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Journal of Contemporary Rural Social Work
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From the Editor

We are very fortunate to have a new institutional home for *Contemporary Rural Social Work*, The University of North Dakota at Grand Forks. The University of North Dakota is located in one of our most rural states, and has a long track record of involvement with rural issues.



Our goals are to have the Journal function as a publication site for rural research and theoretical articles related to rural social work, as well as for short articles related to social work practice in rural areas by practitioners. We also will add case studies related to rural social work and other teaching materials as these are received. The reason for the addition of teaching materials is that there are many sources for urban materials and few sources for rural social work.

Photographs and poetry related to rural issues are also of interest as are other materials that relate to the infinite variation of the rural experience.

We anticipate that we will be able to publish two to three issues a year.

Peggy Pittman-Munke, Editor-in-Chief

**Review: *A Revolution Down on the Farm:
The Transformation of American Agriculture Since 1929***

**Peter A. Kindle
University of South Dakota**

Paul K. Conkin
Lexington, KY: The University Press of Kentucky, 2008
240 pp.
ISBN: 978-0-8131-2519-0 (paperback)

Born in 1929 and raised on a small farm in eastern Tennessee, Paul Conkin, Distinguished Professor Emeritus of History at Vanderbilt University, provides an accessible work on the development of agriculture in the United States over the last 80 years. Conkin is neither an apologist for American agriculture nor a critic. Perhaps he might best be described as an *interested bystander* who has observed that “agriculture has been the most successful sector in the recent economic history of the United States” (p. x). Since 1950, the productivity of American farms has increased at least tenfold, an advance which never fails to astound Conkin. This balanced and partially biographical work is a good place to begin to understand how farming and rural life has changed in the latter half of the 20th century.

Broken chronologically into eight chapters with two parenthetical chapters recounting the author’s personal experience, Conkin merges a historian’s attention to detail with the memories of one who lived a rural farm life before electricity and internal combustion engines. The parenthetical chapters, two and four, are welcome interruptions in a narrative that can become overly detailed at times. In the first chapter, Conkin describes the changes in American agriculture from colonial times to about 1930. Although there was some improvement in farm productivity over these centuries, the efficiencies were modest. In 1800, one farm family could support one additional family, but by 1930 one farm family could raise enough food for ten families. This increase was primarily due to new tools and equipment that promoted labor efficiencies, but readers will also discover the significant role of government policy in promoting and disseminating agricultural research and developing credit markets necessary for farm stability.

In Chapter 3, this history is extended into the maze of new programs that attempted to address the impact of the Great Depression on American farms. President Hoover’s Farm Board attempted to organize producers in a manner that would strengthen their market power in specific food commodities, but failed due to global price declines. In comparison, farm policy during Roosevelt’s administration was less ideologically driven and less consistent. Although rooted in the farm price crisis of 1921, the multi-year price instability of the 1930s laid the foundation for a variety of federal programs with one ultimate aim—to stabilize prices so that farmers would receive a fair price for their products. The perennial problem was over-production. Without a means to regulate the quantity of agricultural products produced, and in the face of the relative inelasticity of demand for food products after a certain level of

consumption, there is little that the invisible hand of the market can do but penalize the farmer if supply exceeds demand. The cooperative marketing and foreign dumping efforts of the 1920s gave way to *de facto* price supports and domestic allotments (quotas) in the 1930s. The base acreage associated with land parcels due to these allotments became an enduring feature of American agriculture with various forms of farm payments being determined on this base. Despite these and other policy changes—new forms of credit, removal of acreage from production, land purchases—the agricultural surplus generated in the 1930s and the resulting low prices were not resolved until the Second World War.

Following World War II, the productivity gains in American agriculture were unprecedented. “In one generation, from 1950 to 1970, the workforce in agriculture declined by roughly half, while the value of the total product increased by approximately 40%” (p. 98). In Chapter 5, Conkin argues that this productivity explosion was due to new machinery, rural electrification, chemical inputs (fertilizer and herbicides), and plant/animal breeding. In Chapter 6, his attention returns to government policy with a focus on production controls and price supports, the farm crisis of the 1980s, and international agreements impacting American farms. Although the farm problems during this period seem to parallel the 1930s, over-production of food products and decline in global demand, the price support mechanisms enacted were significantly more costly in terms of public support and resulted in consolidation of smaller farms into massive concerns so that 89% of total farm output was produced by roughly 15% of farms.

Chapter 6 also discusses federal programs through the passage of the 2008 Farm Bill which continues to direct federal agricultural policy today. This legislation increased federal nutrition expenditures by \$10 billion so that two-thirds cost of this Farm Bill went for food aid and converted the food stamp program into the Supplemental Nutritional Assistance Program (SNAP). Only minor adjustments were made in domestic food programs, conservation efforts, land retirement schemes, ethanol subsidies, and agricultural research. Attempts to limit commodity payments to individual farm operators with adjusted gross income in excess of \$200,000 a year was firmly rejected by Congress. Despite the high publicity associated with Michelle Obama’s garden and child anti-obesity initiative, the Obama administration has only recently addressed farm policy. In negotiations for the pending 2012 Farm Bill, Obama has recommended over \$30 billion in cuts, primarily through decreases in direct payments to farmer operators, higher premiums for some forms of crop insurance, and moderation in conservation programs. As Conkin so well documents in earlier farm policy discussions, it remains unclear whether Obama’s proposals and Congressional intent to reduce federal spending will be strong enough to overcome rural senator opposition to USDA budget limitations. Accordingly, I believe that Conkin remains relevant to contemporary discussions of farm policy.

Chapter 7 provides demographic profiles on American farms in 2002 describing the owners, farmworkers, products, revenues, costs, incomes, and overwhelming consolidation that has taken place. Critics of the contemporary agricultural oligarchy are provided some voice in this chapter, yet the critical tone remains somewhat subdued. Both the externalities associated with farm production (environmental threats) and other victims (farmworkers, abused animals) are acknowledged, but within a framework that seems to give precedence to farm productivity. It is easy to imagine Conkin asking, “How else can we feed 6.5 billion people?” The

alternatives to the present system are discussed in Chapter 8, but in a way that clearly demonstrates that they are unlikely to make a significant impact. When religious minorities (Shakers and Hutterites) provide exemplars alongside contemporary alternatives like sustainable agriculture and organic initiatives, the overall impact is to trivialize all alternatives. Conkin ends this history with a reflective Afterword that expresses his concerns about over-population, potential food scarcity, the questionable applicability of free market economics to agriculture, and the end of cheap oil.

This book is a primer on American agriculture, federal farm and food policy, and the significant changes that took place in rural America in the 20th century. As such, I can recommend it to social work academics and practitioners who may be transitioning from an urban or suburban to a rural context. While it is unlikely that Conkin will answer all of your questions about the differences between urban/suburban and rural life, the background information in this book is invaluable in helping the reader develop an appreciation for the farmer's attachment to the land and a deeper understanding of the complex policy issues interwoven into rural life.

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Addressing Health and Social Disparities through Community-Based Participatory Research in Rural Communities: Challenges and Opportunities for Social Work

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Abstract. *Social workers can increase the translational ability of their research efforts to create sustainable community change in rural communities through the use of community-based participatory research (CBPR). CBPR is a congruent approach to social work values, representing a balance between research and community empowerment. This article focuses on methodological concerns in conceptualization, setting research goals, measurement, data collection, and dissemination of the findings. Recommendations for how interrelated areas of social work education, practice, research, and policy can address rural social and health disparities through CBPR are advanced.*

Keywords: community-based participatory research, social work profession, rural, research methodology, academic-community partnerships, social and health disparities

Social and health disparities experienced by underserved rural populations have deleterious consequences for individuals, families, and communities. Although rural residents make up approximately 25% of the United States population (United States Department of Agriculture [USDA] National Agricultural Library, 2008), they experience lack of parity with urban areas in poverty rates and access to critical health, mental health, substance abuse, and social service facilities. Thus, improving the economic and social conditions of rural residents has the ability to significantly enhance the well-being of a sizeable and critically underserved group. Community-based action research can be successfully integrated with policy analysis and community organizing to affect positive change in underserved communities (Reisch & Rivera, 1999).

Community-based participatory research (CBPR) is an umbrella term utilized to characterize an orientation to research that seeks to integrate participation, research, and social action. It is widely recognized as an appropriate and valid approach to working with diverse populations, types of communities, and target problems. The process has been recognized for its ability to improve outcomes for at-risk and underserved groups; it is appropriate for groups that have been difficult to research historically through other research methodologies (O'Toole, Aaron, Chin, Horowitz, & Tyson, 2003). CBPR highly values both social action and scientific advancement.

Community-Based Participatory Research: An Overview

In a CBPR approach, scientists work collaboratively with community partners in various phases of research: definition of the problem, development of research questions, methods, ethical standards, and interpretations (Shepard, Northridge, Prakash, & Stover, 2002) and dissemination and publication of the research findings (deLemos, 2006). Concepts of full partnership and collaboration include shared decision making and responsibility, as well as the benefits and recognition of the research (Morford, Robinson, Mazzoni, Corbett, & Schaiberger, 2005).

To go beyond mobilizing the marginalized towards activating allies, this research approach to social change begins with a particular community concern and individual experiences, and uses qualitative and quantitative procedures to understand the associated and complex issues of inequality, injustice, and insecurity (Reitsma-Street, 2002, p. 69).

Recognizing the community as the unit of identity, CBPR builds on the strengths and social capital of the community by emphasizing the significance of community-defined social and health problems. The aim of CBPR is to have all participants benefit from their involvement; participation in the research process and its outcomes should be transformative for both academic and community partners. As social scientists engage community members, the participants join in a process of co-learning that can enhance collective professional and personal development.

There has been a consistent increase among academic and community-based organizations in developing an infrastructure for conducting CBPR as well as pursuing funding opportunities (Tandon et al., 2007). Through CBPR, philanthropic organizations have addressed social and health disparities in society. Many philanthropic and government organizations are increasingly providing financial support for research projects that are community *based* rather than community *placed* (Wallerstein, 2006). The National Institutes of Health (NIH) has issued several CBPR-based requests for funding (RFAs) that highlight the importance and value of community collaboration in the scientific community. Recognizing the potential that the social work profession has in contributing to CBPR, NIH offers workshops and RFAs, among other opportunities, to integrate the social work profession more effusively into its funding infrastructure.

Leung, Yen, and Minkler (2004) suggested that CBPR represents a shift in the power base away from sole ownership of the research process by scientists through the “deconstruction of power and democratization of knowledge” (p. 3). This is accomplished through an epistemological shift on the part of the scientific community and the acceptance of other ways of knowing, such as the indigenous knowledge of community members. This shift creates an environment in which communities have greater relevance and participation in the research process and research has significance for the affected communities. When scientists develop egalitarian relationships with communities, they have the ability not only to impact policy through evidence presented to the scientific community via journal publication or presentation, but to provide evidence, education, and programs directly to impacted communities about social problems. Findings of CBPR can be successfully communicated to community residents, media, and policymakers (Shepard et al., 2002). This can take place in the form of town meetings, local conferences, or workshops involving community partners, the media, and political leaders.

Congruence of Social Work Values with a CBPR Approach

Community is widely recognized as a fundamental aspect of social work and is an important place to develop evidence about practice (Coulton, 2005). The focus of the social work profession is:

to pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people. Social workers' social change efforts are focused primarily on issues of poverty, unemployment, discrimination, and other forms of social injustice. These activities seek to promote sensitivity to and knowledge about oppression and cultural and ethnic diversity. Social workers strive to ensure access to needed information, services, and resources; equality of opportunity; and meaningful participation in decision making for all people (National Association of Social Workers [NASW], 2008, p. 3).

Social work emphasizes ethical conduct, egalitarian relationships between clients and practitioners, and personal and community empowerment. Through its Code of Ethics, NASW asserts core values and ethical principals of the profession that encourage social workers to utilize their skills to pursue change efforts that promote social justice, to value the importance of human relationships, and to value the dignity of self-worth of all persons. Moreover, with its strong emphasis on cultural competence and work with underserved groups, social work is a desirable professional perspective in CBPR with increasingly diverse rural communities. Racial and ethnic minorities make up over 18% of non-metropolitan residents with Latinos and Asians comprising the fastest growing minority populations in rural areas (United States Department of Agriculture [USDA] Economic Research Service, 2008).

Addressing Challenges and Strengths of Rural Communities

According to the United States Census Bureau, approximately one-fourth or 61.7 million people in the United States are classified as residing in rural areas (USDA National Agricultural Library: Rural Information Center, 2008). Collectively, rural communities are a powerful economic and political force. Rural communities have clear strengths as well as challenges. Rural communities have a distinctive culture, social independence, and close-knit community bonds. They are diverse in their needs and experiences.

Unique challenges in work with rural communities include fragmentation of network services and structure, geographic distance from large urban centers, lags in connectivity, and limited exposure to modern technology. In addition to challenges in infrastructure, a significant methodological challenge for researchers working in rural communities is defining rurality. Although definition is important for resource allocation, statistical accuracy, and the ability to replicate studies of rural areas, no central definition of *rurality* exists. This can be attributed to several factors, including competing descriptions of what it means to be a rural community. Rurality can be defined by remoteness, distance from urban resources, sparse settlement, or low population density (Ricketts, Johnson-Webb, & Taylor, 1998).

CBPR, as a philosophy and approach, has numerous strengths in work with rural communities. It offers community buy-in and participation in the process. CBPR seeks to utilize the indigenous knowledge of community members, technical assistance by universities, and capacity building in both communities and academic institutions (Strickland et al., 2003). Academicians may be able to effectively engage the community as collaborators in the research process through hiring community members to work as integral parts of the process via

community organizations or as direct employees of the university (Srinivasan & Collman, 2005). This can be attractive and beneficial to rural communities that lack economic resources to address social problems, while at the same time attracting bright and capable community members to remain in the community by providing them competitive salaries and benefit packages, as well as opportunities to further their education via face-to-face or virtual classrooms.

Academic-Community Linkages and Values

Previous literature has asserted that academic and community linkages develop models for ongoing collaboration and communication between research partners (Currie et al., 2005). This is necessary in part due to differences in the goals and values of community and academic partners. Some academic research partners may feel a sense of urgency to publish findings of their work to meet specific milestones to earn tenure. Due to the participatory nature of CBPR, researchers engaging in this model must balance their needs for promotion and tenure with the time-consuming nature of collaboration. Academicians and community partners may have different goals for participation in the project, but both seek respectful recognition of their contributions and both wish their roles to be valued by others. Furthermore, Currie et al. (2005) asserted that CBPR can be methodologically rigorous while making unique contributions not available through other types of research.

The process of collaboration is a clear strength of the CBPR approach. For researchers, scientific rigor is critical to project success. Through the process of co-learning, community partners can appreciate the value of scientific rigor because its advances can significantly enhance community goals and provide the credibility necessary to facilitate change (Srinivasan & Collman, 2005). Researchers can gain a unique perspective into social problems through the eyes of those who are most passionate and impacted.

Strickland et al. (2003) identified trust, cooperation, and readiness for participation as potential challenges in engaging rural communities in CBPR. Community members often lack time, resources, or motivation to participate. There may be communication difficulties, such as researchers using technical language that is not understood by community participants or language barriers due to a significant number of non-English speaking community participants. Logistical barriers such as limited transportation, lack of stable home address, or working telephone can be hindrances to research participation. Having multiple venues for participants is critical so those with various levels of interest and motivation can experience appropriate levels of involvement.

Researchers from academic institutions must be aware of the historical role of their institutions in collaborating with communities. These institutions may have engaged communities in the research process but did not utilize an egalitarian approach to engagement, instead engaging communities without their input or full cooperation. This can cause a legacy of mistrust among community members (deLemos, 2006). Therefore, researchers may have to overcome barriers to relationships established by previous researchers working in the community.

Methodological Strengths and Challenges of CBPR in Rural Communities

Conceptualization

Community participation is usually fueled by the pressing need for social action and intervention to address social and health issues. Community participants are often interested in immediate change, perhaps even prior to the conclusion of the research project. The process of developing mutually defined goals and objectives with various community stakeholders is often time consuming. CBPR can be a successful approach in understanding the nuances of local and regional differences in rural problems, policies, and needs. For example, during the conceptualization phase, various questions must be addressed:

- What are the geographic boundaries of the “rural community” being studied?
- How do local cultural factors differ from one (rural) region to another, by what methods can we detect these differences, and how can we use such knowledge to target interventions to improve health? (Hartley, 2004, p. 1677)
- Who will be involved in problem definition?
- If there is an intervention component, who chooses and designs the intervention?
- Who will be hired and how much will they be paid?
- Will there be a control group?
- Who has ownership or control over the development of papers and presentations?
- Who decides how results will be interpreted and disseminated both locally and nationally?
- Who are the community partners/community leaders involved?
- How will infrastructure for the project be established and developed?

Those seeking to engage communities in research should enter the relationship with guidelines and documentation, such as a memorandum of understanding (MOU), to reduce potential conflicts. Simultaneously, those seeking to engage in CBPR must be open and flexible to changing agendas and expectations to accommodate the needs of community stakeholders. All stakeholders must work together to achieve appropriate balance between process and outcomes.

Congruency in Research Goals

Researchers may encounter community partners who have a sole interest in community interventions and service projects and a lack of interest in scientific questions and processes. This may be a particular problem in rural communities that lack the infrastructure for health care, social services, or even transportation that are in place in larger urban or suburban communities. Scientists must be willing to give up some power over the research process. In this collaborative process, scientists will not have sole control over the establishment of research goals. Ideal community-academic partners will have a mutual interest in both research and social action.

