community. This includes the level of social work with individuals and families with a variety of needs, but also includes the levels of work with organizations, the community, and policy (Ray, 2004; Davis & Meyer, 1996). This wide range of intervention skills is focused on the assets and needs of the particular rural communities where the social worker works. In a sense, the rural social worker must be a specialist, but the specialization is not in particular methods of practice or particular levels of intervention. Instead, it is a specialization and in-depth knowledge about particular rural communities. Based on this specialized local knowledge, the rural social worker can provide a wide range of services and interventions in that rural community. In this sense, the rural social worker is both a local specialist and a generalist.

Innovative programs provide services and encourage community development in rural areas using these community-based and generalist practice approaches (Heartland Center for Leadership Development, 2005; Rural Community Development, 2005). These programs are sometimes strikingly different from the typical programs in urban areas. Effective use of rural community volunteers, rural resources, networks, organizations, and local community leadership extends the power of social work where services are spread thin over large rural regions. By building on the local resources and assets of rural com-

munities, social workers have been able to create outstanding programs even where formal services are scarce and under-funded.

THE BARRIERS TO EFFECTIVE RURAL SOCIAL WORK

If the literature is so consistent in its recommendations for rural social work that is generalist and community-based practice, why has it been necessary to repeat the same recommendations from the 1930s to the year 2005? What obstacles have prevented social work from fulfilling the consistent recommendations in the literature (York, Denton, and Moran, 1998; Mermelstein & Sundet, 1998)?

The answer is that rural social work is embedded in the larger social work profession which has been moving in the opposite direction from the one advocated by rural social workers (York, Denton, & Moran, 1998). Instead of becoming more community-based, the profession has become more and more specialized and service programs have developed into separate institutions with separate streams of funding (Martinez-Brawley, 1998). As part of the consolidation which has been affecting rural communities nationally and world-wide for decades (Goldschmidt, 1947; Goldschmidt, 1978), social and health service agencies are growing larger and more centralized, a trend in the opposite direction from community-based generalist practice. The barriers to community-based generalist practice have grown, rather than lessened. Social work programs in general have been moving in the direction of bigger, more efficient, more centralized operations (Martinez-Brawley, 1998). For the most part, social work education has also moved in the direction of training students for specialized types of clinical practice (Mermelstein & Sundet, 1998). Is it any wonder that rural social workers and advocates of rural social work have felt they are shouting into the wind, and that their voices have not been heard (Mermelstein & Sundet, 1998; Martinez-Brawley, 1998)?

A case in point is the dramatic increase of the regionalization of health and human services in rural areas (Lennox & Murty, 1994; Murty, 2001b). The process began with school consolidation that continues today to increase the size of schools and to increase the distance students travel to get to school (Barker & Gump, 1964). Many health and human service programs that used to be administered by counties or local governments, are now administered from offices in large population centers. In the last few decades, the geographical areas which many of these programs serve have grown. It is now common for a community mental health center to serve 4 or more counties, for a juvenile justice program to serve 6 counties, for an Area Agency on Aging to serve up to 20 counties, and for a large teaching hospital to draw patients from surrounding states (for ex., see National Association of Area Agencies on Aging, 1996). Within these programs, specialization has narrowed the scope of work that any particular social worker provides. Rather than rural communities having one social worker who provides a wide range of services, it is now more likely that residents of the small town are expected to travel to population centers to visit a variety of different specialists in their offices. The cost of travel and travel time tends to reduce service use (White, 1986).

An alternative strategy for service delivery is that the rural community may receive services once a month or once a week from travelling "circuit riders." Each "circuit rider" is a specialist from a different urban program and each takes on a narrow scope of work. For

example, a special education social worker may be available in a particular rural community twice a week, a community mental health worker may visit once a week, an alcohol counselor may come through twice a month, a juvenile probation officer may come when called, and a specialist in youth development may provide services several times a year. None of these individuals is likely to get to know the particular community well or to develop an understanding of its assets, its community leaders, or the interrelationship of community issues. Moreover, it is rare that these "circuit riders" communicate with each other or even know about the services the others provide.

The gradual processes of centralization and specialization have created a professional climate in which it is almost impossible for social workers to use community-based generalist practice approaches in rural areas (Martinez-Brawley, 1998). Agency job descriptions do not allow a social worker to provide a wide range of generalist services in one single rural community. Categorical funding sources do not allow funding to be used to pay such workers. Programs and policies do not encourage social workers to specialize in knowledge of particular communities; instead they encourage knowledge of specialized treatment approaches, populations in need, or diagnostic groups.

ALTERNATIVE FUTURES FOR RURAL SOCIAL WORK

Based on this analysis, I can foresee two alternative futures for rural social work. In the first, we will witness the gradual disappearance of rural social work as a separate and distinct field of practice. Urban social work will take over more and more rural regions as health and social service regions expand, absorb surrounding rural areas. These programs will provide specialized services from population centers with little or no consideration for the local communities where individuals and families live. Social workers will refer families to formal programs which will become the sources of support for families in need. Community based generalist practice will gradually become an historic anomaly which has no more relevance to current practice, except in a few isolated localities.