Measurement

Community stakeholders and researchers must come together to develop precise operational definitions of concepts to be employed in the research study. Academicians must embrace their role as educators to train community partners in how to conduct research. However, before beginning data collection, variables should be defined so that all parties are very clear about what is being measured and what is being observed. This may require bringing all parties together and educating community members about variable and sample selection. Widely accepted operational definitions from the academic literature may vary greatly from a laypersons' definition of the problem. Scientists must understand the culture of the community and how to phrase questions so that the desired concepts are understandable by all research participants. Researchers have the option of utilizing definitions commonly found in the literature or crafting new definitions based on community and scientific collaboration. Further, it is critical to define the boundaries of the rural area being studied utilizing either descriptive definitions developed by collaborative research partners or definitions developed by other organizations. Widely accepted definitions of rurality developed by The Office of Management and Budget and The Census Bureau are commonly utilized in decision making regarding rural health policy (Prouty Vanderboom & Madigan, 2007).

How variables are operationalized has a direct relationship to the findings. Decisions must be made about how to measure variables and the limitations of categorical or ordinal levels should be weighed. If a survey is utilized, questions must be addressed:

- How many questions are too many questions?
- What should be the target level of readability?
- Should a Likert-type scale be utilized? If so, will participants find this confusing?
- What type of sensitive information (e.g., income, sexual history, domestic violence, and medical history) should be included or excluded?

This is particularly critical to enhance participation among rural participants who may be familiar with those persons collecting the data. Pre-testing previously used scales and instruments on the target population prior to implementation are essential. Community partners can often provide valuable input regarding these issues prior to testing phases of the project.

Thinking through these issues in advance can reduce bias and address issues related to external and internal validity.

CBPR projects seek, as its primary goal, *sustainable* social transformation and community empowerment. Evaluation of community partnerships is critical to establishing best practices and developing documentable procedures that can be replicated by other researchers and community partners seeking collaboration. Therefore, CBPR projects must seek to collect data and measure satisfaction with the partnership and evaluate relationships between community partners such as academicians, community leaders, and research participants. Several studies (Anderson, 2000; Gibbon, Labonte, & Laverack, 2002; Rogers, Chamberlin, Langer Ellison, & Crean, 1997; Saegert & Winkel, 1996) have utilized scales to examine personal empowerment and/or community empowerment concepts. CBPR projects must also seek to evaluate and accurately document community transformation by evaluating community changes in local or state-wide policy (i.e. evaluating improvements to health or social care).

Data Collection

This phase of the research project is arguably the most important. The setting is a critical aspect of data collection. Community partners can be helpful in developing a plan about where and how to collect data that takes into account where participants live, public transportation routes, and typical work schedules for the targeted group. These factors are particularly critical in rural areas where poor and underserved participants may lack access to transportation to attend or follow-up with the research study. A budget for data collection in rural areas should consider offering incentives such as child care, transportation, and meals to encourage participation.

Dependent on the goals of the research study and the design of the project, data collection for behavioral research may involve interviewing participants or administering questionnaires. Again, ingredients of community input and scientific rigor produce the best CBPR recipe.

- What is the best way to collect the data—in person, by mail, or by telephone?
- How can respondents be selected to produce the most representative sample?
- What time and place are best to reach the sample?
- Who should conduct the interviews?
- Will confidentiality or anonymity be a problem if rural community members collect the data? If so, one way to address this issue is to provide training and support for community members.

Once community members who will collect data have been trained regarding human subjects protocol and the importance of confidentiality, they can be asked to sign a confidentiality statement. This is critical among rural populations with close knit communities where those

involved in data collection may potentially know research participants. A successful strategy can include partnering community members with researchers or trained master's- or doctoral-level students to assist in explaining human subjects procedures and to ensure data is collected and stored appropriately.

In a CBPR model, recruitment is community focused (Cartwright & Allotey, 2006), thus enhancing possibilities for community buy-in and increased participation by research participants. Participants often participate in research studies with a great deal of trepidation, particularly in minority or rural communities. Mistrust is often fueled by a history of oppression and exploitation. Studies such as the Tuskegee Experiment have left a historical legacy of medical mistrust among ethnic minorities (Anderson Loftin, Barnett, Summers Bunn, & Sullivan, 2006; Scharff et al., 2010). In addition to a historical legacy of impropriety regarding medical ethics, researchers must also address general attitudes of mistrust expressed towards outsiders common in rural communities (Anderson Loftin et al., 2006). In their study of attitudes and beliefs about participation in medical research, Corbie-Smith, Thomas, Williams, and Moody-Ayers (1999) found that African Americans reported a mistrust of doctors, scientists, and the government in general. Further, participants expressed concerns about the ethical conduct of clinicians and investigators in their work with minority communities. Even when risks are explained, many people do not understand the purposes of risk and the purposes of human subjects' protocol. In addition to misperceptions about informed consent, African Americans have reported that signing a document meant relinquishing autonomy in the interests of legal protection of physicians (Corbie-Smith et al., 1999). In working with rural populations that may have issues with literacy, informed consent may require numerous revisions and pretesting.

Baffour, Jones, and Contreras (2006) described innovative techniques to recruit pregnant and parenting women for participation in a CBPR project aimed at reducing infant mortality and prematurity in a rural community. Indigenous community health workers, called Family Health Advocates, conducted informal outreach through personal contacts in churches and grocery stores, as well as door-to-door canvassing. Other social marketing techniques include organization newsletters, public service announcements, and attendance at community events and health fairs. Health fairs have been held at churches, schools, and community centers to attract program participants. Incentives such as child care and meals during focus groups, and pre- and post-test surveys were provided.

Data Analysis and Outcome Expectations

Ongoing evaluation is an important part of a successful CBPR model. Part of a good evaluation model seeks to evaluate outcomes, including satisfaction with the partnership and identification of areas for improvement. Focus groups, surveys, or interviews can provide a venue for partners to communicate regarding their experiences concerning power distribution and control throughout the process. Community members should have an authentic role in the fruits of the research project: the findings. At the onset of the partnership, it is important for community-academic partners to agree regarding how findings will be disseminated and how authorship will be designated.

- How many publications will result from the findings?
- How will the responsibility of data analysis and the work of writing publications be distributed?
- What will be the role of community partners in writing for academic journals, report writing, and presentations at professional meetings and community forums?

Sharing preliminary findings with community members can provide opportunities to incorporate their interpretations into research reports or discern the need for further analysis (Cartwright & Allotey, 2006). This sharing can provide opportunities for all partners to “mentally digest” the results and decide how they can best be utilized to advance agendas of social action and scientific research. Findings can be shared with large community groups via agency or community consortiums, staff meetings, community forums, or partnership meetings. Sharing the findings of the study can be an important “next step” in determining additional possibilities regarding community needs for future research.

Implications for Social Work Education and Research

Social workers in the academy have the ability to increase the translational ability of their research efforts to create sustainable community change through the use of CBPR. Academicians can help to build the infrastructure of local rural community organizations through consultation, field placements for baccalaureate and master’s-level students, and research internships for doctoral-level students. Social work students at all levels can significantly benefit from integrating an understanding of CBPR into their repertoire of skills. In a CBPR approach, researchers must utilize a tool kit of skills that are integrated into the social work curriculum. Social work has a significant advantage over other academic disciplines in that social workers receive significant hands-on and theoretical training in cultural competence, and communication and listening skills. This tool kit can assist social work researchers in the engagement and development of egalitarian partnerships with communities. It can be significantly enhanced by including more courses on community-based research methods, particularly at the doctoral level.

One of the goals at the forefront of social work education is for social workers to become effective consumers and producers of research. Thus, social workers utilize research to inform their practice and their practice to generate new research questions. Thus, communities can serve as effective laboratories for students, their field instructors, and practitioners to learn about real-world methodological challenges of conducting CBPR.

Social work researchers are uniquely positioned in academic institutions to form partnerships with other disciplines to build community capacity. Social workers must continue to collaborate with communities and with interdisciplinary colleagues on research that promotes a CBPR approach while simultaneously promoting evidence-based practice.

Implications for Social Work Practice and Policy

Social work is in a unique position, due to its mission and values, to facilitate a collaborative social justice agenda through research and coordination of services. Social work can play a visible role in CBPR through the administration of both direct (case management, counseling) and indirect (administration, advocacy, lobbying, program design) services to underserved groups. Social workers who are engaged in CBPR should seek to develop partnerships with local organizations, companies, health departments, physicians, and health organizations to create a network that can promote sustainability for services after the conclusion of a research project. Social workers in multifaceted roles must utilize ways to make CBPR a relevant and appealing approach for those populations with whom they seek to work. One method of doing this is to offer services identified by community groups, advisory boards, or community participants. Town meetings, workshops, and retreats with community leaders and researchers can be used to elicit information throughout various stages of the research process. Previous researchers conducting CBPR have found town meetings to be an effective strategy to ensure that affected community stakeholders have a voice in identifying research priorities (O'Fallon, Wolfe, Brown, Dearth, & Olden, 2003).

CBPR must include holistic and comprehensive models of care. Community members' and organizations' interest and involvement in a research project may be part of a larger goal to improve community well-being and improve the quality of life for residents. As rural communities seek to address the needs of more diverse racial and ethnic groups, social work has an increasingly critical and multifaceted role. Social workers engaging in CBPR must not only seek to acknowledge the unique cultural perspectives that rural communities present but consider the physical, emotional, social, economic, and spiritual needs of the community. Accordingly, CBPR models must incorporate service components which include case management services that support holistic conceptualizations of care, such as oral health, HIV testing, support groups, housing assistance, utility assistance, and referrals for concrete services (e.g., health insurance, WIC, food stamps, and Social Security Insurance). One way to recruit project participants is to disseminate information about services being offered.

Social justice goals can be addressed in CBPR through action-research models that seek to teach advocacy skills to the target population. This can be accomplished by events and interventions designed to teach clients about policy and make an impact at state and local levels. Social workers serve a critical role in how social justice interventions are designed, implemented, and evaluated. CBPR has been a successful approach to address health disparities, particularly in rural areas, where gaps in service delivery are critical.

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Online Task Groups and Social Work Education: Lessons Learned

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Abstract: *This paper focuses the use of an online task group for social work students to solve problems and produce recommendations. An online site provides students the opportunity to edit documents produced by the group's work. Online task groups provide an alternative to face-to-face task group meetings in social service agencies with a number of distant service delivery locations. Additionally, online task groups provide a cost effective way to accomplish the business of social service agencies by eliminating the time and cost of travel to attend meetings. This paper offers a stage model of online group development and a discussion of lessons learned from an online task group used in a graduate Clinical Supervision class.*

Keywords: *online task groups, developing an online group document, group work, collaboration*

With the growing use of the World Wide Web in social work practice, students will benefit from learning the effective use of online technology applied to various social work tasks. For those students who will work as practitioners in rural areas, the online staff meeting may become a part of their social work practice. In order to work effectively in the developing online setting, social work students may be trained using the current technology, and prepared to use the technology when they become practitioners.

Online communication between co-workers, agency supervisors, and other social service personnel may enhance rural-based social work practice. Task groups of social workers effectively use technology to solve problems without traveling distances, experiencing inclement weather, or encountering problems with road conditions (Maheu, Pulier, Wilhelm, McMenamin, & Brown-Connolly, 2005). Travel time over long distances may be better spent meeting and working on pressing issues, and may be a hindrance to the effective provision of service delivery. The use of task group meetings in combination with other online tools efficiently allows for the transaction of important agency business.

The purpose of this paper is to discuss pitfalls related to designing and implementing student guided task groups as an online teaching tool, and to present a model for online task group construction. The paper will provide a literature review, discuss online task groups including online group stages, present a proposed online task group, and provide an overview of the implications for social work practice.

Literature Review

This literature review will discuss selected stage theories of face-to-face (f2f) group development, and will review online task group scholarship. There appears to be parallels

between f2f group development and online task group development stages, particularly with regard to the gender make-up of the groups.

Face-to-Face Groups

In order to discuss online groups, it is helpful to understand f2f groups and stages of group development. Using a feminist perspective, Schiller (1995) posited group development stages based on her experience in working with women only (WO) groups (see Table 1). Rather than vying for power and control as seen in men only (MO) or mixed (MX) groups (Garland, Jones, & Kolodney, 1978; Northen, 1988), Schiller (1995) noted that WO groups are more focused on establishing a relational base engendering respect among members. Respect is experienced as mutuality and interpersonal empathy as the group moves into stage two where the members begin to approach the work of the group. Instead of differentiation or separation experiences in MO or MX groups (Garland et al., 1978; Northen, 1988), Schiller (1995) observed that members challenge each other to change in WO groups. The ability to challenge others in WO groups and have others be receptive to feedback derives from establishing relationships, sharing mutually with one another, and expressing interpersonal empathy. Finally, groups experience termination (Garland et al., 1978; Schiller, 1995), or separation (Northen, 1988). Closure is part of termination and a common stage in most groups.

Table 1

Stage Theories of F2F Group Development

Stage	Garland et al.(1978)	Northen (1988)	Schiller (1995)
1	Pre-affiliation	Orientation-Inclusion	Pre-affiliation
2	Power & Control	Dissatisfaction, Power, & Conflict	Establish a Relational Base
3	Intimacy	Mutuality & Work	Mutuality & Interpersonal Empathy
4	Differentiation	Separation, Termination, & Transition	Challenge & Change
5	Termination		Termination

Individuals participate in numerous types of groups including task groups. Task groups are formed to complete a desired work product dictating the life span and membership characteristics of the group. Task groups are often time limited and terminated upon completion of the assigned task. F2f groups allow members to see each other's facial cues and voice tones which are absent in the online environment of a chat room. While there are advantages for both f2f and online task groups, agencies' shrinking budgets hinder staff travel to attend meetings. Reduced travel time and costs increase the allure and cost-effectiveness of online task groups given the current level of technology.

Online Task Groups

The online environment offers a different opportunity for individuals to relate with each other as they engage in task accomplishment. The initial stage of online task group work is to develop a level of rapport among group members. In the development of online task groups, the primary issue of developing rapport concerns building trust among group members (de Laat, 2005). De Laat (2005) asserts that virtual strangers have demonstrated trust in online communities and this phenomenon can be explained by “social cues, reputation, reliance on third parties, and participation in (quasi-) institutions” (p. 167). Task group members expect other members to trust the group in order to accomplish the group’s goals (de Laat, 2005).

Malcolm (n.d.), using a business curriculum, recognized four stages of development: (a) online netiquette, (b) working with opinions, (c) working in online task groups, and (d) collaborating online. Offering a unit about appropriate use of netiquette during the beginning stages of group development may reduce unproductive activities engaged in by group members and limit untoward behavior online. The initial stage of group work sets the tone for the group members as they work toward goal attainment during the semester.

Savicki, Kelley, and Ligenfelter (1996) studied online task groups based on gender composition which included women only (WO), men only (MO), and mixed (MX). WO groups used more words per message, reported higher satisfaction with the group process, and acknowledged higher levels of group development. This finding concurs with Schiller’s (1995) research in reference to f2f groups. Further, Savicki et al. (1996) reported MO and MX groups used fewer words per message, were less satisfied with group process, and reported lower levels of group development than the WO groups. Researchers did not address the gender makeup of the MX groups although the number of men or women in the study group could have affected outcomes. Men tended to be more acrimonious where women sought to reduce conflict. WO groups used more “I” statements than the MO groups (Savicki et al., 1996). Herring (1994) reported men’s styles in groups included: “put-downs, strong often contentious assertions, lengthy and/or frequent postings, self-promotion, and sarcasm” (pp. 3-4). On the other hand, Herring (1994) observed that WO style is composed of two aspects: “supportiveness and attenuation” (pp. 3-4). Herring’s findings concur with Kanter’s (1977) work that demonstrated the effect of gender was proportional to the group’s gender composition. Savicki et al. (1996) reported that groups with a higher percentage of women were more self-disclosing and sought prevention of discord and a reduction in tension.

Savicki and Kelley (2000) conducted a study by sending online etiquette instructions via email to online group participants. The instructions encouraged members to engage in “high self-disclosure, high opinion, high coalitions with others in the group, and low flaming” (p.822). The WO group demonstrated “higher levels of the . . . language and higher levels of group development” following receipt of the instructions (Savicki & Kelley, 2000, p. 823). The MX group demonstrated lower levels of group development and elevated flaming. The MO group demonstrated no difference in language choice or group development. This study found that the gender of online groups is a significant factor with regard to the successful outcome of the group (Savicki & Kelley, 2000).

Savicki, Kelley, and Ammon (2002) stressed the importance of communication training for participants in online task groups observing that the training influenced participation. Santhiveeran (2005) discussed guidelines for maximizing the incorporation of online communication in higher education. Based on the necessity that virtual groups be productive, Savicki et al. (2002) asserts that communication training is a prerequisite for successful online task group success. In concurrence with Savicki et al. (2002), Johnson and Johnson (1996) found that untrained virtual groups fail in their efforts or suffer the problems encountered by f2f groups. Savicki, Ligenfelter, and Kelley (1996) observed that men outnumbered women in online discussion groups in 1996; however, online group characteristics have changed significantly since that time.

Lessons Learned

The virtual environment of online task groups requires students to be actively involved in the educational process. Unlike many f2f classroom settings, courses taught online require students to interact with the course material for each class assignment. It is difficult for students to opt out of reading the assigned material since this material forms the basis for a weekly posting and group interaction online. One of the authors developed an online graduate Clinical Supervision course presented as a virtual mental health center. The majority of members in each of the MX groups were women. The six-week online task group, an assignment of the course, required that groups of five or six students discussed and made recommendations each week about a supervision problem that they might encounter in their work. Upon approval of the recommendations the group developed, each group posted their work on the Discussion Posting link in the online course.

Students were provided with instructions outlining how to maneuver through the online environment, protocols for student behavior, and the course outline and syllabi the first time they accessed the course. Five chat rooms were established during course construction. Only the students assigned to these rooms by the course's instructor were able to access these rooms. Therefore, each group was offered privacy to choose, design, and develop their task group project. In order to facilitate manageable virtual groups, five or six students were selected by the instructor to form a group. During the initial group meetings, the instructor did not provide guidelines or directions in order to observe how the groups formed. One of the key lessons learned was that providing structure and direction early in group development may facilitate a more rapid movement by the group to the working stage. Icebreaker and introductory activities set a warm atmosphere from which to build working relationships. Providing a unit teaching online netiquette prior to the first group meeting may have been helpful.

The students in the Clinical Supervision course held a weekly online staff meeting. Each week the groups were to discuss a problem posted by the instructor and recommend a solution. In the Discussion Posting area, a separate weekly discussion was listed for posting the recommendation of each task group. After each group meeting, the students were directed to have the group recorder post the group's recommendations in the appropriate discussion posting for the week. Each group posted their recommendations, allowing the students to review ideas other groups used to arrive at the solution to the problem. While not part of the assignments discussed here, it is possible to have the students post responses to the recommendations from the various groups to further work on the task between groups meetings. In reviewing the work

of the groups over the course of the semester, a few stages of online group development emerged.

Stages of Online Task Group Development

The online task group appears to follow a progression of stages leading to the final product and closure. Jacinto and Turnage (2003) postulated five stages of online task group development. Reflecting on the five stages and a review of literature about online task groups has led the authors to a revision of the initial stage model of online task groups. The initial stage model will be presented first and then the revised stage model of online task groups will be offered with a discussion of lessons learned from the initial five stage model.

Initial Stage Model of Online Task Groups

Online task groups appear to follow stages characterized by a particular theme as the members work through the assigned task (Jacinto & Turnage, 2003). The stages of online task group development for the Clinical Supervision course included: chaos, clustering, collaborating, consensing, and closing.

Chaos. Students experienced a sense of chaos upon first logging in to the chat room. This first stage appeared to be present only during the first group sessions and was the place where individuals learned how to communicate within an unfamiliar technology. The instructor purposely did not structure the beginning phase of the group in order to understand how students would negotiate the territory. In addition to recognizing the need to provide structure, other lessons learned include awareness that assigning weekly group leaders and recorders saved time and afforded the group the opportunity to begin working on the assigned task more quickly.

Clustering. After the initial sense of ambivalence and chaos, the group members appeared to cluster. Out of the chaos, students adapted and became increasingly comfortable with the environment. The leader's task at this stage was important since the leader began the session by welcoming each member as they logged into the chat room. As the leader established the agenda for each session, his or her presence provided a sense of continuity, consistency, and assurance that the group will accomplish its task. The online task group discussion found group members clustering to address the assigned task. During this stage, a recorder was selected to document the group discussions and recommendations. This was the beginning of the task group's work.

Collaborating. The third stage in the task group process ensued when the leader asked for members of the group to brainstorm ideas to address the topic. One of the leader's goals during the meetings was to keep members on task. In the online environment, it was easy for the discussion to drift from the business at hand. Therefore, the leader must return the group back to the focus of the meeting each time a shift took place. During this phase, many alternatives toward goal attainment were presented, and as a result, it was imperative that the leader controlled the flow of information.

Consensing. The fourth stage of consensus seeking consisted of two major activities. First, the recorder recapped the key ideas generated by the group. After each idea was presented, the leader led the group through discussion seeking a consensus. The most effective leaders attempted to get each member's perception of the item under discussion. In most cases, a consensus was reached. When it was not possible for a group's members to agree on an item, a majority and a minority recommendation was posted.

Closing. When it is time to close the group, the leader asked the recorder to summarize the entire session. If no further comments were offered, the leader directed the recorder to post the recommendation to the appropriate Discussion Posting.

Revised Model of Online Task Group Development

Reflecting on the lessons learned from the first online task group, a unit on netiquette and increased structure for the group members influenced the stages of group development. The chaos stage in the initial stage model (Jacinto & Turnage, 2003) should more likely be labeled coalescing in the experience of the proposed group (see Table 2). In the coalescing stage, members share information through a planned ice breaker exercise using netiquette as they introduce themselves. In this way, they experience coalescence more quickly than in the earlier chaos stage. The experience of chaos is a confusing set of initial interactions as members of the group get to know each other and establish working relationships. More than one group in the Clinical Supervision class spent more than one session getting to know each other and determining who was going to be leading the group each week. Therefore, the coalescing stage replaces the chaos stage and becomes Stage 2 in the revised model.

Table 2

Initial and Revised Stage Models of Online Task Group Development

Stage	Initial Stage Model (Jacinto & Turnage, 2003)	Stage	Revised Stage Model (Jacinto & Hong, 2010)
1	Chaos	1	Coordinating
2	Clustering	2	Coalescing
3	Collaborating	3	Clustering
4	Consensing	4	Collaborating
5	Closing	5	Consensing
		6	Closing

Stage 1, characterized as the coordinating stage, introduces group members to the netiquette unit and assigned group leaders and recorders for each session. An email detailing the duties of the leader is sent to the leader of the first group session. The recorders also receive an email outlining the tasks of the recorder. The coordinating stage is similar to the Pre-affiliation (Garland et al., 1978; Schiller, 1995) and Orientation-Inclusion (Northen, 1988) phases of the

f2f group development theories (see Table 1). It is during the coordinating stage that the instructor informs the groups that they will be using Google Documents to work on the final draft of their recommendation. The recorder first summarizes the group's work and uploads a draft of the document. The other members of the group are encouraged to edit the document and make changes between group meetings. Over a few weeks, the group works on the document coming to a consensus about the final product. The recorder of the last group copies and pastes the final document in the Discussion Posting board within the Blackboard shell for the course allowing other groups to read the group's recommendations. The clustering, collaborating, consensing, and closing stages are projected to function in the same way as described in the initial stage model derived from the Clinical Supervision course.

Implications for Practice

The use of online task groups was well received by the students in the Clinical Supervision course. Students remarked that they enjoyed meeting at a convenient time each week, the group process, and the efficient use of their time to problem solve. Several students suggested that the online setting eliminated classroom distractions such as noise and periodic side conversations that are distracting and do not contribute to the class discussion.

When considering learning styles, students identifying themselves as visual and kinesthetic learners were more likely to favor this approach. However, students categorizing themselves as auditory learners identified some difficulty with this mode of education. For the auditory learners, the absence of the spoken word may impede their ability to immediately grasp the subject matter.

The positive feedback from the students identifies several reasons to incorporate this technique into social work courses. First, all students are able to participate in the learning environment due to the flexible scheduling of group work. During the initial session, group members are able to select future meeting dates and times that do not require transportation to a particular site. Therefore, students who must work, those with children, and/or those whose class schedules conflict can still participate in the learning process. The use of online task groups allows each student to take responsibility for his or her personal learning, thereby enhancing the probability that the student will become an active learner. The course was designed to encourage active learning through the assignments required for the course.

Students who become familiar with online technology while in the classroom environment acquire skills that can enhance performance in practice settings. For the students who will practice in rural areas or become care coordinators in rural or urban areas, online task groups may help them provide quality services to their clientele, and use their time and resources better.

Preparing students to conduct online task groups requires teaching students how to conduct effective meetings. Through these online meetings, students were provided opportunities to learn team-building skills as they mastered important subject matter. The online task groups provided a venue for students to learn how to work toward consensus, deliver respectful interpersonal communication, collaborate with new individuals, and

understand reciprocal exchanges. These skills can be taught in f2f classroom sessions, however, students in the online setting were able to respond constructively to critical feedback, take responsibility for their actions and inactions, and learn from the frustrations of limited visual contact with other group members.

In addition, the online task groups facilitated students' work on their intuitive skills. To fully grasp their fellow group member's messages, students had to look for the meaning not just within the written words. That is, to fully understand each transmitted message, each student had to consider their own feelings and the feelings of the sender, the possible intent of the message, and the appropriateness of the message to the overall process. This lesson is an important one for students who will provide direct client services. As with their fellow group members, not all clients will be able to verbally express themselves completely through written or spoken communication. To become a successful direct practitioner, students must learn to interpret client interactions without becoming emotionally involved. Building intuitive skills online can enhance f2f interactions with supervisors, colleagues, and clients.

New insights arose through interactions with group members as the students learned to use their intuitive skills to understand the communication processes. Ideas were shared between group members that fostered interpersonal and intrapersonal growth. The interactions with the group's members provided each student an opportunity to expand the definition of self and to move toward fuller understanding of their interactional styles.

Finally, it appeared that the use of the online task groups engendered ideas among the students that made its use both efficient and creative in approaching problems. After the students became comfortable with interacting through this medium, they were able to utilize it to expand their ideas. Meeting online allowed the students to immediately share the material they had produced or found via the Internet. This material could be incorporated into their assignment or altered to meet the group's specifications in addressing their weekly supervisory problem.

Proposed Online Task Group

The authors propose a six-week online task group as part of an assignment for the graduate Clinical Practice with Groups class members. The following is a six-week brief of the course.

Session/Week 1

Students will complete a unit on online netiquette and complete a Discussion Posting addressing questions about appropriate use of online netiquette. The instructor will assign the group leader and recorder for week two and provide directions for conducting the group session.

Session/Week 2

Students will introduce themselves using an ice breaker supplied by the instructor to get to know the members of the group. The group leader and recorder will be selected for each of

the following three weeks. Upon completion of the ice breaker, the leader will introduce the group to the task on the document, which they will be working on for the next three sessions. Session/Week 2 is developed around activities that lead to members coalescing as a group. This will prepare them for the working stages of the group that will follow.

Session/Week 3

The group leader will facilitate group members in a discussion of the task to be accomplished. A task that will be used during this session will be brainstorming. Brainstorming naturally leads to the clustering of ideas that will form the foundation of the group's final recommendations. The recorder during this session will construct a narrative document at the end of the group and place it on the group's space in Google Documents. Members will be asked to review the document before the next group meeting and make additions or editorial changes.

Session/Week 4

The group leader will facilitate a discussion of the Google document with members offering additional comments and insights. This session will require collaboration of group members as they agree and/or disagree about the final recommendations the group will be completing. The group is encouraged to respond a second time to the document revisions that the recorder adds after the completion of the Session/Week 4 group meeting.

Session/Week 5

The group leader will review the document with the group and seek a consensus of the group about the final form of the document. Members will agree to the document as written. If a consensus is not possible, a minority opinion will be written by those disagreeing with the recommendation and the minority opinion will also be posted with the document. The minority opinion may only be posted with the support of the majority of the group members. This session will also result in group closure. The leader will facilitate the closure of the group.

Session/Week 6

Individual members of the class will read the Discussion Postings of the groups and will write a Discussion Posting about the solution they most favor and the solution they least favor explaining their reasons for each choice.

The role of the leader is most important for the success of the group. For example, the leader should develop an orderly agenda prior to holding the meeting. This agenda directs the flow of the meeting, informs attendees of the focus, direction, and pacing of the meeting, and serves as an official record. The beginning and ending time should be noted on the meeting's agenda to ensure group members schedule enough time to effectively participate in the meeting's activities. Attendees should receive a copy of this agenda, at a minimum, one-week before the meeting is scheduled. Along with this agenda notification, the leader should send a

copy of the minutes from the last meeting. The recorder of the weekly group should complete the meeting minutes and send them to the assigned leader for the next week's group. The first business item on the agenda is the acceptance of the previous meeting minutes. Providing this material early ensures attendees will have an opportunity to read the minutes prior to the meeting and be ready to discuss any concerns they may have.

On the day of the meeting, the leader should review the agenda items before the meeting to ensure all of the required supportive material has been gathered. Another group member may be responsible for gathering a portion of the supportive material. It is the leader's responsibility to contact this person to confirm that this material has been obtained and will be available to all members at the meeting. The leader must be cognizant of the pace and progress of the meeting. Reminding members of the group's task should discourage side conversations that obstruct the flow of the agenda. Students must also be taught that thanking the group members for contributing their time and effort to the task validates each member's commitment. With an understanding of how to run an effective group, students are ready to practice their new skills through the use of meetings established in a structured online setting.

Recommendations & Conclusion

Three of the most important aspects of online task groups are preparation for group participation, the group's charge (purpose), and leadership. Prior to expecting students to lead a task group, they should be taught how to lead effective groups. This information will be included in a group leader handout that will be given to each group member. With this information, students in the Clinical Practice with Groups online task groups can find an efficient way to tackle their course assignments. This paper focused the use of an online task group for social work students to solve problems and produce recommendations and offered a revised stage model of online group development and a discussion of lessons learned from an online task group used in a graduate Clinical Supervision class. The use of the Internet to transact social welfare agency staff interactions and services will continue to grow and challenge practitioners to create effective human services in the virtual environment.

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Foot Soldiers for Social Justice: Realities, Relationships, and Resilience

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Abstract. *Social justice is embraced as a central mission of social work, yet how the profession defines social justice lacks a clear and common understanding. This qualitative study explored social justice as perceived and practiced by social workers in diverse practice settings in mostly rural areas, small towns, and small cities. Their experiences illustrate ways that social workers engage and advocate for their clients with the goal of improving access to tangible and intangible resources through both conventional and unconventional means. The authors provide insight into the resilience that bolsters social workers' efforts as they navigate between practice ideals and realities.*

Keywords: *social justice, social work, social workers, social work values, resilience*

The National Association of Social Workers (NASW; 2008) Code of Ethics states, "Social workers challenge social injustice." This statement is further clarified that:

Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people. Social workers' social change efforts are focused primarily on issues of poverty, unemployment, discrimination, and other forms of social injustice. These activities seek to promote sensitivity to and knowledge about oppression and cultural and ethnic diversity. Social workers strive to ensure access to needed information, services, and resources; equality of opportunity; and meaningful participation in decision making for all people. (NASW, 2008)

Using this statement, the authors wanted to clarify how practicing social workers define social justice, what they describe as injustices in their communities, and how these same social workers act to challenge injustices. While social justice is embraced as a central mission and organizing value of social work (Marsh, 2005; Reisch, 2002; Swenson, 1998), the question of how the profession specifically defines social justice has lacked clear and common understanding (Galambos, 2008; Reisch, 2002; Wakefield, 1998).

How social workers understand social justice has implications for how they translate this central mission and value into practice. This research adds to the discussion by calling upon contemporary practicing social workers to give meaning and application to their lived experiences with social justice.

Social workers from diverse locales, particularly outside urban areas, were chosen. Social workers serving non-urban areas face issues distinct from their urban counterparts, including fewer resources, longer transportation times to needed services or to clients, and, some would argue, cultures that are distinctly different from urban settings. As Barker (2003) notes in defining rural social work, rural areas generally offer fewer educational and economic opportunities, and there is less acceptance of variations from prevalent social norms, all of which give rise to unique problems for residents in addition to the same problems and needs that urban dwellers have.

Method

This study employed a qualitative methodology using focus groups populated by social workers with BSW or MSW degrees and practicing in social work settings. Participants were drawn from three regions in a Midwestern state representing rural areas, small towns, and cities. Six focus groups were conducted during June, July, and August 2009. Each group averaged seven participants and lasted approximately 45 to 90 minutes. The size and format of the focus groups followed recommendations in the literature (Strauss & Corbin, 1998).

Focus Group Questions

Each focus group was guided by the following five questions:

1. How would you define social justice?
2. Can you give me an example or two of social injustices in your communities?
3. Can you give me any specific examples (or tell me a story) about how social justice techniques have been implemented in your community to solve an issue of injustice?
4. There's been a lot of talk about responsibility lately; how do you think responsibility fits into the discussion we've been having?
5. Is there anything that we haven't discussed that should be added?

Measures

Three social work researchers from regional, comprehensive universities led the focus groups. Each participant completed a short survey of demographic and employment data (e.g., age, race, length of time in practice, and primary practice setting). Naturally occurring themes emerged after the researchers probed the participant responses to the focus group questions (Fern, 2001; Kitzinger & Barbour, 1999).

Procedure

The investigators sought to explore how social justice and injustice were defined and what social justice tactics were implemented from the direct experiences of social workers

practicing in diverse, mostly non-urban, locales. The participants practiced in a wide variety of settings resulting in achieving maximum variation in the sampling (Glaser & Strauss, 1967). Social workers were recruited using a snowball sampling approach (Neuman, 1997) by utilizing personal and professional contacts (Bogdan & Biklen, 1994). E-mails were sent to social workers inviting them to participate in a study “to better understand the lived experiences of social workers with regard to social justice,” and to participate “in a focus group . . . to share their thoughts about how social workers define and participate in social justice.”

Results

Demographic Profile

The study included 41 social work practitioners from diverse settings in various communities in one Midwestern state. The majority of the participants (66%) held MSW degrees, and the rest BSW degrees. Most of their practice settings were hospital/medical (34%), substance abuse treatment (15%), and public schools (12%), with the remainder from homelessness and domestic violence programs, juvenile justice, mental health, protective services, community development, administration, macro policy, and church affiliated agencies. Eighty-eight percent self-identified as Caucasian and 12% as African American or Latino. Ages ranged from 21 to 65 years, with over a third of the participants (15) between the ages of 21 and 25 years old. The participants had practiced an average of 11 years since receiving their first social work degree. They worked in varying community locales: rural areas (12%), small towns defined as less than 50,000 residents (34%), small cities defined as less than 150,000 (27%), and urban/suburban areas (39%). Participants were allowed to check all the settings that applied, thus this total exceeds 100%.