The alternative vision of the future is a revival of rural social work. It will be based on changes in the social and health service system to allow and encourage community-based generalist practice. This future will never come to be without the dedicated work of committed social workers and policy makers, because the first alternative will be the result of inaction. The advantages of this approach is that it will build on the ideas and commitment of rural social work practice (Mermelstein & Sundet, 1998), it will encourage innovative programs that reach rural communities and which may well reduce costs by using local informal resources and by intervening early enough to prevent more serious problems that would require expensive interventions. In addition, this alternative will open up the current social and health system to change, as innovative rural programs lead the way to new approaches to social work practice both in urban and rural communities.

It is unlikely that radical changes in the way services are organized, administered, and funded can occur overnight, or even within a decade. Rather than trying to turn the tide of centralization and specialization, it will be more effective to promote changes within current social and health service systems to allow and encourage effective rural social work. Steps can be take that will help to counteract the pressure toward centralization and regionalization that have had such an impact on rural social and health services (O'Looney,

1993). A supportive organizational and policy environment can nurture the kind of social work that benefits rural communities and their residents

In order to bring about this second alternative for the future, I recommend that urban and rural social workers work together on the following initiatives to re-introduce a level of community-based generalist practice within the current social and health service systems:

1. Regional health and social service programs should use the new methods of identifying relatively rural communities using census tracts, zip codes, and rural commuting codes, to identify rural communities within their service areas (See notes at the end of this article.). All service providers in the agency could be trained to identify the particular assets and needs of these rural communities which the agency should be serving, and which up to now have received little consideration for their rural characteristics.
2. Regional service programs should assign workers to particular rural communities within the region and encourage them to use a community-based approach to learn about these communities so that they can use their informal resources and assets. For example, in a teaching hospital, each social worker could become a specialist on particular communities the patients come from. To make this work, time from social workers' busy schedules should be assigned to spend in the community and to get to know local leaders and organizations such as clubs, churches, and volunteer groups (Murty, 2004). Since it will be difficult to justify this allocation of social worker time, the program could begin with a few rural communities where many of the patients live. Data could then be collected to show the improvement in treatment outcome, reduced days of hospitalization because of improved discharge planning, and reduced relapse to hospital treatment. Once the data document the success of the community-based program, it will be easier to advocate for its expansion to the whole region and the hospital will be able to present its new program as a model to other hospitals. Similar approaches could be used by school social workers, hospice social workers, and family counselling, substance abuse programs and community mental health programs, to give just a few examples. Each social worker in any type of regional program would develop expertise in particular communities within the region.
3. Social workers with responsibility for rural communities could collaborate with other social workers who provide completely different services in the same community. The goal would be to establish local rural one-stop multi-service centers in particular rural communities (Norris, 1980; Martinez-Brawley & Delevan, 1993; Adams & Kraut, 1995; Davis & Meyer, 1996). At a minimum, this would involve co-location of services provided by travelling specialist service providers from population centers. Each of these travelling specialists would use the same local meeting place on their visits to the town. If rent must be paid, the cost could be shared among the programs involved. The initial set of collaborating service providers invited to participate will depend on the community needs, programs active in the

area, and the personalities of the workers. However, the local rural center might host visiting community mental health workers, juvenile justice workers, school social workers, workers from the regional Community Action Programs, social workers from home-nursing programs, social workers from public health programs, workers from county or state TANF and child welfare programs, alcohol and drug treatment and prevention services, and domestic violence and sexual assault programs, as well as workers from the county University Extension Programs, and outreach workers from local and regional programs serving the elderly, people with disabilities, and others. An innovative rural program would include staff from regional programs for economic development, community development, and housing.

Such a multi-service site would encourage a community-based, generalist approach to service provision, even though the visiting service providers would be paid, trained and supervised by different specialized programs. Such a multi-service center's effectiveness would be greatly enhanced if a local community resident were hired to serve as a community liaison to make appointments for local residents with the various service providers, help to connect local people to the services, and do community outreach concerning the services available. The program would be further improved if a time could be scheduled for a team meeting among the service providers using the center so that they could coordinate work with the community and, after appropriate consents for exchange of information, to discuss how to collaborate on with particular families.

Such a plan may sound overly ambitious, but in fact, programs similar to the one proposed, incorporating different groups of co-located service providers, have actually functioned in various areas in the United States and Great Britain and their successes have been documented (Hadley & McGrath, 1985; Martinez Brawley & Delevan, 1991; Adams & Kraut, 1995; Davis & Meyer). Some have been funded by grants, others county governments, and others by state and national policies. The fact that these programs have not been adopted more widely is not due to a lack of effectiveness. Instead the obstacles have been resistance to collaboration among agencies, political and administrative changes, and problems in allocation of funds for costs associated with collaboration, such as the shared community space and staff time for team meetings.