Major Themes

Four major themes emerged from the data: (a) meaning of social justice, (b) realities of social injustice in participants’ communities, (c) confronting and ameliorating injustices, and (d) relationships and resilience as methods and resources for confronting injustices.

Theme 1: Meaning of social justice. Social justice was seen as synonymous with a variety of concepts: equality, fairness, moral obligation (e.g., “the right thing to do”), working for the common good, distribution of resources, equal access to resources, and social responsibility (e.g., “people taking care of each other”). When asked how they defined social justice, participants made statements such as:

“Equal access to resources that people need in order to live a more healthful life,”

“Everyone is entitled to certain basic needs being met, including emotional and relational [needs],” and

“One definition is kind of [at] the macro level . . . [but] then in day-to-day practice, it really has to do with working with people in a way that is relevant to them, that they are

being respected, that they are being given opportunity, those kinds of things. So it's kind of a social policy level and a micro level."

Theme 2: Realities of social injustice in participants' communities. Participants were asked to give specific examples of social injustices. These experiences of social injustice fell into five categories: (a) inadequate resources; (b) insensitivity among community members and other professionals toward vulnerable groups; (c) effects specific to rural areas with high unemployment and generational poverty; (d) personal obstacles such as one's own anger, apathy, and lack of time to address the multitude of problems; and (e) people endangering themselves to qualify for resources.

Inadequate resources. The following two exemplars were characteristic of the theme of inadequate resources. One participant described the impact of the lack of substance abuse treatment programs on help-seeking behaviors:

"There's not too many [drug] programs that will take you unless you can pay or have insurance, so a lot of people get discouraged right off the bat. It's easier to keep the addiction than to seek treatment."

Another described how a problem such as homelessness is dealt with:

"In this [rural] area, we don't have a lot of chronically homeless people like you see in a big city; we have a lot of, you know, families living in trailers that are unfit . . . people that are going between people's homes."

Insensitivity toward vulnerable groups. One participant described the challenges in reaching out to new communities when discrimination is apparent:

"In our efforts to reach out to the Hispanic population, there is an assumption that they are undocumented and not worthy of the equality that is granted to everyone else as a citizen."

Another described frustration when working with a commonly oppressed group:

I worked in a program with adults who had severe mental illnesses. People stereotyped them, and it was so sad because these were wonderful people that had so much to offer, and my program was to keep them out of the state mental hospital. Many other professionals simply wanted to put them in the hospital, and I advocated for the patients to be able to live in the most independent type of setting and to be able to engage with work places that offered supported employment.

Effects specific to rural areas with high unemployment and generational poverty. Nostalgia for times past emerged with this respondent:

In this area, I mean in Appalachia, 70 years ago you had all these very poor families that were taking care of themselves, and that is not happening now. They had so much pride

in their family, they had a huge garden, they were always clean, you know, all these different things; they made sure they were going to school and learning, doing better for themselves. And we've gotten in these very sedentary mindsets that whatever is going on now, that's fine, and this is just how it is and just me and my neighbor, we're all just not trying to do any better than them—you know what I mean? So I really think that's been kind of an injustice to people...

Another participant reinforced:

“I think that, for those people that are abusing the system, that's just all that they know.”

Personal obstacles. One member observed:

I think you have professionals that are totally disenchanting. You know, people are so burned out and worn out with the continuous presentation of these families and just the day in and day out, you know, the revolving door of these families where somebody's addicted or someone's in jail . . . it's almost as if the teachers and social workers are like, “I'm not going to waste my time.” So we contribute to [social injustice], you know, in some ways.

Another responded to reduced-fee school lunch policies in which children's trays were taken away and they were given special bagged lunches when their parents could not keep up with the payments:

I'm sitting here now thinking my blood pressure is [going up], and I'm so mad that I can't . . . that I'm thinking, “What am I going to do when I leave here?” I mean, I'm just pissed, honestly. It makes me really, really angry to think that that's happening, and I think it's emotionally abusive that they're doing that to kids, but I know that I'm dealing with stuff every day that if I shared stories with you all . . . you're going to be, like, “Oh, my God!”

Finally, a respondent addressed the exhaustion, knowing that she should be doing more:

“When you're already working 50 hours a week, how do you make time to go to Capitol Hill and be, like, ‘this is what we need, this is what's going on?’”

People endangering themselves to qualify for resources. One participant gave an example of a homeless woman who came into a hospital emergency room having purposely overdosed on Zoloft in an effort to qualify for disability. The participant quoted the woman as saying,

“If I get my disability check first then I could find a place to live.”

Another described this incident concerning a pregnant woman:

[She] had been in a relationship, ended the relationship, found out she was pregnant,

I think [the man who impregnated her] ended up committing suicide... Her plan was to have an abortion, but because of her morning sickness she'd missed so much work she lost her job; she didn't have money. So she went on a drug binge trying to abort the baby. So by this time she wants drug treatment, she wants an abortion, but if she's not pregnant she loses her medical card which will cover drug treatment. So she has to stay pregnant to get the drug treatment because if she had the abortion then she gets no drug treatment.

Theme 3: Confronting and ameliorating injustices. Respondents confronted injustices through both conventional and unconventional methods. Conventional methods included techniques such as community education and coalition-building. For instance,

“As social workers, we're a lot of times in the business of educating our legislators and educating those people in power, hopefully, and that's a responsibility that we have on our end.”

Another member responded:

I always find it very challenging and interesting when I go do presentations, like, with the Rotary Club or Exchange Club—these clubs that are primarily older, white men. And here I am talking about domestic violence. What I try to do is humanize it to them, because everybody in that room has a mother, a sister, or daughter. It is changing people's thinking on things, and being able to do that on whatever level you possibly can has to trickle up or trickle down at some point, right? Hopefully when he goes back to the bank after lunch today, somehow he's going to put that message out again.

Another respondent suggested the use of coalition-building as a conventional method, stating:

It doesn't always come from the government. Sometimes we need things in our community, tapping into the resources of local businesses, perhaps, and for-profit arenas where they can help fill the gap, because I think there will always be an issue of competing for these limited resources.

Conventional methods also include going the extra mile when clients otherwise would fall into the cracks. The following story was related by a Hospice worker who made a home visit along with a nurse following a new referral received on a Friday. In the home they found deplorable and unsanitary conditions. The patient's wife was mentally handicapped, with the couple's minor daughter acting as primary caregiver. Subsequently they made arrangements to transfer the patient to an inpatient Hospice facility located in a nearby small city.

The little girl, the daughter, primary caregiver, rode in the ambulance with her dad to the Hospice Care Center. Whenever she got there, she was able to sign the papers, [but] she had not eaten. We don't have a cafeteria, but we do have snacks. She was so lost, you know . . . and I said, “Have you been here? Do you know where we are?” No, she had never been to [this city] before. So we got everybody situated, and I thought she was going to stay all night. And I got her some things so she could sleep. And I get home,

thinking she's going to stay all night and that we had at least a handle on [this crisis]. And at 10:00 p.m. [the hospice facility staff] called me and said, "How is she getting home?" And I said, "Well, I don't know. I'll figure something out tomorrow." And they said, "No, she wants to go home now, and she can't stay." So I'm like, urghh, you know, so I said, "Well, you know, I think she can stay." But then it occurred to me that she was scared. [The facility] was intimidating and there was nobody there to kind of nurture her along. So I called my friend and I said, "What are you doing?" She said, "Well, I'm in bed." And I said, "Get up. I'll be there in five minutes. We've got to go get this girl." So we drove to [the city] from my home and we picked up the little girl. She didn't realize that this was going to be the last time she saw her dad and so, you know, I was able to just help her minimally, I mean very minimally. I didn't do anything great. And we stopped and got her some food at McDonalds and took her home that night. It was about two weeks later, she called me and she said, "I wondered if you could tell me something. Was my dad hurting when he died?" So I said, "Well no, I don't think he was. But how about if I come out and we just talk about it?"

Unconventional methods fell into two main, overlapping categories: Manipulating or circumventing the system and straining ethical boundaries. One respondent related that:

If a person dies in a given county, and there is no money for burial, the county's going to pay for the burial . . . But you get buried wherever they tell you. The patient wanted to be buried next to his wife in his home county. Although against agency policy, we had a hospice bed become available in his home county, so we transferred him so that he could die and be buried in his home county.

In a similar story, a participant added:

If you're on Social Security . . . and you die on September 29th you don't get your Social Security check for that month . . . [In a case where the family member was expected to die soon after aggressive medical treatment was discontinued] the doctor had recommended Hospice [thus ending aggressive treatment], and the family said, "But we have nothing to bury her with and we need that check." So I remember asking the doctor if he could hold off a couple of days with his hospice order until that month passed and they—the family—then could get the check to bury the person with.

A respondent related this story about clients who cannot keep sustained employment:

I think that sometimes we have to [oversee] people that can't function and step in and just make sure that social justice is served. You know, whether it be supplying [a woman] with housecleaning jobs to where she can almost make it and then picking up the pieces when her child can't go to New York [for a school trip]. You're doing social work right there. Now, some people would say, "No, you're being an enabler." And there are cases where that is true. But there's also cases where sometimes enabling is all you can do because this person has . . . tried many different things and can't make it . . . And I think that in this lady's situation, you know, social injustice sometimes [means]

just holding their hands. I've got one [client], invariably every other week [he asks], "Can you spare \$20?" You know, now some people would say, "You're enabling that person. You know, you're teaching him not to watch his budget." And it's like, yeah, probably so. But the key is—if I didn't give him that \$20, he would go without. And if I didn't give him that \$20, he wouldn't feel loved. He would feel that he's doing something wrong. And sometimes, let's face it; we don't need a two-by-four upside the head. We need somebody to caress our hair or clean us up because we peed on ourselves.

The following conversation concerned a social worker in the community [not a focus group participant] who reported the neglect of her grandmother in a nursing home to Adult Protective Services (APS):

She came to me as the hospital social worker regarding a patient that I was working with, and she said, "I've reported an incident on another resident at the nursing home for neglect." [APS] investigated, and she called me back. She was so frustrated. She said, "You're not going to believe this, they say there's just nothing there, there's just nothing." And we talked about, what do you do, what do you do? The next thing I know, she has planted this camera in there; she's got photographs. What do you think a lot of people said about her planting that in there? I'm hearing, "Why did she leave her in there that long? Why didn't she take her [grandmother] out sooner, if she felt that way?" But she took that, has stood up to that nursing home, not just that nursing home, but the owners of that nursing home . . . I mean, they paid . . . somewhere at least \$10,000 a day penalty financially. So, you're hitting them in the pocket there, right? You're getting public awareness out there because she and I thought, "How are we going to effect change?" We did it.

Theme 4: Relationships and resilience as methods and resources for confronting injustices. Participants detailed developing resilience for coping with their own anger at social injustices, persevering in their work, and battling burnout by cultivating and maintaining certain personal perspectives. Additionally, they confronted injustices by practicing social work values and skills to foster effective, just alliances with clients.

Personal perspective as resilience in coping with burnout. One participant cautioned:

I think whichever aspect of the field we work in, we hear horrible stories every day that after a while you have to be able to somewhat distance yourself emotionally so that you are able to sleep at night and you don't have ulcers . . .

Another added,

"You have to kind of remind yourself, you know, in the face of conversation with people, what your purpose is and not get blinded by the system frustrations, because we deal with those."

Last, a respondent reasoned:

Yeah, we're dealing with people that most times caused their own problem, but it's not

my job to correct that problem. It's to show them what options there are, because, like we said earlier, sometimes they don't know what the options are, and even when you give it to them, they think, "God, do I really want to do that?" But if they're a challenge, and as long as they're a challenge, I'm going to keep doing this job because I feel like there are some people you can make a difference with and some you can't, but at least you give it your best shot.

Social work values and practice skills. One respondent took comfort in the listening skills he had learned:

God gave me two ears and one mouth, so I listen a lot, and I figure the more I listen, the more I can really hear what they're saying . . . See, if I were in this situation, and I didn't have family support, I might be in this same situation, there but for the grace of God. So you try to tailor each case individually so you don't get in a rut: "Oh here's another COPD, oh, here's another this, another that," and that keeps you from . . . looking [only] at the diagnosis and [not] getting to the person, and that's what you have to look at in this job in particular. And that's what keeps the challenge up.

Critical thinking and problem solving were emphasized with this example:

Here's a drug addict, here's how everybody deals with him; what can you do differently with someone with this kind of problem? So we have that obligation, I think, to think outside the box and not get stagnant in our approach and our work, because [if] you do that you will get burned out and frustrated.

Two participants revealed what their social work training meant, saying:

I think at times the burn out . . . is just a way of coping. I think everybody does that. It's like, hey, you know, we've got another so-in-so in bed whatever . . . As the social worker, at least I think I had good training to have some degree of empathy. So I think just being able to have professionals continue to have insight into the work, into themselves and, you know, what's happening and the reasons behind it, to keep themselves updated and educated on what's going on, you know, within not only their agency, their community, but nationally.

Fostering just alliances. One participant differentiated simply helping the client to cope versus knowing when to be angry:

I think that there's absolutely a time and a place for tact and diplomacy, and that's kind of what I'm hearing—we teach our clients, and we role play and tell them all that stuff, but sometimes you should just be outraged. There's a time to be absolutely outraged. And yes, I think there's an appropriate way to express that without throwing your coffee cup or threatening to blow up a building . . . so I teach them, "You should be mad. I don't blame you at all for being mad." I'm not going to say, "Calm down and ask nicely."

Finally, a participant summarized:

I figure if we have aliens come down from above, we'll be best friends with the Iranians and all those folks [who are our enemies today]—really, think about it—then we'll all have something that when we're fighting amongst ourselves we can't pull together. People pull together when they're headed in the same direction for a central goal.

Discussion

How do practicing social workers define social justice? Social justice eludes simple definition, but the participants in the current study appear to conceptualize it as a responsibility of both society and of individuals. It is about distribution of society's resources in such a way that everyone has access to a minimal standard of living, including health and mental health care, housing, education and employment, protection from abuse and neglect, and protection from marginalization and despair. There is a political dimension, acknowledging that social justice requires government action to shape and enforce how resources are distributed. They view social welfare and their work as professional social workers as methods for ensuring justice. They recognize their own responsibilities as individual, autonomous professional social workers to ensure that the tangible and intangible needs of their clients are being met.

How do practicing social workers translate social justice into their practices? While the NASW Code of Ethics (2008) emphasizes social change, this study indicates that social justice is implemented across the micro-macro continuum as these respondents put into effect their professional skills and values and otherwise go about their daily work as social workers and as citizens. And in accord with the conduct the NASW Code of Ethics prescribes for challenging social injustice, this study's results suggest practicing social workers do "pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people," and that their "efforts are focused primarily on issues of poverty, unemployment, discrimination, and other forms of social injustice" (NASW, 2008).

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A Logic Model for Program Planning and Evaluation Applied to a Rural Social Work Department

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Abstract. *A logic model is framework that is used to delineate goals and resources. It was used by the Social Work Department at Texas A&M University-Commerce to help visualize and establish the initial accreditation of the MSW program and continues to be a valuable tool for this rural social work program. The model has helped faculty determine a vision for the program. This vision has transferred to other areas such as recruitment and retention of faculty, curriculum choices for students, resources for alumni, and community development to reach rural social service agencies that are lacking in resources. The logic model provided a guiding framework that started at the inception of the social work program and has helped clarify strengths and weaknesses in building the social work program.*

Keywords: *logic model, program development, rural social work program, program evaluation*

The purpose of this paper is to apply a logic model framework to social work interventions on all three practice levels: micro, mezzo, and macro. The use of logic models is cross-disciplinary arising from the knowledge base of how social systems function whether as individuals, families, small groups, large organizations, or as macro governmental agencies. From organizational social systems theory, a logic model can illustrate causal links between inputs (resources), outputs (students), and outcomes (achievement of mission) (Chen, Cato, & Rainford, 1998; den Heyer, 2002).

Logic models have become increasingly popular among funding agencies for program planning and evaluation (United Way of America, 1996). Although the terminology may differ depending on the systems model used, the terminology addresses three familiar system elements: inputs, outputs (activities and participants or methodology), and outcomes. Inputs concern resources which are social work practitioners. Outputs concern the product which is the client, family, group, agency or community. Finally, outcome addresses the effect of the intervention or program on the clients, agency, program, or community. Logic models apply short-term, intermediate and long-term outcome measures to assess effectiveness of interventions, and to set goals.

It is especially critical for a guiding framework to be adopted at the inception of an intervention in order to provide coordination and cohesion to the efforts of the various participants. The lack of such a framework often results in wasted time and resources, and can lead to chaos that defeats the purpose of the program. The value of a logic model is that it provides a systematic manner in which to evaluate each step of the process and to integrate the parts into a holistic picture that can then be related to the mission of the program. The nature of the logic model is that if resources are applied correctly, then the specified outputs will be applied. Similarly, if the outputs are applied, then the intervention will achieve its short-term targets that will produce the desired program impact (e.g. Alter & Murty, 1997; United Way of

America, 1996; Wholey, 1987). The process is iterative in that earlier steps are revisited and amended throughout the process. Figure 1 depicts a graphic description of the Logic Model created by Taylor-Powell (1998).

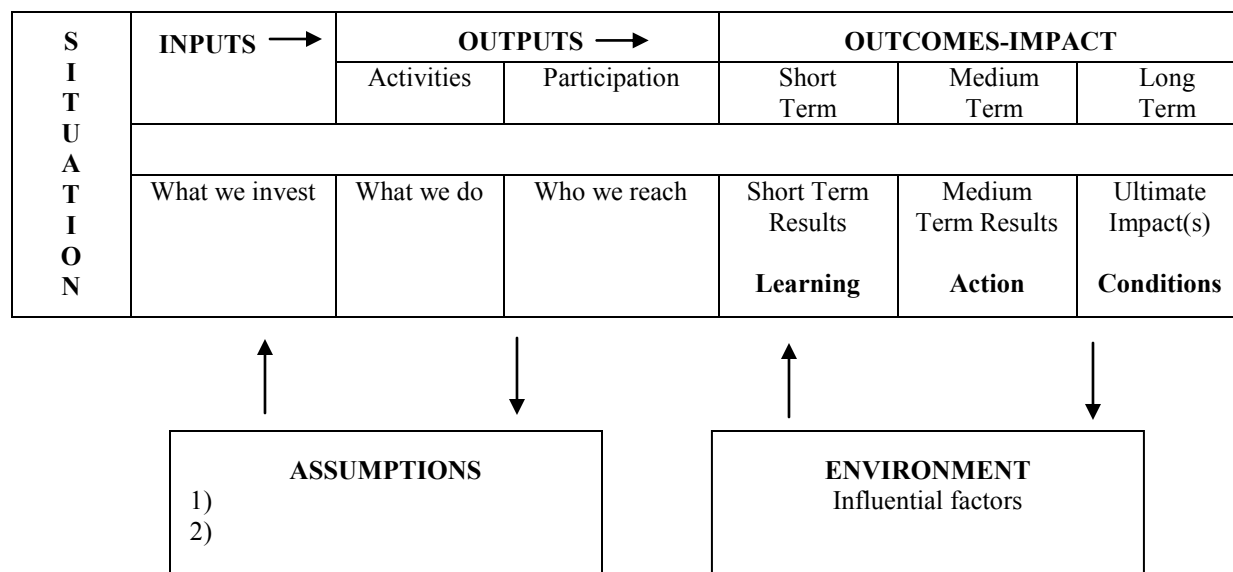


Figure 1. Logic Model: Program Performance Framework. Adapted from *The Logic Model: A Program Performance Framework*, by E. Taylor-Powell, (2001, June 18-21), Paper presented at Providing Leadership for Evaluation, Madison, Wisconsin.

Program evaluation is accomplished by determining if the actual short and long term outcomes are those in the stated goals and objectives. The goals and objectives should be established following the development of a mission statement that addresses the situation requiring action. If the short or long term outcomes are not achieved, the model provides a clear path which can be followed to determine where a problem may exist. The amount and type of input to accomplish the goal should be examined. Was the investment sufficient to support the outputs? The outputs can then be reviewed. Did the activities accomplish what was needed for the expected outcome and did we reach the intended population group? Lastly, did the short term outcomes form the foundation for the medium and long term outcomes to occur? The Logic Model also provides for the impact that environment may have on the desired outcomes. Both quantitative and qualitative measures that examine all stated goals and objectives should be used in the evaluation process. Summarizing, the process is ongoing and provides for constructive program change as necessary to accomplish the mission statement and goals.

Constructing a Logic Model for a University Department

The logic model, as shown in Figure 1, provided a systematic plan for developing a program evaluation based on the previous work of the faculty in developing a mission, goals, and objectives. The following six steps provided a framework for constructing the framework.

1. Stating a problem or mission of the program.
2. Identifying short-term, intermediate, and long-term outcomes (results and impacts).
3. Specifying program outputs (activities and participation).
4. Identifying resources or inputs (what is invested).
5. Identifying environmental factors.
6. Identifying assumptions.

Background

The Department of Social Work at Texas A&M University-Commerce was seeking accreditation for a new master's program (MSW) in northeast Texas. The program was developed as an outgrowth of a 1997 needs assessment of social service providers in the counties adjacent to Texas A&M University-Commerce. The assessment revealed that many rural communities adjacent to Commerce did not have a sufficient number of master's level trained social workers to meet legal and ethical requirements for supervision, to work across problem areas and system levels, and to develop new programs. The closest MSW program was in Arlington, Texas, approximately 100 miles from Commerce. Thus, location and curriculum were primary motivators leading to the mission of the department.

Step 1

Step 1 is to state the problem or mission of the program or department. The Department of Social Work at Texas A&M University-Commerce used a needs assessment to identify curriculum and program needs. Although the needs assessment revealed the type of knowledge and skills desired by local communities, the development of a mission statement was difficult and time consuming due to the identity development that occurs in new programs. The faculty, staff, field instructors, university, communities, and advisory committee all must agree to the formation of the program identity that is reflected in the mission statement. Program identity also dictates the program's emphasis or specialization. Much thought and debate was given to whether the emphasis would be solely on rural communities or whether it should include suburban and urban areas as well. The faculty chose an advanced generalist specialization because it appeared most suited to prepare students for working across system levels in both rural and increasingly urban areas. Thus the following mission statement of the Social Work Department at Texas A&M University reflects an advanced generalist curriculum:

The Department of Social Work promotes and enhances the education and development of professional social workers who seek to improve social, economic and environmental conditions of diverse populations in Northeast Texas (Texas A & M University-Commerce, 2010).

Step 2

Step 2 is to identify short term, intermediate, and long term outcomes of the program that relate back to the department's mission. The short term outcomes of a program, for example, should relate to the resulting differences or changes due to educational activities such as coursework. Intermediate outcomes are target measures that show benchmarks toward meeting goals, such as setting a benchmark of 95% of all students becoming licensed within the first year following graduation from the MSW program. Finally, the central question of program success is related to the long term program outcome, "What impact is the MSW program having on individuals, agencies, communities, and the northeast regions of Texas?"

Outcomes and measurable outcome objectives are continually explored and evaluated by the faculty. The faculty, however, must set benchmarks for determining achievement of a target outcome. A benchmark is a target goal expressed in measurable terms, such as 75%, 80%, etc. An outcome benchmark might be what percentage of entering students can realistically be expected to graduate within two years. In other words, outcomes should be realistic, measurable, and an important way of determining program effectiveness.

Currently, the faculty is in the process of defining intermediate and long term outcome objectives for the program. Until now, most of the focus has been on curriculum rather than on total program evaluation. In part this is the result of realistic expectations to meet accreditation curriculum standards of the Council on Social Work Education (CSWE, 2010). However, setting goals and benchmarks in areas such as faculty development and retention, product development (using new technology in teaching), and partnerships with the community are our next priority. Tentative activities have begun in these areas though benchmarks still need to be set. For example, an intermediate outcome might be that 75% of faculty achieves tenure within six years of their hire date. One long term outcome for the program might be that 75% of faculty are tenured or in tenure track positions.

The MSW program has curriculum goals and objectives aligned with standards set forth by the CSWE. An example of these is included (see MSW program performance goals below). From these goals and objectives, faculty develop course syllabi and course assignments, field assignments, role plays, written interventions, film case studies, papers on assessment and treatment planning, and required field hours to all work in conjunction with departmental objectives. This assures that each class is covering the material that is required by CSWE and that the program addresses all of its goals and objectives.

MSW program performance goals. The following is an illustration of MSW program performance goals and objectives:

Goal 1: To provide students with the knowledge, values, and skills of advanced generalist practice.

- Objective 1: Students will demonstrate the ability to apply the problem solving process to generalist practice intervention with client systems at all levels.

- Objective 2: Students will demonstrate the ability to conduct advanced generalist interventions which take in to account the rural or urban practice context.
- Objective 3: Students will demonstrate the values and skills needed for autonomous practice.
- Objective 4: Students will demonstrate the knowledge and skills needed to provide leadership in social work organizations.

Goal 2: To promote the development and use of evidence-based practices consistent with social work values and ethics.

- Objective 1: Students will demonstrate an understanding of ethical and cultural considerations in the utilization of research to inform social work practice.
- Objective 2: Students will utilize appropriate research to select knowledge and methods appropriate to the rural/urban context of generalist practice with client systems.
- Objective 3: Students will demonstrate a commitment to lifelong learning to remain current with empirically based knowledge and skills.

Goal 3: To socialize students to the profession of social work.

- Objective 1: Students will demonstrate an understanding of social work values and ethics in interactions with clients and colleagues.
- Objective 2: Students will demonstrate cultural competency in practice with all types and levels of client systems.
- Objective 3: Students will demonstrate an understanding of the history and purposes of social work, and the current issues confronting the profession.

Goal 4: To promote the development of social policies and services to reduce the impact of poverty, oppression, and discrimination.

- Objective 1: Students will demonstrate an ability to critically analyze social policies.
- Objective 2: Students will demonstrate understanding of the strategies used to combat the effects of poverty, oppression, and discrimination on client systems.
- Objective 3: Students will demonstrate the ability to analyze and influence social policies and programs as these affect both rural and urban client systems

Step 3

Step 3 specifies the outputs of the program. The outputs are the activities of the program and participants in the program. Various activities of the program include courses offered, recruitment and retention of students, advising, faculty and committee meetings, continuing education for professionals, publications and presentations by faculty, and so on. The participants are the people we reach with what we invest and what we do. In the case of our MSW program this is primarily students, field agencies, and their clients.

The faculty is still in the process of identifying output benchmarks that are assessment tools to measure student learning and achievement of course objectives. An additional section addressing output benchmarks, "Program and Course Objectives Worksheet" (Figure 2) has recently been incorporated into a planning worksheet used to assure that class assignments and readings are derived from program goals and objectives. It takes time to measure whether or not tests and assignments actually measure student learning and if that learning has been generalized into practice abilities. One excellent place to measure the application of student learning is in field placements and later in the work setting as students begin professional practice.

Goal 1	To provide students with the knowledge, values, and skills of advanced generalist practice	Corresponding Course Objectives	Assignment - Outcome Measure	Benchmarks
Objective 1:	Students will demonstrate the ability to apply the problem solving process to generalist practice intervention with client systems at all levels.	Course#: Objective#:		
Objective 2:	Students will demonstrate the ability to conduct advanced generalist interventions which take in to account the rural or urban practice context .	Course#: Objective#:		
Objective 3:	Students will demonstrate the values and skills needed for autonomous practice	Course#: Objective#:		
Objective 4:	Students will demonstrate the knowledge and skills needed to provide leadership in social work organizations	Course#: Objective#:		

Figure 2. Program and course objectives worksheet used to establish MSW program goals and objectives.

As the program continues, it will be easier to measure how successful students have been in obtaining jobs, licensure, and becoming competent practitioners through longitudinal studies of program outputs. Recently faculty has added a Social Work Professional Day to serve alumni and social workers in the communities served by our program. On this day, continuing education credits are offered in areas such as ethics, child and family resilience, spirituality and social work, and other areas in which alumni have expressed an interest. Faculty also provides free workshops for foster care families in Northeast Texas. Figure 2 is the worksheet used to establish MSW program goals and objectives.

Step 4

Step 4 refers to the resources available for program development. Human resources should be considered as well as material resources. The faculty and staff are primary to the success of the program. Other resources are more practical such as classrooms, offices, materials, and money to support activities. Community partners such as the Community Advisory Council, field agencies, and field instructors are also critical resources to the ongoing success of the program. Resources that have been vital to the growth and maintenance of this program have been Title IV-E federal funds for student scholarships, and initial special funding from the Texas State Legislature.

Step 5

Step 5 includes influential environmental factors that may affect the program's success or failure. No program exists in isolation and the surrounding environment on all system levels must be taken into consideration both in planning and implementation. Many factors impact university departments. On the national level, the funding or lack of funding of social programs is reflected in the monies available in our state for programs such as Title IV-E. Also, the state legislature recently dealt with shortages by limiting funding for higher education. This resulted in fewer faculty members and increased workload as our new program was quickly growing. The university environment also impacted the social work department as changes in administrators and priorities brought about policy changes. For example, student graduate fees have gone up while scholarships have not increased at high enough rates to offset family concerns over supporting students in graduate study. This could affect recruitment of new students. Other environmental concerns that are internal include:

- How participants perceive activities' meaningfulness to them.
- How to reach students, agencies, and clients that reflect well on our program.
- Faculty and administration's awareness, knowledge, attitudes, skills, aspirations, and motivations to improve our program.
- Behaviors, practices, decision-making processes, and policies conducive to a productive environment.
- Social, economic, civic, and environmental support for our current program.

Step 6

Step 6 reviews assumptions made by the program that may enhance or hinder its success. The assumptions regarding the MSW program at Texas A&M University-Commerce (TAMU-C) were derived from the original needs assessment, part of the feasibility study that drove the creation of the MSW program. One of the department's major assumptions is that students will remain in northeast Texas; however, many recent legislative initiatives in Texas have decreased resources supporting universities, students, and social service funding. The next assumption is that in spite of recent tuition increases, the increase will not be significant enough at TAMU-C to keep students from being able to attend school. The projected increase for the 2011-12 school year is about 10%. However, the impact of this tuition increase is unknown at present. This is a realistic concern because the current student population is mostly derived from rural northeast Texas. It has already been difficult for some students to cover lower tuition fees.

Another assumption is that faculty pedagogy will help to create student sensitivity toward at-risk populations in northeast Texas. Students are taught how to write grants and how to organize communities to assist in program development. Although this knowledge may increase revenue for existing programs, state and federal funding may no longer prioritize the at-risk populations served by master level social workers in northeast Texas.

The Advantages of Using a Logic Model

A logic model can provide a visual representation of a program. It can depict program growth and development. It can also show the links between the resources, outputs and outcomes that are assumed when evaluating a program's effectiveness (e.g. Alter & Murty, 1997; Bickman, 1987; Chen et al., 1998; Renger & Titcomb, 2002). A logic model can give a clear picture of where the program is going that can be helpful in planning, and illustrate whether or not the program is accomplishing the goals set forth in the mission statement. Social service agencies and the social work profession are increasingly accountable to provide outcome measures of the effectiveness of their programs. A logic model is important because it:

- Gives a graphic representation of a program.
- Is a simple way to show relationships.
- Provides a means of measuring success of goals.
- Provides funding entities with results for public support.
- Meets licensing and accreditation standards for program planning and evaluation.

In an explanation about logic models, Taylor-Powell (2001) says that measurement is the only way we can determine success or failure. Likewise, if we can't determine success, it is hard to know when to give positive rewards, because one does not want to reward failure.

When we have clear measurements, we are able to recognize success and learn from it, as well being able to see failures and make corrections. When success is demonstrated with positive results, it is much easier to obtain public support (Taylor-Powell, 2001).

Conclusion

The processes used in producing a logic model helps programs to: (a) set a clear mission with an understanding of what is invested (inputs); (b) describe what programs will do, who will participate, and what environmental factors may come into play (outputs), and (c) determine the outcomes on three levels (short-term, intermediate, and long term) to measure success or failure. Rapid growth requires programs to constantly re-evaluate, make changes, and move quickly. This creates stress without constantly reiterating a clear conceptualization of the program. Using a logic model as a framework for program development and program evaluation can help keep a clear picture of how change affects the program's mission.

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Building Relationships across Systems to Enhance Resiliency and Improve Foster Care Outcomes

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Abstract. *Court Appointed Special Advocate (CASA) of Lancaster County represents a collaborative, systemic response to gaps in current service systems in a largely rural/suburban area. This paper discusses strategies used to foster support for CASA and on-going efforts to develop, implement, and evaluate the CASA program. We share lessons learned related to the development of innovative systemic responses to service gaps in rural areas.*

Keywords: *CASA, rural social work, program evaluation, community-based services*

Lancaster County, PA has a population of 519,445 and is 943.81 square miles (U.S. Census, 2011). Since the eighteenth century, Lancaster has been known as the Garden Spot of America. Today it is “synonymous in American popular culture with Amish country, a place of peace, prosperity, and traditional values that has somehow survived unscathed the upheavals of the twentieth century” (Walbert, 2002, p. 12).

The farmlands of Lancaster County constitute some of the most productive, non-irrigated agricultural soils in the world. Its farms and related industries provide more than 51,000 jobs and contribute more than \$4 billion to the local economy each year (Lancaster Farmland Trust, 2010). There are nearly 6,000 farms in Lancaster County. The average farm is about 78 acres, and the county ranks fourth in the country in number of farms (Lancaster Farmland Trust, 2010).

Many of the farmers in Lancaster County are Old Order Amish or Mennonite. Their shared heritage embodies the simple, religious lifestyle of their Plain Community ancestors. Amish and Mennonite farmers often farm with horse-drawn plows instead of gas powered equipment and view themselves as stewards of the land. For generations, they have chosen farming as a way of life “based upon the belief that their lifestyle and families can be maintained best in a rural environment” (Lancaster Farmland Trust, 2010).

Though viewed by many as an idyllic, traditional, and historic place (Walbert, 2002), Lancaster is also a rapidly growing population center with progressive farmers, booming industry, and modern challenges (Walbert, 2002). Like many rural communities, Lancaster struggles to meet the needs of its foster care population. Limited resources, traditional cultures, and the influence of a growing urban center challenge public child welfare, the judicial systems, and private service providers.

Public Child Welfare

Abused and neglected children represent a uniquely vulnerable population in need of advocacy (Litzelfelner & Petra, 1997). Public child welfare agencies are responsible for ensuring the safety of children they service and acting in a manner that is in the child’s best

interest. The conditions, under which this work occurs, however, are challenging at best. The literature is replete with descriptions of the beleaguered public child welfare system. Alpert and Britner (2005) describe systemic challenges that include time constraints imposed by state and federal policies and other barriers to effective casework including difficulty in engaging parents, poor communication with service providers, and staff turnover, as well as parent-specific issues such as poverty, transportation, mental illness, drug addiction, and non-foster care obligations.