4. Advocacy at regional, state, and federal levels to support procedures, regulations, and policies should allow funding to be allocated and pooled to cover the shared costs of rural community-based practice. According to current policies, most service programs must document that funds are being used only to serve very specific groups of people in need. By establishing funds to support multi-service sites, advocates could provide incentives for regional specialized programs to participate in rural community-based collaboration to provide one-stop multi-service centers. Although such advocacy will run up against resistance from prevailing systems of specialized programs and

from categorical funding streams, this kind of change at the county, state, or national level is not unprecedented. Programs at the county level in Iowa and Pennsylvania and at the state level in Iowa (Martinez Brawley & Delevan, 1991, Adams & Kraut, 1995) have pioneered this type of pooled funding, and programs in Great Britain have also used this approach (Hadley & McGrath, 1985). The success and continued support of these programs will depend on evidence that innovative pilot programs are cost-effective and improve services and outcomes for rural communities. Skilful work with administrators and legislators will be the key to maintaining support for the needed changes in funding allocations and staff and resource assignments. Mobilizing rural community residents and leaders to communicate with administrators and legislators about the importance of multi-service sites to rural communities will help to sustain support for these programs.

5. Regional programs should be reviewed and funding allocated to regional programs should be contingent on the program serving the needs of the rural communities within the region. Evidence that services are provided in rural communities, rather than only in the main office should be required in proposals, regular reviews, and audits. Input should be gathered from residents in their local rural communities rather than at community meetings held in the population center. In addition, formulas for funding should include factors related to the increased cost of delivering services in rural areas, such as the low density of the population, problems of economy of scale, and the challenges of transportation to provide services to rural communities (Martinez-Brawley, 1987; National Association of State Units on Aging, Minority Issues Committee, 1992; Coward, Vogel, Duncan & Uttaro, 1995; Pugh, 2003).

CHALLENGE TO THE SOCIAL WORK PROFESSION

Although a more positive future for rural social work is dependent on the active support and advocacy of rural social workers, their efforts will not be enough. Changes to improve rural social work must occur throughout the profession in programs that serve both urban and rural people. Social workers in regional organizations that serve large geographic areas must begin to focus on the rural communities within the region. The rural social work movement must target social workers in these agencies and programs, and work with them to improve the way regional organizations serve rural communities. By demonstrating the relevance of rural social work to this much larger group of social workers, rural advocates will be able to provide a critical mass concerned about the rural communities and mobilize a larger proportion of social workers on behalf of rural social work. Based on this larger constituency, and using the skills of organizational change, lobbying, and community mobilization which social workers have long used in the history of the profession, it will be possible to bring about the changes recommended for a positive future for rural social work. . In the process, rural social work may be influential in leading the social work profession back toward community-based and generalist approaches that could benefit the profession as a whole.

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Partial List of Internet Web Sites for Rural Organizations

- National Rural Social Work Caucus: <http://www.uncp.edu/home/marson/rural/>
- National Rural Health Association: <http://www.nrharural.org/>
- National Association for Rural Mental Health: <http://www.narmh.org/>
- Center for Rural Affairs: <http://www.cfra.org/>
- Resource Center for Rural Behavioral Health: <http://www.apa.org/rural/>
- Frontier Mental Health Services Resource Network: <http://www.wiche.edu/MentalHealth/Frontier/index.htm>
- Journal of Rural Community Psychology: <http://www.marshall.edu/jrcp/>
- Rural Community Development. (2005) US Dept. of Agriculture. Internet Site: <http://ocdweb.sc.egov.usda.gov/>
- W. K. Kellogg Collection of Rural Community Development Resources
 Heartland Center for Leadership Development, Lincoln Nebraska
<http://www.unl.edu/kellogg/main.html>

Notes on Sources for Definitions of Geographic Areas on the Rural-Urban Continuum

USDA Economic Research Service

Rural-Urban Area Commuting Codes (RUCA Codes)

<http://www.ers.usda.gov/Data/RuralUrbanCommutingAreaCodes/>

Through this site you can obtain the RUCA Codes for your state by census tract. Using the web site below, you can approximate the RUCA Codes using zip codes.

WWAMI Rural Health Research Center

ZIP CODE RUCA APPROXIMATION METHODOLOGY

<http://www.fammed.washington.edu/wwamirhrc/rucas/methods.html>

USDA Economic Research Service

Rural-Urban Continuum Codes (County "Beale Codes")

<http://www.ers.usda.gov/Briefing/Rurality/RuralUrbCon/>

These codes place counties on a 10 point ordinal scale from most urban to most rural.

Frontier Education Center

National Clearinghouse for Frontier Communities

2000 Update: Frontier Counties in the United States (Counties meeting the "frontier" definition)

<http://www.frontierus.org/index.htm?p=2&pid=6003&spid=6018>

At this site you can obtain information about which counties are classified as "frontier."

Information about alternative definitions of rurality can be obtained at the following sites:

Rural Assistance Center

"What is Rural?"

http://www.raconline.org/info_guides/ruraldef/

USDA Economic Research Center

Measuring Rurality

<http://www.ers.usda.gov/Briefing/Rurality/>

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