Competing professional roles, inherent in public child welfare, further complicates a child welfare worker's task by preventing the worker from focusing solely on the needs of the children. The Child Abuse Prevention and Treatment Act (CAPTA) of 1974 mandated each foster child be appointed a guardian ad litem to represent the best interest of the child in every court proceeding. However, high caseloads and lack of formal child welfare training prevented guardian ad litem from having the intended positive impact on outcomes for abused and neglected children in foster care (Youngclarke, Ramos, & Granger-Merkle, 2004).

Lancaster County Children and Youth Social Services Administration (LCCYSSA)

As stated in the Pennsylvania Department of Public Welfare 2009 Child Abuse Report, in Lancaster County, there are 125,593 individuals who are under the age of 18 and approximately 500 children in foster care. In 2009, there were 803 reports of child abuse, with 151 substantiated (18.8%). There were 16 instances of substantiated re-abuse (10.6%). For the same year, the total expenditure for child abuse investigations was \$783,797.

The challenges present in public child welfare nationally are reflected within Lancaster County's smaller system. Barriers to effective service are compounded by characteristics and trends specific to LCCYSSA. Historically, compared to other counties within the state, LCCYSSA has utilized its own skills, programs, and resources to meet the needs of families, rather than relying on the services of outside providers. Increased caseloads have forced adaptive responses that have affected the culture and capacity of the agency. To meet increased demand, LCCYSSA now contracts with outside agencies to provide resource homes and therapeutic interventions. LCCYSSA also has been asked to make internal changes as a result of the federal Child and Family Service Review (CFSR; Department of Public Welfare, 2003). This review identified persistent court delays as a barrier to permanence for children.

Court Appointed Special Advocates Program (CASA)

Nationally, one response to high caseloads and persistent court delays has been CASA, the Court Appointed Special Advocates program. In 1977, Judge David W. Soukup of Seattle, WA, created a program of trained community volunteers appointed to conduct an independent investigation of the facts and objectively make a recommendation in court that would be in the best interest of a foster child (Ray-Bettineski, 1978). This program was to ensure that all necessary information would be conveyed to the judge so that informed decisions about the needs of children in foster care could be made. The National Council of Juvenile and Family Court Judges embraced the concept and proposed the name Court-Appointed Special Advocate

(CASA; Berliner & Fitzgerald, 1998). In 1990, the U.S. Congress authorized the expansion of CASA with the passage of the Victims of Child Abuse Act (P.L. 101-647). Over time, the nation saw an expansion in the CASA program. As reported by the National CASA Association (NCASAA), last year, over 75,000 CASA volunteers advocated for abused and neglected children in 955 state and local CASA and guardian ad litem programs nationwide (www.casaforchildren.org).

The passing of the Adoption and Safe Families Act (ASFA) of 1997 created an increasing need for thorough information about client families' needs. ASFA places an emphasis on establishing permanency by mandating that a petition to terminate a parent's parental rights must be filed 15 months after a child is placed in substitute care if the parent has not made substantial progress toward service goals (Adoption and Safe Families Act of 1997, 1997). Thus access to detailed information to identify the needs of children and families—and information related to families' use of ordered services—is vital for judges who maintain the ultimate authority in decision-making in child welfare hearings.

CASA: A Program Overview

CASA volunteers provide a stable constant throughout a child's foster care stay ensuring the child is not "lost in the system" (Ray-Bettineski, 1978, p. 69), while involved professionals pursue the long-term goal of permanency. Although the design of CASA programs varies by local jurisdictions, they are unified by the belief that every child has the right to a safe, permanent home (Weisz & Thai, 2003). There are five basic activities performed by every CASA volunteer. Youngclarke and associates (2004) refers to these activities as: (a) fact-finder and investigator, (b) courtroom representative, (c) case monitor, (d) mediator and negotiator, and (e) resource broker. CASA volunteers are afforded access to all records and individuals in order to conduct an independent investigation of the situation. Upon completion of the investigation, CASA volunteers prepare a written report that is presented in court to ensure the child is given a "voice in all dependency hearings" (Ray-Bettineski, 1978, p. 69). This information is to aid the judge in his or her recommendations. The CASA volunteer monitors all court-ordered services for compliance, as well as for timeliness (Calkins & Millar, 1999). As the mediator, the CASA volunteer helps with problem solving through collaboration (Youngclarke et al., 2004). Their role as the resource broker is to advocate for any and all needed services for the child.

The specific components of the CASA program include the inputs, activities, outputs, and outcomes. The inputs are the CASA volunteers who perform activities such as: (a) visit with the child, (b) investigate and gather facts, (c) provide written report of findings to the judge, (d) make recommendations for services, and (e) monitor the delivery of services. The outputs of the CASA program include: (a) an increase in services the child receives, (b) a decrease in court continuances, (c) a decrease in the number of different foster care placements a child experiences, (d) an increase in placement stability, and (e) a decrease in re-entry to the system (Litzelfelner, 2002). The anticipated outcome of the CASA program is a timely, safe, permanent home for every child in foster care.

Empirical Evidence Relating to CASA Outcomes

Research suggests that CASA may mitigate the effect of service barriers in the child welfare system. Weisz and Thai (2003) found that judges rated CASA reports helpful in making case decisions, and that CASA cases had more complete information than non-CASA cases. In the same study, CASA volunteers were more likely to investigate alternative services for a child, and attorney guardians ad litem (GALs) reported that they felt the CASA program was positive for the child (Weisz & Thai, 2003). Litzelfelner (2000) reported that, compared to children without a CASA, more children with a CASA returned to parents or lived with a relative. Additionally, children with a CASA were less likely to be in institutions and were provided more services. Calkins and Millar (1999) reported both a reduction in the number of foster care placements for children assigned a CASA and less time spent in foster care. Another study found that the risk for re-entry into foster care for children with a CASA was half that of non-CASA cases (Abramson, 1991; Poertner & Press, 1990).

Despite these promising findings, several researchers have noted that while CASA appears to meet serious needs in a beleaguered system, studies of the effectiveness of CASA programs have been limited by methodological weaknesses, unclear conceptualizations, biased samples, and a lack of comparison groups (Youngclarke et al., 2004). They also noted that none of the studies, included in their synthesis of the literature, examined the physical and mental health outcomes for children targeted by CASA programs (Litzelfelner, 2000; Youngclarke et al., 2004). Finally, literature and anecdotes suggest that the role of the individual CASA worker is difficult to define, and measurements of CASA programs' "effectiveness" have involved variable perceptions of the role of CASA volunteers (Leung, 1996; Poertner & Press, 1990). Though charged with advocating for the needs of children, complex family systems, full court dockets, limited resources, and the culture of involuntary services create an environment in which it is sometimes difficult to identify the needs of the child vis-à-vis other family members, and even more difficult to efficiently gain information and make realistic recommendations.

CASA of Lancaster County

Within Pennsylvania there are 22 counties with CASA programs (Pennsylvania CASA Association, December 7, 2011). In 2005, a group of concerned Lancaster County citizens met with President Judge Farina to advocate for the development of a CASA program. The first board of directors of CASA of Lancaster County was established in 2007. Program development and implementation were successful despite complex socio-cultural forces and the existence of historically oppositional social service systems.

Conditions for Conflict

Cultural forces, demographic changes, and social trends in Lancaster County create a context of diversity and potential conflict. The Plain community is thriving, but it represents just one dimension of Lancaster County's religiosity. Other Christian congregations are fully engaged in the work of the "modern world" and, with an increasing number of immigrants, Lancaster County boasts an impressive degree of religious, ethnic, cultural, and language

diversity. Though thousands of acres are dedicated to farming, Lancaster City's urban population continues to grow and migration to the suburbs is visible in the new housing developments that encroach upon the farmers' fields.

Though these trends seem oppositional, a true resource of Lancaster County is the common ground that is created by themes that cut across dimensions of difference. Put simply, shared values persist. Relationships remain central and the preferred means for navigating services and tapping into cultural and material resources. Service and philanthropy are valued highly and the Christian impulse to serve others sustains a culture of giving and volunteerism. The primacy of family persists, though the definition of family is now more flexible than it has been historically. Innovative bootstrapping is the preferred means for "getting ahead," and the community remains committed to "helping its own." Lastly, across systems and cultures, community members take seriously the obligation to "do the right thing." Morality is the context for policy and service decisions, and children are viewed as fragile and valuable members of the community who require protection.

Strategies for Working across Systems

In important ways, the CASA program is congruent with the shared values and themes of Lancaster County. Using strategies that resonate with the community and culture (e.g., building relationships, emphasizing the primacy of family, training volunteers from within the community) CASA of Lancaster County pursues the long-term goal of increasing permanency for children in foster care.

Strategies that Foster Support for CASA of Lancaster County

From its inception, CASA of Lancaster County concentrated its efforts on involving stakeholders in every step of the development process. Initially, a steering committee was formed to identify how CASA could benefit Lancaster County. Its primary goals included the development of the mission statement and by-laws and the creation of an active board with members from across the community who would be supportive of CASA's goals. The Executive Director of LCCYSSA was on the steering committee and was actively involved from the start. Caseworkers, however, viewed CASA with some trepidation, concerned that untrained professionals would impinge upon the caseworkers' professional role and/or add additional pressure to their difficult jobs. Steering committee members were tasked with educating caseworkers and the larger community about the role of CASA volunteers, the requisite collaborative nature of their work, and the potential for mutual success. From the start, steering committee members understood that getting "worker buy-in" was critical to the success of CASA of Lancaster County.

Strategies for Implementation Fidelity and Evaluation

We are utilizing a mixed method, longitudinal research design to evaluate the CASA program. Data are collected from key stakeholders (parents/caregivers, guardian ad litem/attorneys, resource parents, caseworkers, judges, youth in care, and CASA volunteers), as well as from a group of youth in care who have not been appointed a CASA volunteer. Data collection occurs at baseline, 6 months, 12 months, and 18 months.

Qualitative Strategies. Focus groups with key stakeholders, ethnographic court observations, interviews with youth, and court document review are being utilized to capture qualitative data that will inform volunteer training, determine the degree to which the program is implemented as intended (fidelity), and help to assess client and stakeholder satisfaction and benefits. For example, a focus group with LCCYSSA caseworkers revealed that some workers were concerned that CASA volunteers might impinge upon their role and function as professional workers. As a result, a presentation at LCCYSSA occurred, which emphasized the distinct and complementary nature of caseworker and CASA volunteer roles, as well as their shared goal of meeting the needs of youth in care.

Ethnographic observations yielded rich data about the culture of courtrooms and dependency hearings. An important finding was that the stress of the formal courtroom environment created a context in which workers might—in the absence of complete certainty regarding a certain case detail—respond vaguely to judicial questions. Involved stakeholders have expressed a commitment to including court preparation in trainings of both CASA volunteers and caseworkers.

Interviews with youth inform our assessment of at-risk behaviors as well as the degree to which youth in care are receiving the services they need. In collaboration with the executive director of LCCYSSA, we have identified certain behaviors on the youth interview survey that would trigger a notification to the involved worker, thereby ensuring that the youth is connected with an appropriate service or provider. For example, if a youth discloses that she is using drugs and/or has considered harming herself, this finding is reported to the youth's caseworker. The youth is informed of this process when the assent form is signed at the beginning of the interview.

Quantitative Strategies. Administrative data from LCCYSSA, program data from CASA, and outcome data for youth with and without a CASA volunteer will be analyzed. Outcome data from LCCYSSA include maltreatment statistics, placement information, re-entry rates, and placement stability information (e.g., number of disruptions). From CASA, volunteer data to assess competency, implementation of activities, and level of satisfaction with supervision and training are collected. Data related to the volunteers will inform training and supervision. If a generalized gap in knowledge is discovered, then the training program can be adjusted to include additional information. For example, volunteers from Lancaster County may be less knowledgeable about the presence and impact of religious diversity on the work they will do. The addition of a module on non-Christian religions might prove valuable. On an individual basis, these data might reveal that a particular volunteer has a unique knowledge deficit that can be most effectively addressed through one-on-one supervision.

The youth survey instrument, *Communities that Care* (Arthur, Hawkins, Pollard, Catalano, & Baglioni, 2002), will yield aggregate data that will help us track changes in at-risk behavior. Our interest is in determining the extent to which, if any, the assignment of a CASA volunteer appears to impact behaviors that may lead to a delinquency status for youth in the foster care system.

Lessons Learned

The importance of engaging stakeholders in the development of the CASA program early on has been emphasized. As natives of Lancaster County and former child welfare practitioners, the authors naturally appreciated the practice wisdom which stakeholders had to offer and understood that the traditional and somewhat conservative culture of the county would necessitate collaboration for the program to be successful. In the initial meetings to discuss the program evaluation, feedback from stakeholders was not sought. The initial impression was that stakeholders, especially the board members, were not interested in the “mundane” matters of program evaluation design. In the end, this misstep led to some confusion. Early board meetings that involved discussions of the program evaluation ended in some frustration when the program evaluators wanted to talk about “rigor,” “fidelity,” and “implementation,” and board members wanted, instead, to immediately track outcomes. In hindsight, getting stakeholder input regarding program evaluation would have been as valuable as their advice regarding program development.

Conclusions

In working to develop and now evaluate CASA of Lancaster County, the authors have been reminded of both the importance of context (e.g., community, rurality) and the dynamic nature of relationships. CASA is a national program; CASA of Lancaster County is a unique, local program that must respond to the culture and conditions of the community it serves. The primacy of relationships, and the networks they create across systems, has been both resource and obstacle. As our roles and responsibilities change—from grant writers to board members to program evaluators and back again—the nuances of these relationships shift as well. Sometimes we lead with familiarity, sometimes with academic distance. Our increased ability to gracefully shift roles has enhanced our ability to work effectively within the CASA program.

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Factors That Impact Service Delivery to Individuals Living With HIV/AIDS in Rural Northeastern Texas

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Abstract. *This study surveyed participants in focus groups to identify factors that affect individuals living with HIV/AIDS in rural northeastern Texas. The average age of the respondents was 45.44. Participants included a diverse group of American Europeans, Hispanics/Latinos, and African Americans. Although results are inconclusive, other studies have supported similar results regarding factors that impact treatment and services (Zuniga, Buchanan, & Chakravorty, 2005). Some of the factors include lack of financial resources for the consumer, stigma and discrimination, and lack of understanding on the part of the consumer and the community. More studies in rural areas serving people living with HIV/AIDS (PLHA) are needed to begin the work towards breaking down barriers to provide healthier environments and achieving social and economic justice.*

Keywords: *people living with HIV/AIDS (PLHA), factors/barriers, social justice, northeastern Texas*

Living in rural areas compounds the barriers/factors of stigma and discrimination for people living with HIV/AIDS (PLHA). And for those living in rural areas, services are limited and difficult to access due to geographic distances and scarce availability of medical staff. Other problems permeate rural communities and contribute to the barriers faced by people who live with HIV/AIDS. When barriers exist, individuals hesitate to seek services and treatment causing the risk for others to become infected. Eradicating these stigmas and barriers is especially challenging for social workers in their attempts to advocate for social and economic justice.

These stigmas and factors are prevalent in rural communities and impact attempts to provide health and dental services to PLHA. Stigmas in communities are largely attributed to the fact that it is a shame-based disease that is contracted by sexual contact, mostly by men having sex with men, (Centers for Disease Control [CDC], 2010), by sex work, (Valdiserri, 2002), and promiscuity. It is sometimes viewed as drug related and that those who contract HIV/AIDS “get what they deserve.” Rural communities may attribute to the severity of stigmatization where attitudes and lifestyles are conservative. Often when one is not familiar or educated about disease, especially where there is a notion of eminent death, fear becomes a contributing factor. Fear is derived not only from the possibility of contracting the disease, but also from the lack of knowledge as to how it is transmitted. Death is the ultimate fear and the lack of knowledge causes intense rumination of this fear. Shame and blame are mostly associated with how HIV/AIDS is acquired and not necessarily the disease itself (Cao, Sullivan, Xu, Wu, & The CIPRA Project 2 Team, 2006).

Although stigma and discrimination are major contributing factors to the barriers individuals experience, there are other factors unique to rural areas such as lack of individual responsibility/ability, accessibility of services (especially dental), service quality, and need for more support and concrete services contribute to the lack of treatment and spread of HIV/AIDS.

The literature supports that the overall barrier to services is the inability to access services due to lower socioeconomic status and poverty (Castañeda, 2000; Godin, Naccache, Brodeur, & Alary, 1999; Kaplan, Tomaszewski, & Gorin, 2004; Marcus et al., 2000; Shiboski, Palacio, Neuhaus, & Greenblatt, 1999; Tobias, Martinez, Bednarsh, & Fox, 2008; Zuniga et al., 2005). Those living in rural areas experience unique barriers to accessing services due to lack of providers, transportation, lack of education and funding, small-town politics, attitudes and values, and lack of education on the part of both patients and residents. Social and socioeconomic factors are germane for social workers in regard to their need to remain vigilant about the injustices for PLHA and those living in rural areas.

As the United States enters its third decade battling the disease, the numbers remain stable and medical advancements continue to prolong life for the individuals suffering from the disease. According to the CDC (2009), an estimated 42,011 people were diagnosed with HIV and estimated 34,247 were diagnosed with AIDS. The total estimation of those living with HIV is estimated to be 1.2 million (CDC, 2009). Data regarding rural communities reports 48,000 new cases in nonmetropolitan areas compared to 83,372 in the metro areas in 2005; a decrease in new cases from 2007 (Zukoski & Thorburn, 2009). Rural areas make-up 20% of the population and though the spread of AIDS appears to be on the decline, rural areas are more susceptible to have an increase if services are underutilized and ineffective due to perceived barriers (Zukosi & Thorburn, 2009).

Texas is a major state with a large population living in rural areas. The Texas Department of State Health Services Surveillance Report, (2010) reports that there were 65,077 people living with HIV and 2,291 new cases of AIDS diagnosed for the year 2010. This report dates back to 2003 and reported that since record keeping there has been 21,582 cases of AIDS diagnosed. Mortality rates beginning from 2002 through 2010 averages between 12,000-13,000 deaths per year (Texas Department of State Health Services Epidemiologic Profile, 2010). Texas is home to a diverse population with a high poverty level and a high percentage of individuals living without health insurance. This contributes to some of the factors preventing PLHA from obtaining the treatment and support they need. In 2011, 24.6% of the entire Texas population had no health insurance. This is the highest of all states in the U.S. (Center for Public Policy Priorities [CPPP], 2011). Poverty in Texas for 2008 was reported to be at 15.8% ranking Texas 8th in the nation per individual living in poverty (U.S. Census, 2010).

Special Health Resources for Texas

In 2006, Special Health Resources for Texas, Inc. (SHRT) received a Special Projects of National Significance (SPNS) grant through the Health Resources and Services Administration (HRSA). The purpose of the grant is to increase the availability of dental and oral health care services to clients diagnosed with HIV/AIDS who reside in the northeastern region of Texas. One of the related activities is the development of a regional provider network to assist with service delivery and planning. In December 2008, SHRT contracted with the School of Social Work at Stephen F. Austin State University to evaluate the services provided by the grant. The evaluation component included the facilitation of regional focus groups for the purpose of identifying factors that impact service delivery. Specifically, the study was designed to answer the following question: "What factors impact the delivery of dental, oral, and primary health

care services to clients who have been diagnosed with HIV/AIDS?” The intent was to inform decisions regarding service delivery.

Before discussing the method and results, it is important to describe the context in which SHRT delivers services. SHRT’s service region is comprised of the Tyler and Texarkana HSDAs (Health Service Delivery Areas), which includes 23 northeast Texas counties and covers 15,522 square miles (see Figure 1). Within this area, public health services are provided by the Texas Department of State Health Services (DSHS), with the exception of seven counties that rely on a local health department (county). Of great concern is that SHRT has one dentist to serve the area, although there are others not providing services within the region. In terms of clients, SHRT was serving approximately 850 clients at the time of this study. One hundred-fifty of these clients were being served under the SPNS dental grant. Of the 850 clients, approximately 30% were female, 70% were male, and less than 1% was transgendered. As for ethnicity, 55% were African American, 33% were Caucasian, and 12% were either Hispanic or of another ethnic group. Client age ranged from 18 to 68 with an average age of 42 years.

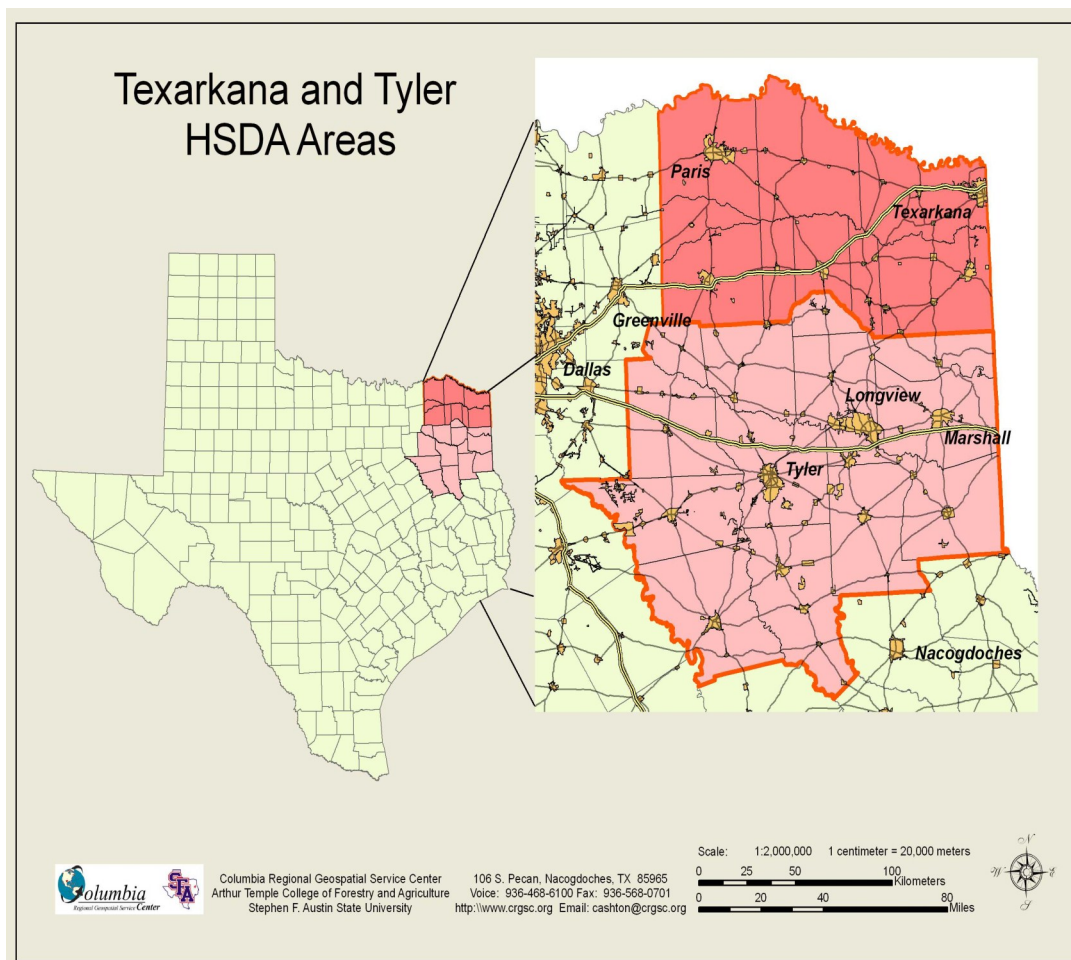


Figure 1. Special Health Resources for Texas (SHRT) Service Region. Copyright 2009 by Columbia Regional Geospatial Service Center. Reprinted with permission.

Rural, for the purpose of the study, refers to those towns, communities, and small cities with populations of less than 50,000. Although some of the communities are adjacent to cities with larger populations they are considered rural due to the geographical distance clients must travel to receive services because of limited resources. The region is consistent with rural lifestyles including conservative attitudes and beliefs due to the geographical location. It is located in the Bible Belt area (see Figure 2) where religion is an integral aspect of the lifestyle. Much of the populations in the area have been there for generations and ties to family and land are strong. Their views are inherent and rooted in Christian beliefs.

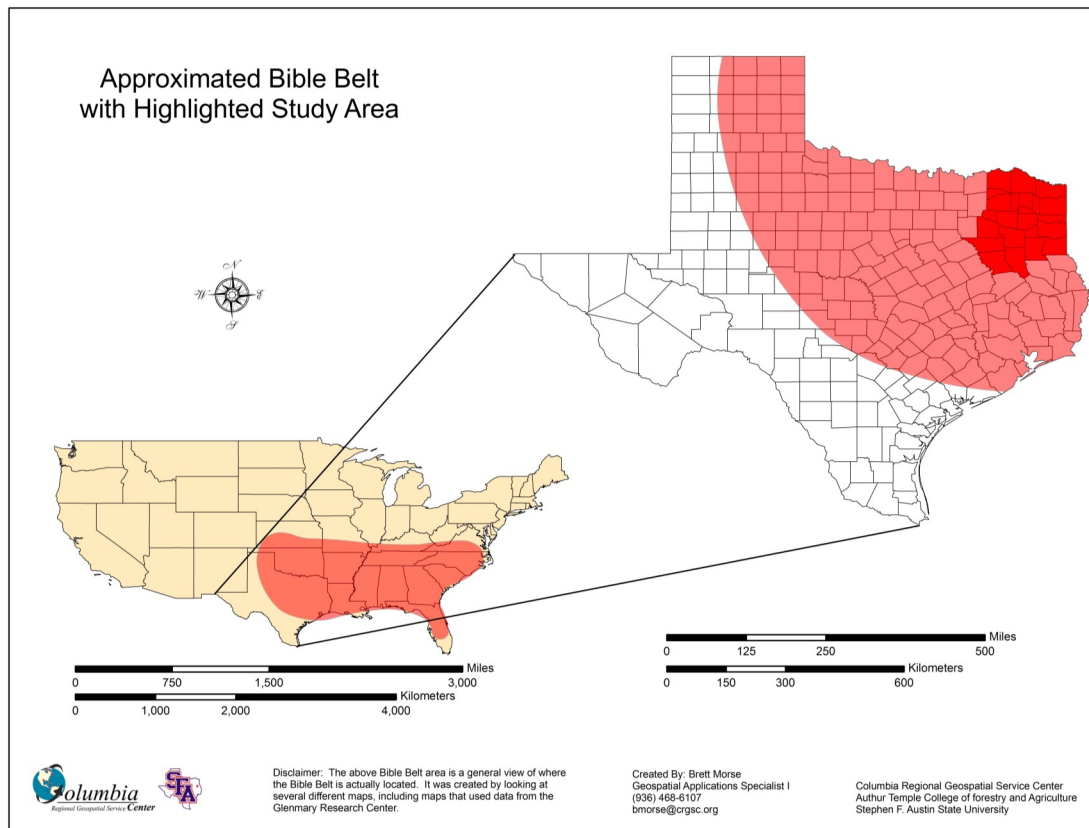


Figure 2. Bible Belt area. Copyright 2009 by Columbia Regional Geospatial Service Center. Reprinted with permission.

Living in the area can be difficult for those viewed as a newcomer or “different” since both experience a sense of unwelcomeness and isolation. Those living with HIV/AIDS may experience a sense of hostility and are unable to develop a support system within the community. Rural communities do respond differently towards newcomers and PLHA, depending on the community. Bible belt rural communities attempt to “do the right thing” or “Christian thing” and their response becomes exalted. Assistance often occurs in the form of attempting to meet concrete needs and social needs on a superficial level but can include offering spiritual guidance and prayer. Although there is diversity in these rural areas, communities seem to share some common bonds such as a sense of pride, good-will, and strong religious beliefs.

In other rural communities distance served as a factor for isolation as neighbors tended to live geographically far from each other and make no attempts at seeking extensive social support. Isolation adds to this factor but living in larger communities can also be a factor for PLHA. The area studied did include cities with larger populations of 50,000 and they too were quite diverse in terms of providing a supportive environment. One community embraced its residents and provided a very active and social life for all citizens including gay and lesbian populations. This is an interesting phenomenon due to its location and historical position.

One of the larger communities had the opposite attitude and did not seem to acknowledge its residents as gay or lesbian. It might be important to note that this community's stakeholders did not participate in the focus group. Participants in the focus groups expressed various reasons for the lack of acceptance in the community where they identified the attitude as apathetic. The community takes pride in its history and is embedded with tradition and beauty. It is progressive and in the last several years experienced a growth in its general population including an increase in diversity. Focus group participants indicated that there is much discrimination towards individuals living with PLHA due to the belief that those inflicted tend to be gay or lesbian. Some of these religious beliefs tend to create an attitude of unwelcomeness and though the community is of an urban size they tend to maintain rural lifestyles and attitudes. However, there does appear to be a sense of change and progressive thinking in some communities within the area.

Methods

Four locations were identified to accommodate focus groups which included stakeholders from the communities, employees, and clients. The focus groups were conducted for the purpose of identifying barriers to treatment and increasing the availability of dental and oral care services to those diagnosed with HIV/AIDS. Due to the large geographical area, the four largest communities were selected to host the groups because they each had a clinic and a room allocated in which to hold the meetings. Transportation was offered to those consumers who lived in the rural areas and they were encouraged to participate by staff members. As is often the case, some were unable to arrive due to lack of transportation, illness, and other issues. Illness and living in rural communities can be unpredictable and complicated; and for those living with HIV/AIDS stigma, discrimination and lack of resources contributes to their inability to participate in opportunities for empowerment. The consumers who did participate assisted in creating the initial list of barriers. The focus group of providers also assisted in generating the list of barriers and tended to keep the consumer in mind while identifying these barriers.

Focus Groups

Subjects. Potential participants for the focus groups were adult stakeholders residing in the region covered by SHRT, including: dental care providers, primary health care providers, hospitals, health educators, and consumers. Potential participants were identified and recruited by SHRT staff using non-probability purposive sampling. Once a potential participant was identified, he/she was contacted by a representative of SHRT who explained the purpose of the project, including the dates/times of meetings, expectations, methods, risks/benefits, and

confidentiality. Whereas the authors had hoped for a total of 75 participants (15 per each of the five focus groups), there were only 38 participants.

Of the 38 participants, 26 were service providers (68.4%), nine were consumers (23.7%), one self-identified as other (2.6%), and two chose not to identify their role (5.3%). It is important to note that all of the service providers were employees of SHRT and the one community-member was a SHRT volunteer. Twenty of the participants were female (52.6%), 16 were male (42.1%), and two did not respond (5.3%). The average age of the respondents was 45.44. Twenty of the respondents self-identified as White/European (52.6%), 11 as African American (28.9%), four as Latino/Hispanic (10.5%), one as Native American (2.6%), and two chose not to respond (5.3%). In terms of education, four had a high school education without a diploma (10.5%), six had a high school diploma or GED (15.8%), one had completed a trade school/training program (2.6%), 12 had some college (31.6%), four had an associate degree (10.5%), five had a bachelor's degree (13.2%), two had a graduate/professional degree (5.3%), and four did not include their educational status (10.5%).

Procedures. Given the large geographical area and number of participants, multiple focus groups were held throughout the region. Specifically, focus group meetings were held in the following towns: Longview, Paris, Texarkana, and Tyler. These towns were chosen because SHRT has a clinic in each one. Two focus group meetings were held in each town: one for providers and one for consumers. The meetings lasted approximately two hours were held in SHRT's facilities and refreshments were provided. The focus group meetings were facilitated by the authors, all of who are experienced focus group facilitators.

Each of the eight focus groups met separately to generate a set of statements that represented the various factors that impact service delivery. Although the process was facilitated by the authors, the participants guided it and were ultimately responsible for the final list of statements. The meetings began by introducing the purpose of the meeting and providing participants with a consent form and a demographic profile form. They were then provided with written instructions for the focus group session, which were explained by a facilitator. At this point, participants were asked to work independently to identify three responses to the following focus prompt: "One factor that impacts the delivery of dental, oral, and/or primary health care services to clients is..." When they had completed the task, one by one each participant was asked to share one of his/her action statements. Once everyone had shared one statement, the process started over again and continued until each person had shared his/her three statements. As the statements were being read, a facilitator recorded them. When all of the statements had been recorded, the group reviewed them and worked together to eliminate duplicate statements. However, the focus group only edited the statements it generated, not the statements produced by previous groups. In order to reduce the amount of duplication, the second and subsequent focus groups were provided with a list of the statements generated by previous groups. This process resulted in the identification of 98 factors that impact the delivery of services. These factors served as the basis of a rating instrument that was subsequently distributed to stakeholders.

Rating

Subjects. All of the focus group participants were asked to participate in this phase of the process. Additional participants were also recruited using a method similar to the one used for focus group recruitment. All potential participants were identified by SHRT and provided a packet containing a consent form, demographic profile, rating instruments, and a postage paid self-addressed envelope. Potential participants included SHRT staff, consumers, and other relevant community stakeholders. It is important to note that the envelopes were addressed to the researchers and SHRT did not have access to completed survey forms. A total of 525 packets were distributed among the various stakeholder groups and 81 were returned (15.4% return rate). It is important to note that only 45 of 350 consumers chose to return the survey (12.9% return rate).

Of the 81 participants, 31 were service providers (37.8%), 45 were consumers (54.9%), three were advocates (3.7%), one identified as other (1.2%), and two were SHRT board members (2.4%). Twenty-seven of the 42 respondents were female (51.2%) and 40 were male (48.8%). The average age of those responding was 45.24. In terms of ethnicity, 44 self-identified as White/European (53.7%), 32 as African American (39.0%), four as Latino/Hispanic (4.95%), one as Asian American/Pacific Islander (1.2%), and one chose not to respond (1.2%). Eight of the respondents reported having less than a high school education (9.8%), seven had a high school education without a diploma (8.5%), 14 had a high school diploma or GED (17.1%), five had completed a trade school/training program (6.1%), 20 had some college without a degree (24.4%), nine had an associate degree (11.0%), 12 had a bachelor's degree (14.6%), and seven had a graduate or professional degree (8.5%).

Procedures. The first step in the rating process involved organizing all of the statements into groups based on their perceived conceptual similarity. This process was completed by the authors and based on a thematic analysis as well as consensus. Once the statements were organized, a rating instrument was developed and distributed to participants. Specifically, participants were asked to identify the frequency at which they experience each of the identified factors. The following scale was employed for this purpose: 1 = none of the time, 2 = very rarely, 3 = some of the time, 4 = most of the time, 5 = all of the time, and 6 = not applicable. In addition to rating the factors and ideas, participants were asked to complete 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

Once the rating data was collected, SPSS was used to calculate the mean score and standard deviation for each item (factor and idea). Whereas the original intent was to conduct comparisons among the various stakeholder groups, the low return rate significantly limited the number of comparisons. The results of the analysis are discussed in the results section.

Limitations

The low level of participation from consumers limits the degree to which the results can be generalized to the population. In other words, there is concern as to whether or not the opinions of the consumers who chose to participate are representative of the larger group of consumers. This concern also holds true for service providers. Specifically, the majority of the service providers were employees of SHRT. Whereas it may be safe to generalize the results to SHRT employees, the results cannot be generalized to the larger population of service providers who work with the client population. Given that the main focus of the project was to inform decisions regarding service delivery, the lack of representation from other community service providers significantly limits the utility of the results. The concerns with the sample also restricted the authors' ability to analyze the data and make comparisons among the various stakeholder groups.

Due to the low participatory involvement from clients in the large area these preliminary results are inconclusive ($n = 45$) and do not represent the responses of all clients. It does encourage and support the need for more such studies and advocacy on behalf of those suffering with the disease. The study is preliminary and exploratory to begin the process of service delivery in a more cost effective and client-centered manner.

Results

As previously noted, the eight focus groups identified a total of ninety-eight factors 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 authors organized these factors into groups based on common concepts or themes. The resulting groups or domains were then reviewed for the purpose of identifying domains that were similar enough to be combined. The process was terminated once the researchers were satisfied that the remaining domains were too different to be merged. The process resulted in 21 domains of statements encompassing 98 factors. In addition to presenting the factors and domains, the table (see Appendix) reports the ratings for all participants, service providers, consumers, and dental service consumers. The responses were rated based on the following scale: 1 = none of the time, 2 = very rarely, 3 = some of the time, 4 = most of the time, 5 = all of the time, and 6 = not applicable.

Those factors with the rating of "most of the time" to "all of the time" will be discussed from the list of 98 factors. Sixteen factors were identified under client concerns and included the consumer's current health condition, social isolation, ability to pay utility bills, and the fear of being identified as a consumer of a provider that serves people with HIV/AIDS. Those responding felt that these factors occur most of the time to some of the time. Other factors of concern included the consumer's mental status, work schedule, literacy level, and willingness to disclose HIV status. The category with the second highest number of factors was service quality. Thirteen factors were identified under the category of service quality and are actually identified as strengths and not necessarily factors, most likely reflecting the respondent representation. Ten factors are identified under the category of client ability/responsibility and include such factors as willingness to seek medical care, ability to address basic hygiene, comply with treatment, ability to take responsibility for health care needs, comply with

medication, willingness to accept responsibility for oral health care, actively participate in services, seek and utilize dental services, and ability to keep appointments. These factors were identified to occur most of the time. One other factor identified occurring some of the time included consumer's no-show for appointments. This again, reflects the responses of the majority of respondent representation and implies that it is the consumers' fault for the underutilization of services due to their lack of ability and responsibility.

Two of the 21 clusters identified seven barriers relating to community attitudes and beliefs and community-based health care services. Respondents viewed community as fearful of individuals with HIV/AIDS and as engaging in sexual activity that places them at risk of contracting the disease. Respondents indicated this occurred most of the time. Similar ratings resonated in the area of availability of affordable health care and access to primary care physicians. These two clusters suggest that stigmas do exist and that financial resources are a challenge for the consumer.

Six of the six factors identified under knowledge/understanding of health ranked as "most of the time" and included such factors as consumer's understanding of how HIV/AIDS impacts their overall health, understanding of basic health care needs, understanding how their health status impacts treatment, understanding basic dental and health care needs, understanding of the impact of oral health care on their overall health, and lack of interest in preventative dental care. Service accessibility has five identified factors and some of them are seen as strengths. Transportation is provided for some of the consumers. Distance to services is a problem for clients in receiving dental services and believed to occur "most of the time". Under the cluster of dental services, all factors are identified as barriers with five. All are ranked to be a barrier "most of the time" with availability of dental services ranked to be "most of the time". The remaining clusters identify four or less factors and some are strengths and not necessarily barriers. The general response indicates that services are limited and fragmented with long distances to travel. One consumer participating in the focus groups recounts this:

"We begin our trip early in the morning and return late in the evening jus' to see the dentist in Dallas . . . sometimes, we don't even have food the whole day . . . if, you know, we don't pack us some. Sometimes we don't feel good . . . with this sickness and all"

Social Justice

As rural communities work towards removing barriers for PLHA so does the need for providers to create a more sensitive and competent healing environment. One case manager recounts this statement from a provider:

Services are not culturally sensitive . . . there was one Mexican client who went to see the physician with his whole family and the doctor said, "Don't come in here (referring to his office and holding up his hand in a stopping motion), you have AIDS and you are going to die." Forget cultural sensitivity . . . but compassion and empathy in general. The client spoke English but his family did not . . . probably a good thing.

One major effort towards changes in care is marked by the recent passing of the Ryan White Treatment Modernization Act of 2006. It proposes a more confluent manner among agencies and providers in their delivery of services (Pizzi, 2008). One of the most comprehensive studies conducted in rural Alabama, Louisiana, Mississippi, North Carolina, and South Carolina identified some of the barriers for new programs and their delivery of services (Zuniga et al., 2005). Identifying these barriers will assist in a process for change. Some barriers included lack of funding, lack of qualified personnel, lack of bi-lingual staff, conservative political sentiment/attitudes, lack of community support, and religious attitudes. Other barriers are identified but the condensed list resonates some of the same barriers of this study. East Texas and especially northeastern Texas are geographically located in the Bible Belt area of the United States and has a long-standing record for voting with the more conservative representation. Not only are views conservative, but belief systems are inherent with religiosity. Views and beliefs about PLHA can go against mainstream Protestant teachings. The research suggests that where there is lack of understanding about the disease and its treatment, stigma and oppression occurs (Cao et al., 2006). Research supports the fact that economics is a major factor in the treatment for PLHA not only due to lack of resources on the part of the consumer, but also due to lack of funding for resources for those who provide services (Castañeda, 2000; Godin et al., 1999; Kaplan et al., 2004; Marcus et al., 2000; Shiboski et al., 1999; Tobias et al., 2008; Zuniga et al., 2005). Factors specific to the research in this study include homelessness and inability to pay for utilities as identified by all participants at a rate of some of the time to most of the time with a higher ranking by the consumer.

One of the most comprehensive studies regarding unmet oral treatment for PLHA conducted by Marcus et al. (2000) identifies social and economic factors as the most common barriers for individuals not seeking treatment. Another study conducted by Zuniga et al. (2005) in rural southeastern United States identified rural attitudes, conservatism, lack of community support, and community and religious attitudes as having a negative influence in the funding for programs providing services to PLHA. In northeastern Texas, other factors include the distance one travels for services and the lack of resources such as transportation, concrete assistance to individual consumers, and lack of providers for oral treatment.

Implications for Practice

The literature supports much of the results of the study in regards to the barriers those living with HIV/AIDS endure. Poverty and socioeconomics certainly have a great impact on whether or not one receives services, but there are other factors as well, such as the continued stigma, discrimination, and oppression inflicted on a vulnerable group of individuals. In rural communities these factors are more prevalent due to collective systems of beliefs and values. Community involvement, interest, and collaboration are all important factors in assuring the success of any program.

The researchers are very much aware of the lifestyle of people living in rural communities and the significant influence of historical, political, religious, economic, social, cultural, demographic, and the global contexts engaging these factors. Understanding rural communities and the contextual implications need to be considered to assure the delivery of culturally competent services. Specific tactics and techniques must be considered to engage

rural communities in advocating for social and economic justice. The researchers assert this project begins the process of understanding rural communities, rural people, and the blending of innovative ideas in the development of quality services to those living with HIV/AIDS.

Social workers must begin to serve as the change agents in breaking down the barriers, stigmas, and oppressive attitudes inflicting PLHA. They can begin by making policy makers aware of the need for services, particularly in rural communities, and for dental services. They must begin to educate important systems that will reach large populations such as schools, churches, hospitals, and community agencies about the need to break down factors that prevent individuals from seeking treatment. More importantly they must begin a campaign to educate community about prevention and treatment.

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Authors' Note

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*Appendix**Factors Ratings for Service Providers and Consumers (Mean Score)*

#	Group/Statement	All	Providers	Consumers	Dental
Knowledge/Understanding of Health					
1.	Client's understanding of the impact of oral health care on their overall health.	3.70	3.04	4.12	4.39
2.	Client's understanding of how his/her health status impacts treatment.	4.03	3.46	4.40	4.46
3.	Client's understanding of basic health care needs.	4.19	3.48	4.58	4.75
4.	Client's understanding of how HIV/AIDS impacts their overall health.	4.27	3.81	4.6	4.71
5.	Client's understanding of basic dental and health care needs.	3.93	3.31	4.37	4.44
6.	Lack of interest in preventative dental care.	2.89	3.42	2.67	3.00
Service Accessibility					
7.	Convenience of hours of operation.	4.03	3.64	4.31	4.33
8.	Availability of transportation.	3.78	3.64	3.89	4.17
9.	Distance to services.	3.79	3.57	3.92	4.35
10.	Impact of travel to dental services upon clients.	3.42	3.38	3.44	4.04
11.	Convenience of services.	4.09	3.65	4.29	4.38
12.	Client's understanding of the agency's protocol for delivering oral health care services.	3.54	3.00	3.82	4.12
13.	Knowledge of available services.	3.92	3.54	4.21	4.16
Service Efficacy					
14.	Ability to maximize services when clients are in the office.	3.96	3.68	4.12	4.22
15.	Ability to make appropriate referrals.	4.00	3.96	4.06	4.18
Client Contact					
16.	Maintaining current client contact information.	4.12	3.68	4.39	4.33
17.	Difficulty maintaining contact with clients.	2.75	3.20	2.45	2.53
Client Ability/Responsibility					
18.	Client's willingness to accept responsibility for his/her oral health care.	3.85	3.08	4.31	4.64
19.	Client's ability to keep appointments.	4.03	3.30	4.51	4.68
20.	Compliance with medications.	4.09	3.75	4.29	4.42
21.	Compliance with treatment recommendations.	4.16	3.80	4.34	4.46

Factors Ratings for Service Providers and Consumers (Mean Score) (continued)

#	Group/Statement	All	Providers	Consumers	Dental
22.	Client no-shows for services.	2.85	3.19	2.58	2.68
23.	Client's willingness to actively participate in services.	3.99	3.65	4.20	4.36
24.	Client's ability to take responsibility for his/her health care needs.	4.14	3.50	4.52	4.63
25.	Client's willingness to seek and utilize dental services.	3.77	3.33	4.10	4.41
26.	Client's willingness to seek medical services.	4.21	3.80	4.50	4.48
27.	Client's ability to address basic hygiene (general and oral).	4.18	3.38	4.64	4.68
Dental Services					
28.	Availability of dental services.	3.65	3.54	3.71	4.00
29.	Ability to provide specialized dental health care.	3.40	3.33	3.46	3.80
30.	Limited number of appointment slots for dental services.	3.42	4.00	2.94	3.35
31.	Inability to schedule initial and follow-up dental appointments in advance.	3.03	3.61	2.69	2.92
32.	The number of appointments necessary to address major dental issues.	3.33	3.27	3.32	3.54
Service Quality					
33.	Friendliness of staff.	4.49	4.32	4.63	4.58
34.	Ability of staff to be sensitive and empathetic to client needs.	4.47	4.22	4.59	4.52
35.	Provider's knowledge of the current interventions.	4.33	4.28	4.41	4.28
36.	Staff's willingness to go above and beyond to help clients.	4.35	4.35	4.37	4.25
37.	Staff's acceptance of clients.	4.51	4.35	4.58	4.42
38.	Staff's treatment of clients with dignity and worth.	4.57	4.42	4.63	4.50
39.	Communication between providers and clients regarding scheduling.	4.27	4.04	4.46	4.28
40.	Willingness of health care providers to listen to client concerns about treatment.	4.34	4.08	4.53	4.42
41.	Communication among providers about coordinating services.	4.13	4.04	4.24	4.16
42.	Staff's personal fears of the clients.	2.17	2.04	2.34	2.42
43.	The service provider's patience.	4.07	3.48	4.43	4.29
44.	The quality of services provided.	4.22	4.00	4.42	4.29
45.	Honesty of service providers.	4.46	4.24	4.63	4.54

Factors Ratings for Service Providers and Consumers (Mean Score) (continued)

#	Group/Statement	All	Providers	Consumers	Dental
Staffing					
46.	Regionalized case management services.	4.26	4.22	4.35	4.17
47.	Client to staff ratio.	4.18	3.67	4.57	4.50
48.	Staff turnover.	2.98	2.88	3.03	3.45
Translation					
49.	Availability of translation services for those whose primary language is Spanish.	3.61	3.54	3.87	3.63
Client Support					
50.	Lack of client support services.	2.42	2.29	2.47	2.83
51.	Lack of community support for clients.	2.83	3.12	2.40	2.82
52.	Lack of social support for clients.	2.52	2.72	2.33	2.60
53.	Family support.	3.34	3.31	3.40	3.72
Medications					
54.	Ability of clients to obtain medications.	3.81	3.52	4.05	4.25
Community Attitudes/Beliefs					
55.	Lack of community understanding of HIV/AIDS and related risk factors.	3.21	3.72	2.71	3.05
56.	Lack of community acceptance of gays and lesbians.	3.19	3.52	2.76	3.50
57.	Perception of gays and lesbians as engaging in sexual activity with multiple partners.	3.47	3.63	3.29	3.54
58.	Perception of gays and lesbians as engaging in sexual activity that places them at risk of contracting HIV/AIDS.	3.80	3.92	3.76	4.08
59.	Belief that same sex relationships are wrong.	3.38	3.41	3.37	3.85
60.	Community perception of HIV/AIDS being a "gay disease".	3.18	3.36	3.03	3.37
61.	Community's fear of individuals with HIV/AIDS.	3.52	3.61	3.45	3.70
Client Concerns					
62.	Fear of being identified as a client of a provider that serves people with HIV/AIDS.	3.17	3.30	3.17	3.41
63.	Lack of self-esteem.	2.84	3.29	2.49	2.83
64.	Willingness to disclose HIV status.	3.07	3.39	2.81	2.79
65.	Social isolation.	2.97	3.30	2.78	3.05
66.	Substance abuse and/or addiction.	2.96	3.41	2.48	2.71
67.	Homelessness.	2.70	2.82	2.58	3.14

Factors Ratings for Service Providers and Consumers (Mean Score) (continued)

#	Group/Statement	All	Providers	Consumers	Dental
68.	Ability to pay for utilities (electricity, water, sewage, etc).	3.33	3.15	3.53	3.80
69.	Client's literacy level.	3.17	3.08	3.27	3.36
70.	Fear of dental care.	2.33	2.80	2.00	2.04
71.	Client's work schedule.	3.23	2.88	3.57	3.62
72.	Nutritional issues.	2.95	3.08	2.94	3.19
73.	Client's mental status.	3.25	3.40	3.12	3.30
74.	Client's current health condition.	3.64	3.68	3.52	3.55
75.	Client's criminal history.	2.62	2.76	2.57	2.85
76.	Client's age.	2.91	2.43	3.41	3.46
77.	Childcare.	2.64	2.29	3.07	3.63
Liability					
78.	Liability of transporting clients to dental services.	2.65	2.29	2.92	2.94
Funding					
79.	Funding.	3.26	3.04	3.36	3.68
80.	Availability of funds to pay for dental lab fees.	2.81	2.43	3.06	3.45
81.	Availability of funds to pay for partials and denture.	2.75	2.38	3.03	3.50
Insurance/Payment for Services					
82.	Client dumping (passive refusal to serve clients who are unable to pay for services).	1.77	2.21	1.53	1.62
83.	Inadequate dental insurance coverage.	2.73	3.57	2.03	2.26
84.	Inadequate health insurance coverage.	2.85	3.79	2.18	2.25
85.	Client's out-of-pocket expenses for health care services.	2.54	2.62	2.42	2.33
Community-Based Dental Services					
86.	Lack of local dental service providers.	3.06	3.46	2.72	2.72
87.	Lack of local emergency dental care services.	3.37	3.59	3.17	3.17
88.	Unwillingness of dental care providers to serve clients with HIV/AIDS.	2.80	3.44	2.33	2.48
89.	Availability of clinics that make crowns and dentures.	2.96	3.17	2.78	2.45
Community-Based Health Care Services					
90.	Unwillingness of primary health care providers to serve clients with HIV/AIDS.	2.68	3.42	2.20	2.22

Factors Ratings for Service Providers and Consumers (Mean Score) (continued)

#	Group/Statement	All	Providers	Consumers	Dental
91.	Lack of local physicians who specialize in treating HIV/AIDS.	2.96	3.68	2.45	2.58
92.	Reluctance of local hospitals to serve clients with HIV/AIDS.	2.63	3.00	2.40	2.29
93.	Reluctance of local emergency rooms to service clients with HIV/AIDS.	2.67	3.04	2.40	2.36
94.	Access to primary physicians.	3.15	3.50	2.95	2.88
95.	Availability of affordable health care.	3.42	3.50	3.37	3.52
96.	The wait for primary healthcare appointments.	2.93	3.31	2.73	2.96
Community-Based Vision Care Services					
97.	Affordability of vision care services.	3.10	3.58	2.79	2.77
Community-Based Mental Health Services					
98.	Unwillingness of mental health care providers to serve clients with HIV/AIDS.	2.64	3.00	2.29	2.43